

# **SEPARATED AT BIRTH**

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**ADOPTION PRACTICES IN RELATION TO  
SINGLE WOMEN CONFINED AT  
THE ROYAL WOMEN'S HOSPITAL  
1945-1975**

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## **ADOPTION PRACTICES IN RELATION TO SINGLE WOMEN CONFINED AT THE ROYAL WOMEN'S HOSPITAL 1945-1975**

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A thesis submitted in total fulfilment of  
the requirements of the degree of

### **Master of Philosophy**

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## **STATEMENT OF AUTHORSHIP AND SOURCES**

This thesis contains no material published elsewhere or extracted in whole or in part from a thesis by which I have qualified for or been awarded another degree or diploma.

No parts of this thesis have been submitted towards the award of any other degree or diploma in any other tertiary institution.

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All research procedures reported in the thesis received the approval of the relevant Ethics/Safety Committees (where required).

Signed.....

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# ABSTRACT

From November 2010, the Australian Government's Senate Inquiry into former forced adoption policies and practices investigated almost four hundred submissions that included claims that past adoption practices were unethical, illegal and used undue influence to coerce never married mothers to relinquish their children. During the period 1945-1975 the demand for adoptable babies for infertile couples in Australia was at its peak, with over 45,000 adoptions legalised in Victoria alone. At this time, often referred to as the 'heyday' of adoption, up to sixty-eight per cent of never married mothers were separated from their babies. Adoption was characterised as a mutually advantageous solution that guaranteed the moral and social redemption of mother and child, with adoptive parents cast as benevolent and sympathetic. Within this context, the relinquishing mothers were marginalised, stigmatised, and unable to acknowledge their grief and loss.

The assumption that such illegal and unethical practices would remain undocumented has underpinned the selection of oral history as the most appropriate investigative tool. However, although this research has been primarily informed by interviews with single mothers and former hospital staff, archival research has also provided rich documentary evidence with which to contextualise and corroborate this testimony. Hospital policy records, departmental reports, committee minutes, and correspondence, as well as a limited number of medical and case files, have confirmed punitive practices and the existences of policies that prescribed differential treatment for married and never married patients.

Current interest in former forced adoption practices—both scholarly and governmental—provides an important backdrop, not only for the timing of this thesis, but in emphasising the need to improve the empirical evidence base on which to develop an appropriate policy response. While some state governments have undertaken inquiries into these practices and others have made official apologies, such action remains to be seen in Victoria. Documenting delivery and adoption practices at Melbourne's Royal Women's Hospital (RWH), the largest maternity hospital in Victoria, this thesis hopes to inform moves towards an apology amid demands from mothers who have lost a child to adoption that past injustices be acknowledged.

In the period 1945-1975, the dilemma facing the single mother was exacerbated by community attitudes and social values that embraced adoption as the solution to illegitimacy and infertility, and failed to provide viable alternatives. This thesis challenges the notion that single women willingly relinquished their babies at this time and argues that mothers faced enormous pressure from the moral pronouncements of the community, professionals, and particularly from their families. Within this social and historical framework, the policies and practices of the RWH were complicit in enabling and enforcing morally driven social norms that venerated the nuclear family and demonised the single mother.

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## ABBREVIATIONS

AASW	Australian Association of Social Workers
ABC	Australian Broadcasting Commission
ACOSS	Australian Council of Social Services
AIFS	Australian Institute of Family Studies
AIHW	Australian Institute of Health and Welfare
ALAS	Adoption Loss Adult Support
ARC	Australian Research Council
ARMS	Association of Relinquishing Mothers
CDSMC	Community and Disability Services Ministers' Conference
CFWB	Catholic Family Welfare Bureau
CSMC	Council for the Single Mother and her Child
CSV	Community Services Victoria
CWD	Children's Welfare Department
DES	Diethylstilboestrol or Stilboestrol
MCM	Melbourne City Mission
RBWH	Royal Brisbane Women's Hospital
RWH	Royal Women's Hospital
SWD	Social Welfare Department
VCOSS	Victorian Council of Social Services

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# CHAPTER ONE

## INTRODUCTION & CONTEXT

*Our history is about the blatant abuse of unsupported young, single mothers when they were at their most frightened and vulnerable. These young mothers were sent to Coventry, removed from the normality of their lives into a Victorian time-warp of unbelievable injustice, punishment and degradation. These young mothers were isolated, bullied, shamed, humiliated, disgraced to family, friends and society and finally left so defeated and totally disempowered that they became easy prey for the final act of the abduction of their newborn babies, betrayed by the very persons who were supposed to have cared for them.<sup>1</sup>*

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<sup>1</sup> June Smith, who was nineteen years old when she gave birth at the Royal Women's Hospital in 1961, quoted in Senate Community Affairs References Committee, *Official Committee Hansard - Reference: Commonwealth contribution to former forced adoption policies* (hereafter *Hansard*), Melbourne Public Hearing, 20 April 2011, CA 33.

## CONTEMPORARY DEBATE

The Commonwealth Government's Senate Inquiry into former forced adoption policies and practices is investigating almost four hundred submissions, many of which claim that these policies and practices were unethical, illegal and used undue influence to coerce single mothers to place their babies for adoption.<sup>2</sup> Inquiries undertaken by the Tasmanian and New South Wales (NSW) Governments more than ten years ago have already documented such practices by hospital staff and social workers, with some form of apology being issued by several of the organisations involved.<sup>3</sup> In the submissions and subsequent public hearings of each of these inquiries mothers have repeatedly described how they were given no choice but to relinquish their babies. In some cases mothers have testified to the use of forcible restraint during labour, and later to prevent contact with the baby; excessive sedation; the unnecessary use of forceps or caesarean delivery; the use of pillows and sheets to shield the baby from view; and falsely being told their baby had died. Once again, the federal and state governments, private and public hospitals and their staff, maternity homes, clergy, and particularly social workers are being asked to accept blame for 'the standards and values of a society that placed female virginity before marriage as being of higher value than the bond between mother and baby'.<sup>4</sup>

Recent apologies to those affected by past closed adoption practices have gone some way to acknowledging the hurt and suffering involved, as well as recognising the 'ill treatment experienced by single women during pregnancy and confinement'.<sup>5</sup> The recent Western Australian (WA) apology was not only a government first, but was also fundamental in initiating the current Senate Inquiry. While the outcomes remain to be seen, disparate support

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<sup>2</sup> 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](http://www.aph.gov.au/senate/committee/clac_ctte/comm_contrib_former_forced_adoption/index.htm). (hereafter Senate Inquiry). Submissions received accurate as of 17 January 2012. The Senate Inquiry continues to accept new submissions and is expected to report on 29 February 2012.

<sup>3</sup> Joint Select Committee, *Adoption and Related Services 1950-1988* (Hobart: Parliament of Tasmania, 1999); Standing Committee on Social Issues, *Releasing the Past: Adoption Practices 1950-1998* (Sydney: NSW Law Commission, 2000), 186.

<sup>4</sup> Joint Select Committee, *Adoption and Related Services 1950-1988*, 3.

<sup>5</sup> Adoption Loss Adult Support (Queensland), "Apology on Behalf of the Royal Brisbane Women's Hospital," [www.alasqld.com/](http://www.alasqld.com/) (accessed 18 January 2010). Through the Senate Inquiry, apologies have also been issued by the Uniting Church of Australia (submission 376), the Benevolent Society (submission 343), and Catholic Health Australia (opening statement at Canberra public hearing 28 September 2011).

groups for relinquishing<sup>6</sup> mothers continue to call for a formal apology from the Commonwealth Government, with Origins Inc. (a non-profit international organisation focused on helping and supporting people separated from children, parents, or other family members by adoption) now campaigning for a Royal Commission, as well as seeking legal redress.<sup>7</sup> Other high profile inquiries and apologies, such as those in relation to the Stolen Generations and the Forgotten Australians and Child Migrants, have not only acted to strengthen these demands, but underpin the expectations of apology for the mothers who have lost children to adoption. In this age of apology, the question of accountability and responsibility is central.

Substantial research is currently being undertaken into the history of adoption in Australia. Under the auspices of the Community and Disability Services Ministers Conference (CDSMC), the Australian Institute of Family Studies (AIFS) has been charged with a national research study on the service response to past adoption experiences. Claiming to be the largest study of its kind ever conducted in this country, the evidence collected is expected to inform best-practice models and guidelines for the delivery of supports and services for affected individuals.<sup>8</sup> An Australian Research Council (ARC) funded project working from Monash University is covering a similar field, but is further seeking to explain 'the historical factors driving the changing place, meaning and significance of adoption' in Australia.<sup>9</sup> More detailed research is also being conducted into the role of specific hospitals and organisations, for example Judith Godden's commissioned history of Crown Street Women's Hospital in Sydney, and this thesis, which seeks to document adoption policy and practice regarding single women confined at the Royal Women's Hospital (RWH) in Melbourne in the period 1945-1975.

This thesis has grown out of the RWH's initiative to investigate their own past adoption practices, particularly having been motivated by the activism of relinquishing mothers. The

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<sup>6</sup> It is acknowledged that the term 'relinquishing' is contentious and has been challenged by some support groups, while being embraced by others. See page 22 of this thesis for a further discussion of language and terminology. Also note that this thesis will use the term sparingly, mainly for the sake of clarity.

<sup>7</sup> Support groups in favour of an apology include: Christine Cole & "The White Stolen Generation", the Association of Relinquishing Mothers (ARMS), VANISH, and Adoption Jigsaw; while Origins Inc. had originally only petitioned for a Senate Inquiry, their submission now calls for a Royal Commission, see Senate Inquiry submission 166; an affiliated closed Facebook group is calling for legal redress, see [www.facebook.com/groups/motherslegalredress/](http://www.facebook.com/groups/motherslegalredress/) (accessed 20 November 2011).

<sup>8</sup> AIFS, "National Research Study on the Service Response to Past Adoption Practices," Commonwealth of Australia, [www.aifs.gov.au/pastadoptionpractices/index.php](http://www.aifs.gov.au/pastadoptionpractices/index.php) (accessed 10 June 2011).

<sup>9</sup> Monash University, "History of Adoption Project," [www.arts.monash.edu.au/historyofadoption/](http://www.arts.monash.edu.au/historyofadoption/) (accessed 2 November 2011).

RWH has taken a leading role exploring the impact of such practices with much of the existing interest and inquiry into this topic being established at a later date—besides the Monash History of Adoption Project and the Royal Brisbane Women's Hospital (RBWH)'s apology. It was unknown at the time this research was undertaken that the government would move so quickly on the issue, with the establishment of a Senate Inquiry into the Commonwealth's contribution to former forced adoption policies and practices in November 2010. The increased concern with, and awareness of, allegations of former forced adoption practices—and the consequences suffered by both mothers and adoptees—places the RWH at the centre of a wider history of adoption in Australia that is presently being written: by the government, by academics, by the institutions and organisations involved, and most importantly by the individuals who have suffered the lasting emotional impact of past adoption practices.

As the largest public maternity hospital in Victoria, the RWH was responsible for the arrangement of over 5000 adoptions between 1940 and 1987, at which point its involvement in adoption ceased.<sup>10</sup> During this period, the hospital gradually increased its stake in the arrangement of adoptions, from ten per cent of the state-wide total in 1963 to nineteen per cent in 1971.<sup>11</sup> The hospital represents just one of twenty-two state approved agencies operating as part of an intricate network of services that managed the referral of single pregnant women to and from other hospitals, religious maternity homes and the Social Welfare Department (SWD).<sup>12</sup> State and international borders were no obstacle to the vital relationships that were fostered and developed between organisations prepared to offer care, accommodation, and adoption arrangements for these women. While it is acknowledged that these connections are significant, thorough research of these records is beyond the scope of this thesis.

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<sup>10</sup> Total from the RWH *Annual Report* (hereafter *Annual Report*) and Social Work Department statistical records (Melbourne: the RWH Archives 1935-1987), representing the entire period in which the RWH acted as an adoption agency and information service. See Appendix 2 for a yearly breakdown.

<sup>11</sup> The committee appointed by the Chief Secretary of Victoria Hon. A.G. Rylah M.L.A., *Survey of Child Care in Victoria, 1962-1964* (Melbourne: A.C. Brooks, Govt. Printer, 1964), 34; and *Annual Report* (1971) number of adoptions arranged in relation to total adoptions legalised in Australian Bureau of Census, *Victorian Year Book*, (Melbourne: By Authority: A.C. Brooks, Govt Printer, 1976).

<sup>12</sup> Social Work Department, "List of Approved Adoption Agencies in Victoria," (Melbourne: The RWH Archives, c.1972). *Annual Report* indicate that no less than fourteen Homes cooperated with the hospital, as well as many more societies, government departments and other hospitals. In later years, evidence indicates referral to the Social Welfare Department (SWD) and even other unspecified hospitals; see also Social Work Department, "Patient Cards", (Melbourne: The RWH Archives, 1935-1975).

The RWH was a charitable institution, which patients attended out of necessity rather than choice, particularly prior to the introduction of Medicare in 1984.<sup>13</sup> Statistics suggest that upwards of sixty per cent of single women used the public hospital system at this time: the RWH accounted for the confinement of forty per cent of ex-nuptial births in Victoria and the Queen Victoria Hospital, Melbourne's other major public institution, was responsible for an additional eighteen per cent (with the remainder scattered between private and public hospitals throughout the state).<sup>14</sup> This disproportionate distribution may reflect the refusal of some private hospitals to book single mothers.<sup>15</sup> As such, the RWH represents the largest single sample of the birthing experience of single mothers in Victoria. The treatment received at the RWH can therefore be read as representative of the public hospital experience.

Assumptions that as a public hospital the RWH embodied secular values which could be equated with progressive and liberal attitudes towards the single mother are unfounded. As an institution run by and serving a multi-denominational population (although decidedly Christian), the hospital was subject to and influenced by the full breadth of religious and moral codes. But, in contrast to its religious counterparts, the hospital's belief system was much less explicit, making it more difficult to understand, let alone navigate. The argument of this thesis is based on the premise that the management of the RWH was far more conservative than widely believed. It is the contention of this thesis that the hospital actively enforced moral and social values that regulated the behaviour of single mothers through policies and practices that prescribed differential treatment of married and never married patients.

In the period 1945-1975, often referred to as the 'heyday' of adoption, a total of 45,458 adoptions were legalised in Victoria.<sup>16</sup> With the demand for adoptable babies at its peak across Australia, adoption accounted for up to sixty-eight per cent of ex-nuptial births.<sup>17</sup> Seen as a mutually advantageous solution, it was argued that adoption guaranteed the moral and

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<sup>13</sup> The earliest available statistics reveal that just prior to the introduction of Medicare only fifty-five to sixty-eight per cent of the population was covered by some form of private health insurance, see Australian Bureau of Statistics, *Australian Social Trends*, (2001), 81.

<sup>14</sup> Nan Johns, "The Health of Babies Kept by Their Single Mothers: A Study of the First Years of Life of a Melbourne Sample" (1974), 36.

<sup>15</sup> Rosemary West, "How Single Mothers Overcame Discrimination," in *Actions Speak: Strategies and Lessons from Australian Social and Community Action*, ed. Eileen Baldry and Tony Vinson (1991), 168.

<sup>16</sup> *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. See Appendix 1 for a yearly breakdown.

<sup>17</sup> Percentage for peak year 1948; see figure 4 on page 97.

social redemption of mother and child, with adoptive parents cast as benevolent and sympathetic.<sup>18</sup> Within this context, the thesis questions the free and informed consent of mothers who placed their babies for adoption, in the light of the limited financially viable alternatives (and lack of knowledge about these), and the accusations of ‘brutal and dehumanising’ treatment at the hands of those whom they approached for help.<sup>19</sup> In finding and deciding ‘the best solution to [the unmarried mother’s] problem’,<sup>20</sup> clergy, counsellors, family members and the wider community cooperated to perpetuate the stigma attached to single motherhood by encouraging silence, secrecy and relinquishment. While acknowledging the punitive community attitudes encountered by single mothers in post-war Australia, this thesis will ultimately challenge the notion that women willingly gave up their babies at this time.

Figure 1 (over) provides a visual representation of the gradually increasing number of adoptions legalised in Victoria after WWII, with a dramatic (and ongoing) decrease after 1971. This line graph registers the total number of adoptions legalised in Victoria (red) and a modified number of adoptions with the subtraction of legitimations (blue). A legitimation is the act by which an ex-nuptial (or illegitimate) birth becomes legitimate through legal means as a result of the subsequent marriage of the parents and whereby a mother adopts her own child. The consequence of legitimations as a distinct form of adoption is significant within the parameters of this thesis in that it differentiates single mothers who maintained contact with their children through marriage and adoption (represented by the space between the blue and red lines), and those who were irrevocably separated from their children by adoption (blue). Figure 1 also provides a graphic representation of the number of adoptions that were arranged by the RWH (green) for consideration alongside state totals.

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<sup>18</sup> Shurlee Swain and Renate Howe, *Single Mothers and Their Children: Disposal, Punishment and Survival in Australia* (Melbourne: Cambridge University Press, 1995), 140.

<sup>19</sup> Christine Cole, ed. *Releasing the Past: Mothers' Stories of Their Stolen Babies* (Sydney: Sasko Veljanov, 2008), 5.

<sup>20</sup> Victorian Council of Social Service (VCOSS), "The Service of Adoption," pamphlet, (Melbourne: VCOSS, c.1960).

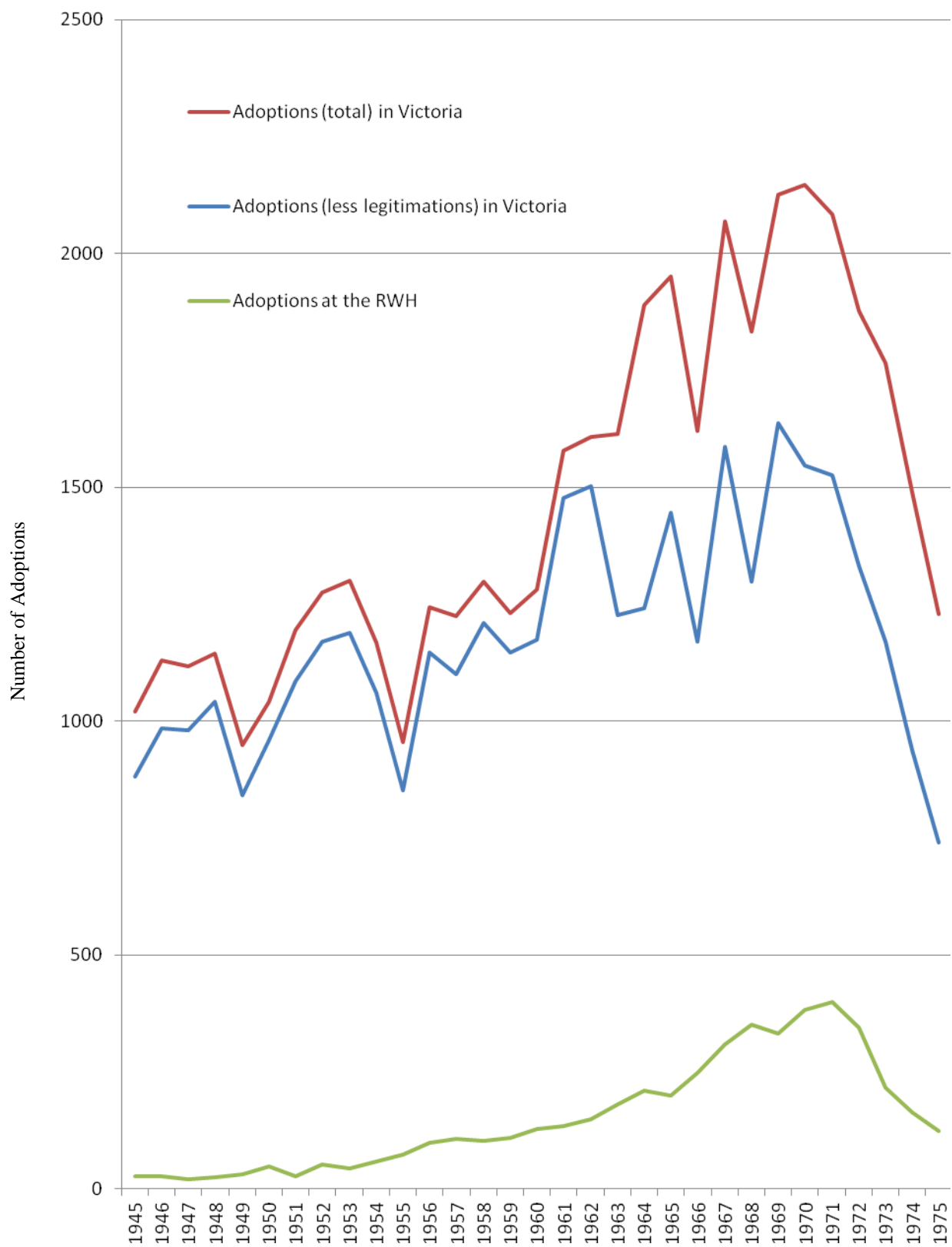


Figure 1: Adoptions in Victoria (1945-1975)<sup>21</sup>

<sup>21</sup> *Victorian Year Book* (1942-1994) and *Annual Report* (1945-1975).



## CONTEXTUAL SCHOLARSHIP

Although much has been written on the topic of adoption, until recently little attention has been paid to the experiences of the mother who lost her child. Autobiography and personal accounts convey the most vivid experiences,<sup>22</sup> but have been condemned for their lack of academic analysis;<sup>23</sup> historical studies consider the social factors that contributed to such practices and examine the experience of single mothers (and to some extent, those who relinquished);<sup>24</sup> and psychological studies have assessed not only factors relating to decision-making at the time, but also the psychological impact with regard to the ongoing adjustment of relinquishing mothers.<sup>25</sup> The accusations of mothers who have lost a child to adoption are not new, but they have been given a greater authority in the submissions to the current Senate Inquiry. With limited research focused specifically on their experiences, this thesis draws not only on the above-mentioned texts, but also makes use of social work, medical, and nursing literature of the time thereby providing insight into the conventional wisdom on which such practices were based.

The institutional history of the RWH is documented in Janet McCalman's book *Sex and Suffering*. From its early days when the majority of births took place in the home, through to present-day, the hospital has championed the medicalisation of childbirth and specialised in diseases particular to women. Looking at its practice and patients, McCalman provides 'a window into the private lives and reproductive health of poor women'.<sup>26</sup> She has exposed an authoritarian public hospital: one in which the comfort of all women was disregarded. Although punitive practices specific to the treatment of single mothers have been identified, all women who attended the RWH were subject to the hospital's rough efficiency where 'the

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<sup>22</sup> See for example: Joss Shawyer, *Death by Adoption* (Auckland, N.Z.: Cicada, 1979); K. Inglis, *Living Mistakes: Mothers Who Consented to Adoption* (Sydney: Allen & Unwin, 1984). C. Valentine, Slaytor, P., "Down the Track: Outcomes of Adoption Reunions: Personal Stories," (Paddington, NSW: NSW Committee on Adoption, Social Work Dept, 1990); Libby Harkness, *Looking for Lisa* (Milsons Point, N.S.W.: Random House, 1991); R. Dessaix, *A Mother's Disgrace* (Sydney: Angus & Robertson, 1994). Evelyn Burns Robinson, *Adoption and Loss: The Hidden Grief*. (Christies Beach, SA: Clova Publications, 2000).

<sup>23</sup> Dr Daryl Higgins, "Impact of Past Adoption Practices," (Melbourne: AIFS, March 2010, amended 30 April 2010).

<sup>24</sup> See Swain and Howe, *Single Mothers and Their Children: Disposal, Punishment and Survival in Australia*.

<sup>25</sup> See Robin Winkler and Margaret van Keppel, *Relinquishing Mothers in Adoption: Their Long-Term Adjustment*. (Melbourne: Institute of Family Studies, May 1984).

<sup>26</sup> Janet McCalman, *Sex and Suffering: Women's Health and a Women's Hospital* (Baltimore: John Hopkins Paperbacks edition, 1999), vii.

good order of the ward became more important than the comfort of the patients' who were subject to being 'slapped, forbidden to sit up in bed, bullied and abused'.<sup>27</sup>

Despite claims that the experiences of single mothers separated from their children by adoption remain largely unknown, a consistent voice, and indeed story, is scattered throughout the existing literature: one in which the themes of silence, invisibility, guilt and shame are central.<sup>28</sup> Kate Inglis has presented the single pregnant woman as 'the object of moral lessons for the "good" girls from whom she was irrevocably separated'.<sup>29</sup> As a result of her 'moral bad luck', she was subsequently removed from her family and friends and sent to a maternity home or a distant relative in order effectively to conceal her condition.<sup>30</sup> It was an issue of preserving her family's moral standing within the community: there was no doubt as to the embarrassment her condition would cause. Ultimately her salvation was to be offered through the sacrifice of adoption. Shurlee Swain and Renate Howe have argued that relinquishment was seen not only as 'a necessary pain', but more importantly within this construct of censure and blame, it was 'the only way in which she could regain her respectability'.<sup>31</sup> It required the single mother to be complicit in her own punishment, as her absolute silence—about her pregnancy and relinquishment—was essential for her redemption, and indeed for her to 'get on with her life'.

As a group, single mothers have always been, and continue to be, subject to an unchanging stereotype: poor, young and vulnerable. Swain and Howe have argued that such assumptions fit within a discourse of innocence and seduction in the nineteenth century, which was replaced by one of romantic love in the twentieth: 'the victim of seduction became in turn the product of poor heredity, poor social conditions or neurotic tendencies'.<sup>32</sup> The stereotype is resolute. Rosemary Kiely has claimed that despite ever-evolving social theories, or explanations for their behaviour, the belief that 'single mothers are generally disturbed adolescents in the grip of fantasies which make them unfit mothers has never quite lost its appeal'.<sup>33</sup> The common thread in the way the single mother has been typecast over time is the underlying assumption that she should want to be rid of her own child.

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<sup>27</sup> Ibid., 122.

<sup>28</sup> Also identified in Higgins, "Impact of Past Adoption Practices."

<sup>29</sup> K. Inglis, *Living Mistakes: Mothers Who Consented to Adoption*, 9.

<sup>30</sup> David Howe, Phillida Sawbridge, and Diana Hinings, *Half a Million Women: Mothers Who Lose Their Children by Adoption* (London: Penguin Books, 1992), 25-28.

<sup>31</sup> Swain and Howe, *Single Mothers and Their Children: Disposal, Punishment and Survival in Australia*, 140.

<sup>32</sup> Swain and Howe, *Single Mothers and Their Children: Disposal, Punishment and Survival in Australia*, 15.

<sup>33</sup> R. Kiely, "Single Mothers and Supermyths," *Australian Journal of Social Issues* 17, no. 2 (May 1982): 156.

By the 1960s, the 'problem' of the single mother came to require specialised attention, raising particular concerns over the way in which stereotypes have affected her clinical and medical 'management'. Australian social workers were largely influenced by British and American texts and movements, following the establishment of professional training bodies by the end of the 1920s.<sup>34</sup> The rise of social work as a profession, especially during the 1950s and 1960s, saw the single mother move from the position of 'victim in need of redemption', to one of 'problem in need of treatment'. Regina Kunzel has argued that 'in removing unmarried mothers from the evangelical narrative and placing them within the scientific scripts of feeble-mindedness and sex delinquent, social workers had gone a considerable distance towards achieving recognition as experts in the field of illegitimacy'.<sup>35</sup> The work of American authority Leontine Young largely underpinned Australian practice.<sup>36</sup> This casework professor asserted that unplanned pregnancies were wilfully premeditated, maintaining that 'anyone who has observed a considerable number of unmarried mothers can testify to the fact that there is nothing haphazard or accidental in the causation that brought about this specific situation with these specific girls'.<sup>37</sup>

Doctors of the time were also quick to offer 'expert' opinions on the question of adoption. Indicative of prevailing attitudes within the medical profession, Dr Lawson of the RWH proffered the following advice in 1960:

The prospect of the unmarried girl or of her family adequately caring for a child and giving it a normal environment and upbringing is so small that I believe for practical purposes it can be ignored. I believe that in all such cases the obstetrician should urge that the child be adopted. In recommending that a particular child is fit for adoption, we tend to err of the side of overcautiousness. 'When in doubt, don't' is part of the wisdom of living; but over adoptions I would suggest that 'when in doubt, do' should be the rule.<sup>38</sup>

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<sup>34</sup> Robert John Lawrence, *Professional Social Work in Australia* (Canberra: Australian National University, 1965), ix-x & 3.

<sup>35</sup> Regina G Kunzel, *Fallen Women, Problem Girls: Unmarried Mothers & the Professionalization of Social Work, 1890-1945* (New Haven: Yale University Press, 1993), 63.

<sup>36</sup> Leontine Young, *Out of Wedlock; a Study of the Problems of the Unmarried Mother and Her Child* (New York: McGraw-Hill, 1954; reprint, paperback).

<sup>37</sup> L Young, "Personality Patterns in Unwed Mothers," in *The Unwed Mother* ed. Robert W. Roberts (New York: Harper & Row, 1966), 81.

<sup>38</sup> D.F. Lawson, "The R.H. Fetherston Memorial Lecture: The Anxieties of Pregnancy," *The Medical Journal of Australia* 30 July (1960).

The detrimental results of such conventional wisdom have now been documented. Psychological research has identified the long-lasting impact of relinquishment and past adoption practices, as well as the lack of choices available at the time. But more importantly, in response to these findings, researchers have identified the need for ongoing counselling and support services to be provided.<sup>39</sup> Robin Winkler and Margaret Van Keppel's 1984 study remains the most comprehensive analysis of factors affecting the psychological health of relinquishing mothers compared with those who kept their children. Findings indicate that for many of these women, the 'sense of loss has in fact intensified with time and is particularly marked at certain of the child's milestones'.<sup>40</sup> Presently, mothers who have lost a child to adoption continue to suffer the lasting emotional impact of these past practices.

## HISTORICAL FRAMEWORK

While formal adoptions were first recorded in Victoria in 1929, it was not until the post-war period that the idea of adoption achieved greater acceptance within the community: pamphlets were published to encourage prospective parents and ease concerns over the genetic inheritance of 'undesirable traits' in adopted babies.<sup>41</sup> The belief that 'a good environment will make a better job of bad genes than a bad environment will make of good genes'<sup>42</sup> was now scientifically supported. The adoption market was open to consumers with women's magazines and the press publicising its benefits.<sup>43</sup> Throughout the 1950s and into the early 1960s the image of a picture-perfect suburban family continued to be promoted, but by the mid-1970s, in the course of radical social change, legislation was introduced that heralded a

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<sup>39</sup> See for example: Robin Winkler and Margaret van Keppel, *Relinquishing Mothers in Adoption: Their Long-Term Adjustment* (Melbourne: Institute of Family Studies, May 1984); J.T. Condon, "Psychological Disability in Women Who Relinquish a Baby for Adoption," *Medical Journal of Australia* 144(1986); Shurlee Swain and Philip Swain, eds., *To Search for Self: The Experience of Access to Adoption Information* (Sydney: Federation Press, 1992); Katarina Wegar, *Adoption, Identity, and Kinship : The Debate over Sealed Birth Records* (New Haven, Conn.: Yale University Press, 1996); Rafael A. Javier et al., eds., *Handbook of Adoption: Implications for Researchers, Practitioners, and Families* (Thousand Oaks, California: Sage Publications, 2007).

<sup>40</sup> Winkler and van Keppel, *Relinquishing Mothers in Adoption: Their Long-Term Adjustment*, 27.

<sup>41</sup> F.O. Barnett, *Is It Safe to Adopt a Baby?* (Melbourne: Department of Human Services, 1948).

<sup>42</sup> McCalman, *Sex and Suffering: Women's Health and a Women's Hospital*, 273.

<sup>43</sup> See Swain and Howe, *Single Mothers and Their Children: Disposal, Punishment and Survival in Australia*, 138-142 and Shurlee Swain, "Dear Problem Page, I'm Single, Pregnant And..." *Lilith* (November 1991).

greater recognition of single mothers and their right to parent, marking an end to the 'baby scoop era'.<sup>44</sup>

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"'.<sup>45</sup> In 1944, Dr Norman Haire expressed these concerns on an ABC radio programme. He proposed a 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.<sup>46</sup>

But the attainment of this goal was hindered by an increased rate of infertility amongst returning servicemen ready to begin their families.<sup>47</sup> 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 these joint social problems.<sup>48</sup> This outcome also had the benefit of relieving the government of accepting any financial responsibility for the ongoing support

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<sup>44</sup> Often used in the American context. See 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).

<sup>45</sup> W. D. Borrie, *Population Trends and Policies: A Study in Australian and World Demography* (Sydney: Australasian Pub. Co., 1948), xiii.

<sup>46</sup> 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.

<sup>47</sup> See "Melbourne Sterility Clinic," *Townsville Daily Bulletin*, 9 January 1945, 3.

<sup>48</sup> Audrey Marshall and Margaret McDonald, *The Many-Sided Triangle* (Melbourne University Press, 2001), 1-17; Swain and Howe, *Single Mothers and Their Children*, 1-11; T. R. Frame, *Binding Ties: An Experience of Adoption and Reunion in Australia* (Sydney: Hale and Iremonger, 1999), 7-8.

of the single mother and her child.<sup>49</sup> 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.<sup>50</sup> The rising demand for adoptable babies after WWII is but one factor that resulted in increasing pressure for single mothers to choose adoption and provide a ready supply of newborn infants.

Operating within the strict social values of post-war Australia, the issue of alternative choices for the single mother is problematic: many women who lost a child to adoption believe that none existed and that adoption was the predetermined path for the single pregnant woman. Indeed, a woman's freedom to choose was, and continues to be, limited by 'social, religious and personal considerations'.<sup>51</sup> Likewise, choice was mediated primarily by family values and reactions, as well as economic considerations. At the 1988 International Conference on Adoption and Permanent Care, relinquishing mother Deborah Lee discussed the reality of the social milieu and the limited opportunities available to a single woman raising a child.

In Australia until the early 1970s the nuclear family was held sacrosanct and rules were rigid. Women were expected to be housewives and raise children, whilst their husbands were the financial providers ... If a woman was without a breadwinner she was almost by definition poor economically, socially and sexually. Mothers who were not married were stigmatised and considered disgraced by a prejudiced community. They were the most undeserving of the undeserving poor. Child-care facilities, career and educational opportunities, equal pay and public housing were not considered necessary.<sup>52</sup>

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.

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<sup>49</sup> Either by financially supporting the mother to keep the child or through a financial commitment for the care of greater numbers of institutionalised children.

<sup>50</sup> 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.

<sup>51</sup> Rosemary Anne Kiely, "Single Mothers in Society: A Study of the Causes and Consequences of Single Motherhood for a Melbourne Sample of Single Mothers Who Kept Their Children" (Melbourne University, 1979), 146.

<sup>52</sup> Deborah Lee, "The Growth and Role of Self-Help Groups," in *To Search for Self: The Experience of Access to Adoption Information*, eds. Shurlee Swain and Philip Swain (Sydney: Federation Press, 1992), 19.

However, statistics indicate that, among other scenarios such as de facto relationships, women were returning to families who were not entirely hostile: hence adoption only accounted for thirty-one to forty-five per cent of all ex-nuptial births throughout the mid- to late 1960s.<sup>53</sup> The attitudes and assistance of her family were central to the single mother's ability to keep her child. Without this support, doctors, lawyers and social workers held firm in their beliefs that the raising of children was best achieved by two parents: namely a married couple. A courtroom exchange from the late 1960s neatly summarises the decisions which the single pregnant woman had to make:

**Villeneuve-Smith:** Dr Guerin, as a matter of fact, if you take a single pregnant girl, she has got three choices open to her, has she not? Let me enumerate them and see if you can add any more. She can marry the boy; she can have the child adopted out; or she can terminate the pregnancy?

**Guerin:** Or she may perhaps have the child if there is interest in the family.

**Villeneuve-Smith:** She has got to have a sympathetic mum and dad ...?

**Guerin:** Yes.

**Villeneuve-Smith:** Who will take it in ...?

**Guerin:** Right.<sup>54</sup>

A 'shot-gun', or even a forced marriage was often considered as the first possible solution to an unplanned pregnancy. Annual reports from the RWH indicate that marriage arrangements were one of the services offered through the Almoner Department in its early years, with 'assistance and advice provided without cost'.<sup>55</sup> K.G. Basavarajappa has shown that the incidence of already-pregnant brides increased between 1940 and 1962-63 when it levelled off and began showing signs of decline.<sup>56</sup> Still, in 1971, seventy-four per cent of marriages of women under the age of nineteen involved a pregnant bride.<sup>57</sup> Despite such numbers, it remains difficult to ascertain 'to what extent pre-marital conceptions have been a cause of marriage rather than a result of intercourse in anticipation of marriages that were already

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<sup>53</sup> Adoptions (less legitimations) as percentage of ex-nuptial births for the years 1965-1970 from *Victorian Year Book* (1965-70).

<sup>54</sup> Transcript of *R v Heath*, Cairns Villeneuve-Smith examining Dr Michael Guerin GP, in Gideon Haigh, *The Racket: How Abortion Became Legal in Australia* (Carlton, Vic.: Melbourne University Press, 2008), 139.

<sup>55</sup> *Annual Report* (1938).

<sup>56</sup> Basavarajappa, "Pre-Marital Pregnancies and Ex-Nuptial Births in Australia, 1911-1966," 141.

<sup>57</sup> Sandra Fitts, "The Single Mother and Her Child," Council for the Single Mother and Her Child (CSMC) pamphlet (Melbourne, c.1972).

planned'.<sup>58</sup> While being forced to marry was one solution, some young women may not have been legally allowed to exercise this option as a result of age and consent requirements.<sup>59</sup>

The introduction of the contraceptive pill to Australia in 1961 heralded a new era of more reliable, female-controlled contraception. By the late 1960s some commentators assumed that contraceptive knowledge had become commonplace and could now allow the 'widespread indulgence in sex without resulting in pregnancy'.<sup>60</sup> But such assertions were invalidated by counter claims that these methods were only available to married women: 'oral contraceptives require a doctor's prescription and need to be taken regularly, and intra-uterine devices need expert medical fitting. Thus neither of these prophylactics is likely to be relevant to youthful, unstable relationships.'<sup>61</sup> Although, single women occasionally did obtain prescriptions from doctors with more liberal attitudes toward the use of birth control, this remained conditional on proving an ongoing relationship and imminent marriage.<sup>62</sup> The continued incidence of unplanned pregnancies and the increase in babies available for adoption after 1968 suggests that the knowledge and use of contraception was far from common.

The first legal precedent with regard to abortion law in Australia was established on 26 May 1969 by Justice Clifford Menhennitt; prior to his landmark ruling, abortion had been illegal in Victoria.<sup>63</sup> Despite this, a number of qualified and 'backyard' abortionists practised throughout Melbourne with a varying degree of success.<sup>64</sup> In 1956, the RWH Almoner Department undertook a three month study into the incidence of abortion as a reason for admission for its patients. Records from the previous three years indicated that one woman was admitted for abortion for every seven live births. While abortion is also the medical term used to refer to spontaneous miscarriage, hospital authorities felt that the rate of admission was alarmingly high and it was subsequently recognised that 'a great proportion of these

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<sup>58</sup> Spencer, "Pre-Marital Pregnancies and Ex-Nuptial Births in Australia, 1911-1966 — a Comment," 121.

<sup>59</sup> Commonwealth of Australia, "Marriage Act 1961," *Act no.12 of 1961*.

<sup>60</sup> K.G. Basavarajappa, "Pre-Marital Pregnancies and Ex-Nuptial Births in Australia, 1911-1966," *The Australian and New Zealand Journal of Sociology* 4(1968): 126.

<sup>61</sup> Geraldine Spencer, "Pre-Marital Pregnancies and Ex-Nuptial Births in Australia, 1911-1966 - a Comment," *The Australian and New Zealand Journal of Sociology* 5(1969): 124.

<sup>62</sup> H. Cook, *The Long Sexual Revolution: English Women, Sex, and Contraception 1800-1975* (Oxford: Oxford University Press, 2004), 272. See also Spencer, "Pre-Marital Pregnancies and Ex-Nuptial Births in Australia, 1911-1966 - a Comment," 124; and H. M. Carey, *The Pill: Principles and Practice*, (University of New South Wales, School of Obstetrics and Gynaecology, 1965): 5.

<sup>63</sup> Menhennitt, "R V Davidson," VR667, Supreme Court (1969).

<sup>64</sup> Haigh, *The Racket: How Abortion Became Legal in Australia*.



abortions was artificially induced'.<sup>65</sup> Of the four hundred and four patients interviewed for this project almost half openly admitted to 'interference'. Gruber concluded (citing the London Minority Report on abortion) that "every normal woman seems to assume this right (to achieve motherhood and to renounce motherhood) emotionally, whether it is legal or not"; and that "women, law-abiding by temperament and up-bringing, faced with the dreadful dilemma of an unwanted pregnancy or breaking the law, do not hesitate to break the law and in doing so, do not feel they are acting immorally".<sup>66</sup>

As a result of the covert ways in which it was performed, abortion had the potential to be dangerous, even in the most capable hands. Consequently, many victims of botched attempts were admitted to the RWH. Limits on how late in the pregnancy practitioners would terminate and the amount charged varied considerably in this unregulated line of work. Rosemary Kiely concluded, 'abortion seems to have been a particularly middle-class solution'.<sup>67</sup> Legality and cost aside, strict religious upbringing and personal beliefs dictated that abortion was not an option for many women. After the Menhennitt ruling, the increased 'legal' availability was reflected in the establishment of the RWH Family Planning Clinic in 1971, where abortions were practised within its constraints.

The 1928 Adoption of Children Act established the first legal recognition of adoption in Victoria. The legislation was firmly centred on the adopters' right to bestow inheritance and succession on their adopted child. The Act also established prohibitions in relation to degrees of consanguinity and incest in the adoption relationship that applied to an adopted child 'both as respects its relations by adoption and as respects its relations by blood'.<sup>68</sup> Amendments in the 1936 Act further entrenched a sense of ownership by introducing penalties for stealing or harbouring an adopted child, as well as increasing secrecy provisions through restrictions on the inspection of entries in the birth registry which had been marked 'Adopted'.<sup>69</sup> Greater inter-state recognition of adoption orders was secured by the 1942 Act.<sup>70</sup> But it was the 1958

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<sup>65</sup> E Gruber, "Social Study of Patients Admitted for Abortions: Royal Women's Hospital 1 March - 31 May 1956," (Melbourne: The RWH Archives, 22 August 1956).

<sup>66</sup> Ibid., 31 which quotes the findings of the Minority Report by Mrs. D. Thurtle: *Report of the Interdeptl. Committee on Abortion*, (London, 1939).

<sup>67</sup> Kiely, "Single Mothers in Society: A Study of the Causes and Consequences of Single Motherhood for a Melbourne Sample of Single Mothers Who Kept Their Children", (Melbourne University: 1979),183.

<sup>68</sup> *Adoption of Children Act 1928*, Victoria, Act no.3605 (1928), s.7.

<sup>69</sup> *Adoption of Children Act 1936*, Act no 4381 (1936).

<sup>70</sup> *Adoption of Children Act 1942*, Act no 4903 (1942).

Act that first considered the issue of a mother's right to revoke her consent, granting her thirty days, plus an additional seven in which to deliver a notice of revocation to the registrar.

Amid efforts to implement a national framework for adoption, the 1964 Adoption of Children Act, which came into operation on 1 January 1966, dramatically tightened and rewrote the existing legislation.<sup>71</sup> With the aim that 'the welfare and interests of the child concerned shall be regarded as the paramount consideration',<sup>72</sup> this Act had been informed in part by the ACT Adoption of Children Ordinance 1965, as well as other collaborative efforts on the part of social workers working in adoption.<sup>73</sup> The Act attempted to abolish a growing illegal trade by limiting the arrangement of adoptions to registered agencies (s.17), while also granting guardianship to the Principal Officer of any such agency upon the signing of consent (s.31). The period of revocation, or time in which the relinquishing mother could change her mind was reduced by seven days (s.26), as she now had only thirty days in which to sign and deliver the documents. At this time, adoption irrevocably severed the relationship between mother and child: a new birth certificate was issued and from that time forward it would be 'as if the child had been born to the adopter or adopters in lawful wedlock'.<sup>74</sup>

Adoption was designed to free the child from the stigma of illegitimacy which supposedly had functioned to deter women from engaging in extra-marital intercourse. The rising rate of illegitimacy seen throughout the 1960s was commonly attributed to 'declines in religious or economic sanctions against unwed mothers'.<sup>75</sup> This is consistent with Roger C. Thompson's contention that this decade marked 'the beginning of the collapse of Christian morality in an increasingly secular Australian society'.<sup>76</sup> The shame of illegitimacy was preserved in the practice of religious-based maternity homes segregating single mothers, as well as the lack of widely available government benefits. At a time when the social norm was represented by an idealised family, fears abounded that the increasing incidence of illegitimacy would dissolve the moral foundations of society. In 1966, Shirley M. Hartley reasoned:

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<sup>71</sup> *Adoption of Children Act 1958*, Act no 6192 (1958) and the *Adoption of Children (Property) Act 1962* were both repealed by the *Adoption of Children Act 1964*, Act no 7147 (1964).

<sup>72</sup> *Adoption of Children Act 1964*, s.8.

<sup>73</sup> Senate Inquiry, submission 224.

<sup>74</sup> *Adoption of Children Act 1964*, s.32. Although this section appears to also apply to a single adopter, provisions in s. 10 curtailed single adoption, unless under 'exceptional circumstances'.

<sup>75</sup> Phillips Cutright, "Illegitimacy: Myths, Causes and Cures: A Family Planning Perspectives Special Feature," *Family Planning Perspectives* 3, no. 1 (1971): 28.

<sup>76</sup> Roger C. Thompson, *Religion in Australia*, (Melbourne: Oxford University Press, 1994), 140.

If the family is the prime instrumental agency through which institutional needs are met, and if a high individual or family commitment to a given norm such as legitimacy is dependent on social integration—the commitment of the community to the cultural norm and the strength of its social controls—it hardly seems possible to eliminate the stigma attached to illegitimacy without at the same time weakening the family as a social institution.<sup>77</sup>

‘Positive’ suggestions to help abolish the incidence, but not the stigma, of illegitimacy in the past had centred on punitive measures including fines to prevent extra-marital intercourse or, at the very least, its potential result.<sup>78</sup> While the father remained anonymous and unscathed by the scandalous behaviour that led to conception, mother and child were subject not only to dishonour, but legal disabilities. By the 1970s, however, community attitudes to extra-marital intercourse began to relax. As a result, single mothers became more visible, suggesting that they and their families had become less concerned with the disgrace previously associated with illegitimacy. By March 1975, the legal disabilities of ex-nuptial children were ‘ostensibly’ removed by the Victorian Status of Children Act 1974.<sup>79</sup> However, proponents of the change believed that attitudes would be more difficult to change than the law, claiming that ‘even after the passing of the Act, the ex-nuptial child may still be disadvantaged in ways which no Act of Parliament can entirely abolish’.<sup>80</sup>

Amid a growing public acceptance of single mothers the self-help group Council for the Single Mother and her Child (CSMC) was established in 1969. Founding member Rosemary Kiely has argued that the more permissive attitudes to be found in the community at this time corresponded with ‘the liberalization of sex mores and the growing independence of women in modern industrialized societies’.<sup>81</sup> The establishment of CSMC would have been impossible while the stigma attached to illegitimacy and single motherhood remained strong. But once in existence, the organisation created a strong voice to pressure for change, in

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<sup>77</sup> Shirley M. Hartley, "The Amazing Rise of Illegitimacy in Great Britain," *Social Forces* 44, no. 4 (1966): 545.

<sup>78</sup> From Kingsley Davis, "Illegitimacy and the Social Structure," *American Journal of Sociology*, no. 45 (September 1939): 215-233 quoted in Hartley, "The Amazing Rise of Illegitimacy in Great Britain," 544.

<sup>79</sup> S. Charlesworth, "The Impact of the Victorian Status of Children Act 1974 on the Legal and Social Rights of Children Born to Unmarried Parents," *University of Tasmania Law Review* 8, no. 2 (1985): 206-207.

<sup>80</sup> Marcia Neave, "The Position of Ex-Nuptial Children in Victoria," *Melbourne University Law Review* 10 (1976): 348.

<sup>81</sup> R. Kiely, "Single Mothers and Supermyths," *Australian Journal of Social Issues* 17, no. 2 (May 1982): 155. See also Swain and Howe, *Single Mothers and Their Children: Disposal, Punishment and Survival in Australia*, which argues that by the late 1960s and 1970s, ‘radical changes in attitudes to sexuality, the family and the status of women enabled single mothers to move from a position of negotiation within the system to one of greater social and economic independence’, 196.

particular for statutory changes like the abolition of the status of illegitimacy and the introduction of government benefits.<sup>82</sup> CSMC was both evidence for and a cause of the changes that occurred simultaneously with the trend towards more single mothers keeping their babies.<sup>83</sup> This trend was evident at the RWH where social worker Kath Lancaster estimated that that by 1975 approximately eighty per cent of single mothers went home with their newborns.<sup>84</sup>

Financial matters present a final consideration in the deliberation of choice. Social welfare researchers agree that Australia has lagged behind the world in welcoming 'the concept of universal social provision based on the social rights of citizenship'.<sup>85</sup> Prior to the expansion of social services in the mid- to late twentieth century, support and services were largely based on charitable relief. Kewley has argued that these principles were conditioned by 'the belief that direct social provision by the State, and especially cash benefits, undermined self-reliance and initiative on the part of the individual and encouraged "pauperism"'.<sup>86</sup> While the one-off payment provided by the Maternity Allowance (1912) was available to eligible mothers irrespective of marital status, subsequent Commonwealth legislation for unsupported mothers (widowed, deserted and divorced) deliberately excluded the unmarried mother. These measures included the 1941 Child Endowment (for which the first born child was ineligible) and the 1942 Widow's Pension.<sup>87</sup> Although, the Unemployment and Sickness Benefits Act 1944 provided benefits by statute (and available to all), payments under these time-limited provisions were a paltry 15/- a week for an unmarried minor.<sup>88</sup>

While unmarried mothers had been included (in principle) in the State Grants (deserted wives) Act of 1968, acceptance for these stop-gap benefits was not guaranteed as the Minister

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<sup>82</sup> Swain and Howe, *Single Mothers and Their Children: Disposal, Punishment and Survival in Australia*, 200-206.

<sup>83</sup> See Neave, "The Position of Ex-Nuptial Children in Victoria." for a discussion of how the Victorian Status of Children Act and the Supporting Mothers' Benefit reflected changing community attitudes towards illegitimacy and coincided with a trend towards more single women keeping their babies.

<sup>84</sup> *Annual Report* (1975), 24.

<sup>85</sup> From P. Saunders, "Social policy in Australia: An introduction and overview of recent developments," *Working Paper No. 303*, (Sydney: Social Welfare and Research Centre, University of New South Wales, 1989) quoted in Jennifer E. De Voe and Stephanie D. Short, "A Shift in the Historical Trajectory of Medical Dominance: The Case of Medibank and the Australian Doctors' Lobby," *Social Sciences and Medicine* 57, no. 2 (July 2003): 343.

<sup>86</sup> T.H. Kewley, *Social Security in Australia, 1900-1972* (Sydney, 1973), 4.

<sup>87</sup> Child endowment was extended to the first child in 1950.

<sup>88</sup> See also Kiely, "Single Mothers and Supermyths." Kiely argues that there were no social welfare payments for a single mother who kept her child in Victoria until 1969 (State Grants deserted wives Act), unless she was sick, unemployed (and looking for work) or breastfeeding.

maintained discretionary power.<sup>89</sup> Neither was the provision on equal terms with other unsupported mothers: compared to widows and deserted wives, unmarried women 'receive less money, have an absurdly harsh means test, and in general any income by way of maintenance and earnings is deducted directly from her allowance'.<sup>90</sup> In a 1972 submission to the Australian Council of Social Services (ACOSS), Rosemary Kiely argued that 'a single mother who is without family support and who is unable to live cheaply in a housekeeping position is unable to afford independent accommodation at the present rate of benefits'.<sup>91</sup> These restricted financial provisions made self-sufficiency a near impossibility. The introduction of the Commonwealth Supporting Mothers' Benefit in 1973 marked a new era of egalitarian provision of social security, providing, for the first time, a widely available alternative to relinquishment for unsupported single mothers.

The availability of contraception, the legality of abortion, and the age requirements of marriage conspired to limit the choices available to the sexually active single woman. Combined with the continued stigma of illegitimacy and invisibility of single mothers in the community into the mid-1970s, particularly as a result of inadequate financial support, choices were further restricted. With all other options exhausted and amid enormous social pressures, adoption often remained the only viable solution.

## THESIS OUTLINE

The thesis is divided into five chapters. This chapter has provided an historical and contextual framework for the thesis, while the following chapter sets out to explain the methodological approaches used, addressing the practicalities of the research design and implementation, as well as providing a focussed discussion of language and terminology. Finally it considers the underlying theoretical framework, particularly with regard to oral history, by reviewing the methods used for gathering and analysing data, issues surrounding the use of memory as an historical source, and the debates about the ways in which historians can use and read archival evidence as a source that potentially gives voice to individuals.

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<sup>89</sup> For example see Swain and Howe, *Single Mothers and Their Children: Disposal, Punishment and Survival in Australia*, 196.

<sup>90</sup> Fitts, "The Single Mother and Her Child."

<sup>91</sup> R. Kiely, "Disadvantages of the Present Scheme for Assisting Single Mothers," in *CSMC (Vic.)* pamphlet, (Melbourne, c.1972). Kiely's emphasis.

In the final three chapters, the thesis focuses on the experience of the single mother by drawing on the interview material to present a first-hand account of this period of her life. Using her own words, as well as those of former hospital staff, Chapters Three and Four closely follow the journey of a single pregnant woman, from the initial discovery of pregnancy through to the signing of consent. Focusing exclusively on pregnancy, Chapter Three explores the range of services with which the single mother interacted leading up to her confinement, beginning with the reaction of her family and the organisations to which they turned for support. Chapter Four's attention to delivery and relinquishment is firmly located within the hospital and identifies policies as well as practices that determined differential treatment for the married and unmarried patient. Finally, Chapter Five: The Business of Adoption looks at past practices from an industrial perspective in which mothers were regarded as 'suppliers' to the 'customers' of adopting parents—with the hospital operating as an intermediary. This concluding analysis relies on the language of supply and demand to present the particular way in which the adoption industry operated during its heyday.

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# CHAPTER TWO

## THEORETICAL FRAMEWORK & METHODOLOGY

*Oral sources are credible but with a different credibility. The importance of oral testimony may lie not in its adherence to fact, but rather in its departure from it, as imagination, symbolism, and desire emerge. Therefore, there are no 'false' oral sources. Once we have checked their factual credibility with all the established criteria of philological criticism and factual verification which are required by all types of sources anyway, the diversity of oral history consists in the fact that 'wrong' statements are still psychologically 'true' and that this truth may be equally as important as factually reliable accounts.<sup>92</sup>*

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<sup>92</sup> Alessandro Portelli, "What Makes Oral History Different?," in *The Oral History Reader*, ed. Robert Perks and A Thomson (London; New York: Routledge, 2006), 37.

In undertaking research into past adoption practices and investigating claims that these were unethical or even illegal, it was assumed that most would remain undocumented.<sup>93</sup> As such, the use of oral history was fundamental to this thesis, but archival research has also provided rich documentary evidence with which to contextualise and corroborate this testimony. After addressing the mechanics of the research design, this chapter will debate issues concerning the validity and reliability of memory as an historical source; the ways in which identity and narrative interact; the interconnectedness of individual and collective remembering, particularly in terms of the language which has been available for expressing this experience; and the theoretical framework for working with trauma narratives. With regard to the archival evidence, the chapter will address the debate surrounding the ways in which historians can read this material, as well as investigating the interaction with oral sources in terms of constructing a coherent history of past adoption practices. But firstly the issue of language and terminology must be addressed as it represents a decidedly contentious battle ground for women who have lost a child to adoption.

## LANGUAGE AND TERMINOLOGY

Historically, in the treatment of single mothers as well as throughout the existing adoption literature, specific language has been used to label and portray them in a particular way. This characterisation, which often includes the child, has been overwhelmingly negative: each label is potentially loaded with judgement and prejudice. However, when reclaimed, language has been equally empowering for these women, particularly in creating a platform for the expression of political agendas. In the seminal work on single mothers in Australia, Swain and Howe raised the issue of language and specific terms, warning that it is often designed to be intentionally hurtful.<sup>94</sup> And in her work interviewing mothers who lost a child to adoption, Judith Modell argues that the various and changing terms have reflected 'cultural values

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<sup>93</sup> Swain and Howe, *Single Mothers and Their Children: Disposal, Punishment and Survival in Australia*, 7. which successfully used oral history and substantiated earlier claims by C. Hay, "The Pangs of the Past," *Oral History* 9, no. 1 (Spring 1981). See also Alistair Thomson, "Making the Most of Memories: The Empirical and Subjective Value of Oral History," *Transactions of the Royal Historical Society, Sixth Series* 9(1999), 291.

<sup>94</sup> Swain and Howe, *Single Mothers and Their Children: Disposal, Punishment and Survival in Australia*, 3.



concerning sexuality, parenthood and family'.<sup>95</sup> This tug-of-war over appropriate terminology has seen the language debate take centre stage in the agenda of the adoption reform movement and as a fundamental consideration in the naming of CSMC at the time it was established in 1969.<sup>96</sup> For CSMC, the usage of 'single mother' was a matter of emphasising what women *are*, as opposed to what they are *not*, replacing earlier labels such as 'unwed mother' or 'single girl'.

While the term 'single mother' has remained in favour since, the preference for terms describing the single mother who placed her child for adoption has evolved over time. While 'birthparent' held sway in the early 1990s, more recently women have stripped this label to its essential element: mother. In their submission to the Senate Inquiry, Origins Inc. proclaims 'we have been mothers from the moment of conception, throughout the birthing experience until infinity'.<sup>97</sup> This view claims that this simple title no longer needs to be qualified. The term 'birth' or 'biological' mother is now seen as demeaning because of its emphasis on women as breeders; 'first parents' was used briefly, but has a competitive feel to it; and the notion of a 'natural mother' suggests that motherhood could be unnatural.<sup>98</sup> Unfortunately, for the sake of clarity, the use of some qualifying term may sometimes be necessary within this thesis, but it is noted that this will be done without the intent of devaluing any woman's claim to motherhood.

Other negative terms that have disappeared from adoption literature, but live on in the media, include 'teen parent', 'out-of-wedlock birth', and 'illegitimate birth' (with the last two referring to the parent through the child's status). While 'illegitimacy' was officially removed from the legal vernacular with the 1974 Victorian Status of Children Act, birth outside of marriage continues to be recorded in official state publications as an ex-nuptial birth.<sup>99</sup> Similarly, the term 'relinquishing mother' poses an ongoing dilemma as a descriptor. Despite

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<sup>95</sup> Judith Schachter Modell, "'How Do You Introduce Yourself as a Childless Mother?' Birthparent Interpretations of Parenthood," in *Storied Lives: The Cultural Politics of Self-Understanding*, ed. George C. Rosenwald and Richard L. Ochberg (New Haven and London: Yale University Press, 1992), 79.

<sup>96</sup> Rosemary West, "How Single Mothers Overcame Discrimination," in *Actions Speak: Strategies and Lessons from Australian Social and Community Action*, ed. Eileen Baldry and Tony Vinson (1991), 172.

<sup>97</sup> Senate Inquiry, submission 166.

<sup>98</sup> See *Why 'Birthmother' means 'Breeder'* by Diane Turski in *Ibid.* For examples of the usage of 'first parents' see The Committee of the Second Australian Conference on Adoption, *Current Concerns and Alternatives for Child Placement and Parenting: Proceedings of the Second Australian Conference on Adoption*, ed. C. Picton (Melbourne: May 1978), 221 and Access Age, "Disregard for People," *Age*, 19 September 1988; for a debate about 'natural' and 'unnatural' motherhood see Suzan G. Kiesel, "Natural and Not: Articulating Mother(Hood) within the Adoption Triad" (Ph.D., Southern Illinois University at Carbondale, 2007).

<sup>99</sup> *Victorian Yearbook* (2010).

being adopted by the Association of Relinquishing Mothers (ARMS), those opposed to its use reject its implication that the mother was willing (and relieved) to be rid of the child. This double-edged sword represents the dilemma of the single mother: ‘if you love your child, you will give it up for adoption’; only to be later chastised ‘how could a loving mother give up a child?’ Mindful of this dilemma, the term ‘relinquish’ will only be used when required to describe the act of placing a child for adoption and without any assumptions as to willingness.

The father must also be addressed in this discussion. While his experience does not form part of the investigation of this thesis, his role is undeniable. Of note is his description in the archival documents that have been accessed in the course of this research in which he is referred to as the ‘putative’ father: putative being synonymous with ‘alleged’ or ‘assumed’. Prior to paternity testing, the onus of proof was placed on the mother, and she needed to be willing to support such accusations in court—with witnesses. Long-held assumptions that a single mother’s promiscuity precluded her from naming the correct father must be corrected here. While most women were well aware of the father’s identity, legal obstacles and adoption practices prohibited the recording of his name.

While it is the intention of this thesis to tread respectfully and conscientiously through the minefield of labels, it is necessary to maintain the contemporary terminology when quoting historical documents or interview-specific material. Such consideration will provide a clear indication of the motives and bias of the author, as well as honouring the integrity of interview material and respecting the candour of participants. Where possible this thesis will endeavour to use the term ‘single mother’. However, the emphasis on what women are *not* will often become necessary in the context of this thesis and the term ‘unmarried’ will be used interchangeably with ‘single’. Indeed, marital status and the analysis of women’s consequent treatment is a primary concern of this research, specifically in the way these women are positioned in opposition to the ideal married family.

A prime example of such distinctions can be found in the Social Work Department records at the RWH, in which there is an obvious and divisive classification of married *women* and single *girls*. With regard to these and other hospital documents, it must be noted that the designation of ‘single girls’ is specific to those who had never been married: a vulnerable and predominantly young group from which divorcees, deserted wives and widows are excluded irrespective of their age. Similarly, it has been found that women in de facto relationships

were often inscribed in some hospital records as married.<sup>100</sup> During the time in question, marriage conferred an imagined maturity on a woman, even in the case of a marriage-like relationship where a woman's 'official' status was sometimes ignored. For all intents and purposes she was considered an adult, regardless of her age. On the other hand the implied immaturity of a 'single girl' was a lifelong affliction.

## RESEARCH DESIGN

The objective of this thesis is to examine the policies, practices, and staff attitudes of the RWH in order to understand how these affected the experiences of single mothers who gave birth at the hospital in the period 1945-1975. Oral history has provided one valuable tool for investigating allegations of illegal and unethical past adoption practices, but the hospital archives have been equally informative.<sup>101</sup> A limited number of patient medical files and social work department case files have been accessed, as well as hospital policy records, departmental reports, committee minutes and correspondence gathered through archival research which provided a basis through which to analyse internal cultural changes—that is, changes that occurred within the hospital's administration, policy, and practice.

In-depth interviews of sixty to ninety minutes were conducted with twenty-one participants. Of the thirteen single mothers, two kept their babies; and of the eight former hospital staff, one doctor, six midwives, and one social worker are represented.<sup>102</sup> Interviews with single mothers represent a range of birth experiences between 1963 and 1977, while interviews with former hospital staff represent a professional life at the RWH that covers the period from 1953 through to 1994. The testimony provided by this intimate sample was strengthened by bringing together relevant stories gathered for the Monash University *History of Adoption* project, evidence submitted to the current Senate Inquiry, and voices that appear in other historical accounts, particularly Janet McCalman's *Sex and Suffering* and Shurlee Swain and Renate Howe's *Single Mothers in Australia*. The importance of all of these accounts does not

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<sup>100</sup> Johns, "The Health of Babies Kept by Their Single Mothers: A Study of the First Years of Life of a Melbourne Sample", 36-37.

<sup>101</sup> This research has been approved by the Human Research Ethics Committee at Australian Catholic University (Ethics Application Register No: V2010 07). See Appendices 3-8.

<sup>102</sup> While it had been intended to interview twenty-four participants: with a ratio of 3:1 (eighteen mothers and six former hospital staff), the recruitment of single mothers was difficult. Several potential participants pulled out as a result of their emotional state and others were prevented from participating as a result of distance.

lie in their access to the 'truth', but instead in the access they offer to 'that version of the truth which the person providing the information wishes to be told'.<sup>103</sup> These testimonies convey the impact of past adoption practices from those with first-hand experience.

The recruitment of former staff was accomplished via the hospital and representative associations' newsletters, as well as word of mouth. The sample of single mothers was drawn from advertisements placed with a range of experience-specific support groups including: ARMS, CSMC, Origins Inc., Adoption Jigsaw, and VANISH. A call for participants was also placed in the *Journal of Adoption*. Further recruitment was possible as a direct result of recent media attention for this project which attracted some interest from women not affiliated with these groups, thereby broadening the sample.<sup>104</sup>

While the use of support groups may have created a biased 'sample' of women, as it has restricted recruitment to those who have sought help and are willing to speak openly about their experiences, this was a necessary ethical consideration. Membership of these groups provides a supportive and compassionate environment where the recollection of these memories can be safely shared. For the most part, the silence, shame and secrecy required of mothers at the time of relinquishment have been maintained over time; many have never spoken of their experience and continue to be reluctant to do so. According to Origins Inc, even today 'there are many mothers that cannot even voice their story to their families'.<sup>105</sup> Feelings of betrayal may have similarly contributed to an unwillingness to come forward; lack of trust has a lasting effect. At the Melbourne public hearing of the Senate Inquiry, one mother commented:

We have learned not to trust, suffer from mental anguish and trauma and have had to live with the fact that we were betrayed, and that betrayal continues to this day.<sup>106</sup>

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<sup>103</sup> Swain and Howe, *Single Mothers and Their Children: Disposal, Punishment and Survival in Australia*, 7.

<sup>104</sup> The most recent media attention includes: "Adoption Scandal," (Channel 7, 7 June 2009); Carol Nader, "Decades on, Pain of Forced Adoption Lingers," *Age*, 20 February 2010; Peter Kirkwood, "Staying Mum on the Pain of Adoption," *Australian*, 17 April 2010; Clair Weaver, "How Could You Keep *This* a Secret?," *Madison*, March 2011; Carol Nader, "The Trauma of Forced Adoption for Shamed Single Mothers," *Age*, 7 May 2011; "2 of Us," *Age: Good Weekend Magazine*, 28 May 2011. Previous interest from the media and/or government include a series of articles in 1998 as NSW and Tasmania initiated state inquiries, for example see: Cheryl Critchley, "Adoptions Records Destroyed," *Herald Sun*, 3 February 1998; ———, "Adopt Families Urged to Pay," *Herald Sun*, 16 February 1998; P Carlyon, "Adoption 1961: A System of Shame," *Doncaster Templestowe News*, 4 March 1998; ———, "Seeking Their Origins," *Doncaster Templestowe News*, 4 March 1998.

<sup>105</sup> Ms Kinghorn in *Hansard*, CA 30.

<sup>106</sup> June Smith in *Hansard*, CA 34.

Other studies have faced similar difficulties: if there is indeed a silent majority for whom the adoption experience was not negative, then they are determined to remain silent. Of the numerous submissions to the Senate Inquiry, only one provided a positive account of the relinquishment experience—and this was presented by a third party.<sup>107</sup> While recent media interest in the plight of mothers separated from their children by adoption calls attention to the pain and trauma of losing a child in this way, with these stories, as with the submissions to the Senate Inquiry and the Monash Adoption Project, it is often the same voices that continue to speak on behalf of what they claim to be the silent majority.

The interview material was used not only to determine differences and similarities in the experiences of single women giving birth at the RWH at this time, but also to develop thematic categories of experience. According to Paul Thompson, this allows greater expository potential because ‘the stories can be used much more easily in constructing a broader historical interpretation, by grouping them—as a whole or fragmented—around common themes’.<sup>108</sup> The data collected was first categorised with demographic markers such as: age at time of pregnancy, religious affiliation, the involvement (or not) of a maternity home, the eventual outcome, and the year of the experience in order to track changing social values, as well as looking for comparative measures with which to analyse hospital statistics. The impact of the 1964 *Adoption of Children Act* was of particular interest as hospital policy and procedure was noticeably affected by this legislation, as were the stories that emerged prior to and after its introduction.

A narrative analysis of the material revealed many commonalities in the stories of single mothers. The ‘historian’s model’ of analysis as proposed by Valerie Yow urges the researcher to seek ‘the common meanings of the shared experience ... [as well as] the meanings unique to the individual’.<sup>109</sup> Using this technique has revealed that the experiences of single mothers expressed in this group of interviews were consistent with previously documented accounts. Common themes of silence, invisibility, shame and guilt, as previously identified in the existing literature, were equally present across the timeframe. Issues of powerlessness and lack of control also emerged while conducting, reading, and listening to the interviews. There is no question that some of these had already been distilled through the discourse of the

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<sup>107</sup> Senate Inquiry, submission 30.

<sup>108</sup> Thompson, P. *The Voice of the Past: Oral History, Third Edition*. (Oxford: Oxford University Press, 2000), 270.

<sup>109</sup> Yow, *Recording Oral History: A Guide for the Humanities and Social Sciences*, 284.

adoption reform movement in terms of the availability of language with which to express the experience.

## ORAL HISTORY

Although the use of oral history continues to be contested, recent Senate Inquiries such as those into the Stolen Generations and even the Forgotten Australians and Child Migrants have helped to increase the acceptance of testimony as a legitimate source of evidence. While debates surrounding the validity of memory as an historical source raise important questions, particularly regarding reliability and ‘factual’ evidence, this thesis places its emphasis on the *impact* of past adoption practice. Indeed, therein lies the value of oral history. As Alessandro Portelli explains in his interviews with workers in Terni: ‘oral sources may not add much to what we know, for instance, of the material costs of a strike to the workers involved, but they tell us a good deal about its psychological costs’.<sup>110</sup> With regard to mothers who have lost a child to adoption, oral history provides the greatest opportunity to understand the effects and psychological costs of past practices.

Motivated by a need to ‘provide empirical evidence about undocumented experience, and to empower social groups that had been hidden from history,’<sup>111</sup> Alistair Thomson maintains that oral history is a powerful methodological approach that allows access to previously undocumented material. As such, oral history is not only a source of material evidence, but a method that is ‘informed by the more complex understandings of memory and identity’ and which explores ‘the relationship between individual and collective remembering, between memory and identity, or between interviewer and interviewee’.<sup>112</sup> These interactions and relationships form the key tensions inherent in the use of this methodology.

Memory is incredibly robust, notwithstanding suspicion about its reliability. The experiences that people store in their long-term memory have significant personal meaning and importance, and as a result these events are often revisited and reviewed. As Thomson has argued ‘significant episodes are usually made into durable memories, and the creation and

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<sup>110</sup> Alessandro Portelli, "What Makes Oral History Different?," 36.

<sup>111</sup> Thomson, "Making the Most of Memories: The Empirical and Subjective Value of Oral History," 295.

<sup>112</sup> Alistair Thomson, Michael Frisch, and Paula Hamilton, "The Memory and History Debates: Some International Perspectives," *Oral History* 22, no. 2 (Autumn 1994), 34.

rehearsal of a memory story is fundamental to the consolidation of long term memory'.<sup>113</sup> Memory functions as 'a vital part of the mental equipment that individuals use to register and process information about the world around them'.<sup>114</sup> Without memory, individuals would have limited understanding of their role or place in their family, or even within the community. Memory is one of many resources or tools that an individual has available in order to make sense of, and feel a belonging to, the world in which they are living.

Memory is fundamentally charged with defining a person's identity and sense of self. According to Geoffrey Cubitt, a subjectivist approach to memory emphasises the consequence of such an assertion.

Memory is ... the central vehicle of subjectivity, crucially engaged in fabricating the inner meanings that we give to our psychic experience. Memory in this view is important chiefly as the primary locus of our sense of self and is assumed to be geared to maintaining that sense of self in the face of life's disruptive vicissitudes.<sup>115</sup>

Therefore, central to the function of memory is its ability to provide justification and reinforcement for the ways in which we want to see ourselves, as well as the ways in which we want others to see us. Affirmation of identity is fundamental to these projections. It must also be noted that this multifaceted sense of identity changes over time, as the individual re-works old memories to fall in line with the new. From this perspective, identity is plural.

The creation of such identities involves a selective process and active choice in the consolidation of memory. Yow has argued that 'people choose memories important to them: they repeat them over the years as they seek to reinforce meanings in their lives.'<sup>116</sup> Although anchored in the past, memories (in the form of stories or narratives) are continually re-worked to reinforce meaning that is relevant to the present situation and to protect the individual's sense of the self. Mark Roseman's research with Holocaust survivor Marianne Ellenbogen explored how this re-working of memories can be used to make painful memories more bearable.<sup>117</sup> He postulates that the discrepancies in her accounts are a result of her deeply held guilt for surviving at the cost of her family, but more importantly an indication of her attempt

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<sup>113</sup> Alistair Thomson, "Memory and Remembering in Oral History," in *The Oxford Handbook to Oral History*, ed. Donald A. Ritchie (New York: Oxford University Press, 2011), 85.

<sup>114</sup> Geoffrey Cubitt, *History and Memory* (Manchester; New York: Manchester University Press, 2007), 72.

<sup>115</sup> *Ibid.*, 72.

<sup>116</sup> Valerie Raleigh Yow, *Recording Oral History: A Guide for the Humanities and Social Sciences* (Second Edition) (Walnut Creek, CA: AltaMira Press, 2005), 39.

<sup>117</sup> Mark Roseman, "Surviving Memory: Truth and Inaccuracy in Holocaust Testimony," in *The Oral History Reader*, ed. Robert Perks and A. Thomson (Routledge, 2006), 238.

‘to impose some control on a memory which could not otherwise be borne’.<sup>118</sup> The selective nature of her memory is thus a tool for the self-preservation of a present-day, guilt-free identity.

The use of mechanisms for creating bearable and usable pasts is an essential tool in connection with traumatic memories, particularly because it is believed that ‘such experiences produce shame, anger, often guilt in the victim, and are regarded as secrets rather than as stories to tell’.<sup>119</sup> Other mechanisms include outright denial of the experience, repression or suppression of the memory, or even attempts to depersonalise the event. A working knowledge of the potential difficulties that could have arisen out of working with survivors of trauma was particularly pertinent while conducting interviews with mothers who lost a baby to adoption. It is not only the mothers themselves who insist that their experience be understood as traumatic; the AIFS report *Impact of Past Adoption Practices*, published in early 2010, stresses ‘the usefulness of understanding past adoption practices as “trauma”, and seeing the impact through a “trauma lens”’.<sup>120</sup>

Other recommendations for conducting interviews with survivors of trauma include learning to expect the unexpected because interviewees ‘may have defense mechanisms in place that might make their responses sound strange or “off”’.<sup>121</sup> Mark Klemptner explains that trauma narratives almost always involve an attempt by the narrator to find closure and advises the interviewer to also anticipate unexpected emotional reactions.<sup>122</sup> Furthermore, a feminist perspective on psychic trauma can be useful in understanding it as an ongoing process, not simply as a singular event. Laura Brown proposes that we might begin to ask ‘how many layers of trauma are being peeled off by what appears initially to be only one traumatic event or process?’<sup>123</sup> For the mothers who lost a child to adoption interviewed for this thesis, this was often the case: while it was initially assumed that relinquishment was the one traumatic event in their life, a peeling of layers, as the interview progressed, often revealed sustained and seemingly ‘unconnected’ stories of trauma.

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<sup>118</sup> Roseman, "Surviving Memory: Truth and Inaccuracy in Holocaust Testimony," .238.

<sup>119</sup> John Robinson quoted in Mark Klemptner, "Navigating Life Review Interviews with Survivors of Trauma," in *The Oral History Reader*, ed. Robert Perks and A. Thomson (London and New York: Routledge, 2006), 198.

<sup>120</sup> Higgins, "Impact of Past Adoption Practices," 2.

<sup>121</sup> Klemptner, "Navigating Life Review Interviews with Survivors of Trauma," 203.

<sup>122</sup> Klemptner, "Navigating Life Review Interviews with Survivors of Trauma," 199-201.

<sup>123</sup> Laura S. Brown, "A Feminist Perspective on Psychic Trauma," in, Cathy Caruth. *Trauma : Explorations in Memory*. (Baltimore: Johns Hopkins University Press, 1995), 110.



While a socio-cultural approach to the study of memory varies between disciplinary methods such as sociology, anthropology, constructivist psychology, and literary studies, they share a particular view of the relationship between the individual and society:

What they have in common is a disposition to view the mnemonic life of individuals as something not just casually influenced but framed and structured by those individuals' positioning within society and within culture [and] in which selfhood may be seen as 'relational' rather than a purely individualized phenomenon.<sup>124</sup>

According to this model, the very act of encoding and consolidating a personal memory is controlled by the dominant cultural discourses and the individual's relationship within this configuration. Within this framework, it has been argued that although 'autobiographical memory ... is highly personal and idiosyncratic [it] never escapes its social and cultural boundaries'.<sup>125</sup> Individual memory, therefore, is always bound and socially mediated by the cultural context within which it is created. This view of personal memory emphasises the private/public interaction and has the potential to connect individuals to, or position them against, the larger collective memory.

While memory is inherently personal, involving emotion and cognition, the processes by which storage and recall are achieved are equally mediated by the cultural context within which these take place. There is no denying that a memory is initially created (and contained) at an individual level in response to personal events and experiences, but the act of sharing—particularly within a group—contributes to the creation of broader social and public narratives, which in turn affect the 'remembering' of the individual. Equally, the selection process will always be dependent on 'present concerns and wider contexts including those of victimisation' as explored by Denise Phillips, in her work with Hazara refugees.<sup>126</sup> Memories must be framed within the context of current issues.

The current Senate Inquiry, along with other recent research seeking interviews with mothers who lost a child to adoption has created a milieu in which women are free to share their stories. The nature of the Inquiry also dictates that these stories are driven by particular expectations of victimisation and apology. The interviews that formed the basis of this project

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<sup>124</sup> Cubitt, *History and Memory*, 73.

<sup>125</sup> Katherine Nelson quoted in Yow, *Recording Oral History: A Guide for the Humanities and Social Sciences* (Second Edition), 36.

<sup>126</sup> Denise Phillips, "Wounded Memory of Hazara Refugees from Afghanistan: Remembering and Forgetting Persecution," *History Australia* 8, no. 2 (2011), 193 citing the works of Linda Shopes and Deborah Levenson in Guatemala

gave narrators the opportunity to share their stories with a wider audience—of which they were all acutely aware. Interviews were guided by and developed along terms dictated by the women themselves, whether this involved reinforcing a specific identity or conveying a political message. There is no doubt that these stories have been constructed in the interest of ‘making sense’ of their experiences, not only in finding a place for them in their own identity, but also within the larger community’s narrative.<sup>127</sup>

James Wertsch argues that collective memory is a political process whereby ‘memory is assessed from the perspective of how effective it is in creating a usable past’<sup>128</sup> for a particular public or society: in this construction accuracy is of no consequence. The practical function of the group narrative is one in which common beliefs about the past are harmonised and are consolidated in the creation of a group identity. This is further defined by John Bodnar:

Public memory is a body of beliefs and ideas about the past that help a public or society understand both its past, present and, by implication, its future. It is fashioned ideally in a public sphere in which various part of the social structure exchange views. The major focus of this communicative and cognitive process is not the past, however, but serious matters in the present such as the nature of power and the question of loyalty to both official and vernacular cultures.<sup>129</sup>

Societies use collective memory to stake their claim on a present-day group identity and project this into the future.

Collective representations are likely to create a social narrative which doesn’t always match the individual. The availability of language is an important factor in determining whether individual remembrances can be publicly shared. One space in which minorities (that is those whose experiences do not conform to the dominant narrative) have found a voice is that of support groups. With a mantra of ‘you are not alone’, support groups provide a safe place within which counter-experience is acknowledged. Alistair Thomson contends that ‘our memories are risky and painful if they do not conform with the public norms or versions of the past’.<sup>130</sup> The recognition provided by support groups offers individuals affirmation and

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<sup>127</sup> A. Sheftel and S. Zembrzycki, "Only Human: A Reflection on the Ethical and Methodological Challenges of Working with ‘Difficult’ Stories," *Oral History Review* 37, no. 2 (2010), 201.

<sup>128</sup> James V. Wertsch, *Voices of Collective Remembering* (Cambridge, U.K.; New York: Cambridge University Press, 2002), 33.

<sup>129</sup> Bodnar quoted in *Ibid.*, p.33.

<sup>130</sup> Alistair Thomson, "Anzac Memories: Putting Popular Memory Theory into Practice in Australia," *Oral History* 18, no. 1 (Spring 1990), 25.

aids in both the development of a language with which to express experience, and indeed in the revisioning of personal identity. Memory then can be used as a resource to contest dominant narratives.

While the shame and secrecy surrounding past adoption practices initially suppressed the possibility of the emergence of any narrative (personal or collective) about the experiences of mothers who lost a child to adoption, the language became available as their stories were first shared in support groups. The establishment of these groups for women who shared the relinquishment experience occurred in the early 1980s, alongside the adoption reform movement. Support and activism combined and the emergent discourse portrayed adoption as an 'exploitative system in which the "rich and powerful" took advantage of the "poor and vulnerable"'.<sup>131</sup> Within this context, the women interviewed for this research were able to integrate the trauma of relinquishment into a larger narrative of manipulation and abuse at the hands of those they trusted. But equally within this context there is no room for the positive experience of adoption—if indeed there is one.

Judith Modell's work with birthparent narratives in the early 1990s found that the language with which her narrators recounted their stories drew on a rhetoric developed within the American adoption reform movement and further 'popularised on television shows and in magazines and best-sellers'.<sup>132</sup> In the Australian context, the Victorian branch of ARMS, formed in 1982, continues to emphasise the victimisation of the natural mother by societal standards and (past) adoption practices in calling attention to the negative impact of relinquishment. This is evidenced by the common feelings of 'guilt, shame, worthlessness and loss of self-esteem ... ultimately affecting [mothers'] emotional, psychological, physical and spiritual health.'<sup>133</sup> The sharing of personal memory within support groups contributes to the creation of broader social and public narratives, which in turn affect the 'remembering' by the individual. The current (and indeed past) inquiries into past adoption practices have also provided a specific forum within which to share a particular story.

For those who did come forward, the need to tell is a vital component to their story. Of the mothers who participated in this project, all bar one insisted on the use of her full name. Self-

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<sup>131</sup> Modell, "'How Do You Introduce Yourself as a Childless Mother?' Birthparent Interpretations of Parenthood," 78-79.

<sup>132</sup> Modell, "'How Do You Introduce Yourself as a Childless Mother?' Birthparent Interpretations of Parenthood," 78.

<sup>133</sup> ARMS website [www.armsvic.org.au/about-relinquishment](http://www.armsvic.org.au/about-relinquishment). (accessed 30 September 2011).

perception, projection, and the need to be heard are integral to personal identity. As Portelli points out 'oral sources tell us not just what people did, but what they wanted to do, what they believed they were doing, and what they now think they did.'<sup>134</sup> The opportunity to share their stories provides the opportunity to overcome the injustices of the past: the silence, the separation, and the guilt. Telling, then, fulfils a therapeutic role as well as satisfying a more compulsive need to justify past actions. Dori Laub refers to the 'imperative to tell', in which a narrator may be compelled to constantly re-tell their story, but warns of the risks of it becoming an all-consuming life task where no amount of telling seems to ever be enough. He says: 'There are never enough words or the right words, there is never enough time or the right time, and never enough listening to articulate the story that cannot be fully captured in *thought, memory and speech*.'<sup>135</sup> With regard to the current research undertaken by AIFS on the Service Response to Past Adoption Experiences, over 1000 people have already completed the survey. Of particular note is the seventy-six per cent of respondents who want to participate in follow up focus groups.<sup>136</sup>

Despite an emphasis on meaning over fact in the use of oral history, this in no way privileges the use of documentary evidence over testimony. Portelli warns that 'this does not mean that we accept the dominant prejudice which sees factual credibility as a monopoly of written documents.'<sup>137</sup> Both oral sources and documentary evidence must be scrutinised to determine the veracity of, and the bias contained within, each. While oral history has provided insights into the narrator's understanding of their experiences, archival documents have provided insights into the policies and attitudes that affected these experiences.

## ARCHIVAL EVIDENCE

Extensive archival research at the RWH has uncovered a range of records that have provided rich documentary evidence through which to contextualise and corroborate the experiences recounted by staff and mothers alike. While this does not purport to be a comprehensive comparative study, where possible the experience of single women will be considered

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<sup>134</sup> Portelli, "What Makes Oral History Different?," 36.

<sup>135</sup> Laub, Dori. "Bearing Witness or the Vicissitudes of Listening," In *Testimony: Crises of Witnessing in Literature, Psychoanalysis and History*, edited by Shoshana Feldman and Dori Laub, (New York and London: Routledge, 1992), 63.

<sup>136</sup> AIFS on Twitter: <http://twitter.com/#!/search?q=%23PastAdoption>. (accessed 21 December 2011).

<sup>137</sup> Portelli, "What Makes Oral History Different?," 37.

alongside that of their married counterparts who attended the hospital. Archival evidence has included annual reports, Social Work Department reports, medical directives, birth registers, hospital memos, and correspondence, as well as meeting minutes from the Board of Management and a range of other relevant committees.

Patient records were not generally consulted. With over 7000 births per year for much of the period under investigation, thorough examination of these records (even a small representative sample) would require at least one year full-time attention. However, there were other barriers. Generally these files are available only to the respective patient.<sup>138</sup> There are also claims that some files have been destroyed.<sup>139</sup> For the purpose of this thesis two volumes of de-identified patient medical records from the years 1964 and 1965 were made available for examination. These dates were chosen for several reasons: they fell within the range of available oral evidence (either through the interviews or submissions to the Senate Inquiry) for comparison; they also fell within the period in which the hospital maintained a supply of heroin for use in labour, and the prescription of Stilboestrol for the suppression of lactation, thereby providing the opportunity to investigate the frequency with which these drugs were administered.

A small number of Social Work Department patient cards were also examined. Again, the selection process was somewhat a matter of chance. In 1988 all adoption records were transferred to Community Services Victoria (CSV) as the RWH ceased operating as an adoption agency and Adoption Information Service. Two boxes of unaccessioned Social Work Department patient cards remained in the RWH archives. These documents were not specifically adoption records, but included a full alphabetical range of approximately two hundred social work clients dating from 1935-1965. The limited number of cards allowed for a full examination of its contents. Overwhelmingly, the records document the lives of poor married women with very large families. Hidden amongst these files were approximately twenty-five records that mention adoption, either in recommendation of, or in advising against the practice.

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<sup>138</sup> Some women claim that they have been denied access to their medical records at the RWH, see June Smith in *Hansard*, CA 34.

<sup>139</sup> See Cheryl Critchley, "Adoptions Records Destroyed." *Herald Sun*, 3 February 1998 which claims that records are destroyed after thirty years.

The language of these files is replete with judgement and potentially indicative of attitudes within the wider community. They provide a rare glimpse into the mind of the social worker. In her research on the surveillance of post-war Melbourne families, Nell Musgrove argues that 'from case files, it is possible to generate an understanding of popular attitudes' as well as 'the extent to which these instilled a moral component into social workers' "diagnosis" and "treatment" of patients'.<sup>140</sup> While her work focused on the interaction of social workers with families, her assertion can equally be applied to their interaction with single mothers. These case files provided further evidence of the differential treatment of married and unmarried women, as well as evidence of the selection process (that adoption was only the solution for first-time single mothers).

In this thesis, the combination of both oral interviews and archival evidence has allowed and more in-depth and well-rounded understanding of the experiences of single mothers who lost their children to adoption. Despite concerns over the validity and reliability of each, these two sources of evidence have supported each other to reveal an incredibly consistent story. Single mothers' accounts of feeling that their treatment at the hospital was discriminatory and unjust have been strengthened by documentary evidence that uncovered hospital policies for the differential treatment of married and unmarried women, as well as the underlying moral assumptions on which decisions were based; while archival material has been contextualised and clarified by the voices of former hospital staff.

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<sup>140</sup> Nell Musgrove, "'Making Better Families' Surveillance, Evaluation and Control of Families in Melbourne 1945-1965," (MA thesis, University of Melbourne, September 2003), 2.

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# CHAPTER THREE

## PREGNANCY

*When a wrong wants righting,  
or a truth wants preaching,  
or a Continent wants opening,  
God sends a baby into the world to do it.<sup>141</sup>*

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<sup>141</sup> Dr George Simpson at the opening of the Henry Pride Wing, Friday 7 May 1954.

Over time, the RWH experienced a growing reputation as *the* hospital to which unmarried mothers were sent, particularly with the opening of the Almoner Department in 1934. From providing ‘assistance and advice’ to eighty-one ‘single pregnant girls’ in that first year, by 1971 the hospital was delivering in excess of 1500 ex-nuptial babies and arranging up to 400 adoptions annually. Although the proportion of unmarried women delivering at the RWH increased steadily between 1955 and 1968, at its peak this only represented twenty per cent of the hospital’s obstetric population. The increase at this time was attributed to the post-war baby boom: the 1968 annual report explained that ‘there are significantly more young women in the average peak-age range for unmarried mothers (eighteen to twenty) as a result of the increase in birthrate following the war’.<sup>142</sup> Exaggerated projections for an ever-increasing population of unmarried mothers, based on the increasing Victorian rates (see figure 2 below), raised serious concerns among hospital administrators. An extensive publicity campaign designed to attract prospective parents was planned in order to care for the “‘crucial number” of illegitimate children awaiting adoption’.<sup>143</sup>

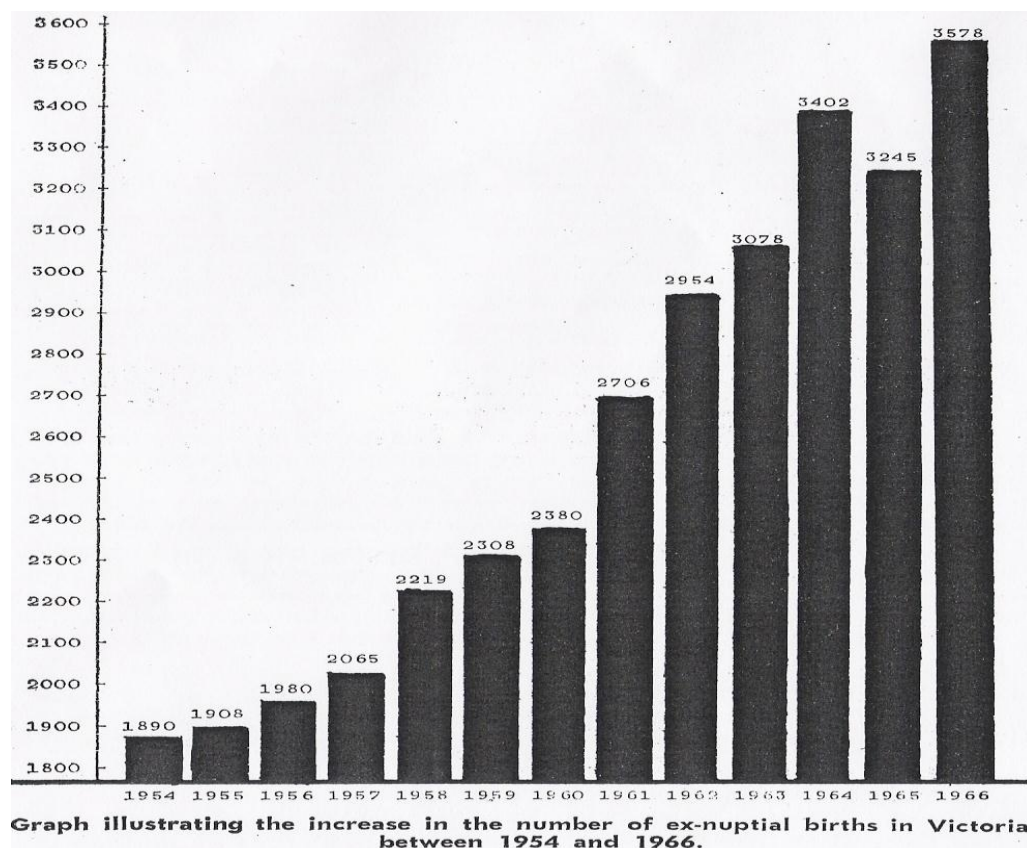


Figure 2: Ex-nuptial Births in Victoria (1954-1966)<sup>144</sup>

<sup>142</sup> *Annual Report* (1968), 32.

<sup>143</sup> "Illegitimate Births Rise," *Age*, 18 September 1968.

<sup>144</sup> This graph was originally presented in Rev. E. G. Perkins, "Population Changes Affect Adoptions," *Advocate*, 15 February 1968, 9.



Despite the ‘shocking’ appearance of such statistics, the media failed to publicise the equally dramatic increase in total births—which had effectively doubled between 1945 and 1975. Ex-nuptial births are more accurately understood when read in conjunction with this overall number. As a result, these would then be more modestly represented with a gradual increase from 3.6 per cent of total births in 1945 to 7.1 per cent in 1975 (while alarm bells were ringing when the rate of ex-nuptial births in Victoria reached 5.9 per cent in 1968, compared with the national rate of 8.0 per cent). Fuelled by such sensationalist reports, prevailing social attitudes towards the single mother, particularly in the 1950s and 1960s, were bound not only by a strict moral code, but also by a heartfelt belief in adoption. As stated by Dr William Chanen:

At the time, there was a significant social stigma attached to being a single mother, and I think there was a genuine feeling that they would not cope, neither financially nor emotionally, and that keeping their baby would be a great encumbrance on them for their future life and aspirations, whereas adoption would give the child a better chance of security and welfare.<sup>145</sup>

Reflecting widely-held community beliefs, Dr Chanen naively regarded adoption as a pragmatic solution to the single mother’s dilemma, and didn’t necessarily see it as a form of punishment. In the light of the limited options available, there was an optimistic trust in the assumption that adoption would provide the best option for both mother and child.

While community attitudes were inevitably of consequence in relation to the experience of the single mother, it was the attitudes of professional social workers, medicos, and researchers that were to have an even more profound effect on the outcome of her pregnancy. Early research was firmly focused on the illegitimate offspring’s needs and rescue, largely ignoring the single mother, but after WWI scrutiny was more clearly placed on the single mother herself. In an analysis of the existing literature during her own research into the health of babies kept by single mothers in 1974, Nan Johns argued that it was the emergence of a ‘new dynamic psychiatry’ that moved the interest away from the child-centred focus. From the 1920s onward, the single mother became the fixed subject.

For the next 40 years attention was to be focused increasingly on the psychology and later the social background of the unmarried mother herself. Little apparent

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<sup>145</sup> Interview with Dr William Chanen, 1 June 2010.

consideration was given to the father, or more importantly, to the effects of the union on the welfare of the child.<sup>146</sup>

The most enduring of these pseudo-psychiatric analyses of the unmarried mother is found in the work of American social worker Leontine Young who maintained that the act of falling pregnant was an indication of an unwed mother's dysfunctional family relationships and unfulfilled desires.<sup>147</sup> The conviction in Young's theory about family disturbance lying at the centre of the unmarried mothers' problem was not only prevalent among social workers at the RWH, but it was also picked up to various degrees in the wider population. Dianne Gray was eighteen years old when she gave birth in 1970. Reflecting on her experience, she expressed an eerily similar understanding of the reasons why she fell pregnant.

So in other words, I had a real need to have a baby because I had no love. There was no love at home. Children who have been very deprived—and where there has been abuse—often the women or female children of that type have a strong desire to have a child because they have something to love and someone to love them.<sup>148</sup>

The myth of the unmarried mother, and professional response to her treatment, has been largely perpetuated by a (mis)representation in early research studies. The use of unsatisfactory and biased sampling techniques have been blamed. Much of the research prior to 1960 targeted captive samples from maternity homes and welfare agencies—which were never balanced by the use of control groups.<sup>149</sup> Clark Vincent contends that this method of sampling prolonged the notion that 'the illegitimate child was conceived in a relationship based primarily on force, moral depravity, and exploitation, and that his or her natural mother was a socially, morally, psychologically, and mentally inferior woman'.<sup>150</sup> Vincent goes further and champions the obvious conclusion: that these studies reveal more about the clientele of a specific agency than providing any enlightenment as to the causes of unwed motherhood.<sup>151</sup>

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<sup>146</sup> Nan Johns, "The Health of Babies Kept by Their Single Mothers: A Study of the First Years of Life of a Melbourne Sample" (1974), 9.

<sup>147</sup> Young, *Out of Wedlock; a Study of the Problems of the Unmarried Mother and Her Child* (New York: McGraw-Hill, 1954).

<sup>148</sup> Interview with Dianne Gray, 31 August 2010.

<sup>149</sup> Kiely, "Single Mothers in Society: A Study of the Causes and Consequences of Single Motherhood for a Melbourne Sample of Single Mothers Who Kept Their Children", 75.

<sup>150</sup> Clark E. Vincent, *Unmarried Mothers* (New York: Free Press of Glencoe, 1961), 262.

<sup>151</sup> *Ibid.*, 21.

Despite the seemingly irrevocable stereotype of the poor, young, and vulnerable single mother, this can and has been challenged (but often to little avail). In 1950, the average age of the single mother attending the RWH was 21.72 years.<sup>152</sup> While the age did drop over time, it remained consistent with the age of first births in their married counterparts. Statistics from the RWH in 1968 reveal that although five per cent of unmarried obstetric patients were under fifteen years of age, the majority fell in the age groupings of sixteen to nineteen (58.9 per cent) and twenty to twenty-four (29 per cent).<sup>153</sup> Statistics from the 1976 *Victorian Year Book* indicate that the proportion of marriages involving minors (under twenty-one) had also been on the rise throughout this period, increasing from 22.94 per cent of all marriages in 1947 to 42.5 per cent in 1973, when the age of majority was reduced to eighteen.

Nor could these women be strictly relegated to a particular social class. In recounting her time as Almoner of the RWH, Isobel Strahan observed that the pattern of the 'typical' single mother had changed throughout the war years:

They now came from every group of society: the idle rich, university students, nurses, social workers, clerks, secretaries, factory workers, Army, Navy, and Air Force personnel and teachers. Up to this time, it had been mainly from the poorer groups that they came.<sup>154</sup>

Single mothers were not all cast from the same mould: 'there were almost as many "stories" as there were women pregnant without the benefit of marriage'.<sup>155</sup> Despite such assertions, this premise often escaped the attention of professionals working to assist them, or failed to translate into meaningful practice.

The continued stigma attached to single motherhood and illegitimacy underpinned the way in which single mothers experienced their pregnancy, delivery, and relinquishment: some families refused to support their daughters; they were rejected at the social security office; and they were often not even accepted into the maternity wards of private hospitals.<sup>156</sup> The discrimination suffered by single mothers is evident in the emotional responses evoked by memories of their personal experience: 'In those days it was like that. You are just like a

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<sup>152</sup> Almoner Department, "Almoner's Report," 26 October 1950.

<sup>153</sup> Medical Social Work Department, "New Patient's Statistics from January '67 - December '67," c. early 1968).

<sup>154</sup> Isobel Strahan, "Looking Back: 25 Years of Social Work at the RWH," c. 1966.

<sup>155</sup> Swain and Howe, *Single Mothers and Their Children: Disposal, Punishment and Survival in Australia*, 12.

<sup>156</sup> Swain and Howe, *Single Mothers and Their Children: Disposal, Punishment and Survival in Australia*, 196-208.

pariah, and no one cared about the man, the father. It was all about this disgusting sight of a woman.<sup>157</sup>

## DISCOVERY & DISCLOSURE

Prior to the late 1970s, confirmation of pregnancy required a visit to a doctor.<sup>158</sup> Maureen Rust recalls that revealing appointment, ever conscious of the need to conceal her single status:

So, I had a girlfriend who—we went through the phone book, and I was trying to find a female doctor [Laughing] and we went to this lady doctor, and I've gone in there and I don't know, she probably knew. But I had a wedding ring on and everything and just said, 'Oh, I've come for a check-up.' She said, 'Oh, you'll be really pleased to know you're four months pregnant.' [Laughing] So I said, 'Really?!'

Most women simply worked out the signs they were pregnant and turned to a girlfriend for advice. As Patricia Shine pointed out, 'you know how girls talk'.<sup>159</sup> Another ready source of advice was provided through the problem pages of women's magazines; Shurlee Swain has argued that these actually offered little in the way of practical advice for the single mother—and if anything confused and compounded the problem. 'Indeed by offering inadequate, and at times completely incorrect, information to their readers they often added to the difficulties of the single mothers who society so harshly judged.'<sup>160</sup> Beyond seeking solace in a friend or advice from a problem page, most women eventually turned to their mothers, but generally not until it was absolutely necessary.

The majority of the women who were interviewed described feelings of shame at learning of their pregnancy. As a result, they all attempted to hide their condition. Denial became a common strategy for those who were overcome by embarrassment: if no one noticed, or asked questions, perhaps it would just go away. Dianne says she 'just wore bigger clothes and sort of hid the fact that I was growing and it got to about five and a half months before it was very

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<sup>157</sup> Interview with Dianne Gray, 31 August 2010.

<sup>158</sup> Home pregnancy tests were not introduced until the late 1970s, see Sarah Abigail Leavitt, "'A Private Little Revolution': The Home Pregnancy Test in American Culture," *Bulletin of the History of Medicine* 80, no. 2 (Summer 2006).

<sup>159</sup> Interview with Patricia Shine, 3 September 2010.

<sup>160</sup> Shurlee Swain, "Dear Problem Page, I'm Single, Pregnant And..." *Lilith* (November 1991): 110.

noticeable'.<sup>161</sup> Maureen Rust hid her pregnancy for six and half months, describing how she managed to hide the fact that she suffered from severe morning sickness.<sup>162</sup> These women had effectively internalised society's views of the single mother and adjusted their behaviour accordingly. By hiding their pregnancies they were able to postpone the judgements they would inevitably face when their condition became visible.

Fear was another key motivating factor for not disclosing their condition. At sixteen, Sandi Barry remembers learning of her pregnancy: 'I kept it to myself because I didn't want to be forced into marriage, which I would've been'.<sup>163</sup> Several women kept their pregnancy secret for fear of being forced to have an abortion—or marry the father. Yet others were forbidden from further contact. Lack of information about other potential choices (or indeed the availability of any options) is the most often quoted reason for the eventual decision to relinquish. Ann Allpike guarded her secret for fear of the embarrassment her condition might cause. Her concern over her family's reputation came at the expense of her ability to choose:

Yeah, I just sort of got sucked into the system and taken along with it. I don't remember anyone ever discussing any options with me. I think that the idea of bringing shame upon my family back here was too great for me to even consider.<sup>164</sup>

While these women all struggled to maintain a level of autonomy in their decision-making, in the end this was always usurped by an uncompromising system that saw adoption as the only solution.

The path from conception to birth is not straightforward, especially in the case of an unplanned pregnancy. Contact was often made with a number of organisations, as well as interaction with a range of people in whom the single woman confided and who offered her advice. The most common among these included friends, family members, clergy, local doctors, and maternity homes. The hospital was rarely the first port of call. Reports from the RWH reveal that as many as thirty per cent of unmarried mothers who presented at the hospital were referred to an outside organisation which often facilitated the adoption arrangements, while the RWH maintained responsibility for the medical care and delivery of

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<sup>161</sup> Interview with Dianne Gray, 31 August 2010.

<sup>162</sup> Interview with Maureen Rust, 1 September 2010.

<sup>163</sup> Interview with Sandi Barry, 31 August 2010.

<sup>164</sup> Interview with Ann Allpike, 10 November 2010.

the patient.<sup>165</sup> Equally, women were being referred from maternity homes to the RWH, representing up to twenty-two per cent of the hospital's confinements of unmarried mothers.

The RWH worked with a range of charitable and religious organisations willing to provide care and accommodation for the single mother. Of the thirteen mothers in this sample, seven spent a part of their pregnancy confined at a maternity home. The attitudes faced in these early encounters, combined with the experience at the RWH, interact to shape the overall memory of relinquishment. It is a relationship in which institutional boundaries and interactions become blurred. For these women, the treatment they received from one is often indistinguishable from or contingent on the other. For example, while Ann Groves first presented at the hospital and was then referred to the Presbyterian Sisterhood for confinement, Dianne was referred to the RWH from the Sandringham hospital. Referrals were also known to cross state borders: a 1950 report claimed that 'quite an exchange of patients' was occurring between the almoners at Crown Street, Sydney, and the RWH.<sup>166</sup> When an article appeared in the *Women's Weekly* advising single pregnant women to get in touch with the RWH, the result was 'a spate of letters from all parts of Australia, and even a remote country district of Queensland'.<sup>167</sup>

For almost all the women interviewed, the moment of disclosure often resulted in intensely emotional reactions from family members and partners: over the top, irrational and sometimes bizarre. Gillian Thomas recalls the moment when, as a nineteen-year-old, her mother and boyfriend learned of her pregnancy. Without discussing the issue with her, each independently took control of the situation by attempting to induce a miscarriage:

She then took me for a long walk on the beach, which I'm presuming she thought may have had the effect of actually causing me to miscarry or something—because it was hot and we walked for miles. Then she gave me a huge dose of laxatives, none of which worked ... The father of the child was nineteen, the same age as me. When I told him I was pregnant, he tried a similar sort of tactic, but not the same tactic. He—I was having a shower at his place, and he threw a bucket of water over me [Laughing] because someone told him that would cause a miscarriage.<sup>168</sup>

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<sup>165</sup> *Annual Report* (1940). While this was the most common arrangement, on occasion the maternity home only maintained responsibility for accommodation, while the adoption arrangements remained the responsibility by the hospital.

<sup>166</sup> Almoner Department, "Almoner's Report," (26 October 1950).

<sup>167</sup> *Ibid.*, 25 (July 1958).

<sup>168</sup> Interview with Gillian Thomas, 22 October 2010.

While this example is somewhat extreme, it does illustrate the power with which others, especially the single mother's family, managed her pregnancy. In their recollections, single pregnant women were not trusted with the ability to make adequate decisions with regard to their own bodies.

In her history of the RWH, Janet McCalman has argued that 'the decision to adopt most often was driven by the single girl's own family, but it was left to the professionals to take responsibility'.<sup>169</sup> There is no doubt that family negotiations and power plays performed an important role in the elimination of potential choices—marriage, abortion, or keeping the baby—with the repeated result that adoption was presented as the final and only solution. The support of the woman's family was indeed crucial in the consideration of available options, particularly if the single mother was still living at home. Dianne found herself in this no-win situation, controlled by her parents' ultimatum:

I wanted to keep the child. I didn't know how I was going to survive. I knew if I wanted to stay at home, I had to say I'd have an adoption, yes. Otherwise my mother was trying to get me to have an abortion. I was caught. I wanted the child. I didn't want an abortion and I managed to escape that because I was already five and a half months pregnant—it would have been pretty hard to do it at that stage. But, I did feel completely powerless. Like, I had no say in anything. I got out of the abortion, but I wasn't able to get out of the adoption. I got railroaded into it.<sup>170</sup>

At just sixteen, Maureen Phillips was also subject to the strict control of her mother. Despite having concrete plans for a future with her boyfriend (whom she subsequently married three years later) and their baby, her mother was unsympathetic to her plight.

Mum was just relentless. She was not going to let it happen, but I just sort of went along in my fantasy head that 'Oh, there's nothing they can do'. It was like I just didn't realise what was going on in the background. She must've gone around to the local church, and the priest there had told her 'No, you can't let her have the baby'. And, he must have put her on to this place in Carlton where they sent the unmarried mothers. I said 'I'm not going there'. But, because my mother was so strong and strict, it was very hard.<sup>171</sup>

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<sup>169</sup> McCalman, *Sex and Suffering: Women's Health and a Women's Hospital*, 273.

<sup>170</sup> Interview with Dianne Gray, 31 August 2010.

<sup>171</sup> Interview with Maureen Phillips, 25 August 2010.

While Maureen was able to avoid confinement at a maternity home by the grace of being able to stay with an older sister, she was unable to prevent the adoption of her child at her mother's insistence. Legally, Maureen's mother could not take the decision out of her hands, but the intense pressure of her family was inexorable.

Families maintained decisive control over the fate of their daughters, effectively endorsing society's message of wrongdoing, and further instilling a sense of guilt and shame. Maureen Rust recalls finally revealing her pregnancy in 1963:

Mum was saying how I was going to destroy my father's reputation and his life and my sisters' and brothers' lives and her life and it was like—you'd think I'd murdered somebody—and at this stage [I had only just told them] it was absolutely horrific ...

And between when I told them, two days later I was taken to Grattan Street.<sup>172</sup>

By sending her to this Catholic maternity home, Maureen's parents ensured that no one would know of their secret. In this particular case, the family's control of their daughter was even more severe. During her stay at the St Joseph's Receiving Home under the management of the Sisters of St Joseph, Maureen was also subject to her mother's set of rules, above and beyond those of the home, rigorously restricting visitors and contact with the outside world.<sup>173</sup>

## ACCOMMODATION

Swain and Howe have asserted that the punishment suffered by the single mother could be avoided if she managed to legitimate the pregnancy through marriage or indeed, by effectively hiding the evidence of her transgression altogether, either by arranging an abortion, or by hiding in a maternity home.

The women who were able to arrange an abortion or a hasty marriage were largely able to escape punishment, leaving their less fortunate sisters to bear the force of social disapproval. Accepting their fate, they set out alone to make arrangements for their pregnancy and confinement, leaving respectable society to move to that separate space set aside for women who had fallen from grace.<sup>174</sup>

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<sup>172</sup> Interview with Maureen Rust, 1 September 2010.

<sup>173</sup> St Joseph's operated Receiving Homes in Carlton and Broadmeadows.

<sup>174</sup> Swain and Howe, *Single Mothers and Their Children: Disposal, Punishment and Survival in Australia*, 59.



In the 1950s and 1960s, pregnant women were not a visible part of everyday society; this was particularly true of single women. When a married woman ventured out in public, a knowing glance at her wedding band would secure public approval. Despite a few notable exceptions, once the pregnancy became visible, it was necessary for the single woman to become invisible: hidden from the outside world. Over half of the women who participated in this study were sent to one of Melbourne's maternity homes, this is slightly higher than the thirty to forty per cent of single women in the population as a whole that available statistics would suggest.<sup>175</sup> The exclusion from everyday life and the support of friends and family enforced the sense of shame and guilt in these young women. They were removed from the security of home and segregated with strangers at one of the most vulnerable times in their lives. To add insult to injury, some women were denied the use of their own names, while others were persuaded to wear a wedding ring.

The fear of discovery was an ongoing concern, even with the promised seclusion (and isolation) of the maternity home. Antenatal appointments at the hospital offered a rare opportunity for women to leave its confines. Patricia Shine recalls one such visit where she was almost identified by a former neighbour. In recounting the event to her mother, she was offered the advice, 'Be careful who you see',<sup>176</sup> reinforcing Patricia's responsibility to remain invisible, not only for her sake, but for the sake of her family's reputation. While residents of Berry Street, the Fairfield Girls Memorial Home and both St Joseph's Homes attended the hospital for ante-natal check-ups; residents of Hartnett House, the Haven and the Presbyterian Sisterhood were closely guarded within the walls of the institution. Ann Allpike recalls the impersonal and assembly-line-like character of the doctors' visit to Hartnett House.

There was a little room that the doctor went to and then we lined up and he examined us. I have this idea, and I've always held it, that we used to be told to take our underwear off and just put our dress on and stand in the passageway and wait to go in. Perhaps this was very convenient as far as getting us in and out in a hurry. I remember being examined, but I don't ever remember being told anything about what was discovered, or what he noticed. I wasn't given any information about the birth.<sup>177</sup>

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<sup>175</sup> See Ibid., 79 which has drawn data from the *Annual Reports* (1941-1946); E Meredith and P Brotherton, "Some Characteristics of a Sample of Melbourne Single Mothers," *Australian Social Work* 27, no. 1 (March 1974): 17; and S. Miller, "Maternity Homes: The Case of a Dying Institution," *Journal of Sociology and Social Welfare* (Fall 1973): 80.

<sup>176</sup> Interview with Patricia Shine, 3 September 2010.

<sup>177</sup> Interview with Ann Allpike, 10 November 2010.

Daily life varied from home to home, but most were maintained by the work of their residents. Household chores and the care of babies and toddlers was standard practice. Sandi Barry recalls her confinement—again at Hartnett House.

When we came to the Home it was also an orphanage, and a place for the wards of state to go—the older toddler children. We had a newborn to look after and a toddler. Most of us were only sort of fifteen, sixteen, seventeen [years old] and we had to feed, bath, dress and play with them. We also had chores to do in the house: sweeping, washing the dishes, washing the floors and all that sort of stuff.<sup>178</sup>

While the denomination of the homes may have differed, the message of sin and damnation was invariable. Maternity homes operated with a view to reforming the women who stayed there. And while domestic duties were part of this package, salvation also required God's absolution. At St Joseph's prayers were compulsory and residents attended chapel daily. Nancy Johnson recalls being ordered to 'stand up and ask God to forgive our terrible sin that we had committed'.<sup>179</sup> At other homes, sermons were delivered with every meal. For the women who were confined in maternity homes, consistent and unrelenting reminders of their wrongdoing—in the eyes of God and the wider community—were an inescapable daily occurrence.

The hospital also coordinated less formal living arrangements for the single mother. Loving and supposedly altruistic couples advertised their services in the newspaper. For a reasonable fee, 'to suit the financial circumstances of the girls and of their parents', one advertisement read, unwed mothers could spend the final weeks of their pregnancy in private and homely surroundings in the Dandenong Mountains.<sup>180</sup> But more often than not, accommodation was provided in exchange for housekeeping services.<sup>181</sup> Isobel Strahan reported that 'hospital almoners have a list of families who, every year, take unmarried, pregnant girls into their homes, treat them as one of the family, ask for nothing, and look after them for a while'.<sup>182</sup> These arrangements sometimes also had the result of encouraging the young woman to place

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<sup>178</sup> Interview with Sandi Barry, 31 August 2010.

<sup>179</sup> Interview with Nancy Johnson, 23 June 2010.

<sup>180</sup> "A Haven for Unwed Mothers," *Melbourne Truth*, Saturday 10 June 1967 and "Haven for Girl in Trouble," *Melbourne Truth*, Saturday 1 July 1967.

<sup>181</sup> See Almoner Department, "Nurses' Lecture," (c.1955) where it is claimed that such arrangements are 'very often helping on both sides. Families with children find it difficult to get domestic help and it is better for these girls to be working if they are fit.'

<sup>182</sup> Isobel Strahan quoted in *New Idea*, 29 November 1961 in Swain and Howe, *Single Mothers and Their Children: Disposal, Punishment and Survival in Australia*, 67.

her child for adoption, supposedly having arrived at this conclusion quite independently of her family's belief—or the advice of the social worker.

Some of these [adopting] couples have also proved most helpful in caring for an unmarried mother while waiting to come into hospital. In the instance they are people who have already adopted one or two children so that there is no temptation for them to feel that they would like to have the baby. I find them most helpful and sympathetic to these girls. Recently a girl who felt that she had to have her baby adopted because of her parents' attitude, stayed with such a couple. She said that actually being in a household with an adopted child and seeing how much she was loved and how beautifully cared for, had helped her to arrive at her decision with less unhappiness.<sup>183</sup>

Beyond the maternity home and 'private' arrangements, alternative forms of accommodation (for those unable to remain with family) were extremely limited. What of the women who refused to enter (or were refused entry) at Melbourne's maternity homes? In 1953 Isobel Strahan, the RWH Almoner, pleaded for the establishment of a hospital-run hostel 'where we can place the girls who do not fit into these [maternity home] surroundings'.<sup>184</sup> Strahan was not only referring to the punitive practices described earlier, but was also concerned by situations in which the unwed mother returned with, and breast fed her baby for a period.<sup>185</sup> The abandonment of the requirement to care for the baby prior to adoption was consistent with a discursive shift 'which saw relinquishment replace maternal care as the ultimate expression of both the punishment and the love of the single mother and her child'.<sup>186</sup> The post-war trend was for early separation. Strahan's desire was for a hostel which could accommodate patients from the country and outer areas, as well as being used to provide maternity home accommodation for patients awaiting confinement. The proposal was again canvassed in 1964, 1967 and 1970, but never eventuated.

The concept of a hostel had been inspired by the precedent of other hospitals' ventures in this area.<sup>187</sup> Crown Street Sydney had two 'successful' maternity homes, Wakehurst and Cannonbury.<sup>188</sup> Both were situated away from the main hospital and catered for unmarried

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<sup>183</sup> Almoner Department, "Almoner's Report" (July 1957).

<sup>184</sup> Almoner Department, "Suggestions re Care of Single Girls at Henry Pride Wing," (21 October 1953); See also *Annual Report* (1954).

<sup>185</sup> With the exception of the St Joseph's Home and the Methodist Home, this was common practice that continued into the 1950s.

<sup>186</sup> Swain and Howe, *Single Mothers and Their Children: Disposal, Punishment and Survival in Australia*, 140.

<sup>187</sup> The Royal Newcastle Hospital and Crown Street Sydney both operated hostels.

<sup>188</sup> Medical Social Work Department, "General Report," November 1967.

mothers; but the latter was specifically for those who were keeping the baby. Senate Inquiry submissions have challenged the notion that such homes were successfully providing care for the single mother. At Wakehurst, it has been alleged that women were drugged, told their babies had been stillborn and tricked into signing consent (believing it was a discharge notice). It has also been claimed that at Crown Street unmarried mothers were segregated in a 'dark and frightening place' under the hospital itself.<sup>189</sup>

## ATTENDING THE HOSPITAL

Once in the hospital's domain women were subject to its rules and expectations. Doctors at the RWH were known to provide the highest quality medical care, with patients from private hospitals being transferred in cases of complication. Their authority on all matters, including social—despite no real expertise in this area—was not to be questioned. Maggie, a student midwife, recalls the atmosphere in 1971 being 'really all medical. [Patients] were all supposed to comply with orders, the patient was supposed to do what they're told, when they are told.'<sup>190</sup> The lack of consideration for the patient's feelings has been well documented by Janet McCalman who concluded that, 'however efficient and skilful the hospital was in dealing with the body, many staff, both nursing and medical, had no aptitude in dealing with feelings'.<sup>191</sup> Compounded by the harsh judgements and crushing expectations of family and society, some women were pushed to the brink of suicide; while some knew of women who had succumbed when faced with similar circumstances.<sup>192</sup> Dianne recalled the intense pressure of the situation:

I felt I had no recourse. I felt so guilty and so ashamed that I felt like I was lucky to have lived, because I had a second cousin who jumped off—when she found that she was pregnant—she jumped off a bridge and killed herself.<sup>193</sup>

The RWH has always been an overcrowded and overworked hospital with its services constantly in demand, but between 1945 and 1955 the accommodation crisis became acute: the total annual admissions doubled from 8000 to 16000. This rapid increase has been

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<sup>189</sup> Senate Inquiry, submission 15.

<sup>190</sup> Interview with Maggie, 2 June 2010.

<sup>191</sup> McCalman, *Sex and Suffering: Women's Health and a Women's Hospital*, 278.

<sup>192</sup> Interview with Maureen Rust, 1 September 2010.

<sup>193</sup> Interview with Dianne Gray, 31 August 2010.

described as a two-step process in which the first phase (between 1945 and 1948) ‘reflected the returning war servicemen and women starting their families, whereas the second from 1951 to 1954 was the coming of the migrants’.<sup>194</sup> Dianne remembers the systematic way in which patients were processed, likening it to farming practices:

You lined up with all these women. You had your card or something. There were lots and lots of Greeks, Italians, all sorts of different cultures and they'd call out. It was like a production, like cows, you know you wait out there in the waiting room with your card and then you go like that: blood test, dah, dah dah.<sup>195</sup>

Maureen Rust was equally taken aback by her treatment, which seemed to her like the person was completely disconnected from her medical management.

I'd never been to a hospital like that where they give you a number and there are rows and rows of people. All you had was a little cubicle and you never saw the same doctor. Each time I went, it was a different doctor. It was like a check-up sort of thing. So, it was all very, very ordinary really. You know, you felt sort of—I'd be sitting there and I'd be number 200 or something<sup>196</sup>

Many explanations have been offered to justify the RWH's system of numbering patients. In the late 1970s, the new Director of Nursing recalled being told that patients were given numbers because the names were too difficult to pronounce,<sup>197</sup> while midwife Mary Jones insists that it had more to do with anonymity and privacy concerns.

One of the things you'd find in the outpatient department, everybody was called by a number rather than a name, and everybody was called ‘Mrs’. It didn't really matter who they were or what they were: they will always be Mrs Brown, Mrs Jones, Mrs Smith and so really, you didn't know. Although everyone complained about being called by a number, it was so other people who were waiting in the antenatal clinic who may have known them didn't know that they were there. They were all called by a number and everybody, when they were admitted, were called ‘Mrs’.<sup>198</sup>

Despite any pretence of treating women equally by identifying everyone as ‘Mrs’, Gillian Thomas recalls her care quite differently. The condescending attitude of doctors during her

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<sup>194</sup> McCalman, *Sex and Suffering: Women's Health and a Women's Hospital*, 257.

<sup>195</sup> Interview with Dianne Gray, 31 August 2010.

<sup>196</sup> Interview with Maureen Rust, 1 September 2010.

<sup>197</sup> McCalman, *Sex and Suffering: Women's Health and a Women's Hospital*, 343-44.

<sup>198</sup> Interview with Mary Jones, 4 August 2010.

antenatal check-ups reinforced a sense that her condition had rendered her worthless in the eyes of future potential partners.

So, although they called you ‘Mrs’ it was marked on your chart [that you were unmarried] and they treated you as such. When they examined you, they always had other students there. They never asked your permission, but they had them there. [The message] that no one else will ever want you just kept going. I remember when the doctor looked to me and said, ‘Aren’t you doing anything about those stretchmarks?’ I said, ‘Well, they’re just happening anyway’ and he said, ‘You know, no one will ever want you when you’ve got stretchmarks, you’d better try a bit harder.’ That was constantly reinforced.<sup>199</sup>

An obstetric examination was (and continues to be) an extremely intimate experience between doctor and patient. In the period 1945-1975, sex was not discussed in polite company and the authority of doctors was not questioned. Social worker Valerie Douglas claimed that ‘the honoraries, at that stage, were perceived by their patients as almost gods—because you can’t get more personal than gynae with a woman’.<sup>200</sup> It was not until the early 1970s, as health information became more readily available, that women were more willing and able to speak up in regards to their treatment. American historian David Rothman has argued that this was a time when ‘docile obedience was to give way to wary consumerism’.<sup>201</sup>

From 1948, the RWH offered ante-natal or ‘relaxation’ classes for booked patients.<sup>202</sup> These were more focused on breathing exercises to assist during labour, rather than providing any information on the mechanics of child birth—of which most women remained completely ignorant. While unmarried mothers were not explicitly excluded from these classes, nor were they made to feel welcome. Lynda Stevens recalls the cool reception:

The first thing I remember in regards to there was attending some prenatal classes, and I stopped going very quickly because they were going on and on about how important it was for the husbands to be there as well, and that made me feel extremely uncomfortable. I stopped going.<sup>203</sup>

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<sup>199</sup> Interview with Gillian Thomas, 22 October 2010.

<sup>200</sup> Interview with Valerie Douglas, 19 August 2010.

<sup>201</sup> David Rothman quoted in Linda Bryder, *A History of the 'Unfortunate Experiment' at National Women's Hospital* (Auckland, N.Z.: Auckland University Press, 2009), 109.

<sup>202</sup> McCalman, *Sex and Suffering: Women's Health and a Women's Hospital*, 250.

<sup>203</sup> Interview with Lynda Stevens, 9 November 2010.

Lyn Kinghorn, who had not been put off, found the classes to be encouraging and helpful with regard to managing her labour. After the completion of the classes she felt 'very knowledgeable and quite capable on my own'.<sup>204</sup> However not all of her hospital experiences provoked such welcome memories, especially one particularly confronting internal examination.

I had to go into hospital about—I think I was about six months. I must have had high blood pressure or something like that. I had a doctor who just yelled at me and examined me really forcefully in the ward. Even the nurse that was standing there when he left said, 'What a bastard'. And I cried because he was so rough. I think he was giving me a pelvic examination or something and it felt like he was up to his armpits, just pressing into me, and it was really distressful. Then he asked me something and I said I didn't know and he said, 'You're sixteen, you ought to know.' And, he just wiped his hands on the bedspread and stomped out. That was pretty horrible.

Notwithstanding an overriding belief in the stigma of illegitimacy, there was no single way in which staff attitudes were manifest. The treatment of unmarried women—and the treatment of all other patients—depended more on individual values and personality types which may have resulted in inequitable practice. While many of the staff members expressed a sympathetic and caring attitude towards their patients, some were completely indifferent, and yet others maintained a strict authoritarianism. The 1970 *Annual Report* reproached staff for these 'old' attitudes—especially the idea 'that patients were being done a big favour by being seen at the Hospital'.<sup>205</sup>

Condemnation of the single mother occurred regardless of her intention to keep or relinquish the baby. Maryanne Craker, with the support of her partner, kept her child but recalls being heavily sedated during labour and for several days after the birth. Despite representing a so-called 'success story', Maryanne's overall memory of the hospital is negative.

Some of the clinic staff's comments and body language clearly showed their disapproval when it was realised that I was keeping our child. Other staff just got on with examining and attending the endless line of pregnant women. [In hindsight] many of the hospital staff, particularly the nurses and midwives were so judgmental

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<sup>204</sup> Interview with Lyn Kinghorn, 27 September 2010.

<sup>205</sup> *Annual Report*, (1970).

and saw themselves as the bastion of society's morals. They were going to save us 'bad girls' from our wicked selves in spite of ourselves!<sup>206</sup>

Although she experienced a 'mixed bag' of attitudes from doctors, nurses and allied staff when she attended the hospital for checkups during her pregnancy, it is the discriminatory treatment that has left a lasting impression. Social Workers, previously known as Almoners, have been particularly criticised for their inflexible management of single mothers.

## THE ALMONER

Almoners first established themselves in Australian hospitals in 1929 and would eventually come to be known as medical social workers. In his history of social work in Australia, Robert Lawrence has argued that the stunted growth of the new profession was 'both a cause and a result of the comparatively slow recognition by the Australian medical profession of social and psychological factors in health and disease'.<sup>207</sup> The structure of the young profession also left much to be desired in terms of teaching in the field as 'even in Sydney and Melbourne by the early 1960s, much of it was still being done by relatively inexperienced social workers'.<sup>208</sup> Nor had the question of registration yet been carefully considered.<sup>209</sup> In Australia, the national social work establishment was made up of a particularly small group. The situation in 1968 was one in which 'those occupying the top positions were still those who had pioneered the profession'.<sup>210</sup> For those who chose social work as their profession, Strahan argued 'it was not a job; it was a way of life'.<sup>211</sup>

Based on the British system, the primary function of the RWH almoner was to assess the patient's ability to pay for treatment. It took over twenty years for the almoners at the RWH to challenge this role—and they claim to be the only ones in the world still charged with fee

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<sup>206</sup> Maryanne Craker, "Personal Communication to Author," (2011). Maryanne had just turned nineteen when she gave birth in 1970.

<sup>207</sup> Robert John Lawrence, *Professional Social Work in Australia* (Canberra: Australian National University, 1965), 156.

<sup>208</sup> Ibid., 144. While the training of students had long been a part of the hospital, almost since the inception of the department, a dedicated teaching almoner did not exist until 1956, see Almoner Department, "Almoner's Report," 2 August 1956.

<sup>209</sup> Lawrence, *Professional Social Work in Australia*, 98.

<sup>210</sup> Michael Horsburgh, "Personal Reflections on Australian Social Work," *Australian Social Work* 60, no. 4 (2007): 392.

<sup>211</sup> Strahan, "Looking Back: 25 Years of Social Work at the RWH."



assessment in 1955.<sup>212</sup> With the increasing ex-nuptial birthrate and the growing problem of infertility, particularly in the post-war period, adoption came to be recognised 'as a field that required specialised worker training'.<sup>213</sup> The staff of the Almoner Department saw the opportunity for a greater role in the services they could provide to their clients, one in which they could 'maximise her benefit from hospital treatment'.<sup>214</sup> Whereas this often involved providing supplementary charity help, finding clothes and layettes, organising child care and negotiation with sustenance offices, the almoner also assumed a duty to 'help single girls to make suitable plans'.<sup>215</sup> The first hospital adoption was arranged in 1941.

In these early years, the department appears to have run quite independently within the hospital. Almoners had yet to convince the medical staff of the usefulness of their services, particularly with regard to the way in which a patient's social problems could affect her physical well-being. At this time, the department was only reported on yearly to the Board of Management. In 1950, the House Committee stipulated three-monthly reporting and requested that these reports be personally delivered at meetings.<sup>216</sup> The contents of existing archival material suggest that this was not strictly adhered to and reports continued to be written sporadically, varying both in style and frequency. Legislative changes to adoption in the mid-1960s drastically transformed the department and its accountability. The new legislation also coincided with a staff turnaround. While Isobel Strahan had carried the full adoption work load from 1942 to the mid-1960s, the Department moved in a new direction under the leadership of Valerie Douglas from 1965.

McCalman has argued that during this time social work was changing its focus, with adoption becoming an increasingly fundamental aspect of the profession, particularly at the hospital.<sup>217</sup> Indeed, the Department had long since shifted its emphasis from 'patients in need of care because of poverty, when a great deal of material aid has been needed, to patients in need of guidance and advice with problems'.<sup>218</sup> With the appointment of Valerie Douglas, the Department was renamed the Medical Social Work Department, and she worked hard to

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<sup>212</sup> Almoner Department, "Almoner's Report," 3 November 1955.

<sup>213</sup> J. P. Triseliotis, Joan F. Shireman, and Marion Hundleby, *Adoption : Theory, Policy, and Practice* (London; Herndon, VA: Cassell, 1997), 8.

<sup>214</sup> McCalman, *Sex and Suffering: Women's Health and a Women's Hospital*, 204.; see also *Annual Report* (1949).

<sup>215</sup> Almoner Department, "Duties of the Almoner," (c.1950)

<sup>216</sup> Manager, "Intra-Hospital Memo to Miss Strahan," (28 March 1950).

<sup>217</sup> McCalman, *Sex and Suffering: Women's Health and a Women's Hospital*, 271.

<sup>218</sup> *Annual Report* (1960).

establish the professional credentials of social workers, especially amongst the doctors. Douglas was adamant that she was a social worker—not an almoner.

It was the Social Work Department, from when I started—or at least from when I had the authority to change it. Sometimes I threw them things: I took off my white coat. When I had the choice, I took off my white coat and the others took off their white coats. To me that was an assertion of authority, and you didn't want to approach people as if there was a power difference between them and you. They had equal rights as anyone.<sup>219</sup>

But social workers held onto an unwavering belief that the obstacles facing the single mother were insurmountable, to such an extent that the professional advice offered was considered to be more appropriate than the single woman's right to make her own decision. With the support of her mother, twenty-year-old Lynda Stevens was determined to keep her baby, but the RWH social worker had other ideas about her ability to raise the child. Lynda recalls this encounter:

The only thing I can remember is that horrible final meeting with her, when she told me that the child would grow up in the gutter and I'd be forced to become a prostitute to support her. Oh, it was quite horrible. And, she really did get red-faced. I remember it vividly.<sup>220</sup>

While Lynda did keep her child, she was not provided with any assistance from the hospital. This memory stands in stark contrast to Isobel Strahan's claim in 1964 that 'a large number of girls kept their babies and received assistance of one kind or another from us. A great deal of baby clothing was provided.'<sup>221</sup>

Submissions to the Senate Inquiry are rife with accusations that social workers were not assisting single mothers in accessing available government benefits. In contrast, documentary evidence at the RWH indicates that the department provided small loans to women in need, albeit to facilitate inter-state travel expenses that might eventuate in a hospital-arranged adoption.<sup>222</sup> Similarly there are indicators that social workers were assisting single mothers in completing and submitting forms for sickness and unemployment benefits that were temporarily available to pregnant and breastfeeding women. Requests for medical certificates

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<sup>219</sup> Interview with Valerie Douglas, 19 August 2010.

<sup>220</sup> Interview with Lynda Stevens, 9 November 2010.

<sup>221</sup> *Annual Report* (1964).

<sup>222</sup> *Annual Report* (1960).

to prove a patient's eligibility for benefits were common.<sup>223</sup> While other stop-gap payments may have been available in other states, these did not exist in Victoria.

The Almoner Department had initially implemented as standard procedure that all ante-natal patients be interviewed on their first visit to the RWH.<sup>224</sup> But the busy Department, its insufficient staff besieged by an ever-increasing volume of work, as well as the practical difficulties of recruitment and retention of workers, needed to better prioritise its time.<sup>225</sup> By 1962, preference was given to never married women, who were the only patients to be routinely interviewed on the first visit. The almoners' time was unevenly allocated, with the midwifery patients receiving a 3:2 preference over the gynaecological patients, who consisted mainly of women receiving radio-surgical treatment for cancer.<sup>226</sup> Although married midwifery patients were still assisted by the department, they would have to make the approach and request help themselves.

Figure 3 (over) provides a rudimentary statistical overview of the confinement of single mothers at the RWH, indicating the number of adoptions arranged at the hospital as a percentage of total births (blue); the number of single mother confinements as a percentage of total births (red) and finally the likelihood that an ex-nuptial birth would result in a hospital arranged adoption (green). Although single mothers only accounted for twenty per cent of the midwifery population, they constituted up to eighty per cent of the Medical Social Work Department's work; the 1967 *Annual Report* claimed that 'four-fifths of our time is spent with one-fifth of the hospital's total patient population'.<sup>227</sup>

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<sup>223</sup> *Annual Report* (1949) and "Social Work Department Patient Cards." (c. 1935-1965).

<sup>224</sup> *Annual Report* (1949).

<sup>225</sup> See *Annual Report* (1951) when the department was in the process of moving offices; and also Almoner Department, "Almoner's Report," (July 1957).

<sup>226</sup> Based on statistics from *Annual Report* (1960).

<sup>227</sup> *Annual Report* (1967).

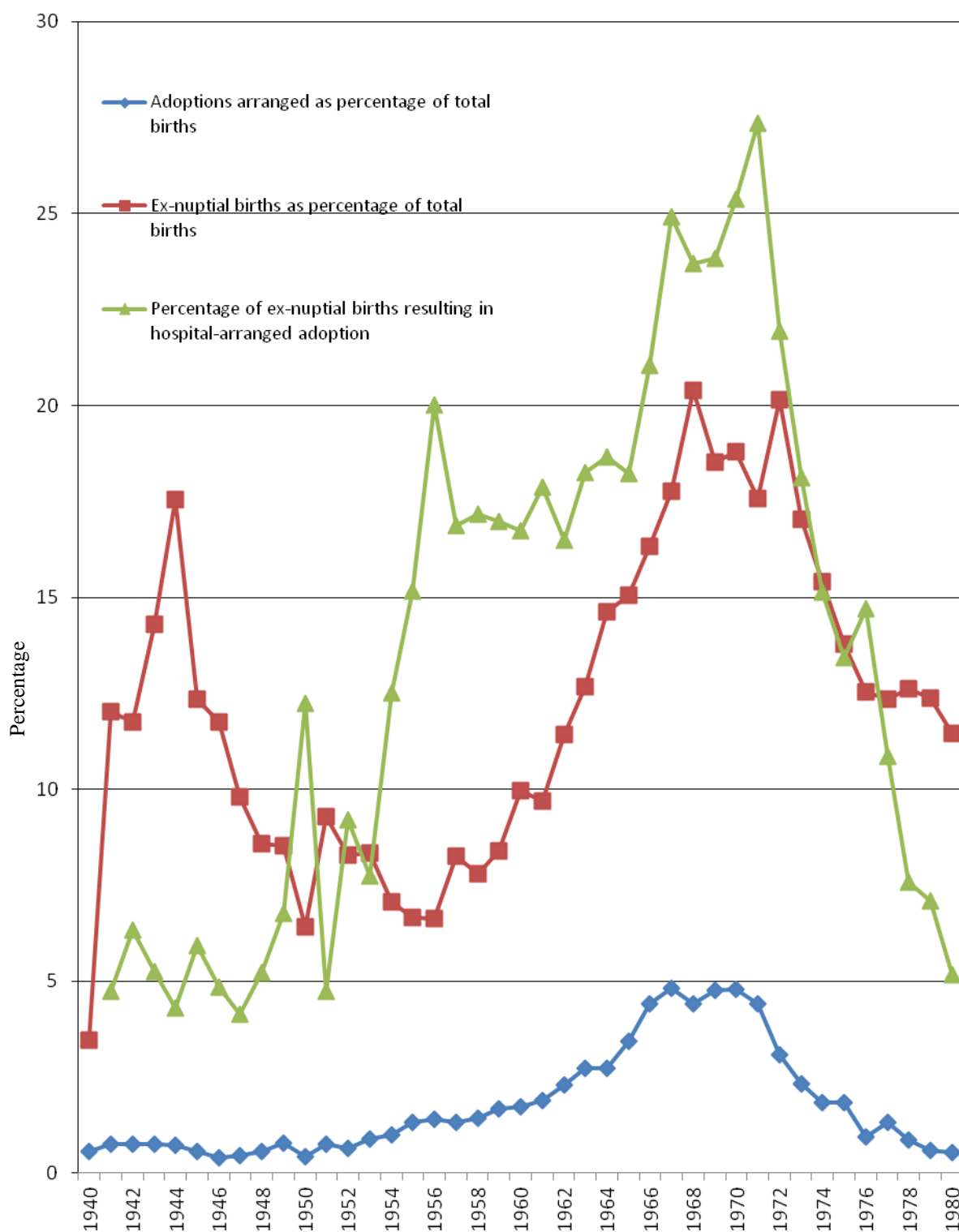


Figure 3: Adoption and Confinement Statistics for Single Women at the RWH (1940-1980)<sup>228</sup>

<sup>228</sup> Data for this figure was gathered from the following sources: the total number of babies born per calendar year as recorded in the Birth Registry; adoptions arranged per calendar year as recorded in Social Work Department Reports and Records; and single mothers (Almoner only) per calendar year after 1955, also in Social Work Department Reports and Records. Unfortunately, prior to 1955 the records are scarce and of those, it is impossible to determine if the single mother numbers have been recorded per calendar or per financial year.

The casework service to single mothers had been offered at the RWH since October 1959. It was during these counselling sessions that the social worker took it upon herself to challenge the unwed mother to 'recognize and overcome personal and environmental problems' and to accept the reality of her situation.<sup>229</sup> That she had no means of financial or emotional support, as well as nowhere to live provided the evidence that would lead to a single conclusion: adoption. In outlining the adoption procedures practised at the RWH, hospital manager A.J. Cunningham reported that in her ongoing contact with the Social Work department, the mother is 'fully informed and advised as to the particular social problems involved'.<sup>230</sup> This emotional blackmail involved convincing the single mother that if she loved her child, she would relinquish it.

Of course I was seeing her every week, for so-called counselling, but it was just complete brain-washing to give the child up. I was told that I had no means of support. I had nowhere to live, and that if I loved the child, had any feeling for the child whatsoever, I'd give him up. The social worker stuck to that line right from the beginning to the end.<sup>231</sup>

The rhetoric used by social workers was echoed in the problem pages of women's magazines such as *Woman's Day* and *New Idea*. Single mothers were advised that their 'baby will go to loving adoptive parents and a good home', and asked to consider the question: 'could you as an unmarried girl, offer as much to the child?'.<sup>232</sup> This type of response dominated the column throughout the 1960s.<sup>233</sup> Social workers made similar promises:

You were giving up your child for the best of reasons; you were giving up your child to give it a good happy life, which you couldn't possibly provide for it ... Usually they sort of made it sound like the couple who were adopting the child were wealthy, secure marriages, mature people, experienced, loving ... Really it seemed like to keep your baby was to be very selfish anyway.<sup>234</sup>

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<sup>229</sup> Almoner Department, "Almoner's Report," (October 1959).

<sup>230</sup> A.J. Cunningham (Manager & Secretary), "Letter to Dr J.H. Lindell, Chairman of the Hospitals and Charities Commission Re: Adoptions," (19 November 1964).

<sup>231</sup> Interview with Dianne Gray, 31 August 2010.

<sup>232</sup> "Problem Page," *New Idea*, 28 March 1962.

<sup>233</sup> Swain, "Dear Problem Page, I'm Single, Pregnant And...": 106.

<sup>234</sup> 'Angela' in Swain and Howe, *Single Mothers and Their Children: Disposal, Punishment and Survival in Australia*, 142-43.

This chapter has explored the ways in which pregnancy was experienced by the single mother. Despite evidence suggesting that stereotypes were unfounded, her treatment continued to be based largely on the belief that her behaviour (pregnancy) was the result of unresolved emotional conflict and severe emotional disturbance.<sup>235</sup> And while the community and professional attitudes encountered by the single mother early in her pregnancy maintained that adoption offered the best solution, decision-making was most strongly influenced by her family's support or opposition to keeping and raising the baby. The resulting adoption was sanctioned by families in three distinct ways: as a result of direct pressure for adoption, as a strategy to avoid an abortion or forced marriage, and through total secrecy for fear of bringing shame upon one's family. Unfortunately, women were unaware that they would later be chastised for the decision which once had been encouraged. One County Court judge was claimed to have remarked that 'it seemed a sad and extraordinary thing that anyone would go through the whole process of having a baby simply to give it away to someone else'.<sup>236</sup> Single mothers at this time were caught in a situation destined to failure: 'damned if you do; damned if you don't'.

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<sup>235</sup> Social Welfare Department, "Service and Counselling to Natural Parents in Relation to Adoption," Lecture for Adoption Course, 1971.

<sup>236</sup> Almoner Department, "Nurses' Lecture: Adoption," (c.1963).

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# CHAPTER FOUR

## DELIVERY & RELINQUISHMENT

*The picture of a young couple flashed through my mind – a tall, handsome bloke and a pretty girl. They must have been very much in love. I wonder why they didn't marry? Perhaps it was all one big mistake, and they hated each other for it.*

*I sat there listening, yet not listening, to the voice.*

*'She is a typist, and it is her biggest dream to go travelling all over the world.'*

*'Well, my dream is coming true. I hope hers comes true too,' I thought. I could see the excited girl, hair flying, running to catch a plane. She could enjoy herself, not having the responsibility of a baby.<sup>237</sup>*

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<sup>237</sup> A reader's story of adoption, 'Our Baby Isn't Called Lennox Any More,' *Australian Women's Weekly*, (Wednesday 6 November 1974), 122.

Prior to the women's rights movement of the late 1960s and early 1970s, the sheer lack of knowledge women possessed about their own bodies is remarkable. Some women had even failed to make the connection between intercourse and pregnancy. The lack of meaningful childbirth education only served to exacerbate this problem. Within this context, the onset of labour was a particularly fraught experience. One midwife recounted the extent of women's ignorance about the mechanics of childbirth, as well as their own bodies.

I had a woman once and she said to me, 'Am I going to have a very big scar?' And I said, 'No. Why do you think you're going to have a scar?' 'Oh,' she said, 'When I have the baby won't I have a big scar?' And I said, 'Well, you tell me what you think is going to happen to you'. She said, 'Well, my tummy when I get the pain comes up to a point and like a carnation it bursts and you pick the baby out and then it all folds up again'. And, we just couldn't believe it. She was married. And, it just was incredible! We had to madly get the birth atlas and take it out and show her this is what's going to happen. She nearly died when she saw what's really going to happen.<sup>238</sup>

While this lack of understanding inevitably coloured the experience of childbirth, it would equally be affected by the RWH's role as a teaching hospital. Registrars and pupil midwives clamoured around patients to ensure that the delivery quotas required for the completion of their courses and qualifications were met. That these younger staff members often lacked a sense of professionalism or bed-side manner goes without saying. Women at the RWH were further at the mercy of a fragmented administrative system that privileged the practices of individual senior doctors and midwives at the expense of an overarching and cohesive hospital policy. This chapter will critically examine the distinct organisational structure of the RWH, particularly with regard to the way in which this system was open to the subjective moral judgements of the professionals holding positions of power, although some umbrella policies will also be noted. It will then consider the experience of labour, delivery, and finally relinquishment, especially in the light of hospital policies and practices which regulated the specific management of single mothers.

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<sup>238</sup> Interview with Mary Jones, 4 August 2010.



## HOSPITAL ADMINISTRATION

The administrative structure of the RWH was—and continues to be—distinct from other hospitals in that it is arranged into a series of five ‘units’ which operated their clinics on a specific day (and for which the unit is subsequently named). With regard to practice and procedure, each unit was managed and run independently of the other, much like separate hospitals for each day of the week. Headed by a senior gynaecologist and obstetrician, each unit was also responsible for the total care of its assigned patients. Dr William Chanen claims that in this, the RWH is unique when compared to other hospitals across the country. As a result of this disconnected system, a variety of unwritten policies and practices were implemented. These differed within each unit, as did the attitudes and personalities of particular doctors, midwives, and nurses. Chanen was a resident in 1953 and recalls the flexibility with which each independent unit was allowed to operate.

I do not believe there were specific guidelines or policies that were codified within the hospital. At that stage there were five separate units functioning in the hospital. Each of those units was quite independent and ran their own system as they thought fit. They managed the patients in the mode that they thought fit, so there was no overall hospital plan.<sup>239</sup>

Unit procedure was dictated by the preferences of the doctor(s) in charge, with everyone claiming to be following the lead of a more senior staff member. Amid rules constantly changing at the whim of those in command, no one questioned the authority by which orders were given, nor did they speak up on behalf of vulnerable patients. In remembering her birthing experience, Dianne recalls the doctors and nurses she encountered.

Well, one doctor that delivered the child, he said, ‘I’ve never given anyone so many stitches,’ and he looked quite compassionate and I think he looked as if he thought it probably wasn’t right. But who was he to say anything? And as for the nurses, I can’t say that they were all nasty or anything like that, I mean they just grabbed the child. Everyone just followed the rules. The rules were already stipulated and that was already mapped out, so people just did what they had to do and felt that they had to do.<sup>240</sup>

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<sup>239</sup> Interview with Dr William Chanen, 1 June 2010.

<sup>240</sup> Interview with Dianne Gray, 31 August 2010.

While the attitudes of the older staff were often more rigid in their moral pronouncements and subsequent treatment of their patients; it was not until a younger generation of nurses, midwives and doctors entered the hospital that change was being effected by the late 1960s.

By and large, there were some old timers there who would always be old timers who would never change. But the younger midwives—and especially when you had the chance to talk to midwives during their training (because it was the leading hospital for training and midwifery as well). It was just younger people coming into the hospital, taking charge, and being charge sisters and all the rest of it, and that was generational change in many ways. I don't remember ever—except for one sister in the, of all places, in the delivery room. She was so authoritarian and assertive for politeness' sake, with people who didn't do what she thought they ought to be doing—the patients I mean—she, too, had to retire someday, didn't she?<sup>241</sup>

Despite an apparent autonomy in the daily operation of these units (particularly with regard to the management of patients), there also existed a measure of accountability to the hospital administration and board. Positioned at the head of this administrative hierarchy were the Medical Superintendent and the Manager/Secretary. Combined, these two positions functioned much like the Chief Executive Officer (CEO) of the hospital, with the former more concerned with medical matters, and the latter managing the finances.<sup>242</sup> The position of medical superintendent was held by the tall and imposing John Laver from 1951-1969. He has been described as 'a new breed of medical superintendent: hospital administration was his career and superintendency was not a stepping stone to senior private practice'.<sup>243</sup> Laver was dedicated and hands-on in this role: a man who knew what was going on in every corner of his hospital. And while 'the immediate war service of the medical and nursing staff coloured their professional culture' at the time Laver was appointed, his command of the hospital was unquestionable.<sup>244</sup>

While the treatment and management of the single mother was often left to the discretion of senior staff members, some aspects of hospital policy and practice were maintained more consistently across all units, particularly medical charts. Rumours and accusations abound regarding the intention to adopt being recorded on these documents, often without the

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<sup>241</sup> Interview with Valerie Douglas, 19 August 2010.

<sup>242</sup> In 1978 the positions of Medical Superintendent and Manager/Secretary were abolished and combined in the role of CEO.

<sup>243</sup> McCalman, *Sex and Suffering: Women's Health and a Women's Hospital*, 236.

<sup>244</sup> Ibid.

mother's knowledge. In NSW, it has been established that charts were marked 'BFA' (Baby For Adoption),<sup>245</sup> while at the RWH, it has been alleged that these were marked 'A' for adoption. A brief examination of medical charts from 1963-64 indicate that this coding system did in fact exist, but midwives contend that the 'A' simply indicated that the patient was a client of the Almoner Department—and not necessarily an indication that the baby was for adoption. Kath Curtain explained: 'They were down as Mrs. Smith on your bed list and there would be an "A" beside the patient indicating it was an Almoner case.'<sup>246</sup> Indeed some of these medical charts coded with the letter 'A' did indicate that the patient was married.

Despite such claims, statistical evidence reveals another side to this story. The reality of the situation was that an overwhelming number of almoner clients were single mothers. Never married women constituted 67 per cent of obstetric patients seen by the Department in 1963, and by the end of 1967 this number had increased to 77.6 per cent.<sup>247</sup> The remainder of Almoner/Social Work clients consisted of de facto, separated, divorced, deserted wives and widowers, with married women only representing 6.4 per cent of new patients. That assumptions would be made as to the significance of the letter 'A' is not surprising.

For doctors, an "'A" Class' obstetric record indicated the way in which a patient would be allocated to particular ante-natal and general gynaecological clinics.<sup>248</sup> As for potential medical complications, these were noted on a patient's card by way of coloured or 'special' labels: some alerted the Medical Officer that his personal attention was required (such as a red label for a non-specified 'case at risk'); others denoted abnormalities which carried a potential for complications (such as a yellow label for women under the age of 18). Being an unmarried mother was considered a risk in itself.

[Unmarried mothers] were singled out in the context that they were considered a high risk group, and therefore, a lot of them had what they call red labels on them, which identified individuals that might have more problems obstetrically, than others; trying to predict the possibility of problems. So, a lot of them had red labels on them, which was a warning sign on their actual card.<sup>249</sup>

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<sup>245</sup> Cole, ed. *Releasing the Past: Mothers' Stories of Their Stolen Babies*.

<sup>246</sup> Interview with Kath Curtain, 4 August 2010.

<sup>247</sup> Medical Social Work Department, "Report Prepared for Medical Social Work Sub-Committee ", (July 1963) and (January 1968).

<sup>248</sup> Medical Superintendent, "Medical Directive," Med. 3/1970.

<sup>249</sup> Interview with Dr William Chanen, 1 June 2010.

Again, as a result of the different units operating within the same hospital, different procedures were in operation based on the specifications of the particular unit. It was recognised that the response to the various coloured labels on a patient's card would be different. For example, in the case of a red label, 'the action taken by the registrar, subsequent to being notified is dependent on the policy of the unit for whom he is working', while 'normal procedure' was to be followed 'unless there is a specific instruction written by the doctor to vary the usual procedure' in the instance of a yellow one.<sup>250</sup>

## DELIVERY

The labour ward was a particularly frightening place for a first time mother: noisy and chaotic. Few women knew what to expect of the birthing experience because it was something that was not discussed. On the other hand, the behavioural expectations were very clear: bear your pain in silence. Patricia Shine recalls her experience in the hospital, particularly 'being told to keep quiet, I was just disturbing the other mothers'.<sup>251</sup> The unwanted noise was alarming and disturbed the military order of the ward. While Australian mothers obeyed instructions to keep quiet, it was the immigrant women who threw caution to the wind and openly expressed their fear and discomfort. They too were reprimanded for their unlady-like outbursts.

In the labour ward, I had pain, they help with medicine. They done what they had to do, but they don't help me or any kindness. They treat me very strange. They treat me not a friendly. They done their proper job that they have to do, and of course it was the main thing but no one come to me and say 'I'm sorry for you', or some nice kind word. I remember one nurse who say 'Shut up you, you naughty girl', because of I don't care, I was screaming, I don't care. I was a scream because they expect me not to scream. I can't be quiet. I was screaming because I was lonely. I was scared. I did not know anything about labour because we were brought up strictly in a respectable family. We not allowed to talk about these things.<sup>252</sup>

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<sup>250</sup> Medical Superintendent, "Medical Directive," Med. 57A/1973, (31 December 73).

<sup>251</sup> Interview with Patricia Shine, 3 September 2010.

<sup>252</sup> 'Gina', twenty-one year old proxy bride quoted in McCalman, *Sex and Suffering: Women's Health and a Women's Hospital*, 262.

Lynda Stevens was admitted early due to pre-eclampsia. While she wasn't yet in labour, she was placed in the labour ward awaiting induction.

And the shaving was one thing and the fact that it was done by a lot of giggling student nurses practising, didn't help, and then I went to the labour ward and to a cubicle and all I could hear was screaming. There were lots of Greek and Italian type women in the hospital at the time, who made an awful noise during childbirth and that was going on all around me. That was quite terrifying hearing all the screaming of women giving birth while I was sitting on the side of a bed feeling quite fine. I can remember actually I had some notepaper with me and I got out a pen and paper and wrote a letter to a friend saying, 'Hey, I'm writing you this from the labour ward in the hospital'.<sup>253</sup>

For Ann Groves, it was the sheer loneliness and isolation while in hospital that made it so harrowing.

I remember being in this room by myself, and I remember being in an awful lot of pain. I do remember, someone—a nurse—giving me a Cortisone injection for something. I don't know what. I also remember a group of students coming in and poking and prodding and looking and talking and I was absolutely and totally on my own. I felt absolutely and totally on my own. Scared. You've no idea how scared I felt. And now when I look back—I mean what, it's forty-odd years ago. I don't remember a lot of the actual pain, a lot of the—it's almost like a blur, a dream. But, it wasn't. It was an awful time. Horrible. I can't remember actually being in the hospital for that long, but [my medical record] says I was, so I must've been, and then I was sent back to the Sisterhood.<sup>254</sup>

A woman's pain during labour was managed by her doctor and the attending midwife. While women could certainly ask for pain relief, but they often didn't; again the lack of knowledge resulted in women being unaware that they could. And whereas some women laboured well, others became increasingly distressed. Doctors and midwives would determine the level of analgesia administered by these outward signs of pain, although these would not be evident if the woman were obeying conventions to labour quietly.

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<sup>253</sup> Interview with Lynda Stevens, 9 November 2010.

<sup>254</sup> Interview with Ann Groves, 28 May 2010.

Of course the patient would influence that decision. If they were obviously in pain, and, and if they were crying out for pain relief, they would be given pain relief. Whether it was adequate or not is a different question.<sup>255</sup>

Pethidine was the most commonly used drug in the management of labour pain. Helen Johnstone remembers that ‘we were always giving pethidine as student midwives and we were always checking the drugs after every shift’.<sup>256</sup> Another drug often used during labour, especially for first time mothers, was heroin. When the export of heroin was to be banned worldwide in the early 1950s amid mounting concerns of drug abuse in the United States, the RWH stockpiled a massive supply.

The Medical Superintendent at the RWH at the time thought so highly of the drug and was wise enough to buy it in about a ten-year supply. After its import was banned, the hospital used it for about ten years afterwards, and we were one of the few hospitals in Australia who still has a supply of heroin.<sup>257</sup>

According to the Senate Inquiry submissions, there is evidence that heroin was still being used at the RWH as late as 1966.<sup>258</sup> Furthermore, based on a small sample of medical records covering 1963 and 1964, there is supporting documentary evidence that the use of heroin continued after its ban. These records revealed that in each instance the mother was primigravida, and in one out of three instances, she was married. The ages of the mother ranged from sixteen to twenty-three. This sample of records also indicated that morphine was administered immediately after most births, for both married and unmarried mothers.

Doctors at the RWH had become reliant on the use of heroin in labour. Arguing for its effectiveness, especially over other analgesics that can complicate and prolong a woman’s labour, Dr Chanen explained:

The doctor always ordered the analgesic, and in those days, we used to use heroin, which was a marvellous and wonderful drug in obstetrics. I would venture to say that if it were re-introduced it would probably halve the incidence of caesarean section. It was just that good. If they were single mothers, first time around, they used to get their ‘sixth of heroin’. In fact, there was a particular obstetrician who used to preach that never, ever, perform a caesarean section on a first time labour unless the patient has

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<sup>255</sup> Interview with Dr William Chanen, 1 June 2010.

<sup>256</sup> Interview with Helen Johnstone, 4 August 2010.

<sup>257</sup> Interview with Dr William Chanen, 1 June 2010.

<sup>258</sup> Senate Inquiry, submission 176.

had a ‘sixth of heroin’, and it was good advice. Often, when their progress had been quite slow—and I used to also preach the dictum—‘Is it safe to wait another four hours before I make up my mind?’—Give them heroin and come back in four hours and re-assess the situation and the degree of progress. Very frequently they would be ready for delivery soon after.<sup>259</sup>

Midwife Margaret Mabbitt also confirmed the usefulness of heroin in labour:

Heroin was used a lot for primigravida, first babies, because we had a good stock of heroin. It was marvellous because it relaxed [the mothers] and they went to sleep. They woke up with the head on the perineum. It was great.<sup>260</sup>

But while heroin was admired for its medical efficacy, the subsequent effect on the mothers remained unacknowledged. For some women, the doses of heroin and morphine were excessive and left them feeling dazed and confused:

... no wonder labour, delivery and after is ... a vague impression? A sense of ... My next memory is fuzzy, blurry white in a darkened room. Hands and arms mill around, dart out from all directions, I recall struggling to sit up, a distinct feeling of euphoria sensing my child's [sic] presence and I may have even touched him, fleetingly ... but having no visual memory, just a sense of? ... I'm overwhelmed with spontaneous joy, the reality, the shock of my very own son impacts ... Then another black out when morphia was administered according to the records, *after* the birth.<sup>261</sup>

However, claims that unmarried women were administered excessive doses of sedatives during and after labour, sit alongside claims from others that pain relief was withheld. Meg recalls her labour in 1964:

The nurse came over ... she brought a young guy with her ... She gave the instructions to him, there was to be no anaesthetic and to be no mask ... Then he must have wanted to do an episiotomy, but she said, ‘No, let her tear.’<sup>262</sup>

Individual practitioners supervised labour and pain relief as they saw fit. There is no evidence of any explicit policies in regard to the administration of pain relief to single mothers in labour, be it in excessive dosage or in its refusal, either within specific units or in overall hospital management. For example, the use of heroin was advocated in practice for

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<sup>259</sup> Interview with Dr William Chanen, 1 June 2010.

<sup>260</sup> Interview with Margaret Mabbitt, 4 August 2010.

<sup>261</sup> Senate Inquiry, submission 176.

<sup>262</sup> Swain and Howe, *Single Mothers and Their Children: Disposal, Punishment and Survival in Australia*, 88.

primigravida, but again, this was not consistently administered in all cases. In the end, it was the attitude of individual doctors and midwives toward the patients that resulted in a variety of experiences. Dr Chanen did not feel that this was a deliberate practice, but instead the result of the diversity of personalities working at the RWH.

There was no selection of unmarried women, saying well, 'let them suffer'. I don't believe that at all. I might have seen some midwives, at the time, whose personality suggested that they felt single mothers were 'guilty' in the sense 'you have sinned: pay for your sins'. But that was an individual reaction, and I guess there might have been medicos who felt the same way. After all, there is a spectrum in human nature. But, by and large, I feel they were pretty sympathetic to the girls.<sup>263</sup>

For a normal delivery at the RWH, women gave birth lying on their left side with a midwife holding the leg up (or 'legging'). This conservative and outdated position was known as left lateral and midwives report that it was used into the 1970s. It was comfortable neither for the midwife, nor the patient, although it may have suited the obstetrician and the student.<sup>264</sup> Despite professing to be quite flexible, one mother recalls the infamous birthing position.

The way of giving birth was terrible. Giving birth on your side—I forget what it was called now—on your side with your leg pushed up like a flagpole. I remember it hurt.

It was bloody agony giving birth like that with your knee pushed up.<sup>265</sup>

Besides the pain, another unfortunate result of the 'legging' position is that it automatically prevented any mother seeing the baby at birth. Student midwife Margaret explained the different way in which things were done—and the difficulties that this often entailed.

There were a lot more drapes around and stirrups and so [all mothers] often really didn't see because we did deliveries in the left lateral position then, so the mum was facing away. As the baby was born, it was handed over to somebody on the right and wrapped up and taken away out into the baby room, because they then had a baby room. So, you might have been the nurse in the baby room cleaning the baby and making sure it was clean, and you did observations on the baby out there.<sup>266</sup>

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<sup>263</sup> Interview with Dr William Chanen, 1 June 2010.

<sup>264</sup> See also McCalman, *Sex and Suffering: Women's Health and a Women's Hospital*, 20. McCalman explains that this 'classic British position gave the accoucheur clear access and was good for teaching, but the most important reason for the left lateral position was the control it gave the accoucheur over the speed of the birth.'

<sup>265</sup> Interview no. 40, in "Single Mothers Oral History", Collected Interviews, held in private collection of Professor Shurlee Swain.

<sup>266</sup> Interview with Margaret A, 19 May 2010.



With regard to forceps delivery and caesarean section, women would be positioned on their backs with their legs up in stirrups. As these were both considered medical procedures, a sterile field was required at all times. And while midwives dismiss claims that pillows and sheets were deliberately used to shield the unmarried mother's view of her baby, they confirmed that it was common practice to remove all babies immediately upon giving birth, before their mothers had a chance to see them.<sup>267</sup>

Caesarean section was a far more conservative practice in past obstetrics. Not only was the procedure more dangerous than it is today, but some doctors considered it an admission of defeat. Whereas, in the 1950s and 1960s the rate of caesarean at the RWH was around five per cent, today the incidence in public hospitals is much closer to twenty per cent, and possibly as high as fifty per cent in private bookings. The low rate of caesarean section in past practice at the RWH is even more extraordinary when one considers that the hospital was dealing with a higher percentage of problem births than those encountered in private institutions.

In our unit the senior obstetrician was very conservative. He would run labour for three or four days or more, which in today's light would be seen as terribly cruel. But, they were often an attempt to avoid caesarean section, and it was 'safe'. It might have been unpleasant and tiring, but was cut short if there was a considered risk to either mother or baby. In general, it was not all that uncommon to have much longer labour than is the practice today.<sup>268</sup>

That such prolonged labours could be viewed as a punitive measure towards the single mother is not surprising, especially since the practice was most likely directed at her. But it has been argued that this practice was in line with more respectable intentions, particularly to leave minimal evidence of the illegitimate birth on the mother's body as a result of medical concerns for future pregnancies, and more importantly in order that she might pass as single and unblemished for her future husband.

Some of the senior obstetric staff, to make matters worse, refused to perform a caesarean section on an unmarried woman unless her life was in danger. They did not want to leave a scar on her uterus for fear that it might rupture in a subsequent pregnancy; and since the unfortunate might one day rehabilitate herself into a

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<sup>267</sup> None of the women interviewed recounted an experience of having their view shielded by pillows or blankets at the RWH.

<sup>268</sup> Interview with Dr William Chanen, 1 June 2010.

respectable married woman, she should be able to start her legitimate family as though she were virginal.<sup>269</sup>

Midwife Mary Jones supported reports that doctors were reluctant to perform caesarean sections on unmarried women—and again emphasised the underlying belief that the decision was medically grounded, as well as completely safe.

The only thing was with single mothers in the '60s was doctors were very loath to Caesar them because they would have left a scar on the uterus, and so they tended to be left in labour a little bit longer than say a married woman, but it was only because they felt they were doing the right thing.<sup>270</sup>

## SEPARATION & RELINQUISHMENT

The impact of the hospital's labelling system for medical charts was felt in the serious consequences it had for the unmarried patient. Statistically speaking, it was already assumed that her baby was to be placed for adoption based on the presence of the letter 'A', but more alarmingly this coding indicated that the mother was not to see her baby. In 1960, the Medical Superintendent implemented a hospital-wide policy that the babies of mothers who were clients of the Almoner Department should be taken directly from labour ward and placed in the nursery. The intra-hospital memo dated 11 February clearly instructed labour ward staff:

In future babies of patients whose ante-natal card is marked 'A' will be cared for in the Nursery after transfer from labour ward and will not go out to the mother, until the Almoner is contacted regarding the future of the baby, or unless the mother specifically requests to see and care for the baby.<sup>271</sup>

As a student midwife in the late 1960s, Margaret recalls these specific orders being issued by the midwife-in-charge:

The midwife in charge would be telling you: 'She's not to see the baby. The baby's up for adoption.' They were known as 'A' babies and it was known right from the start that it was an 'A' baby.<sup>272</sup>

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<sup>269</sup> McCalman, *Sex and Suffering: Women's Health and a Women's Hospital*, 275.

<sup>270</sup> Interview with Mary Jones, 4 August 2010.

<sup>271</sup> J.C. Laver (Medical Superintendent), "Intra-Hospital Memo to Ward 34, Re: 'A' Patients," (11 February 1960).

<sup>272</sup> Interview with Margaret A, 19 May 2010.

Although the mother maintained her legal right to contact, this policy dictated that she must explicitly express the desire to see her baby—a convention that did not extend to married mothers. Carrying on from this policy, further practices of separation of the newborn infant and its single mother developed. Social worker Valerie Douglas confirmed that it had become a matter of practice for contact to be routinely withheld, particularly prior to, or on condition of, the signing of consent.

There is no question that nursing staff were instructed by their director of nursing who had been instructed by the Medical Superintendent that single mothers should not see their babies if they were going to sign a consent to adoption. There was nothing ever produced in writing, but it was practice.<sup>273</sup>

While Dr Chanen recalled that hospital practice did not expressly forbid contact between mother and child, this was never actively encouraged.

If the baby was for adoption, they frequently didn't see their babies. I think there could have been instances where they wanted to and they would, and I think it's fair to say they were generally discouraged, because it was believed that this might aggravate guilt or various psychological problems.<sup>274</sup>

The belief as to whether or not it was in the best interest of the mother to see her baby (and vice versa) varied to some extent. To be sure, the baby's very survival depended on its mother's breast milk until artificial feeding was firmly established in the mid-1920s. At this point the practice of maintaining contact between mother and child essentially ceased and early separation became de rigueur. Swain and Howe argue that the punishment of single mothers had been effected through forcible care prior to WWI; later it was dependent on early separation as the key to salvation and in which 'mothers were transformed from nurturer into enemies of the newborn child'.<sup>275</sup> Isobel Strahan explained the philosophy at the heart of early separation to the *Argus* in 1950:

If the baby is to be released to adoption it is much better for both mother and child that they are parted as soon as possible after birth ... Such girls are often in a very emotional state after confinement and the parting with the child after caring for it for several weeks may have a serious psychological effect ... The only way to assist such

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<sup>273</sup> Valerie Douglas, "Personal Communication to Author," (2011).

<sup>274</sup> Interview with Dr William Chanen, 1 June 2010.

<sup>275</sup> Swain and Howe, *Single Mothers and Their Children: Disposal, Punishment and Survival in Australia*, 113.

a girl to rehabilitate herself is to find work for her which is not only suitable but will provide her with a fresh interest in life.<sup>276</sup>

That it was in fact more compassionate for the mother not to see her child became a fixed idea in the minds of professionals. For example, when the accommodation of sick babies awaiting adoption became problematic in 1968, the suggestion that unmarried mothers care for their own baby while awaiting placement met with intense disapproval. It was reasoned that ‘forcing girls temporarily to hold medically deferred babies is a course which holds such dangers that—humanitarian reasons aside—it would be against the community’s interests to permit this to occur’.<sup>277</sup> While such opinions were presented as holding the mother’s best interests at heart, the practice of separation equally supported the view that the presence of single mothers in the community would be dangerous and potentially compromise society’s strict moral values.

The decision about the mother’s ability to see her baby was often made prior to the birth and contained in her history or outpatient notes. As an ‘A’ patient, the explicit policy as to the care of her baby was already in place. But midwives also recall receiving advice as to the treatment of the single mother from the social worker, who would have already determined the intentions of the single mother.

Usually there had been discussion with the social worker in advance from my vague recollection, as to what they intended to do, and if the baby was for adoption the social worker would discuss with them the advisability of seeing the baby or not as you are relinquishing your baby, and that might be in the advice that we got.<sup>278</sup>

In the light of the existing evidence, women were most likely advised not to see their babies. Although they may have agreed with the logic presented before giving birth—afterwards it was another story.

Following delivery, most women returned to the wards without their babies. While the consent had yet to be signed; largely the decision had already been made. Post-partum recovery was much longer than is common today: typically up to ten days—coinciding with the time required for doctors to medically clear the baby for discharge and adoption. While women were required to remain in bed for the first forty-eight hours, they were often

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<sup>276</sup> Isobel Strahan quoted in *Argus*, 18 July 1950.

<sup>277</sup> *Annual Report* (1968), 32.

<sup>278</sup> Interview with Mary Jones, 4 August 2010.

provisionally discharged not long after this compulsory period of recovery; either to the Henry Pride wing or returned to their respective maternity home to continue their convalescence.<sup>279</sup> While still confined at the RWH, many of the mothers recall futile attempts to locate the nursery in which their baby was being held.

They wouldn't let you out of bed for forty-eight hours so by the time you got out of bed you'd be—you couldn't stand or it was quite horrendous. I remember trying to get out of bed and going down the hallway when no one was around— trying to find the nursery. I got caught down there and was immediately taken back and because of that they came and told me that they'd removed the baby to another floor.<sup>280</sup>

But the post-war baby boom had placed enormous pressure on the capacities of the already busy maternity hospital. Policies dictating long convalescence exacerbated the shortage of beds at the hospital, so the Medical Superintendent was hard at work, discharging as many patients as possible.

There was always a problem of bed shortage, day after day. I recall the Medical Superintendent would do a daily round and discharge as many as possible to Henry Pride, or get them home with District Nursing. That was another way they handled them, but of course you couldn't do that with single mothers post-partum because they didn't necessarily have homes to go to.<sup>281</sup>

While married women could be more readily discharged to their home to take advantage of the domiciliary nursing service, single mothers, particularly those who had travelled from interstate, could not.<sup>282</sup>

It has been claimed that the practice of isolating single mothers from other hospital patients first developed at the RWH and then spread to other maternity wards across the country via the doctors and midwives who had trained there.<sup>283</sup> In the course of this research, conflicting stories have emerged amongst patients and former hospital staff as to whether or not single women were in fact separated from their married counterparts. Midwife Margaret Mabbitt recalls that the practice was dictated by the ward on which the single mother was placed:

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<sup>279</sup> Henry Pride was a convalescent home established in Kew in 1949 to which 'healthy' post-partum mothers, both married and unmarried, were sent. Women with any medical complication or condition, such as diabetes, were maintained at the hospital.

<sup>280</sup> Interview with Maureen Phillips, 25 August 2010.

<sup>281</sup> Interview with Dr William Chanen, 1 June 2010.

<sup>282</sup> Single mothers were prohibited from using the domiciliary service.

<sup>283</sup> Swain and Howe, *Single Mothers and Their Children: Disposal, Punishment and Survival in Australia*, 80.

In two of the wards, which were big open wards with a balcony, all the single mums were out on the balcony, away from mums with babies on the whole. In the other wards, they were more mixed up.<sup>284</sup>

In the wards where the separation of single and married mothers did occur, it was not necessarily a matter of hospital policy, but instead, recalls Matron Betty Lawson, it was a matter of routine practice:

We got into the habit of putting the single girls out on a balcony because we thought it was nice for them, but it came to be assumed by then that they were out there for punishment. That wasn't the intention at all—it was to protect them from closer contact with ward babies.<sup>285</sup>

Midwives have claimed that the intention of such practices was to safeguard the single mother from distress or jealousy at seeing other mothers care for their babies. Notwithstanding claims that it was not motivated by punishment, the way in which it was received by single women is quite another matter. Another midwife recalls that the balcony provided the lesser-quality accommodation on the ward: 'it was quite a cold old balcony with screens and it was quite bleak and desolate, really'.<sup>286</sup> Despite the attempt at separation, the thin screens did little to shield unmarried mothers. Dianne vividly recalls her separation from the mothers who had their babies:

When you had the child, you couldn't go and mix with the others. This wasn't right, and we were all put in this ward on our own and we were only separated by a curtain, a thin curtain, so all the other mums on the other side were breast feeding. Here we are with all our milk running out and no child. It's pretty traumatic.<sup>287</sup>

Other women were tormented by their placement on wards with married women who were allowed to hold and cuddle their babies, while the unmarried mothers were forbidden from doing so. The sight of mothers feeding and bonding with their babies was often too much.

My baby was taken from my bedside and placed all alone in a nursery. I was forbidden to see him or go in the nursery. I was then left for several days sitting on a bed in a ward full of married mothers who were allowed to have their tiny babies next

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<sup>284</sup> Interview with Margaret Mabbitt, 4 August 2010.

<sup>285</sup> Matron Betty Lawson quoted in McCalman, *Sex and Suffering: Women's Health and a Women's Hospital*, 276-77.

<sup>286</sup> Interview with Margaret A, 19 May 2010.

<sup>287</sup> Interview with Dianne Gray, 31 August 2010.

to their beds. They were able to hold their babies, cuddle them and feed them whilst I sat and watched and cried.<sup>288</sup>

While it may have been hospital practice (and indeed policy) to separate the unmarried mother from her baby, no formal policy existed to forbid contact. In fact, such actions would have been illegal. It has also been alleged that by withholding contact, women were coerced into authorising consent, indeed being promised that they could see their baby once they had signed. Despite keeping her baby, Lynda Stevens recalls being separated from her daughter, during which time she was visited by a social worker making a final attempt to convince her to relinquish.

It was a younger woman coming around trying to get me to change my mind. Asking me to sign the papers, yes. And at that stage other than the fleeting glimpse of this slimy bundle when she was born, at that stage I hadn't even seen my daughter. They were keeping her from me. But the reason was that they stated that she was sickly and had to be in the humidi-crib for longer. Yes, she was a bit premature and she was only about five and-a-half pounds birth weight. So, it was a plausible reason. I can't say for sure that they did it on purpose, but certainly it was before I was allowed to see her or hold her that they came around asking me to change my mind about adoption.<sup>289</sup>

Notwithstanding policies to the contrary, some mothers did care for their babies. Maureen Rust gave birth to her daughter in 1963 and recalls the brief time they spent together in hospital.

I had her with me the whole time I was there. I was breastfeeding, but you don't have a lot of milk the first couple of days, you're trying to breastfeed and then I started—I did give her a bottle as well. And then I went to the after care. That was at St Joseph's.<sup>290</sup>

But Maureen also remembers the trauma of relinquishing her baby after having bonded with her over those first few days.

That day was horrific. I was just—I don't know. I was probably quite mad. I sort of curled up in the corner and was screaming and didn't talk properly for a day or two. You know I was—mortified. I can't describe how bad it was. It was just absolutely horrible because I didn't really want to give her up and I was quite bonded with her.<sup>291</sup>

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<sup>288</sup> June Smith in *Hansard*, CA34.

<sup>289</sup> Interview with Lynda Stevens, 9 November 2010.

<sup>290</sup> Interview with Maureen Rust, 1 September 2010.

<sup>291</sup> Interview with Maureen Rust, 1 September 2010.

In another exceptional case, Lyn Kinghorn, who also gave birth to a daughter in 1963, was able to care for her baby too. She guarded this secret from her mother, who she felt would have forbidden it from happening.

When I was in the ward, I had my baby with me all of the time, except at visiting hours. I didn't let mum know that I had her with me. I pretended that she was away from me, because she would have made sure that that didn't happen if she knew. So, I had her with me and then they came and said that she was too small and she would have to be in the prem nursery and so I just parked in the prem nursery. So I cared for her and had a really beautiful time caring for her, and then they sent someone to take me back to Berry Street, and to leave her behind. And, I'd been in there for a week, and I ran to this sister screaming to get her. And, she just said, 'Go home and be a good girl.' So, I was dragged out just absolutely screaming and out of control and got back to Berry Street and the matron was there and she said, 'I hope you've learnt your lesson'.<sup>292</sup>

There is no question as to the strong feelings that Maureen and Lyn developed for their daughters during the short time for which they were able to provide their care. The difficulty with which these women subsequently relinquished their child after bonding is also undeniable. The emergent policy of rapid and absolute separation was possibly a reaction to heartfelt and distressed responses such as Maureen's and Lyn's. The conviction that seeing the baby would exacerbate feelings of guilt over the relinquishment—and potentially lead to a change of heart—became the main reason for not allowing contact. Increasingly, the belief that the single mother should not see her baby was upheld by hospital staff. Gillian Thomas recalls begging to see her son in 1968:

I came to after sedation and everything else and I said I wanted to see my son and they said 'No, no, no, that's not in your best interests,' and I said, 'But I want to see him.' 'No, no, no, no.' So, in the end, after I made a fuss, the matron came in and she said, 'You're a silly, silly, silly girl wanting to see your child'. She said, 'We don't like it' but she said, 'If you are so determined, you can walk to the labour ward.' Now, I had something like thirty-two stitches and she said, 'If you think you can walk—if you can walk to there, then I'll let you see your son.' So, I went from bed to bed because I was dead determined. She put me in this little room, opened the door, handed me my son, had a stopwatch. Put a chair against it and said, 'You've got five minutes and then you

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<sup>292</sup> Interview with Lyn Kinghorn, 27 September 2010.



can walk back again.’ So, she gave me exactly five minutes and I unwrapped him and looked at him, and if I’d thought of it I would have tried to breast feed him but you know, it was all too overwhelming. And then in five minutes, the door opened and she grabbed him and said, ‘All right now, find your own way back’.<sup>293</sup>

Regardless of when or by whom the decision was made to allow or forbid contact between the single mother and her baby, the end result was that many did not. Medical Superintendent, doctor, midwife, and social worker were all complicit in confirming to the mother that it was in her best interest not to see her child. In response one mother explained,

I just did what I was told ... I have a vague recollection of seeing the nurse holding him, wanting to hold him, of really wanting to hold him, but you don’t hold your baby I was told, you don’t touch your baby, you stay right away from your baby ... right through I just did what I thought I was supposed to do ... I didn’t allow myself to feel any kind of closeness.<sup>294</sup>

While single mothers may have attempted to control their feelings, they could not control their body’s physical response to having given birth. Engorged with milk for a baby they could not feed, they had their lactation was routinely suppressed.

They were given drugs to suppress lactation—that was the routine. In general, breast-feeding didn’t have quite the same enthusiasm as it does have today. But, they would routinely be given drugs to suppress lactation, and would be discharged from the RWH very soon after delivery, often to the annex out in Kew.<sup>295</sup>

Student midwife Margaret’s impression of this practice was that it was simply another way in which the unmarried mother was punished:

One of the things I did notice, though, was that these women who were relinquishing their babies, their milk had to be suppressed. There was this terrible feeling of, ‘well, you’ve got yourself into this trouble so you need to pay for it’.<sup>296</sup>

There is no doubt that many unmarried mothers were given ‘some pills’ to dry out their milk. And while the long-term effects of these drugs are uncertain, another emergent concern regards the fact that lactation was suppressed prior to signing consent. The belief that the

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<sup>293</sup> Interview with Gillian Thomas, 22 October 2010.

<sup>294</sup> ‘Diane’ quoted in Swain and Howe, *Single Mothers and Their Children: Disposal, Punishment and Survival in Australia*, 88.

<sup>295</sup> Interview with Dr William Chanen, 1 June 2010.

<sup>296</sup> Interview with Margaret A, 19 May 2010.

early suppression of milk provided 'prima facie evidence' of the intention to take the baby prior to any legal recognition of a mother's intent to relinquish has led some women to claim that the hospital 'intended taking my baby for adoption regardless of what I wanted'.<sup>297</sup> From a medical point of view, early suppression was preferable in all cases, as oestrogens are less effective when lactation has already been established and the course of therapy would subsequently be lengthened and increased discomfort and pain would result in the certain use of analgesic drugs.<sup>298</sup>

Adoption was one of nine contra-indications to breastfeeding alongside various concerns over the physical and mental health of the mother, certain diseases and malformations in the infant.<sup>299</sup> A married woman's right to choose not to breastfeed as a result of prior difficulties or simply because of a busy lifestyle was equally recognised and treated accordingly. Of the specific drugs that were prescribed, medical records reveal that women were as likely to be given Aprinox, Mixogen or simply aspirin as an alternative to Ethinyl Oestradiol or Stilboestrol.<sup>300</sup>

First manufactured in 1938, Stilboestrol (also known as diethylstilboestrol or DES) is a synthetic oestrogen that has been used to prevent miscarriage, for the management of menopause, as a morning-after contraceptive, as a lactation suppressant, and in the livestock industry. Stilboestrol is much cheaper to produce than plant or animal derived oestrogens and is also three times stronger.<sup>301</sup> In 1971, the use of DES was linked to a rare type of cancer (clear cell adenocarcinoma, or CCA of the vagina and cervix) amongst the daughters of women who had been prescribed the drug during pregnancy. These daughters have up to a forty times greater risk of developing this type of cancer: as a result the drug was banned.<sup>302</sup>

Studies on the adverse effects of Stilboestrol have focused on its use during pregnancy and its consequent effects on these mothers, their sons, their daughters, and even the potential risk to third generation offspring. Women who took DES while pregnant have 'a small increased risk

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<sup>297</sup> Senate Inquiry, Submission 176.

<sup>298</sup> Campbell, (1965 revision edited by Dr T.G. Maddison, and Begg), "Neonatal Paediatric Lecture Notes."

<sup>299</sup> Dr. Kate Campbell, Dr. J. Glyn White (1965 revision edited by Dr T.G. Maddison, Dr. K. McCaul, Sister E.M. Begg), and (1969 revision edited by Dr. W. Kitchen and Sister E.M. Begg), "Neonatal Paediatric Lecture Notes," (1969).

<sup>300</sup> "Medical Records," (Melbourne: The RWH Medical Record Archives, 1963-1964).

<sup>301</sup> Barbara Seaman, *The Greatest Experiment Ever Performed on Women: Exploding the Estrogen Myth* (Melbourne: Schwarz Publishing, 2003).

<sup>302</sup> Centres for Disease Control and Prevention, "DES Update: Health Care Providers," <http://www.cdc.gov/des/hcp/nurses/history.html>. (accessed 10 June 2010).

of breast cancer' while the greatest risk remains with those who were affected in utero.<sup>303</sup> No studies have been conducted on the effects of Stilboestrol and its short-term use as a lactation suppressant. DES Action Australia (NSW) claims that Stilboestrol was sometimes administered to overdose, without informed consent, to former forced adoption victims.<sup>304</sup> While interviews, neonatal paediatric lecture notes, and medical records confirm the use of oestrogen as a lactation suppressant at the RWH between 1941 and 1971, neither accusations of nor evidence of overdose have emerged. By 1981, the RWH had established a DES referral clinic and has continued to produce literature on the risks of DES exposure.<sup>305</sup>

## CONSENT

Prior to the introduction of the 1964 Adoption of Children Act, there were no provisions as to when consent could be taken. As a consequence, most arrangements were finalised prior to the baby's birth. Maureen Rust recalls already having signed the consent to adoption and having resigned herself to the finality of her decision when her father belatedly suggested she might keep the child.

'If you want to keep this baby you do it,' and I said, 'Dad, I've already signed the baby away, I've already signed the papers', which was something underhand that was done because you weren't advised or anything. I said, 'You're just a little bit late'. And he said, 'Well, you can still think about it'. But I'd gone through so much to do what I'd done and I thought: why didn't he say that to me at the start, and why am I in this place and you know lots of things.<sup>306</sup>

And while Maureen gave birth at the RWH, her adoption was arranged through the Catholic Family Welfare Bureau (CFWB). She had not been advised of her right to revocation under the 1958 Adoption of Children Act.

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<sup>303</sup> The Cancer Council (NSW), "DES and Cancer - Position Statement," [http://www.cancercouncil.com.au/html/prevention/risks\\_factsheets/print/fact\\_desandcancer.htm](http://www.cancercouncil.com.au/html/prevention/risks_factsheets/print/fact_desandcancer.htm).

<sup>304</sup> Senate Inquiry, submission 21.

<sup>305</sup> See Health Commission of Victoria and The RWH, "The DES Problem," in *Bulletin for Medical Practitioners* (Melbourne: The RWH Archives, March 1981); The RWH with the contribution of DES ACTION and the Health Issues Centre, "Could This Be You? DES Exposed," (Melbourne: The RWH Health Promotion Unit, April 1989); The RWH, "More Information on DES Exposure," (January 1990); Women's Health Information Centre, "Were You Pregnant or Born between 1938 & 1971? You May Be Affected by DES," (Melbourne: The RWH, June 1999).

<sup>306</sup> Interview with Maureen Rust, 1 September 2010.

The 1964 Act stipulated that consent not be taken prior to the sixth day after the birth of the child. The signing of consent effected a blanket provision that extinguished all parental rights and bestowed these *ad litem* on the Principal Officer of the adoption agency, rather than the couple who would adopt the child.<sup>307</sup> The problem with this condition was that in some cases the child was not in fact adopted, but as a result of any issues that may have arisen after the signing of consent (and for which the mother had no legal right), the child ended up a state ward, despite the mother's intention to provide the best possible care of her child by having it adopted by a married couple.<sup>308</sup> It is sadly ironic that the child should subsequently end up in state care as women were threatened with that very scenario in order to encourage the signing of consent—and guarantee the best possible outcome for their child. Sandi Barry remembers the intimidatory remarks that were used to bully her into a decision:

And then we were back at the home and I was having a paper shoved underneath my nose, and told to better sign the adoption papers otherwise your son won't have a good life because people here want to give him a good life and you won't be able to, so you're best to sign these papers and get it over with. So again, you just did what you were told.<sup>309</sup>

With hindsight, concerns have been raised in relation to the legality of consents to adoption signed by minors. In interpreting the 1964 Adoption of Children Act, Bourke and Fogarty explain that 'the mother of an illegitimate child is recognized by the Act as having the full status of a parent of a child born in wedlock'.<sup>310</sup> The Act clearly stipulates that the consent required in the case of an illegitimate child 'is every person who is the mother or guardian of the child'<sup>311</sup> (effectively dispensing with the consent of the putative father). While the premise

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<sup>307</sup> See Bourke and Fogarty, *Bourke and Fogarty's Maintenance, Custody and Adoption Law : Comprising Maintenance, Custody and Adoption under the Maintenance Act 1965 of Victoria, Marriage Act 1958 of Victoria and Adoption of Children Act 1964 of Victoria, and Maintenance and Custody under the Commonwealth Matrimonial Causes Act 1959-1966*, (Melbourne: Butterworths, 1967), 307 and also *Adoption of Children Act 1964* in which s.24 stipulates that 'every consent to adoption of a child shall be construed as a general consent to the adoption of a child by any person, except where the consent is for the adoption of a child by a relative.'

<sup>308</sup> In one particular case in the "Social Work Department Patient Cards" a Sydney woman placed her child for adoption in good faith, but when the child was returned from its placement for 'medical reasons', it became a ward of the state and was sent to the SWD.

<sup>309</sup> Interview with Sandi Barry, 31 August 2010.

<sup>310</sup> J. P. Bourke and J. F. Fogarty, *Bourke and Fogarty's Maintenance, Custody and Adoption Law: Comprising Maintenance, Custody and Adoption under the Maintenance Act 1965 of Victoria, Marriage Act 1958 of Victoria and Adoption of Children Act 1964 of Victoria, and Maintenance and Custody under the Commonwealth Matrimonial Causes Act 1959-1966*, 306. The consent of both parents (regardless of age) is required if the child is born in wedlock. See 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).

<sup>311</sup> *Adoption of Children Act 1964*, s.23.3.

on which consent to adoption was taken from a minor was one which upheld the mother's inalienable right to make decisions on behalf of her child, in hindsight the ability of a minor to make such irrevocable decisions in a mature and reasoned fashion is questionable.<sup>312</sup>

A potential conflict of interest has also been identified with regard to the witnessing of consent. The Principal Officer of an adoption agency was often responsible for, and acted as counsellor to, both the relinquishing mother and the prospective adoptive parents. It is difficult to imagine the ability to provide an evenly balanced service to each of these clients with quite distinct needs. Again, the issue of advocacy is raised in relation to the social worker and the vulnerable single mother: her parents were generally not present at the signing of consent, despite their obvious influence in earlier stages of the decision making. The lack of parental involvement at this stage is of particular concern in the case of minors. Eighteen-year-old Dianne recalls signing the consent:

You weren't regarded as young; even though you were young you were still regarded as fully responsible. There's no interview of parents or anything like that. That didn't come into it. You signed the dotted line and the job is done, you know, that's it. So, it was a massive scar, a massive wound. It was very traumatic.<sup>313</sup>

Around this time it was also required that the birth be officially registered. This blue form was separated into two parts: the top part was completed in labour ward, the rest done by the birth clerk, who visited mothers on the ward in the days following delivery. While women at the RWH were required to name the child, they were forbidden from recording the name of the father on the birth certificate.

The birth registration was horrible at that stage. I don't know what it says now, but I'm pretty sure that the forms at that stage, they had to enter in 'unknown' as the father's name unless the father was prepared to sign, and I used to fight afterwards for that to be changed to 'undisclosed' rather than 'unknown' but I don't know whether that change ever happened. It would seem horrible to have to put in 'unknown.'<sup>314</sup>

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<sup>312</sup> It has also been argued that 'a single mother whatever her age is the sole legal guardian of her child and remains so until a consent to adoption is signed.' See Dr J. Friend, Preamble, *A Policy Concerning the Rights of Parents Planning to Surrender a Child for Adoption and Hospital Practices in Regard to Such Parents*, Health Commission of New South Wales, Circular no. 82/297, No. 5659, File no. C108, Issue 1 September 1982, quoted in Senate Inquiry, submission 166.

<sup>313</sup> Interview with Dianne Gray, 31 August 2010.

<sup>314</sup> Interview with Lynda Stevens, 9 November 2010.

In the hospital birth registry the instruction for the father to register, particularly in de facto situations, was always expressly indicated, while in the case of the single mother the entry was left blank. By 1961 the instruction became explicit for the father *not* to register in all instances of unmarried mothers (except de facto). Swain and Howe have argued that ‘depriving the illegitimate child of the right to its father’s name was central to preserving the sanctity of marriage’.<sup>315</sup> So while de facto couples were not legally wed, they enjoyed a marriage-like arrangement for all intents and purposes, with the mother often using her partner’s surname; the single woman, however, flaunted her status at the expense of the institution of marriage.

All such practices were business as usual for the hospital, designed to ensure its smooth operation with little concern as to their impact on patients. An Ann Allpike recalled,

No one was friendly towards me. Everybody was just doing their job. And, that was it. I mean I remember the woman coming to register the birth, and they were all very businesslike. But, no one was cruel. Well, it depends how you define ‘cruel’ and ‘abusive’ and all that sort of thing doesn’t it? I didn’t look upon it as being cruel. They were very distant, and gave me no information, and I didn’t ask. I didn’t know what to ask and I didn’t know that I had any rights, and I just went through it all.<sup>316</sup>

This chapter has outlined the ways in which a single mother was particularly vulnerable as she approached her labour and the delivery of a baby she would ultimately have to relinquish. As a result of her limited understanding of her body and the mechanics of childbirth, as with most women giving birth at the hospital, her experience was particularly frightening and traumatic. The fragmented organisational structure of the RWH that privileged the practices of individual senior doctors and midwives at the expense of an overarching and cohesive hospital policy allowed personal and subjective moral judgements to enter hospital practice. On the other hand, a limited number of cohesive hospital policies operated in such a way as to regulate the behaviour of the single mother by assuming her intention to adopt, separating her from her child, and ensuring that consent was signed. This chapter has challenged the notion that women willingly relinquished their babies and has presented the way in which the RWH’s management of single mothers regulated their expected behaviour, facilitating the desired outcome of adoption through both policies and practice.

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<sup>315</sup> Swain and Howe, *Single Mothers and Their Children: Disposal, Punishment and Survival in Australia*, 181.

<sup>316</sup> Interview with Ann Allpike, 10 November 2010.

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# CHAPTER FIVE

## THE BUSINESS OF ADOPTION

*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?*<sup>317</sup>

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<sup>317</sup> Letter to the Editor, "Import Babies," *Argus* 29 March 1947.

The idea that children should be permanently removed from their parents in order to improve their life chances consolidated during the early twentieth century. The 1928 Adoption of Children legislation entrenched this ideal 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.<sup>318</sup>

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'.<sup>319</sup> 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.<sup>320</sup>

Media campaigns focused on promoting the benefits of adoption coincided with a rise in its popularity after World War II. Women's magazines were particularly vocal in their advocacy of adoption as a solution, both for the infertile couple and the single mother.<sup>321</sup> 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'.<sup>322</sup> The RWH was often the first agency to receive requests for assistance when

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<sup>318</sup> Attorney-General Slater quoted in Swain and Howe, *Single Mothers and Their Children: Disposal, Punishment and Survival in Australia*, 137.

<sup>319</sup> F. Oswald Barnett, *The Unsuspected Slums* (Melbourne: Herald Press, 1933), 28.

<sup>320</sup> McCalman, *Sex and Suffering: Women's Health and a Women's Hospital*, 271.

<sup>321</sup> Swain and Howe, *Single Mothers and Their Children: Disposal, Punishment and Survival in Australia*, 142-144.

<sup>322</sup> Medical Social Work Department, "Report Prepared for Medical Social Work Sub-Committee" 21 June 1968



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’.<sup>323</sup>

In a sense, adoption arrangements were akin to a business transaction and used a language of economics, with single mothers supplying a market demand for adoptable babies. In hindsight, the mechanics of this arrangement were obvious. Dianne recalls feeling swept into a power imbalance.

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, so I felt like it was a real imbalance of power. Like, we had no power and I felt like as if the hospital policy at the time was to make sure that there was at least sixty per cent of the women who gave their children up, you know, as if that was the mandate of the social work department to encourage women to give their children up, at least have a certain percentage, to fulfil all the demands of the wealthy clients wanting children.<sup>324</sup>

The demand for adoption 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, Isobel Strahan noted that ‘though there was an increase in the number of adoptions arranged last year, the waiting list is still very long’.<sup>325</sup> By 1955, the almoner was bemoaning a decreasing number of available babies.<sup>326</sup> 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.<sup>327</sup> By 1974, the waiting lists for adoption were closed. The supply of infants had indeed dried up marking the end of ‘the era of the “perfect baby” for the “perfect couple”’.<sup>328</sup> At this time, infertile couples increasingly looked to the new technologies of artificial insemination at the RWH.

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<sup>323</sup> Almoner Department, "Almoner's Report," 16 March 1945.

<sup>324</sup> Interview with Dianne Gray, 31 August 2010.

<sup>325</sup> *Annual Report* (1953).

<sup>326</sup> Almoner Department, "Almoner's Report." 3 November 1955.

<sup>327</sup> *Ibid.* 25 July 1958.

<sup>328</sup> Triseliotis, Shireman, and Hundleby, *Adoption : Theory, Policy, and Practice*, 7.

## ADOPTIVE PARENTS AS CUSTOMERS

A large proportion of adoptive parents at the RWH were private patients of the hospital's honorary doctors. As the number of available babies decreased, restrictions were placed so that only the esteemed honorary staff could make referrals. The procedure that followed had to include an investigation of 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.'<sup>329</sup>

However, while hospital social workers prided themselves on the thorough investigation of prospective adoptive parents, honorary medical staff 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 arrange 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.<sup>330</sup>

There is no question that the service of adoption was provided primarily for infertile couples who created the demand. But social workers remained aware that adoption should not be used as a cure-all. In a 1963 Nurses' Lecture, Isobel Strahan warned of sentimentality as a driving force, perhaps at the expense of proper consideration.

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<sup>329</sup> Conference of Approved Adoption Agencies, *Notes on Adoption (for Distribution to Doctors, Solicitors, Nurses, Ministers and Other Professional Groups)* which in turn cites Victorian Government "Adoption of Children Regulations" (Regulation 31).

<sup>330</sup> A.J. Cunningham, "Letter to Miss V. Douglas, Medical Social Worker," 1 September 1967.

The weight of public opinion in this regard is far too [sic] much directed to the childless couple and sentimentality rather than a real consideration of the pros and cons sways their judgement ... It would appear that far too often adoption is regarded as a therapeutic measure.<sup>331</sup>

Social workers also remained attentive to the fact that it was not only the adoptive parents or the children involved for whom they were responsible, but the relinquishing mother as well. For Valerie Douglas, it was important 'that we placed [their] babies with people that we considered would give them the care that they would want for their child'.<sup>332</sup>

Prior to the introduction of the 1964 Adoption of Children 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, wealthy couples could take advantage of such an opportunity in order to fulfil their family dream. William Chanen 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.<sup>333</sup>

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'.<sup>334</sup> 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'.<sup>335</sup>

Midwife Mary Jones recalled a particular incident prior to the introduction of the 1964 Act.

I can remember one woman and the social worker was saying she wondered about it too because the woman came in as Mary Smith and Mr Smith came to visit her. When they went to go home, the baby was dressed in the most exquisite clothes from Bambi

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<sup>331</sup> Almoner Department, "Nurses' Lecture." (c.1963).

<sup>332</sup> Interview with Valerie Douglas, 19 August 2010.

<sup>333</sup> Interview with Dr William Chanen, 1 June 2010.

<sup>334</sup> Almoner Department, "Nurses' Lecture" (c. 1963).

<sup>335</sup> Strahan, "Looking Back: 25 Years of Social Work at the RWH."

Cross that you could ever imagine and they went home in a lovely big car. The social worker asked me: 'What happened to Mary Smith?' and I told her she had gone home with Mr Smith. The social worker replied, 'There isn't a Mr Smith.' Mr Smith's wife couldn't have any children, so I don't know whether it was his child or whether he had just found this woman, who was pregnant, and so the baby was registered as the child of Mary Smith and Tom Smith, and the wife took the baby. *She* was Mary Smith and the girl disappeared.<sup>336</sup>

Despite the changes enacted by the 1964 Adoption of Children Act, which intended to eradicate the business of illegal adoptions, 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'.<sup>337</sup> 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.

Another example of how the adoption process could be perverted became apparent when the Eildon property of Anne Hamilton-Byrne, leader of notorious cult 'The Family', was raided in 1987 resulting in the removal of ten adopted children. 'The Family' consisted of fourteen adopted children, nine or ten of whom had been acquired through the RWH in the period 1968-1974.<sup>338</sup> Sect members posed as legitimate applicants and subsequently handed the children over to Hamilton-Byrne.<sup>339</sup> According to Sarah Hamilton-Byrne, one of Anne's adopted daughters and author of a tell-all account of life inside 'The Family', sect members were respected individuals in the wider community.

Almost without exception the members of the sect are professionals, without whose active participation such an organisation would have failed. It was their names, their

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<sup>336</sup> Interview with Mary Jones, 4 August 2011.

<sup>337</sup> Social Welfare Department, "Seventh Conference of Adoption Agencies."

<sup>338</sup> Lynne Holroyd, "An Adoption Dream That Went Wrong," *Age*, 24 August 1988.

<sup>339</sup> Sarah Hamilton-Byrne, *Unseen, Unheard, Unknown* (Ringwood, Vic.; New York: Penguin Books, 1995), 121.

qualifications and their social status, that has bestowed the credibility and social influence.<sup>340</sup>

With the level of subterfuge with which these adoptions were arranged, it would have been difficult for any professional to 'pick' that there might be something amiss. For all intents and purposes, the adoptions were arranged with articulate and educated couples. However, this incident does highlight the lack of follow-up with adoptive families.

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, but had come to expect it. Senior social worker at the Psychiatric Centre in North Ryde, N.S.W., 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'.<sup>341</sup>

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).<sup>342</sup>

Babies who did not fit this ideal were harder to place. 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

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<sup>340</sup> From a paper presented by Sarah Hamilton-Byrne and Antoinette Sampson to a psychology and law conference, quoted in Holroyd, "An Adoption Dream That Went Wrong," *Age* 24 August 1988.

<sup>341</sup> M. Mills, "2. Who is the Unadoptable Child?," *Australian Journal of Social Work* 20, no. 1 (1967): 18.

<sup>342</sup> Triseliotis, Shireman, and Hundleby, *Adoption : Theory, Policy, and Practice*, 7.

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.<sup>343</sup> 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.

### **SINGLE MOTHERS AS SUPPLIERS**

The service provided at the RWH excluded married mothers wishing to place their children for adoption until 1972.<sup>344</sup> 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'.<sup>345</sup> 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.<sup>346</sup> 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'.<sup>347</sup> 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

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<sup>343</sup> B. Vaughan, "3. Placing the Unadoptable Child," *Australian Journal of Social Work* 20, no. 1 (1967): 21.

<sup>344</sup> Medical Social Work Department, "General Report." (March 1972).

<sup>345</sup> *Annual Report* (1961), 28.

<sup>346</sup> Medical Social Work Department, "General Report," (July 1969).

<sup>347</sup> Almoner Department, "Almoner's Report," (25 July 1958).

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.<sup>348</sup>

The 1965 Adoption of Children Regulations stated that mothers seeking to place their child for adoption should be provided with counselling prior to, as well as after, the signing of consent. But while the Regulations stipulated that the natural mother must be given 'all information and assistance about her sole right to keep or surrender her baby as she decides is best', the overburdened staff of the Social Work Department found these intentions difficult to fulfil.<sup>349</sup> Miss Gruber claimed that:

Hardly more than an hour (66 minutes) can be allocated for the five or six occasions on which I see each patient, and I think that few colleagues will quarrel with me when I assess the time needed for good case-work in such circumstances at not less than 2 ½ hours per patient ... I find not time for home visiting, none for after-care unless the patient persistently seeks this.<sup>350</sup>

In the mid-1960s, an anomaly appeared in the chain of supply and demand. The Department predicted that the number of applicants for adoption might be outnumbered by, or at best only equal, the number of babies available.<sup>351</sup> While these concerns suggest that adoption was more popular than ever with single mothers, the 1965 annual report claimed that adoption numbers were down as a result of the 'larger percentage of these girls who keep their babies'.<sup>352</sup> What is clear is that the hospital did not continue to see a growing number of single mothers keeping their children until 1972. The hospital had a plan to ensure that this was to be a brief lapse in the continuity of ever-increasing numbers of adoptions and initiated a large-scale publicity campaign with the aim of recruiting adoptive parents.

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

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<sup>348</sup> Mary Kathleen Benét, *The Politics of Adoption* (New York: The Free Press, 1976), 177.

<sup>349</sup> Sister Mary Borromeo R.S.M., "2. The Natural Parents," *Australian Journal of Social Work* 20, no. 1 (1967): 13.

<sup>350</sup> E. Gruber, "Memorandum to Miss Strahan, Chief Almoner," 12 May 1957.

<sup>351</sup> *Annual Report* (1964).

<sup>352</sup> *Annual Report* (1965).

as a mother and all the things which I think he should have, but which I cannot give him.'<sup>353</sup> 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'.<sup>354</sup>

With the growing 'demand' 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 CWD.<sup>355</sup> 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.<sup>356</sup> The woman was described as dull and unattractive. The hospital subsequently applied to the Victorian Children's Welfare Department (CWD) 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 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.

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

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<sup>353</sup> *Annual Report* (1960)

<sup>354</sup> Social Work Department, "Information for Women Considering Adoption." (n.d.)

<sup>355</sup> Medical Social Work Department, "Report Prepared for Medical Social Work Sub-Committee ", 20 September 1968.

<sup>356</sup> While all adoption records were transferred to 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. See "Social Work Department Patient Cards."



intent.<sup>357</sup> 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.<sup>358</sup> These numbers are also indicative of the extent of choice enjoyed by the hospital in regards 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.

Figure 4 (over) illustrates the increasing likelihood of an ex-nuptial birth at the RWH resulting in a hospital arranged adoption (green). In the overall population the practice reached a peak in 1948 when 67.9 per cent of single mothers were separated from their children by adoption (blue). This percentage markedly decreases from that time forward. Of particular note in this graph is the contrasting direction in which the lines travel; while hospital instances of adoption are increasing, the incidence in the wider population is decreasing. On top of this, up to thirty per cent of unmarried mothers who presented at the hospital were being referred to outside organisation to facilitate adoption arrangements, while the RWH maintained responsibility for the medical care and delivery of the patient.<sup>359</sup> This added number of referrals, combined with the increasing incidence of adoption as the outcome for the single mother, suggest the degree to which the hospital advocated adoption as a solution. As per previous figures, the distinction between the total state adoptions (red) and the modified number of adoption accounting for legitimations (blue) has been made in this graph.

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<sup>357</sup> Dr Nan Johns, statistics for April – June 1969, in Medical Social Work Department, "General Report," July 1969.

<sup>358</sup> Using Johns data and those reported in the *Annual Report* (1969).

<sup>359</sup> *Annual Report* (1940). These statistics were also reported for 1967, 1968 and 1969, while this data could not be located for the period 1946-1966.

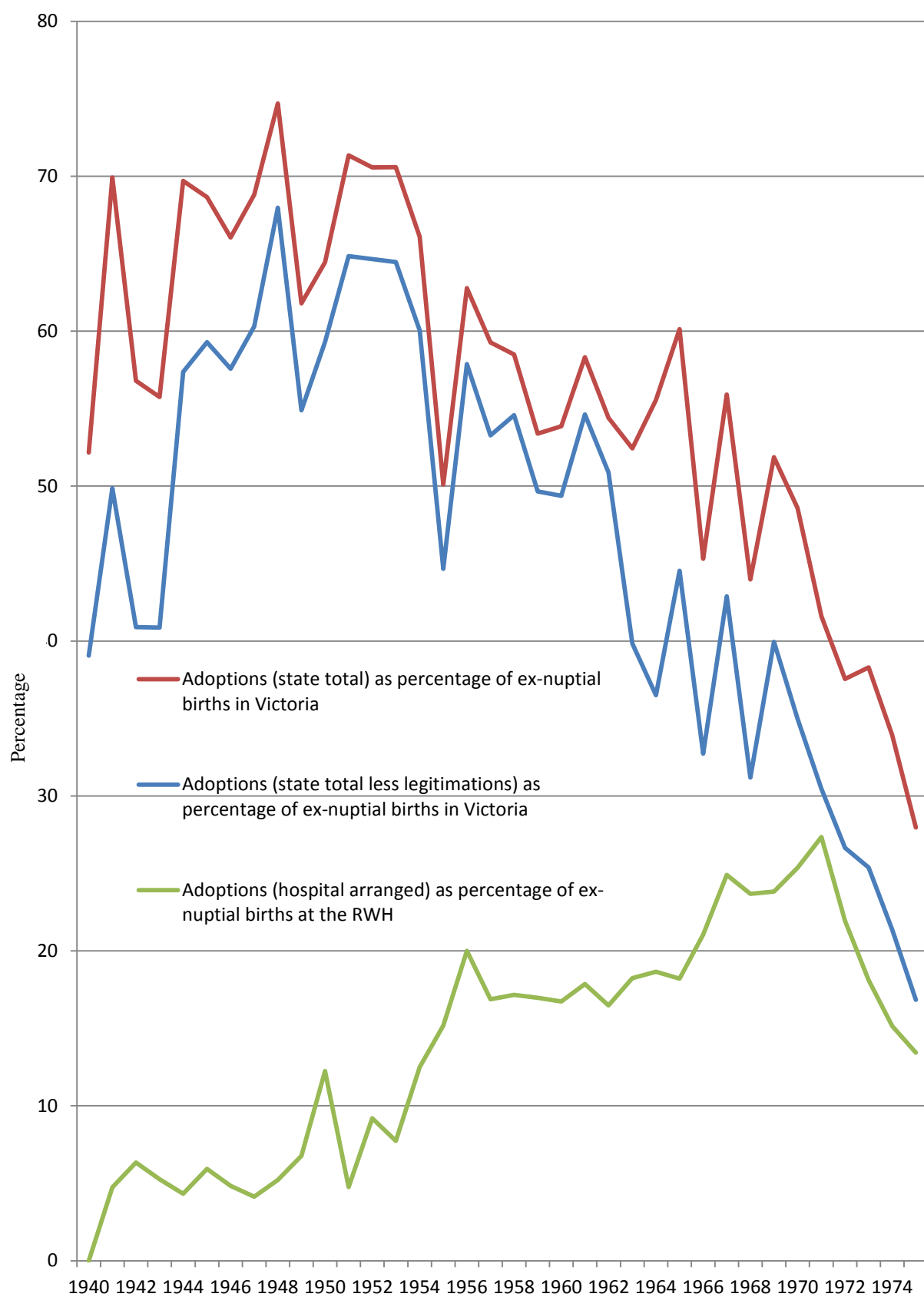


Figure 4: Adoption as percentage of ex-nuptial births (1940-1975) <sup>360</sup>

<sup>360</sup> *Victorian Year Book* (1940-1980) & *Annual Reports* (1940-1975)

Between 1969 and 1975, the proportion of single mothers who kept their babies increased dramatically: by 1970, it had risen to fifty per cent, and by 1975 it had further increased to eighty per cent.<sup>361</sup> The supply of adoptable babies was quickly dwindling. While the increasing presence of single mothers in the community has been attributed to more permissive sexual and social mores, as well as the growing independence of women, above all else it would be the acceptance of a woman's own family that would determine her success. Nell recalls the conversation in which she first considered that she could raise her own child:

So I then went home for Christmas and told my mother that I was pregnant. And, I said that I would have to have the baby adopted and she said to me, 'Why?' [Laughing] Thank God for mothers who ask questions, because in fact I hadn't—I mean, it was still very early days, obviously, but I actually hadn't had—nobody asked the question. The social worker certainly hadn't asked the question. I think the doctors were probably just more interested in the pregnancy itself, and so that made me think, and my mum said, 'You're working, you can support a child, you don't need to put your baby out for adoption'. Oh, great, if you say so. So, that actually changed it, and I came back to Melbourne and continued with the pregnancy.<sup>362</sup>

For those mothers who decided to keep, support was difficult to find and the stigma lingered in many quarters. Hospital interpreter Liliana Ferera recalls the limited help that was offered to the unmarried mother.

Those who kept their babies were given some help, but they didn't even have clothes. They'd give them an old singlet and maybe a better one and two nappies. There was no money, no clothes, they had nobody knitting and crocheting for them. They didn't have a toothbrush or toothpaste. I had to go with the social worker and give them a bit of money—they had nothing, not a nightie, it was terrible. And they had to hide from the relatives, most of them. We had to usher them through a different door—painful times.<sup>363</sup>

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<sup>361</sup> *Annual Report* (1970) and (1975).

<sup>362</sup> Interview with Nell, 26 September 2010.

<sup>363</sup> Liliana Ferera, the RWH interpreter quoted in McCalman, *Sex and Suffering: Women's Health and a Women's Hospital*, 274.

## HOSPITAL AS INTERMEDIARY

In 1946 A.J. (Jim) Cunningham was appointed assistant secretary and manager, and for the next three decades he controlled the financial interests of the RWH. According to Janet McCalman, 'Cunningham was devoted to the Women's and was a fine strategic thinker'.<sup>364</sup> Laver and Cunningham worked together to manage the expanding hospital during a time of massive population growth, as well as dramatic social change. That the economic climate was one of the most important considerations guiding decision making in the hospital is often overlooked. It is essential to consider the perspective of hospital administrators in order to better understand the outcomes and experiences of the hospital's patients. Running a hospital was no different from running a business.<sup>365</sup>

A public hospital, like a private hospital, required patients to pay for their care. And while some may be 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'.<sup>366</sup>

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 also received many 'donations' from people who had adopted babies.<sup>367</sup> 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"'.<sup>368</sup> It is unclear if this was directed towards recuperating fees from the biological or adoptive parents—or both. Prior to 1964,

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<sup>364</sup> McCalman, *Sex and Suffering: Women's Health and a Women's Hospital*, 257.

<sup>365</sup> In response to debate surrounding the cost of running the adoption service, the Manager/Secretary commissioned a cost analysis from the hospital accountant, see A.F. Campbell, "Cost Study of Cost Operating Adoption Agency," (22 May 1968).

<sup>366</sup> A.J. Cunningham, "Intra-Hospital Memo Re: Frances Perry House Adoption Babies," 3 March 1971.

<sup>367</sup> Almoner Department, "Almoner's Report," 7 November 1957.

<sup>368</sup> "Administrative Order No.194", 26 February 1958.

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'.<sup>369</sup>

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.<sup>370</sup> The Victorian Year Book states that in the case of institutionalisation, the endowment was payable directly to the institution in question.<sup>371</sup> 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.<sup>372</sup> A final avenue for the recuperation of 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.<sup>373</sup> Eventually, the Minister capitulated and granted a state subsidy of \$30 to be paid to the agency for each adoption arranged.<sup>374</sup>

Another consideration of running the business of adoption was the hospital's ability to house and care for the mothers, and especially the babies. The increasing number of ex-nuptial births raised serious concerns for the Board of Management.<sup>375</sup> 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

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<sup>369</sup> Opposition family services spokeswoman Christine Campbell quoted in Critchley, "Adopt Families Urged to Pay."

<sup>370</sup> *Victorian Year Book* (1954-58).419.

<sup>371</sup> *Victorian Year Book* (1954-58).

<sup>372</sup> W.C. Wentworth, "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," (The RWH Archives, 1970).

<sup>373</sup> Social Welfare Department, "Seventh Conference of Adoption Agencies," (18 February 1969).

<sup>374</sup> Hospital correspondence indicates that the hospital received a state subsidy of \$30 for each adoption finalised, see Valerie Douglas, "Submission to Mr A.J. Cunningham, Manager/Secretary and Dr G. Trevaks, Medical Director," (Melbourne: Royal Women's Hospital, undated (c. 1971-1978), submission to Mr A/J Cunningham, Manager/Secretary and Dr G. Trevaks, Medical Director. See also Finance Committee Minutes, (June 1971).

<sup>375</sup> *Annual Report* (1967), 11.

nurseries were overflowing with babies awaiting adoption and the associated expense was becoming a major financial burden for the hospital.

The suggestion to reduce the time granted for revocation as the solution to this problem 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.<sup>376</sup> 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.<sup>377</sup> Midwives at the RWH had also been voicing concerns in regards to the care and attention of babies since the early 1960s, particularly in respect to those awaiting adoption who were failing to thrive.<sup>378</sup> Social workers defended the mother’s right to a full thirty day period of revocation, and for consent to be taken after birth.<sup>379</sup> 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.<sup>380</sup>

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

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<sup>376</sup> L. Howard Whitaker, "Memorandum Re: (a) Babies for Adoption (b) Adoptive Parents," (Melbourne: The Royal Women's Hospital Archives, 10 October 1968).

<sup>377</sup> Dr John Bowlby, "Maternal Care and Mental Health," (World Health Organization, 1951). For the media spin on his theories see, Women’s Interests, "Grandmother was right about ‘mother love’", *Brisbane Courier-Mail*, 28 March 1952; Women’s Interests, "Children need affection to develop normally," *Brisbane Courier-Mail*, 4 April 1952; "Should The Adoption Law Be Changed?" *Sydney Morning Herald*, 1 October 1953.

<sup>378</sup> See Matron Betty Lawson, "Letter to Medical Superintendent, Re: Adoption Babies," (9 July 1971) where she 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 know falls far short of proper care.’

<sup>379</sup> Medical Social Work Department, "Report Prepared for Medical Social Work Sub-Committee" (February 1969).

<sup>380</sup> A.J. Cunningham, "Letter to Chief Justice, Sir Henry Winnecke " (22 December 1967).

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.<sup>381</sup> 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.<sup>382</sup> Social workers estimated that there was a revocation rate of seventeen to twenty 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.<sup>383</sup> 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. Mary Jones 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.<sup>384</sup>

To care for the increasing number of babies, close collaboration with the various agencies was required. Cunningham maintained a steady correspondence with his network of contacts, establishing important ties with cooperative agencies. In 1968, he wrote relentlessly to request their support with the ongoing nursery shortage. These included the Family Welfare Division of the Social Welfare Department, Berry Street Babies' Home and Hospital, the Chairman of the Hospitals and Charities Commission, and the Victorian Baby Health Centres Association. Unfortunately, at this time his efforts were to little avail. Cunningham expressed his concern at the inability of community facilities to absorb the increasing number of ex-nuptial infants. Finally, he wrote to the Chief Secretary, the Honourable Sir Arthur Rylah, requesting his assistance:

Failing relief we shall be faced with the alternative of requesting large numbers of single mothers to take their baby with them on discharge from hospital. The implications of this can be imagined.<sup>385</sup>

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<sup>381</sup> J.C. Laver, "Memorandum to Manager/Secretary from Medical Superintendent: 'Adoptions'," (20 May 1968).

<sup>382</sup> J.C. Laver, "Memorandum to Manager/Secretary from Medical Superintendent: 'Adoptions'," (20 May 1968).

<sup>383</sup> Adoption Sub-Committee, "Minutes of Meeting Held on 4 November 1966."

<sup>384</sup> Interview with Mary Jones, 4 August 2010.

<sup>385</sup> A.J. Cunningham (Manager & Secretary), "Letter from Manager & Secretary to Chief Secretary the Hon. Sir Arthur Rylah Re: Ex-Nuptial Births," (3 September 1968).

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.<sup>386</sup> 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.<sup>387</sup> 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, to care for both medically deferred babies, and the children of undecided mothers.<sup>388</sup> 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'.<sup>389</sup> 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 weeks'.<sup>390</sup> It is more likely that this was insisted upon, as historically, such payments were common.<sup>391</sup> 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'.<sup>392</sup> By 1978, the programme was being funded by the newly established Foster Fund which sourced its income from the adoption subsidy,<sup>393</sup> by specific donations from outside organisations, as well as ongoing contributions made by natural mothers.<sup>394</sup>

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<sup>386</sup> ———, "Letter to Mrs J. Kwiatek, Manager/Secretary, Berry Street Babies' Home and Hospital," (20 August 1968).

<sup>387</sup> Mrs W. Stephens, "Letter to A.J. Cunningham from the Victorian Baby Health Centre Association," (6 November 1968).

<sup>388</sup> The fostering system began informally in August 1967.

<sup>389</sup> *Annual Report* (1969)

<sup>390</sup> Social Work Department, "Information for Women Considering Adoption," (March 1976).

<sup>391</sup> See for example Swain and Howe, *Single Mothers and Their Children: Disposal, Punishment and Survival in Australia*, 124.

<sup>392</sup> Medical Social Work Department, "Social Work Committee Minutes of Meeting.", Meeting No.14 held on 15 November 1968.

<sup>393</sup> 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).

<sup>394</sup> Deputy Business Manager, "Memo from Deputy Business Manager to Acting Chief Executive Officer, Re: Foster Fund," (1 March 1978).



A major limitation of the adoption service was in its ability to provide ongoing counselling to any member of the adoption triangle: adoptive parent, relinquishing mother or adoptee. Contact often ceased once the paperwork had been signed. Despite a growing awareness that this was simply not good enough, follow-up care failed to eventuate, to the detriment of all parties. A reality of the busy Social Work Department was that it was rarely possible to conduct adequate follow-up with adoptive parents. While Isobel Strahan claimed that fifty per cent of her time was taken up with adoption, specifically interviewing applicants, visiting their homes, follow-up visits and going to court, she remained anxious about the supervision of placements.<sup>395</sup>

It concerns me very much that more follow-up work cannot be done with [adoptions]. In studying the methods of Great Britain and America, I feel that in comparison, from the point of view of supervision, our set-up here is very poor. We are careful in our placement of the child, but good supervision is also essential.<sup>396</sup>

While the 1964 Act removed the necessity of the Principal Officer attending court, there is nothing to suggest that this time was replaced with follow-up care. In advocating for the rights of the single mother and her child, Sandra Fitts commented on the absence of counselling for relinquishing mothers:

Skilled counselling available to [the relinquishing mother] after the birth is virtually non-existent. This could explain the remark of a woman following the signing of the adoption papers: 'I had the feeling of being an ignominy, of being a useless shell which must be disposed of, in which nobody had any further interest'. This feeling increased almost to despair proportions after my discharge from hospital.<sup>397</sup>

For women who had travelled from interstate, access to counselling (had it been available) was made impossible by virtue of distance. Instead, the hospital remained content with the role it could play in providing limited financial assistance for single women to travel from interstate in order to appropriately deal with an unplanned pregnancy.

Recently one of the unmarried mothers of the past sent a donation to the Samaritan Fund. She had come from another State, found herself temporary clerical work, and managed to keep herself until the baby was born. The baby was adopted and she was very upset. She wished to return home directly from the hospital, but as she did not have sufficient money for her fare we lent her an amount, which she has steadily paid

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<sup>395</sup> Almoner Department, "Almoner's Report," 9 July 1963.

<sup>396</sup> Ibid., 2 August 1956.

<sup>397</sup> Fitts, "The Single Mother and Her Child."

back, and with the final instalment she sent an extra £1 as a donation, saying it might help some other girl as the Fund had helped her.<sup>398</sup>

While the hospital was able to provide a small loan to ease her financial burden, the social work department was unable to offer more substantial help for this mother to deal with the potential emotional burden of relinquishment—indeed, such a convenient case study offered proof that hospital social workers were providing meaningful support.

The experience of single pregnant women in the period 1945-1975 was characterised by secrecy, shame, guilt and invisibility. Many continue to be haunted by the guilt surrounding their decision. The trauma is such that the details of their experience have been blurred, but the feelings are as vivid as the day they lost their baby. At the beginning of each interview, women consistently claimed ‘I can't remember very much. I don't know whether I deliberately blocked it or not, but I really, really can't remember.’<sup>399</sup> But the stories they shared conveyed the emotional impact of this experience. For some women, it was specifically the hospital experience that was blocked as was the case for Sandi.

After that, I don't remember a thing. I don't remember eating, I don't remember showering. I don't remember going to the toilet, nothing. The next thing I remember I was back at Hartnett House. It was a week later, or four days later.<sup>400</sup>

For others, the lapse in memory covered a larger time span.

I can't remember. I remember coming back after six weeks. They told me my son had a displaced hip, a dislocated hip. I had to sign the papers. I don't remember any other counselling. No. I mean, perhaps I might have seen her again. I can't remember that. It was a bit of a blur after that.<sup>401</sup>

But the final issue is one which they all remember vividly. When they returned home, returned to their lives, and tried to move on, they were confronted with the accusatory question: how could a loving mother surrender her child? So while they thought they had played by the rules and relinquished their child as required—they continued to bear their punishment each day.

I went down once and saw him. But, you've got to remember I had to completely psychologically detach myself so it was like I wasn't really seeing him or wasn't really

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<sup>398</sup> *Annual Report* (1960).

<sup>399</sup> Interview with Ann Groves, 28 May 2010.

<sup>400</sup> Interview with Sandi Barry, 31 August 2010.

<sup>401</sup> Interview with Dianne Gray, 31 August 2010.

holding him. It was extremely sick, it was sick. You know, what I mean, like it was totally against nature. And then of course after that everyone would say how could you possibly have abandoned your child, how could you possibly do it? And my mother said to me I had to do it, and she waited until I signed that six-week thing where you get six weeks to change your mind and then you said you're such a—because I was abused as well as a child. I had a lot of abuse. 'You're such an idiot, you're such a no-hoper that you can't even look after your own child, you give it away to the state.' That was after I had all that manipulation from her as well to make sure I kept going and doing it. So after I've actually gone through with it, and she waited until the six weeks was up and then she turned and said you know, 'How could you?'—so it was completely confusing and completely soul destroying.<sup>402</sup>

Within this chapter it has been argued that adoption practice operated on a business model in throughout the period 1945-1975. It was claimed that the service provided by the RWH was one which benefitted its patients, as well as the wider community. These provisions were underpinned by a belief that the life chances of the illegitimate child would be improved by removing him from his mother and placing him with a respectable, middle-class, married family. Unfortunately the Principal Officer was expected to act on behalf of all members of the adoption triangle. The potential conflict that this situation entailed was especially apparent when anxieties increased over the decreasing supply.

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<sup>402</sup> Interview with Dianne Gray, 31 August 2010.

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# CONCLUSION

*But when the time comes,  
we will purge the fury and the rage  
with the love of a mother for her child.  
No other love is so indissoluble.  
No matter what.  
No matter why.<sup>403</sup>*

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<sup>403</sup> Lorraine Dusky, *Birthmark*. (New York: M. Evans, 1979), 147.

Elizabeth Edwards, president of Origins Victoria, claims that a mother who relinquished her baby ‘is still treated with the same contempt that she was treated with in the labour ward when they marked her file before she delivered her baby’.<sup>404</sup> In the period 1945-1975, single pregnant women were treated as sexual deviants and bullied into placing their newborn infants for adoption. The belief that adoption would provide the ideal solution for both the unmarried mother, who wished to uphold her good reputation, and protect her child from the stigma of illegitimacy—as well as for the infertile couple desperate to start their own families—was unshakable. The secrecy surrounding past closed adoption practices rendered relinquishing mothers invisible, caught in silent prisons in which they suffer ongoing shame and guilt.

The period 1945-1975 represents the peak adoption years throughout Australia. At this time up to seventy-five per cent of ex-nuptial births resulted in adoption and as many as 36,664 single mothers lost their children to adoption. As one of many agencies legally registered to make adoption arrangements, the RWH played a pivotal role during this ‘heyday of adoption’. The conservative hospital culture resulted in differential treatment for married and unmarried patients in both policy and practice. More recently, doctors, midwives, social workers, and hospital administrators have come under fire for their role in the traumatic experiences of single women who gave birth at the RWH.

The idealised image of adoption has always been maintained at the expense of the relinquishing mother, especially with regard to the positive outcomes for adopting parents. Stereotypes and stigma have been powerful determinants of the behavioural expectations of single mothers within their families, both in professional circles and within their community. Discrimination against the single mother was widespread. In addressing the National Council for the Unmarried Mother and her Child in 1968, Mr Justice Scarman observed:

The sad truth is that the unmarried mother and her child are more unpopular with their neighbours than they are with the law ... by and large the unmarried mother continues to be rejected by society ... her real deprivation is that she loses the dignity, the comfort and the support of being accepted.<sup>405</sup>

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<sup>404</sup> Elizabeth Edwards in *Hansard*, CA19.

<sup>405</sup> Mr Justice Scarman, chairman of the English Law Commission, address to the Golden Jubilee Conference of the National Council for the Unmarried Mother and Her Child, November 1968, quoted in Swain and Howe, *Single Mothers and Their Children: Disposal, Punishment and Survival in Australia*, 153.

Living in a society at a time when a gendered socialisation was the norm, women were taught to willingly oblige others; to love, honour and obey; to never question authority. Hera Cook has argued that at this time ‘women were brought up to accept, and prioritize, other people’s need, not to express their own feeling or desires’.<sup>406</sup> This sentiment of unquestioning obedience and of accepting what one was told to do was echoed in the interview with Maureen Phillips:

I always felt very—I’d done something wrong and it just couldn’t be talked about and discussed because we just had to get it over and done with. Nobody really talked to me to allow me to express any feelings. I was only ever told.<sup>407</sup>

The complex combination of changing social values, community attitudes, and legislation culminated in the mid-1970s, at which point single mothers became increasingly visible members of society. Janet McCalman has characterised the time ‘between Harold Holt’s pledging in 1966 that Australia would “go all the way with L.B.J.” and the bitter dismissal of the Whitlam Labor Government in 1975’ as one of cultural transformation.<sup>408</sup> The increasing affluence and expanded educational opportunities that had arisen out of the post-war boom provided fertile ground for the blossoming of a newly radical and extraordinarily idealistic generation. The greater autonomy this afforded women corresponded with growing workforce participation, a falling birthrate, and an increased rate of births outside of marriage.

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. Previously inaccessible to single women, contraception became readily available by the mid-1970s. The RWH opened its Family Planning Clinic in 1971. The *Annual Report* indicated that the clinic was providing advice to single as well as married patients as early as 1971, but (at least initially) this was limited to existing patients.<sup>409</sup> The clinic was also providing abortions, which had become provisionally decriminalised under the Menhennitt ruling. These changes coincided with a trend towards more single women keeping

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<sup>406</sup> Cook, *The Long Sexual Revolution: English Women, Sex, and Contraception 1800-1975*, 3.

<sup>407</sup> Interview with Maureen Phillips, 25 August 2010.

<sup>408</sup> Janet McCalman, *Journeyings: The Biography of a Middle-Class Generation 1920-1990*, (Melbourne: Melbourne University Press, 1993), 243.

<sup>409</sup> *Annual Report* (1971), 22.

their babies.<sup>410</sup> The RWH *Annual Reports* (1934-1987) confirm a sharp decline in babies available for adoption after 1971-72,<sup>411</sup> a trend that is consistent with declines Australia-wide.<sup>412</sup> While this drop in numbers clearly pre-dates the legislation, it is indicative of the impact of shifting social and moral standards. Unfortunately, the stigma of illegitimacy continued to be felt by the children who were placed for adoption. It has been claimed that the function of secrecy on which past adoption practices were implemented were intended to conceal the illegitimacy of the child. That adoption could expunge the taint of illegitimacy would never eventuate; instead, adult adoptees are still left to face this reality.

[It] came as a shock to me; I mean, I am illegitimate and we all know what people think about illegitimacy ... No, I don't think that adoption wipes out illegitimacy. I am now holding on to the hope that my mother was not a street walker.<sup>413</sup>

And single mothers continue to be haunted by unfounded stereotypes.

This thesis has detailed the experiences of the single women confined and delivered at the RWH. The distinct way in which this public hospital was organised created an administrative system in which policies and practices could vary based on the individual preferences of those in charge and emphasised that women should be grateful for the care they received. Treated as a breed apart from the staff who cared for them, all women were subject to the brutal efficiency of the hospital. But there is also evidence of the differential treatment of married and unmarried patients in practices that saw the latter labour for longer and prevented them from seeing their babies, as well as in hospital policies that called for the routine referral to the Social Work Department and removed their babies after birth.

While the hospital operated within the constraints dictated by the social norms of the times, it was also quick to adapt to the changes that were occurring. Hospital social worker Kath Lancaster was a key organiser for the First Australian Conference on Adoption in February 1976.<sup>414</sup> The conference addressed the changing nature of adoption, as the available number of babies decreased. Speakers included not only professionals, such as social workers, but also other key stakeholders including both relinquishing mothers and adoptive parents. This

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<sup>410</sup> Marcia Neave, "The Position of Ex-Nuptial Children in Victoria," *Melbourne University Law Review* 10 (1976).

<sup>411</sup> *Annual Report* (1934 -1988).

<sup>412</sup> Australian Institute of Health and Welfare (AIHW), "Adoptions Australia 2007-08," in *Child Welfare Series No.46* (Canberra: AIHW, 2009).

<sup>413</sup> Triseliotis, *In Search of Origins: The Experiences of Adopted People*, 126.

<sup>414</sup> "Proceedings of First Australian Conference on Adoption," ed. Cliff Picton, (Sydney, 1976 February 1976).

open forum acknowledged the inherent difference between adoptive and biological family formation asserting that ‘adoption is not identical with producing one’s own child. It is raising and integrating another’s biological child into one’s own family. Not to recognize this reality is to romanticize adoption, and adoption literature abounds in such pretense [sic].’<sup>415</sup>

Today women who relinquished a baby for adoption in the 1950s to the 1980s are able to come forward and challenge the notion that young mothers ‘willingly surrendered their newborn babies en masse to strangers.’<sup>416</sup> The current Senate Inquiry into the Commonwealth contribution to former forced adoption practices has publicised the testimony of almost four hundred people who have been touch by adoption. Sadly the issue of grief and loss continues to be ignored as a priority of care for mothers who have lost a child to adoption who have carried the burden of their secret for a long time.

And, we just—we had a loss and grief that we silently suffered over the years, because when I came home—I’ve got four sisters and one brother. When I came home, nothing was—nothing was mentioned. And it’s only a few years ago I said to my sisters and my brother, ‘Do you know why I left home years ago?’ They said that ‘Yeah, we were told, but we were told not to say nothing.’ So—<sup>417</sup>

With hindsight, questions will always remain with regard to the professional—and ethical—capacity of social workers and their ability to influence the lives of their clients for better or for worse. In her exploration of the politics of adoption, Mary Kathleen Benét questioned the potential prejudice inherent in the profession of social worker:

How expert in fact are the social workers, and how much of their expertise is—as some of their clients would charge—simply prejudice dressed up as fact? There are innumerable stories about the narrowness of some of their judgments, but most of the stories indicate that, like the law, social work practice simply codifies the prejudices of the community.<sup>418</sup>

Single mothers consistently recall a time when their voice was silenced in regards to decision-making. Within a hostile social milieu, and under the misguided pressure of family and adoption professionals, they felt powerless to speak up and challenge social beliefs that

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<sup>415</sup> Sanford N. Katz, Introduction in J. P. Triseliotis, *In Search of Origins: The Experiences of Adopted People* (Boston: Beacon Press, 1975), xi.

<sup>416</sup> Origins Inc. "Senate Inquiry Petition." [www.originsnsw.com/senatepetition.html](http://www.originsnsw.com/senatepetition.html). (accessed 24 August 2011).

<sup>417</sup> Interview with Nancy Johnson, 23 June 2010.

<sup>418</sup> Benét, *The Politics of Adoption*, 203.



revered the nuclear family above all else. Submissions to the Senate Inquiry reflect the degree of powerlessness felt by single mothers, especially in regards to doctors and social workers.

But these people in that era were so powerful. They had absolute power. They had a way of making you believe in the end that you were doing the right thing. You know, 'What are you going to do for your son? You cannot take him out of here. You have got nowhere to go.' In the end you think, 'Well, this is right. I have got nowhere to go. I have got no support. There is no-one. I had better sign over because I am not going to be able to look after my baby.' There are people like that. There were a lot of innocent girls. Even though we were pregnant we were still very naive in many cases.<sup>419</sup>

Such assertions ignore the role of the single mother's family whose social beliefs and aspirations also drove the decision to adopt. Without family support it was almost impossible to follow through with a decision to keep. Swain and Howe have also argued that families were often the most judgemental of the single woman's transgression.

In Australia it was respectability rather than class which was the critical factor. There were women of all classes who were able to disregard the stigma which pregnancy attracted but, until recent years, they were a very small group who did not crave social acceptance. Most women were condemned first by their own families, their respectability under threat.<sup>420</sup>

The authoritarian influences of family, partners and professionals whose foremost interests were not necessarily those of the single mother—or the child—have left an indelible stain. Perhaps in the light of present findings, current adoption reform will begin to see parenting as a privilege rather than as a right. Sometimes with the best of intentions, but, more commonly, bound by community attitudes, and in the interests of hospital efficiency, the RWH played a crucial role in the implementation of this supposed solution to the assumed dilemma of single motherhood. Informed by the findings of this research, the Board intends now to apologise to mothers separated from their infants as a result of hospital practices in the past.<sup>421</sup>

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<sup>419</sup> June Smith in *Hansard*, CA44.

<sup>420</sup> Swain and Howe, *Single Mothers and Their Children: Disposal, Punishment and Survival in Australia*, 63.

<sup>421</sup> The RWH, Director Communications & Foundation, "Personal Communication to Author," (2012).

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# APPENDICES

**STATE OF VICTORIA:**  
**ADOPTIONS, LEGITIMATIONS, AND CONFINEMENTS**  
**—NUPTIAL & EX-NUPTIAL (1929-1986)<sup>422</sup>**

	<b>Adoptions</b>					
<b>Year</b>	<b>Male</b>	<b>Female</b>	<b>Total</b>	<b>Legitimations</b>	<b>Ex-nuptial births</b>	<b>Total births</b>
<b>1929<sup>423</sup></b>	31	56	87			
<b>1930</b>						
<b>1931</b>						
<b>1932</b>						
<b>1933</b>						
<b>1934</b>						
<b>(1930-1934)<sup>424</sup></b>	492	833	1325	435		
<b>1935</b>						
<b>1936</b>						
<b>1937</b>						
<b>1938</b>					1301	30344
<b>1939</b>					1149	30493
<b>(1935-1939)<sup>425</sup></b>	843	1156	1999	584	<b>1228<sup>426</sup></b>	
<b>1940</b>	273	304	577	145	1106	31962
<b>1941</b>	402	393	795	228	1137	34406
<b>1942</b>	344	420	764	214	1345	35297
<b>1943</b>	447	426	873	233	1566	39117
<b>1944</b>	492	582	1074	190	1541	39358
<b>1945</b>	511	509	1020	139	1486	41200
<b>1946</b>	531	599	1130	145	1711	46693
<b>1947</b>	547	571	1118	138	1625	47366
<b>1948</b>	572	573	1145	103	1533	46099
<b>1949</b>	501	447	948	106	1534	46873
<b>1950</b>	518	524	1042	83	1617	49830
<b>1951</b>	607	588	1195	109	1675	50553
<b>1952</b>	656	620	1276	107	1808	53738
<b>1953</b>	651	650	1301	113	1843	53561
<b>1954</b>	604	564	1168	107	<b>1767<sup>427</sup></b>	<b>52468<sup>428</sup></b>
<b>1955</b>	453	503	956	104	1908	56336

<sup>422</sup> *Victorian Year Book* (1942-1994).

<sup>423</sup> First registration effected on 14 October 1929.

<sup>424</sup> Totals for five years.

<sup>425</sup> Totals for five years.

<sup>426</sup> Represents the average per year during the period 1935-1939.

<sup>427</sup> Represents the average per year for the period 1950-1954.

<sup>428</sup> Represents the average per year for the period 1950-1954.

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Year	Male	Female	Total	Legitimizations	Ex-nuptial births	Total births
1956	600	643	1243	97	1980	58393
1957	612	612	1224	124	2065	60464
1958	633	665	1298	87	2219	61269
1959	576	656	1232	86	2308	62245
1960	633	649	1282	107	2380	64025
1961	772	806	1578	100	2706	65886
1962	840	767	1607	104	2954	65890
1963	834	780	1614	388	3078	65649
1964	995	895	1890	648	3402	64990
1965	1005	946	1951	506	3245	63550
1966	835	786	1621	450	3578	64008
1967	1011	1057	2068	482	3699	65485
1968	939	893	1832	533	4166	70228
1969	1052	1073	2125	488	4098	71035
1970			2147 <sup>429</sup>	601	4420	73019
1971			2084	558	5010	75498
1972			1878	545	5001	71807
1973			1766	596	4611	67123
1974			1490	551	4394	66201
1975			1229	489	4395	61897
1976			1330 <sup>430</sup> 1130 <sup>431</sup> 1032 <sup>432</sup>	517	4426	60667
1977			1179 <sup>433</sup> 908 <sup>434</sup>	415	4391	59518
1978			991 <sup>435</sup> 951 <sup>436</sup>	407	4718	58861
1979			956	433	5033	57767
1980			914	423	5300	58206
1981			711	523	5615	59513
1982			753	451	6165	59983
1983			692	450	6433	60123
1984 <sup>437</sup>			686	461	6580	59763
1985						61555
1986					7395	60152

<sup>429</sup> The male/female breakdown of adoption numbers is no longer detailed.

<sup>430</sup> *Year Book* (1978).

<sup>431</sup> *Year Book* (1979).

<sup>432</sup> *Year Book* (1980 and 1982).

<sup>433</sup> *Year Book* (1979 and 1980).

<sup>434</sup> *Year Book* (1982).

<sup>435</sup> *Year Book* (1980).

<sup>436</sup> *Year Book* (1982).

<sup>437</sup> These numbers are from the *Year Book* (1986), after which point information on adoptions and legitimizations disappear from the record.

## APPENDIX 2

### THE RWH ADOPTIONS (1941-1986)<sup>438</sup>

YEAR	ADOPTIONS	YEAR	ADOPTIONS	YEAR	ADOPTIONS
1941	21	1957	107	1973	217
1942	27	1958	103	1974	163
1943	26	1959	110	1975	124
1944	25	1960	128	1976	122
1945	28	1961	134	1977	84
1946	28	1962	150	1978	60
1947	21	1963	181	1979	54
1948	24	1964	211	1980	39
1949	32	1965	200	1981	39
1950	49	1966	249	1982	20
1951	28	1967	310	1983	19
1952	52	1968	351	1984	21
1953	43	1969	333	1985	10
1954	59	1970	382	1986	11
1955	73	1971	400		
1956	98	1972	344	TOTAL	5310

<sup>438</sup> Represents the entire period in which the RWH arranged adoptions.

## APPENDIX 3



### Human Research Ethics Committee

#### Committee Approval Form

**Principal Investigator/Supervisor:** SHSWAIN Melbourne Campus

**Co-Investigators:** Melbourne Campus

**Student Researcher:** Christin Quirk Melbourne Campus

**Ethics approval has been granted for the following project:**

Delivery Practices in relation to single women confined at the Royal Women's Hospital 1945-75

**for the period:** 01.03.10 - 02.12.10

**Human Research Ethics Committee (HREC) Register Number:** V2010 07

The following standard conditions as stipulated in the *National Statement on Ethical Conduct in Research Involving Humans* (2007) apply:

- (i) that Principal Investigators / Supervisors provide, on the form supplied by the Human Research Ethics Committee, annual reports on matters such as:
  - security of records
  - compliance with approved consent procedures and documentation
  - compliance with special conditions, and
- (ii) that researchers report to the HREC immediately any matter that might affect the ethical acceptability of the protocol, such as:
  - proposed changes to the protocol
  - unforeseen circumstances or events
  - adverse effects on participants

The HREC will conduct an audit each year of all projects deemed to be of more than low risk. There will also be random audits of a sample of projects considered to be of negligible risk and low risk on all campuses each year.

Within one month of the conclusion of the project, researchers are required to complete a *Final Report Form* and submit it to the local Research Services Officer.

If the project continues for more than one year, researchers are required to complete an *Annual Progress Report Form* and submit it to the local Research Services Officer within one month of the anniversary date of the ethics approval.

Signed: \_\_\_\_\_ Date: .....01.03.2010.....  
(Research Services Officer, Melbourne Campus)

## APPENDIX 4

School of Arts & Sciences



AUSTRALIAN CATHOLIC UNIVERSITY

Australian Catholic University Limited  
ABN 15 050 192 660  
Melbourne Campus (St Patrick's)  
115 Victoria Parade Fitzroy VIC 3065 Australia  
Locked Bag 4115 Fitzroy MDC VIC 3065  
Telephone 613 9953 3242  
Facsimile 613 9495 6141

### USER DISCLOSURE OF NATIONAL PRIVACY PRINCIPLES: REPORT TO GOVERNMENT

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TITLE OF PROJECT: 'Delivery Practices in relation to single women confined at the Royal Women's Hospital: 1945-1975'

PRINCIPAL SUPERVISOR: Professor Shurlee Swain

STUDENT RESEARCHER: Ms Christin Quirk

PROGRAMME IN WHICH ENROLLED: Master of Philosophy

HREC REGISTRATION NO.: V2010 07

APPROVAL END DATE: 02.12.10

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Concerning the above research and the disclosure of health information relevant to public health or public safety, a justification based on the National Privacy Principles is outlined herein, specifically, in relation to the following Principles:

**2.1 An organisation must not use or disclose personal information about an individual for a purpose (the secondary purpose) other than the primary purpose of collection unless:**

**(a) both of the following apply**

**(i) it is impracticable for the organisation to seek the individual's consent before that particular use; and**

**(ii) the organisation will not charge the individual for giving effect to a request by the individual to the organisation not to receive direct marketing communications**

The purpose of such disclosure relates to academic research in the best interest of public health and safety. Access to hospital records contained within the archives department of the

## APPENDIX 4

Royal Women's Hospital, such as patient records, labour ward casebooks, midwifery books, extern casebooks, nursing reports, social welfare department casebooks and reports, birth registries, submissions, memos and correspondence will be used for the purpose of a statistical analysis of the extent and variability of past adoption practices at the Royal Women's Hospital. Likewise, the data will be used to 'reconstruct' the experiences of women who gave birth in the period 1945 – 1975.

The form of these records is such that it would be extremely time-consuming and impracticable (on the part of the archivist) to provide this information with identifiers removed prior to access, as names might occur in unlikely places.

It is impracticable to seek the individual's consent before the proposed purpose as contact with, or indeed obtaining consent from these women is impracticable due to extreme age or that the individuals are deceased.

The organisation will not charge the individual for giving effect to a request by the individual to the organisation not to receive direct marketing communications.

**10.3 Despite subclause 10.1, an organisation may collect health information about an individual if:**

- (a) the collection is necessary for any of the following purposes:**
  - (i) research relevant to public health or public safety;**
- (c) it is impracticable for the organisation to seek the individual's consent to the collection**

As mentioned above, the collection is necessary for research relevant to public health or safety. The data collected will be used for a statistical analysis of the extent and variability of past adoption practices at the Royal Women's Hospital. Likewise, the data will be used to 'reconstruct' the experiences of women who gave birth in the period 1945 – 1975. Collection of data will occur in a non-identifiable form, as identifiers (such as names) will be removed at the first point of contact with the material and not be transcribed into research notes.

The research findings will be shared with the Royal Women's Hospital with the hopes of informing moves towards a possible apology in regards to single women who were confined and delivered at the hospital in the period 1945-1975. The research will also be published: a copy of the thesis will be lodged in the ACU national library in Melbourne. Health information will not be published, unless in de-identified form.

It is impracticable to seek the individual's consent as contact with, or indeed obtaining consent from these women is hindered by extreme age or that the individuals are deceased.

Regards,

Christin Quirk,  
S00054348  
Master of Philosophy candidate,  
Australian Catholic University



## APPENDIX 5

School of Arts & Sciences



AUSTRALIAN CATHOLIC UNIVERSITY

Australian Catholic University Limited  
ABN 15 050 192 660  
Melbourne Campus (St Patrick's)  
115 Victoria Parade Fitzroy VIC 3065 Australia  
Locked Bag 4115 Fitzroy MDC VIC 3065  
Telephone 613 9953 3242  
Facsimile 613 9495 6141

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### INFORMATION LETTER TO PARTICIPANTS

TITLE OF PROJECT: 'Delivery Practices in relation to single women confined at the Royal Women's Hospital: 1945-1975'

PRINCIPAL SUPERVISOR: Professor Shurlee Swain

STUDENT RESEARCHER: Ms Christin Quirk

PROGRAMME IN WHICH ENROLLED: Master of Philosophy

Dear Participant,

You are invited to participate in a historical study of the experiences of single women who gave birth at the Royal Women's Hospital between 1945 and 1975. The study aims to discover what it meant to be a single expectant mother at this time and explore these women's ability to choose whether they kept their babies or placed them for adoption. Ultimately, this study seeks to answer the question: "what role was played by the Royal Women's hospital in these women's experiences?"

This is in an oral history project and you are invited to share your experiences and memories. Christin Quirk will conduct all the interviews which will offer an opportunity to share stories and reflect on your past experiences.

The themes to be explored are not intended to cause discomfort in any way, although it is recognised that recalling life-events associated with adoption may be distressing for some participants.

Your participation is entirely voluntary and would involve a (60-90 minute) interview on a date that suits you between April and December 2010. In some cases a follow-up interview (60-90 minutes) may be requested. The interview will take place at a mutually agreeable location. To assist in the accurate transmission of stories and ideas, the interview will be recorded. You will have an opportunity to edit your transcript and you may also request an audio copy of the interview for your personal archives, if you wish. Please note that if you become distressed at any time during the initial or follow-up interview, we will stop the discussion and counselling referral will be provided.

## APPENDIX 5

The stories you share in the interview will form an important part of the student's Master of Philosophy thesis. On a larger scale they will contribute to a better understanding of the history of adoption in Australia. The research findings will be shared with the Royal Women's Hospital and will also be published: a copy of the thesis will be lodged in the ACU national library in Melbourne.

You are, of course, free to refuse consent altogether without having to justify that decision, or to withdraw consent and discontinue participation in the study at any time without giving a reason.

You may choose to use your own name in this study or, if you prefer, to use a name of your choosing in order to protect your identity. All data files will be securely stored at Australian Catholic University for five years after which time they will be destroyed.

Any questions regarding this project should be directed to Professor Shurlee Swain and the Student Researcher, Christin Quirk: (email: [caquir001@myacu.edu.au](mailto:caquir001@myacu.edu.au)) or;

Professor Shurlee Swain  
Ph. 9953 3239  
School of Arts and Science  
Locked Bag 4115, Fitzroy MDC, Fitzroy Victoria 3065

You may choose to supply your email address in order to receive a short report at the end of the year on the outcomes of the research.

This study has been approved by the Human Research Ethics Committee at Australian Catholic University.

In the event that you have any complaint or concern about the way you have been treated during the study, or if you have any query that the Investigator or Supervisor and Student Researcher has (have) not been able to satisfy, you may write to the Chair of the Human Research Ethics Committee care of the nearest branch of the Research Services Office.

VIC: Chair, HREC  
C/- Research Services  
Australian Catholic University  
Melbourne Campus  
Locked Bag 4115  
FITZROY VIC 3065  
Tel: 03 9953 3158  
Fax: 03 9953 3315

Any complaint or concern will be treated in confidence and fully investigated. The participant will be informed of the outcome.

If you agree to participate in this project, you should sign both copies of the Consent Form, retain one copy for your records and return the other copy to the Supervisor or Student Researcher in the stamp- addressed envelope provided.

.....  
Principal Investigator (or Supervisor)

.....  
Student Researcher

## APPENDIX 6

School of Arts & Sciences



AUSTRALIAN CATHOLIC UNIVERSITY

Australian Catholic University Limited  
ABN 15 050 192 660  
Melbourne Campus (St Patrick's)  
115 Victoria Parade Fitzroy VIC 3065 Australia  
Locked Bag 4115 Fitzroy MDC VIC 3065  
Telephone 613 9953 3242  
Facsimile 613 9495 6141

### CONSENT FORM *Copy for researcher*

TITLE OF PROJECT: 'Delivery Practices in relation to single women confined at the Royal Women's Hospital: 1945-1975'.....

SUPERVISOR: Professor Shurlee Swain .....

STUDENT RESEARCHER: Christin Quirk .....

I ..... (*the participant*) have read (*or, where appropriate, have had read to me*) and understood the information provided in the Letter to Participants. Any questions I have asked have been answered to my satisfaction. I agree to participate in this (60-90 minute) interview, as well as a (60-90 minute) follow-up interview, should this be required, on a date between April and December 2010 at a mutually agreeable location that will be audio recorded, realising that I can withdraw my consent at any time without comment and without affecting my future relationship with the researchers. I agree that research data collected for the study may be placed in the public realm in the form of the submitted thesis and the research findings will be shared with the Royal Women's Hospital. This means that other researchers will have access to information (in a form that does not identify me in any way *or* I choose to use my own name in this research project).

For the purposes of the interview I choose:

to use my own name.....

OR

to use the following name to protect my identity.....

If you would like to receive a brief report at the end of the project, please supply your preferred email address: .....

PHONE NUMBER OF PARTICIPANT: .....

NAME OF PARTICIPANT: .....

SIGNATURE: .....DATE:.....

SIGNATURE OF SUPERVISOR:.....DATE:.....

SIGNATURE OF STUDENT RESEARCHER:.....DATE:.....

Please return this letter in the envelope provided to Ms Christin Quirk, c/o Professor Shurlee Swain, School of Arts and Science, Locked Bag 4115, Fitzroy MDC, Fitzroy, Victoria 3065.

## APPENDIX 7

School of Arts & Sciences



AUSTRALIAN CATHOLIC UNIVERSITY

Australian Catholic University Limited  
ABN 15 050 192 660  
Melbourne Campus (St Patrick's)  
115 Victoria Parade Fitzroy VIC 3065 Australia  
Locked Bag 4115 Fitzroy MDC VIC 3065  
Telephone 613 9953 3242  
Facsimile 613 9495 6141

### CONSENT FORM *Copy for participant*

TITLE OF PROJECT: 'Delivery Practices in relation to single women confined at the Royal Women's Hospital: 1945-1975'.....

SUPERVISOR: Professor Shurlee Swain .....

STUDENT RESEARCHER: Christin Quirk .....

I ..... (*the participant*) have read (*or, where appropriate, have had read to me*) and understood the information provided in the Letter to Participants. Any questions I have asked have been answered to my satisfaction. I agree to participate in this (60-90 minute) interview, as well as a (60-90 minute) follow-up interview, should this be required, on a date between April and December 2010 at a mutually agreeable location that will be audio recorded, realising that I can withdraw my consent at any time without comment and without affecting my future relationship with the researchers. I agree that research data collected for the study may be placed in the public realm in the form of the submitted thesis and the research findings will be shared with the Royal Women's Hospital. This means that other researchers will have access to information (in a form that does not identify me in any way *or* I choose to use my own name in this research project).

For the purposes of the interview I choose:

to use my own name.....  
OR  
to use the following name to protect my identity.....

If you would like to receive a brief report at the end of the project, please supply your preferred email address: .....

PHONE NUMBER OF PARTICIPANT: .....

NAME OF PARTICIPANT: .....

SIGNATURE: .....DATE:.....

SIGNATURE OF SUPERVISOR:.....DATE:.....

SIGNATURE OF STUDENT RESEARCHER:.....DATE:.....

Please return this letter in the envelope provided to Ms Christin Quirk, c/o Professor Shurlee Swain, School of Arts and Science, Locked Bag 4115, Fitzroy MDC, Fitzroy, Victoria 3065

## APPENDIX 8

### SAMPLE QUESTIONS

The interviews were designed be open-ended, allowing participants to lead the discussion and focus on the aspects of their experience they deemed important. These questions were designed to open the conversation, with follow-up where necessary. Questions directed at former hospital staff varied somewhat based on their role and the nature of their contact with single mothers.

These are some indicative examples of the interview questions for the women:

- What brought you to the Royal Women's Hospital?
- How were you treated when you first presented at the hospital?
- Did you receive antenatal care?
- When was the issue of adoption raise?
- By whom?
- What happened when you gave birth?
- The day after?
- What kind of after-care did you receive (if any)?
- What were the attitudes of the staff?
- Who took consent and who acted as witness?
- Did parents counter-sign (especially if underage)?
- Did you ask to see your baby while in hospital?
- Was this allowed?
- Were there attempts at contact after discharge?

For former hospital staff the questions had the following focus:

- When and in what capacity were you employed at RWH?
- What was the prevailing attitude to single mothers at that time?
- What policies were in place in regard to the management of such women and their children?
- What was the impact of such policies on the women?
- What were the staff attitudes towards such policy?

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Gillian Thomas

Helen Johnstone

Kath Curtain

Lyn Kinghorn

Lynda Stevens

Maggie

Margaret A

Margaret Mabbitt

Mary Jones

Maureen Phillips

Maureen Rust

Nancy Johnson

Nell

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