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ASSOCIATION OF RADICAL MIDWIVES

NEWSLETTER No.15

Contents

ASSOCIATION OF RADICAL MIDWIVES

APATHETIC MIDWIVES STRIKE AGAIN!(?)

The NHS pay claim has become an ever-present feature in the media as well as being part of our daily lives. How do we feel about it?

Since Maternity Services have been considered by the Unions as an Emergency Service, it might seem easy enough for us to ignore the whole issue. In addition the RCM has not seen fit to give us the opportunity which the members of RCN have had, to state their opinions. It would thus appear that midwives (with the exceptions of some individuals) have had little impact on the debate.

Yet there are several reasons why it is inexcusable to bury our heads in the sand. Firstly, whilst we may decry a society in which money equals status, that is the reality in which we live. Therefore, to defend the role of the midwife we must defend at the very least, a living wage. Most of us can cite several examples of our colleagues leaving because they are financially unable to continue working for the NHS, and are attracted out of midwifery into private work either in this country or abroad. Some find Health Visiting more financially, if not professionally, rewarding! The fewer working midwives there are, the less of us there are to defend our profession.

Secondly, the NHS industrial action is more than just a pay claim. The fact that is has occurred within a service renowned for its non-militancy implies that it is more than this. The continued decrease in funding, the chronic understaffing and the obvious encouragement of the private sector are all elements showing the decreased value placed by the Government on the NHS. The sharp contrast of how they care about us compared with what they will spend on defending a few rocky islands on the other side of the world can only add to this demoralisation. Whilst we have many criticisms of the NHS, its availability to all women (compared with private health care) means that for the sake of the childbearing woman we must defend it.

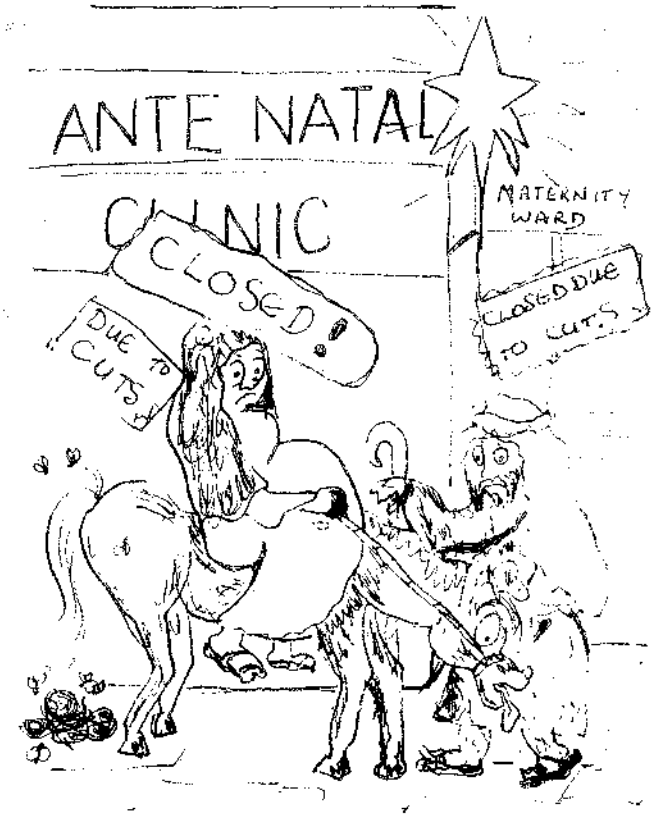
Nevertheless, despite our own profession's apathy, we are being carried along by the NHS unions, the RCN ballot and by many other unions willing, despite the questionable legality of it all, to come out in support of us. What will happen if the Government does finally get forced into giving us all a bit more?

Government directives to the HAs with reference to the 7.5% rise is that Central Government will only pay a proportion of this rise, and only for the first year. After that the Health Authorities themselves will have to find the whole increase! The way they will do this is already being planned - they are going to freeze all jobs and close down any smaller units which have so far managed to miss the axe.

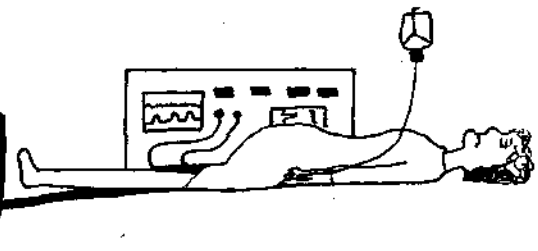
It says something about the erosion of our role, that cuts are first made by freezing our jobs, whilst money for expensive equipment and ever more elaborate blood tests can still be found.

A truly critical appraisal of NHS Maternity Services might surely doubt the value of many of the serial blood tests, the real need for routine scans, or the benefits to be gained from treating all women as potential high risk "patients".

If Midwifery skills were used to the full, then the cost of the maternity services could be held at the present level, whilst at the same time paying the midwives a more realistic salary, and perhaps even engaging more midwives, to bring the staffing levels up to meet the requirements of satisfactory standards.



Robbed of Joy



In January 1982 Janet Jennings was invited to present a paper at a conference of Health workers worldwide, held in Strasbourg, called "The Medicalisation of Life".

She called her paper ROBBED OF JOY - THE CASE AGAINST MEDICALISED CHILDBIRTH.

The definition of a midwife by the W.H.O. is that she is the expert in normal midwifery.
A favourite statement by many obstetricians and doctors is that no birth can be considered normal except in retrospect, which conveniently disposes of the need for midwives at all.
Men showed very little interest in midwifery until the middle of the 17th century. This was the time when forceps were invented which could only be used by members of the Barber Surgeons Guilds. Midwives were excluded from the Guilds so men had to be called in for emergencies to perform last resort operations in the hope of saving either the mother or the baby when the other was already dead. A hundred years later, male midwives were fiercely competing for trade amongst the aspiring middle classes, who assumed that a man who had to be called in for emergencies must be a safer bet for normal childbirth as well.
In the middle ages, the French term "sage-femme" (wise woman) reminds us that midwives were not then seen as medical auxiliaries. During the later middle ages there is evidence that, particularly in Europe, midwives became targets for witch hunters; they were accused of the same crimes as witches - securing abortions, offering contraceptive advice, offering children to the devil, effecting sterilisation and so on. Another reason they were persecuted was because of their habit of meeting to discuss their work with at a time of political turmoil was regarded as seditious.
Obstetrics was recognised as a medical speciality in 1858, but developed apart from the mainstream of medical practice. It was not until 1888 that attendance at 12 confinements was required for medical students by the General Medical Council. A register of midwives was created by the Midwives Act 1902 which also set up the Central Midwives Boad which regulates the training and practice of midwives.
Maternity care was at a low ebb in the 19th century. Local midwives were fast disappearing and the slums of the new industrial cities created health problems with which the medical services of the day could hardly cope. As obstetrics developed as a science and a profession, bringing greater medical control over midwifery, the hazards of childbirth tended, as a whole, to increase, especially those due to puerperal sepsis.
At the time of the First World War, well-to-do women had their babies at home. Many of the poor were delivered in hospital where the death rate was high, both of mothers and their babies, which eventually led to public clamour for improvements in the maternity services and played an important part in influencing Government health policy in the 1920s. In the years following the First World War, when the safety of childbirth first became a political issue, a committee investigated the problems related to childbirth and it was found that safety was directly related to the quality of the mother's general health and the importance of preparing women for childbirth began to be realised.

The price paid by midwives for State registration was control of their professional regulatory body by a rival higher-status occupation, the medical profession. Until very recently medical practitioners have constituted a majority of the Central Midwives Board membership and only in 1973 did the Board have its first midwife Chairman. It is also highly significant that although there is provision for the appointment of lay members to the Board, at present there is only one such member. Indeed, in the seventy odd years since the Board's foundation the appointment of a member who has actually borne a child has been a rare occurrence.

The image of British midwifery is a curious one. The foreign observer perceives the profession as not only alive and well but a paragon from which other countries can learn a lot. But from within, there is much room for concern that all is far from well with the British midwife and some would even say that midwifery is in a crisis. Her skills are often wasted and her status undermined by misguided attitudes and a mismanaged maternity service. There is definite correlation between the erosion of the midwife's autonomy and the battery farm approach, according to lay groups in U.K.

It is against this background that we must appraise the medically-inspired and government-backed move towards 100% hospital delivery which has resulted in the deliberate dismantling of the domiciliary midwifery service - a policy, argue the cynics, which owes more to the obstetricians' desire to keep their hospital beds filled and their career prospects secure in a period of falling births than to patient choice or medical need. The running down of domiciliary midwifery, while depriving many midwives of the job satisfaction previously derived from their continuing responsibility for the woman during the antenatal period, delivery and puerperium, has also robbed the mother of the choice of giving birth at home, in familiar surroundings, where the professionals are her guests, not her masters, and where it is her decision, not theirs, whether her partner is present or not. At the same time the increasing mechanisation or "active management" of hospital delivery, the wiring up of the mother to monitors, and - very dangerous in my opinion, routine episiotomy, increased use of forceps, and epidural anaesthesia (already shown to have its dangers), all militate against the woman's control over her own body. All these interventions, along with a high rate of artificial induction and acceleration of labour (often associated with increased pain and trauma for the mother and adverse consequences for the infant) increasingly combine to rob the mother of the experience of natural childbirth. Equally important, it also deprives the rising generation of midwives, medical students and mothers of the knowledge that such an event is even possible. The baseline of normality is in the process of being lost. Yet in Holland half the births take place at home, and the maternal and perinatal mortality rates are much lower than in Britain, indeed among the lowest in the world.

Birth is a unique event and unless you have been present at a home birth, without the noise, the clinical environment, the machines and the green gowns, which all

tend to detract from the wonder of birth, it is hard to describe the tremendous energy and the joy experienced as the mother and the father lift their own baby into their arms, with the midwife attending quietly as guardian.

The topic of home birth in Britain is a very emotive issue and my previous paragraph will evoke horrified cries of "Yes, but what if .....?" with an endless list of obstetric emergencies which might occur and the implication that the couple concerned are irresponsible, selfish and cranky.

90% of women who request home birth are very suitable with good obstetric histories and are young and fit. They have discussed the whole issue and have made an informed and responsible choice. Of course there is an element of risk, but so is there with hospital care but this is rarely discussed. Infection, intervention, and rigid hospital policies are my main objections to hospital delivery. Also the whole idea of being anonymous, with nobody to whom you can relate, is in itself a great danger. The one-to-one basis that we have in the community dispels much of the tension and fear, which in itself can affect the outcome of labour.

Life is full of risks and to imagine that a woman and her baby are protected from them merely by being in hospital is a fallacy. There was a case investigated by the Ombudsman last year, where a woman in Birmingham lay screaming for help for an hour, unattended, and eventually had a stillborn baby. The midwives concerned did not have to appear before their professional body as the mother concerned did not wish to "make a fuss". It seems that it is not what you do but who you are.....

Women in Britain do owe a debt of gratitude to two French men, Frederick Leboyer and more recently, Dr. Michel Odent, who have introduced a more relaxed and empathetic approach to childbirth, with special emphasis on the reception of the baby into the world - thus improving bonding; (a ghastly word for love).

Michel Odent was speaking at a conference in Birmingham recently, mothers and midwives will have enjoyed his listening to his views. The frustrating part is that for those of us who practice the old-fashioned midwifery he is saying very little that is new.

As can be seen, some very old questions are currently being posed by both medical and lay critics of the present system. Is the increasing mechanisation of labour merely "meddlesome midwifery" - modern style? Is active management the latest manifestation of male medical imperialism which midwives and their protagonists have attacked for nearly three centuries? Is the increasing mystification of childbirth, which gives the (usually male) doctor control over a basic female function, (the pains and joys of which he can never fully understand but with which he feels compelled to interfere) merely the result of his desire to raise his own professional status?

It is not just an articulate middle-class minority of "women's libbers" who question these developments. Medical opinion is also divided, and there are those who suggest that practices hotly defended as progressive today may tomorrow rank with the wholesale tonsillectomy and other discredited medical fashions of the past. The move towards 100% hospital deliveries has considerable implications for the cost of obstetric care, still rising despite a falling birth-rate. At a time when hospital costs are rapidly increasing, distressing gaps in our health service remain.

People are beginning to ask whether we should continue to accept arrangements which may perhaps prove of more benefit to the medical profession than to the patient.

It is for these reasons that although the English midwife is still recognised by law as an independent practitioner, competent to attend childbirth on her own responsibility, and is still the senior person present in approximately 76% of all deliveries, many midwives fear that the increasing medicalisation of childbirth is fast reducing them to the status of the North American maternity nurse - a mere minder of machines and handmaiden to the obsetrician, often performing clerical and orderly duties.

If midwifery <u>is</u> a profession, then midwives <u>must</u> make a stand and alter their outlook. Patching up midwifery in isolated situations will not save the profession. Each midwife has a responsibility to fight for her rights and those of the women in her care, but what is most needed is a complete change in the way that midwives have been conditioned into seeing themselves - by their selection, their nursing training, their midwifery training and their sphere of practice. We must dispel apathy and try to find strong leadership which has an uncompromising vision of midwives as independent practitioners.

It was in this period of increasing uneasiness that the Association of Radical Midwives was born in 1976. I have personally found it most rewarding. As individuals, midwives feel angry, frustrated and isolated, but together we can be effective in restoring courage and strengthening the midwives' role. Membership at present stands at about 580.

Much improvement in maternal and perinatal mortality rates reflects a more healthy population. People eat better and live more hygienically than they used to, and since women have fewer children, high risk groups of older mothers have been reduced in size.... the tendency is to attribute greater safety in childbirth wholly to better medical car. Doctors themselves have probably encouraged this tendency; obstetricians are peculiar among doctors in having such a clear index by which to measure their success and they tend to forget that medical care is not the only reason why people survive.

In the past, and still in many cultures today, women have babies without any medical help. Their attendants are other women; usually those who have had babies themselves. Babies are born in the home, in the family setting, and birth proceeds as the woman's body dictates it should - there is little or no intervention in the

natural process. None of this holds in industrialised societies, where attendants at childbirth are professional "deliverers"; hospital is the proper place for having a baby which has become an occasion on which the family is split up, not united. Trust in nature has been replaced by trust in technology.... people are no longer responsible for their own health, their own illnesses, their own births and deaths. Doctors are saviours, miracle workers, mechanics, culture-heroes. For the first time since she grew up, a woman having a baby is considered not to know what is in her own best interests. It is really ludicrous that a doctor should imagine that <u>he</u> cares more about the baby than its own mother.

Last year I had to work in hospital for twelve weeks and the time I spent on the labour ward was an absolute nightmare. In the nine years since I had qualified, active management of labour, with doctors in charge, had taken over, and although the midwife was the senior person present, the complications at the births I saw were quite frightening. I saw a mother collapse after an epidural due to hypotension. I saw at least two post partum haemorrhages and a vulval haematoma due, I feel to artificially accelerated labour. I saw hypoxic babies due either to high speed deliveries or the effect of Pethidine. In the antenatal clinic, doctors invariably repeated whatever the midwife had previously done, thereby negating her judgement and undermining her authority. The indiscriminate use of ultrasound with so little research on its effects is surely questionable I also saw many babies who became jaundiced after birth a known side-effect of Syntocinon. This can lead to severe feeding problems for the baby and depression in the mother. I noted that the student midwives usually went straight to the monitoring machine, often completely disregarding the woman and her partner. The fact that so many of our machines are faulty is anxiety-making for both mothers and midwives. The important use of eye-to-eye contact and of touch, when the midwife sits patiently by the bed, monitoring the progress of labour with her hands, is very much underestimated.

Did you know that in USA there are only 1500 professional nurse/midwives practising against tremendous opposition from the medical profession, with many more joining their ranks annually? These midwives are committed to being "with woman" during the natural course of childbirth, unlike their British counterparts who are practising "with doctor". These American nurse/midwives are determined to give childbirth back to the family and are doing so with success if statistics on family satisfaction are the criteria.

[illegible] to participate in the birth of their child, [illegible] parents and their families are turning from [illegible] dominated obstetrics to the nurse/midwife. [illegible] attend, and pay for, childbirth preparation [illegible] and are well informed on the physiology of [illegible]. Special classes are held also for those [illegible] to give love and support to the mother during labour; they are shown how to give basic care, as well as the psychological support which is so vital at this time. These midwives are not just attending births at home but in alternative birthing centres or in birthing rooms in the local hospitals - they all have one thing common however, a commitment of sharing childbirth and its responsibilities with the family in mutual trust.

There are midwives in Britain who are trying to provide a similar service; some operate within the National Health Service, but a growing number are now practising independently, where there is less bureaucracy and more freedom, and the midwives have total patient care, which is very rewarding. It is sometimes argued that this is a case of double standards. It is sad to see sensitive and caring women leave the NHS for the private sector, but I fully understand and frequently envy them. I may in fact join them, as I do feel I am being frozen out by colleagues who do not approve of my attitude.

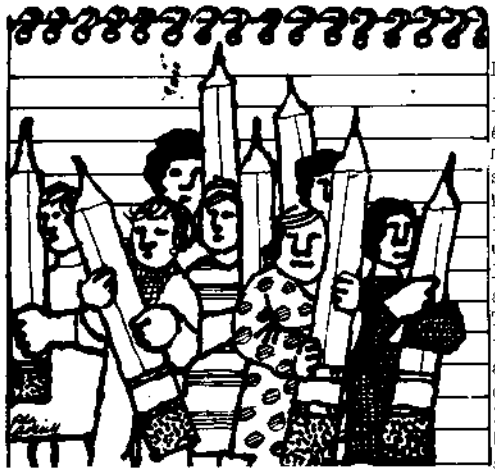
In the NHS you are expected to get on with your job, keep your mouth shut and your head down. Whilst this suits many people, I find it hard to cope with.

The possibility that the British midwife may be reduced to a mere maternity nurse also has implications for the future of midwives in countries which are Britain's fellow members in the E.E.C., since the Treaty of Rome requires the harmonisation of professional qualifications within the E.E.C. This requirement has brought the British negotiators into conflict with other E.E.C. countries, where midwives, because of earlier government provision for their education and regulation have much higher status than their British counterparts. The education standards of pupil midwives in France, for example, are much higher than those required in U.K.; pupils train for three years and qualify as midwives only, not as nurses, and hold University qualifications. They thus stand in relation to the medical profession more on a par with the dentist than with the nurse, as is the case in U.K. The question is therefore whether the dawning consciousness of the danger they are in, will spur the British midwives to fight to gain lost ground, or whether, having striven over the past seventy years to throw off the image of Sarah Gamp in exchange for the "respectability" they needed in order to survive, they are now too busy being 'respectable' to fight at all! In that case, not only may we be witnessing the demise of the British Midwife but ultimately the gradual reduction of French, Dutch and other E.E.C. midwives as well.

A leading British obstetrician has said of midwives - "We have stolen their role of providers of primary health care and it will take a fair amount of work by enthusiasts to get midwives back on their traditional trail. They must get used to being in charge again."

It would thus be paradoxical if it were from America, where the fashion for "active management" of parturition originated, that the impetus should come for a return to the view that childbirth is, after all, a natural process, in which modern science has a supplementary, but not dominating, part to play, and that more heed should be paid to the wishes and feelings of the mother herself, since despite men's contribution to our understanding of it, it is still, and should be recognised to be - "women's business".

LETTERS



Dear Editor,

May I comment on Rachel Celia's Forum Article, in the July 82 ARM Newsletter?

I very much enjoyed this contrubution, especially as it provided so much to think about, and the implications of what Rachel wrote go to the heart of childbirth and midwifery. Here are just two points.

Rachel's practice of encouraging women "to admit to and express their fears and feelings" is obviously healing, and I can well believe that she has known depression to lift in these circumstances.

However, without the sort of integrity and genuineness that Rachel has, these techniques are just another form of manipulating women and are worse than useless. Can you imagine this translated into a course on "counselling" or "therapy"?

Secondly, is this sort of remedial care enough? Isn't it also important to give women the strength and skills to protect themselves in future? This probably isn't practicable for NHS midwives, though.

Love, Elizabeth Cockerell.

Dear Editor, 7th March 1982

I feel I must write and say how sad I felt when I read Belinda Ackerman's account of the combined ARM/RCM meeting.

The report seemed to imply that Ruth Ashton (and therefore the RCM) has no particular interest in the "key" issues affecting midwifery practice, e.g. episiotomy, and is primarily concerned with management issues. In the present climate, with midwifery under a very real threat as a result of the proposed re-organisation, I am relieved to know that this is Ruth Ashton's primary concern.

To suggest that Ruth should be available to attend every ARM/RCM meeting does appear naive when one considers the demands of her job. Her willingness to attend the initial meeting must surely reflect her keenness to encourage communication between the two groups.

I hope that the report in question does not serve to widen the gap between ARM and RCM, although I do feel that RCM representatives will be reluctant to attend such meetings in the future, if the reports that follow are written in the same highly critical tones as the first one.

Yours, Kate Newson, SRN, SCM, MCD.

Dear Editor, May 1982

I should like to share my recent experience in trying gain admission to a newly approved direct-entry midwifery course, as I am very disturbed by what I see as a potential trend in future programmes of this kind. At present there are only two in Britain, and I have been told that the other one has no vacancies until 1986.

I was put on the short list for the eight places available and invited back for a second interview. There were twelve of us in my group. Out of the twelve I was the only one who had had babies. Our academic credentials ranged from O levels to college degrees. I was not accepted.

I feel strongly that I have been discriminated against, because I am older, (I'm 33) more mature and experienced a single mother with a university degree, I am a member of ARM, NAPSAC, NCT and the Birth Centre, London. and, horror of horrors - I have given birth, once at home! Perhaps I know too much. I believe however that these very things the interviewers probably found threatening are in fact good qualifications for a would-be midwife. I still have a great deal to learn, but am highly motivated. I am working now with mentally handicapped adults, a constant reminder of what can go wrong. I have attended childbirth conferences, been to Pithiviers, and read copiously.

I want to be a midwife, not a nurse, which is why the three-year direct-entry course appealed to me. Now I am effectively blocked from becoming a midwife, because I suspect that only those women most likely to accept standard hospital procedures without question are thos most likely to be selected. If that is the case, it is especially disappointing that it should be happening in a direct-entry programme. The old system of midwifery seems to be perpetuating itself through its training methods, with little chance for change, even in the face of evidence that challenges certain obstetric practices in use today. And those student midwives who might wish to effect changes are unable to do so.

Helen Bagshaw, Step House, West Chillington, Pulborough W.Sussex RH20 2JY.

Dear Editor,

I was very interested by Rosie [illegible]'s article, 'Does abcess make the heart grow fonder?' She obviously suffered a great deal of pain and distress despite her knowledge and application of the "usual treatment". However she makes no mention in her article of the things La Leche League would regard as the mainstays of treatment of sore nipples, and of mastitis. Her pessimistic conclusion that she could not breastfeed any future child runs directly counter to the information we have from our medical advisers.

Of course it is possible that she tried all the measures I am about to mention and just didn't say so in the article - but I feel I really must share them with you just in case midwifery training does not contain mention of them - because they really do work and can prevent nearly all abcesses from occuring.

1. It's a bit academic, but I wonder what caused the cracked nipple in the first place - possibly thrush, or the baby's position at the breast? Rosie does not say where on the nipple the crack was - that could give a clue to the cause. Perhaps prevention was possible at this stage. (Enclosed are our leaflets "Nipple care", and "Position at the breast and its relation to nipple problems")

2. Again the "usual treatment" for cracked nipple makes no mention of the all-important position of the baby at the breast, or what the baby was doing with his tongue. Improving the baby's position so that his gums are pressing away from the cracked area can substantially reduce the pain, even if malpositioning is not the original cause of the trouble. Other great healers include air; salt water; ice; checking that plastic backed bra liners are not keeping the nipple soggy; starting feeds on the "good" side, so that the let-down has started and the baby sucks more gently on the cracked side. Rotersept spray contains no agent which is healing or pain-killing. It is a disinfectant and there is no evidence that it is effective in healing cracked nipples nor in preventing mastitis. (Enclosed is our leaflet "Rotersept Spray".

3. Rosie mentions antibiotics and Syntocinon nasal spray as a treatment for mastitis but does not mention increased nursing to keep the breast empty and force the milk through the blockage; use of heat to relieve pain and help let-down; use of ice after feeds to reduce circulation; bed rest; nutritious diet; Vit.C etc.

Other ways of preventing a recurrence or a worsening of an abcess are more "non-medical" - finding the cause: does the baby breastfeed irregularly or infrequently or sleep through the night, causing engorgement? Is a too-tight bra or baby carrier pressing on a milk duct? Is the mother overworking? Is the baby fed in a variety of positions to ensure emptying of all the ducts?

Most important as a way of preventing an abcess is the increased breastfeeding - as often as the baby is willing - hourly if possible. Reading between the lines, it looks as if the "usual treatment" for cracked nipples includes temporary weaning from that breast - a disastrous step if mastitis is in question. Saline, or Otrovine drops if necessary will usually clear a baby's nose so that he can co-operate in the all important task of emptying the infected breast. There is a great deal of evidence that the most frequent cause of breast abcess is not breastfeeding itself but the sudden weaning which is not infrequently recommended by doctors, concerned about babies ingesting infected milk. Even if an abcess occurs, weaning from the affected breast is only necessary if the wound is near the nipple where the baby's mouth would be, and even then only temporary weaning is advisable - and this not only from the baby's point of view, but also from the mother's so as to prevent recurrent milk stasis, infection and abcess. (Enc. LLL leaflet on "Sore Breast".)

4. I do not understand why Rosie thinks she can never breastfeed again. I can well understand a <u>decision</u> not to risk such severe pain again, but it is certainly not the case that she "cannot feed". I recently counselled a lady who continued to breastfeed through and after breast surgery to remove a possibly cancerous lump (it was benign). The surgery cut through a couple of milk ducts but breast feeding - for a short time on one breast only but very soon on both - was still possible. Other counsellors have helped women who have had a mastectomy breastfeed on one breast only. It is highly unlikely that the draining of an abcess would sever milk ducts, but even if it did, Dr. Andrew Stanway (of "Breast is Best") informs me that while the ducts will not knit together like bone, they will force their way through to the nipple, giving the mother a complete set for the nursing of any future baby.

This letter is now very long, but I would like to make a couple more points.

A. About Midwifery training - particularly as your plans for the 1983 Conference included this topic. Is it possible that midwifery training is over-medicalised, stressing drugs for treatment rather than the equally or more important aspects of treatment, such as in this example - breastfeeding technique. I have limited experience here, so could well be wrong - but when I have experienced breastfeeding problems with my own children I have been struck by the doctorish reaction of the midwife; sore nipples - lanolin; cracked nipple - Friars Balsom or Rotersept. I could almost hear the rustle of the non-existent prescription pad! The reassurance I badly needed I had to practically drag out of her: "Have you ever seen a crack in just this place before?" - "Yes". "Did it heal?" - "Yes." Did the mother take the baby off the breast?" - "No."

It is such a pity. Finding out exactly what a mother is doing, sharing information, on mundane matters such as breast pads, giving reassurance takes much longer than mentioning a chemical - but it is every so much more effective.

B. The last thing I'd like to say is that LLL has a lot of things your members might like to make use of- such as the very numerous information sheets. We have a review of breastfeeding literature especially for professionals; a Drugs list of what information there is available regarding the effects of maternal drugs on the breastfed baby; leaflets in a variety of languages; some very good books such as "You can breastfeed your baby - even in special circumstances", and "The Womanly Art of Breastfeeding", plus of course our breastfeeding counselling and group support services. One really helpful service you might like to tap into is our access to our professional advisors - for unusual or tricky situations. All LLL Leaders (Counsellors) have fast telephone access through a professional liaison leader to expert medical advisors, in this country usually, but not exclusively Dr, Penny Stenway and Dr. Ebrahim (of "Breastfeeding - the Biological Option.) Any mother, midwife or other professional is welcome to channel difficult questions this way too - either by telephoning their local LLL leader or 01-404-5011.

Sorry this letter grew so long, and I hope you take it in the spirit it is meant - if pain such as Rosie's is ever preventable, let's all work together to prevent it.

Best Wishes,

Jo Paton (La Leche League Leader)
15 Bradwell Road,
Bradville,
Milton Keynes MK13 7AX

BOOK REVIEWS

A GUIDE TO MIDWIFERY by Elizabeth Davis.

John Muir Publications - approx. £3 - £4.

I think this book is a very practical and realistic guide to midwifery. It is written by an obviously widely experienced lay midwife, covering a wide variety of subjects, i.e. becoming a midwife; setting up a practice; antenatal, birth and postnatal care; also management of complications. There is also a fair amount of detail on topics rarely seen in other publications. There are good sections on hypertension, pre-eclampsia, single mothers, working class women, older women, gay women, estranged couples, these being just a few.

Alongside discussing midwifery as an art rather than a science, and childbirth as an experience not an experiment, this book faces the realities of today's society and our pathology orientated maternity system and employs what is useful.

There are some excellent illustrations, specially useful to student midwives, for example performing vaginal examinations. In the preface, the author stresses the need to consult other practitioners before using practices in the book. All in all it covers nearly everything you want to know about midwifery but were afraid to ask!

Jane Tucker.

THE BOOK OF THE CHILD

Pregnancy to 4 yrs. old) cost 75p.

Available from Health Education Centres, this book is published by the Scottish Health Education Unit, and is endorsed in principle by the Royal College of Physicians of Edinburgh, the Royal College of Obstetricians and Gynaecologists Scottish Executive Committee and the Royal College of Midwives (Scottish Board).

It is written for pregnant women and mothers, and apparently is very similar, except in price, to the Marks and Spencer Baby Book.

It is ideally suited to being the kind of book that can be left around in antenatal clinics, maternity wards, etc. The impression I've had from pregnant women, mothers and midwives has been one of enthusiasm

In addition to the usual material, there are some very good photographs taken from Lennart Nilsson's A child is Born", showing the development of the embryo - fetus, and pictures showing the actual birth from "New Life" by Janet Balaskas. (Some midwives found these "disgusting" but after persuasion from mothers began to appreciate them). There is also a full frontal of a woman, with diagrammatical organs superimposed, showing where everything is situated, with lay and medical terms.

There is ammple supply of pictures to capture interest, and the written material also mostly appears quite down to earth, including complications which may arise during pregnancy, labour, puerperium and up to four years old, i.e.why do babies cry?; bowels and bottoms, is my child ill?, what to do in emergencies, etc. Well worth looking at.

Jane Tucker.

BREASTFEEDING IN PRACTICE - A manual for Health workers, by Elisabet Helsing, with Felicity Savage King. (£5.20 - Oxford University Press)

Written principally by a Norwegian Nutritionist who has worked in Norway, Niger and Bangladesh, Elisabet Helsing's practical experience shines through this authoratative, but un-dogmatic manual. She starts by placing breast feeding in its historical and social context, and coninues by explaining the need for advice and the various ways it can be given.

The importance she gives to the "Doula" (a lay woman who has practical knowledge and experience and who is always available to the lactating mother) is a constant theme of the book.

A clear description of the anatomy of the breast and the physiology of breast feeding is followed by a series of chapters on antenatal advice, how to start breast feeding, common problems encoutered, both early and late, supplementation, weaning and the mother's diet. I encountered a strange relief in seeing in print things I know, believe and consequently advise women - they're not, after all, the crazy ideas that some of my fellow workers would have me think! Also there are ideas new to me; not least the "horse cure" for reversing a dwindling supply of milk. (page 68!)

The third part of the book deals with "Special cases" e.g. relactation and induced lactation (with some nice anecdotes), the special needs of low birth weight babies, illnesses of baby and of mother, and how these might affect breast feeding, mechanical aids, and finally expression of milk and methods of storage.

The book is rounded off by a look at the future: A practical listing of current "malpractises" (with facts that refute them and suggestions on how to change them) is follwed by a well argued case for the need for legislation and practical change both to help women to breast feed whilst working outside the home (if they so wish) and to discourage the baby food industry from its greedy pursuit of profits. It is encouraging to learn that Papua New Guinea has banned the sale of formula, and feeding bottles can only be bought on prescription.

If you are not already on your way to your nearest bookshop, might I add that Chloe Fisher feels that the need for a book of her own has been considerably reduced by the publication of this book, and finally, that the postnatal ward I last worked on is getting a copy shortly.

Liz Davidson.

GP/Midwife Unit

at Park Hospital, Manchester by Jean Towler.

This small unit was set up as a result of the closure of the local Cottage Hospital, due to lack of NHS finances. The Cottage Hospital had specialised in normal deliveries, transferring those mothers who developed complications during labour to the parent Consultant unit.

The new suite consists of a six-bedded ward with a birth room attached. This was previously part of a postnatal ward and so the patient's day room became the birth room! I was new to the Authority when the Cottage Hospital was scheduled for closure, and I was not therefore fully aware of the fact that this matter was a political "hot potato"! The GPs had been told that there was no alternative accommodation and that their patients would have to be delivered with the Consultant Unit patients.

Time was running out when I, desparate to maintain and develop a normal delivery unit, seized upon the idea of using the six-bedded ward and converting the day room. This seemed to solve the problem and the Consultants agreed to the reduction in post-natal beds.

The Plans were accepted, I wrote to the GPs offering the use of the new unit to any of their patients wishing to have such a birth experience. Their response was encouraging, quite a few GPs being glad of the opportunity for re-education about the process of childbirth and wishing to be present at the delivery, others content to let the midwives perform their complete role.

The midwives run the unit, undertaking antenatal care as well as deliveries and postnatal work.

A file has been compiled of all the individual wishes of the GPs covering the unit, e.g. whether they would prefer to come and suture, etc. Thus midwives can turn to the file on admission of a woman and be quite clear about the wishes of her doctor.

The day room with walpaper, carpet and curtains was ideal for the type of birth room I wanted to create. Many of the staff, especially the domestics, were aghast when they learnt that such a room was to be used for deliveries, and I had to convince them, various members of the Works Dept., the Bacteriologists and the Area Medical Officer that I would ensure this was a "safe" place for delivery! I discussed the philosophy and advantages of such a natural birth unit with them all, and fortunately they gave in.

This is obviously a non-conventional birth room. It simulates a bedroom and a non-clinical atmosphere has been created by storing the minimum of "equipment" on shelves behind curtains. The room contains two easy chairs and a coffee table, so that the couple can play scrabble or other games over a cup of tea or coffee, a delivery bed covered by a pretty counterpane, a table lamp and a birth chair.

The only other light in the room is a ceiling light, so that the mother does not have harsh bright lights shining into her eyes. The chair, in contrast to the expensive £5000 chair costs only £52. We have had it raised on a plinth and mothers and midwives who have used it - both in the Unit and at home - have found it advantageous in many ways. (See comments at the end of the article.)

The philosophy behind this GP/Midwife suite is the provision of facilities for low risk mothers to have a physiological labour and natural birth. The mother is not confined to bed by "drips" or machines, can stand or walk about, and this is encouraged, to aid descent and dilatation, and to increase uterine efficiency. Some mothers relax by sitting in a warm bath, and others like to regress in the birth room with its subdued lighting, soft music and homely atmosphere. Analgesics are not given routinely. The fetal heart is monitored with a Pinards stethoscope, Sonicaid or electronic stethoscope.

The mothers can choose their position for delivery. Some sit on the birthchair when they want to push, but transfer to the bed for delivery, others find the stool very comfortable and have been delighted to deliver on it. The head is "breathed out" between contractions and a physiological third stage is encouraged. The mother can assist in delivery of the baby's body and put the baby to the breast.

Fortunately it has once more been realised that a woman who is free to behave as a birthing human animal directed by her instincts, takes the labour and birth in her stride.

As a preventative measure the walls are washed regularly, the carpet shampooed monthly, or more often if necessary, and spot check swabs are taken by Laboratory staff for culture. The cushion covers, curtains and bedspread are washed and changed regularly, more often if necessary. There has been no infection in the unit. The babies are alert and aware at birth, not suffering the hang-over from sedation or analgesia given to the mother.

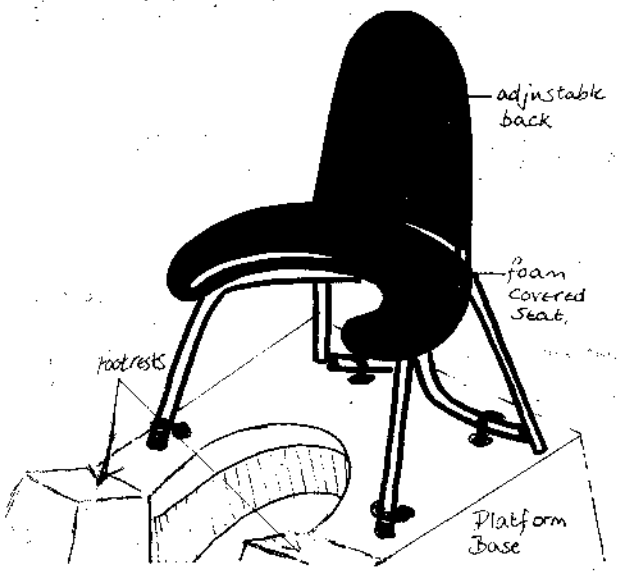
Unfortunately some of the Medical Staff are still resistant to this Unit, but it is tolerated. Some doctors are advocating water only - which I feel is only a subtle step away from a dextrose drip and confinement to bed, but so far we have continued to advise the mothers to take honey throughout labour and small nourishing meals early in labour.

However, some mothers - and even some who meet the low risk criteria - are still being denied an experience which I believe is their right, i.e. to give birth how and where they choose. Where such a unit exists within the confines of a hospital the obstetricians should be only too glad to vive their assistance when, and only when, necessary.

There is much room for change in the attitude of staff even perhaps to allowing natural breech deliveries as in Pithivers and elsewhere - but at least we have made a start.

The midwives, many of whom have been practising for many years delivering in the dorsal or left lateral position are with much support and encouragement now learning to go along with the wishes of the birthing woman in whatever position she chooses, and are becoming more adaptable and experienced in fulfilling these choices.

Jean Towler. 1982.



<u>The following are a few of the many favourable comments made on birth chair deliveries:</u>

Having heard numerous comments on the birth chair, I was most anxious to observe for myself how the patient was managed in the 2nd Stage of labour. I had no preconceived ideas about the chair and was most surprised at the shape and size and how accommodating the stool was.

We were able to visualize the perineum by kneeling in front of Mrs. W. I was most impressed at how well the perineum was distending, no guarding of the perineum was needed and the head descended well with each contraction. The placenta and membranes were expelled with little effort on the part of the mother.

Midwife, 17 yrs. experience.

I found kneeling down in front of the mother quite comfortable for delivery. The technique of delivery i.e. flexion and extension of the head is easy to execute and it is very nice to lift the baby up into the waiting arms of the mother. 5 minutes later, the mother stepped from the birth chair, baby and all, into her bed nearby.

Community Midwife, 27 yrs. experience.

Contractions appear to be less painful with the mother standing or sitting on the chair in an upright position, and even in a primigravid mother the head advanced easily with little effort required for pushing. I found it easy to flex the head and had a very good view of the perineum. This position allows more space to direct the head downwards to free the anterior shoulder. The placenta separated spontaneously and was expelled quickly after the delivery by maternal effort. The uterus contracted well, and blood loss was less than 2 oz.

Midwife, 36 yrs. experience.

I've never particularly enjoyed the 2nd stage of la labour, I'm not a very good pusher, so was interested in anything that might make it less hard work! 9

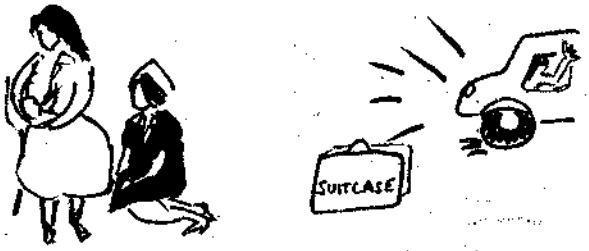
When I was ready to push I climbed aboard and found it very comfortable both during and between contractions.

One of the nicest things was that I really did feel the progress of the baby's head and afterwards I didn't ache, particularly my arms, as I had done after holding my legs in previous labours. The baby was born easily placed immediately against my thigh and then in my arms. I can't remember the placenta coming away. It was really wonderful for all of us. My husband thoroughly enjoyed himself and said it was the best yet.

I do believe the chair made for a very easy 2nd stage, I had no discomfort and wasn't exhausted. I would encourage anyone to use it, particularly women who have had tiring 2nd stages previously.

Hopefully, more women will use the chair, I will certainly talk about it and tell other women about its existence.

A Mother.



<u>I am very much in favour of the birth chair for the following reasons:</u>

The "natural" posture for birth for many women is to squat and the rim of the chair gives support for what is virtually a squatting position, and it allows the maximum pelvic capacity and outlet space; (30% more). Contractions seem to be stronger and more efficient, in spite of (or perhaps because of), being less frequent.

This upright posture positions the mother's body in an optimal configuration for gravity assisted descent and expulsion of the baby.

The upright position prevents supine hypotension syndrome.

Gravity also aids the expulsion of the placenta and membranes.

The adjustable back allows the mother to lie back temporarily whilst the fetal heart rate is counted, and for the rubbing up of a contraction should this be necessary in the 3rd stage.

Episiotomy has not been required. The head is "breathed out" between contractions and only minor grazes have been sustained.

The mother delivers - is not "delivered". She retains control over the situation.

JEAN TOWLER.

10 POLLUTANTS IN HUMAN BREAST MILK

Suzanne has sifted through many publications in a variety of languages to produce this thought-provoking article. We (the editorial collective) are awed by her findings but feel it is important to reiterate that this is not an article to be used pro-artificial feeding. It raises important ecological issues and how these affect our bodies and our children's bodies concerns us all.

There is a growing awareness on the continent regarding the problem of chemical residues in breast milk.

It is said that the level of some of the pollutants is 10-20 times higher in human breast milk than in cow's milk, probably because we are at the end of the food-chain.
An analysis of the breast milk samples in a German maternity hospital has shown that 95% of these samples were so polluted that their chemical content would have been above permitted levels for foodstuffs on general sale, in other words "unfit for human consumption"! *There have been many similar studies and a lot of* publicity mainly in France and Germany.

I have seen many scaring articles in magazines which are given to pregnant women. At a time when more and more women wish to breastfeed it is obvious who benefits from this kind of scare-mongering! The solution to the problem, however, is NOT artificial feeding. To be breastfed is the birthright of our children, and we have to make sure that they get the best quality milk.

In order to achieve this we have to develop an informed approach to diet and life-style, and we also have to become aware of the politics of food-production, (i.e. pesticides in the Third World, etc.).

In Germany many women's groups have sprouted recently demanding the right of unpolluted breastmilk for their children. Some of their aims are to raise consciousness regarding the problem; to get free-of-charge analysis of breastmilk samples; provision of organically grown foods for pregnant and nursing mothers; and eventually the ban on the use of pesticides and other toxic chemicals.

Which chemicals am I talking about? DDT is probably the best known one. Although it has been banned in U.K. it is still around us and inside us and will be so for some time yet. Its use is still permitted in the Third World!

The biggest problem seems to be the PCBs, (Polychlorinated biphenyls). Their use is so varied that their toxic compounds have contaminated soil, water, air and food. The chief dietary source of PCBs is fresh water fish.

The list of other chemicals is long and includes for example Dioxin, and heavy metals such as lead.

We should realise that most of these chemicals are fat-soluble, which means that they enter the general circulation when fat stores are used up for some reason, i.e. in dieting or during breastfeeding. The effect of PCBs and similar compounds has not yet been shown to be harmful to babies. But at the same time, animal experiments have demonstrated carcinogenic effects in some instances, damage to nerve and liver tissues in others. As many of these chemicals produce delayed long-term effects, it will be very difficult to prove the connection between illness a few years later, and chemical residues in breastmilk consumed when a baby.

Although this issue is very depressing, there are many ways in which we can lower the chemical residues in breast milk. The following information might be useful when advising pregnant and breastfeeding women on their diet:

Generally, women should be dissuaded from trying to lose weight while breastfeeding, ideally they should try to keep their weight stable.

A vegetarian diet reduces the content of substances like DDT in breastmilk, as a lot of these chemicals are absorbed in conjunction with animal fats.

Meat-eaters would be advised to avoid port, veal, wild-fowl, game, and offal, and to prefer lean lamb or beef.

Fresh water fish and fish from coastal waters should be avoided also. It is not a very good idea to advise pregnant women to eat liver or take cod-liver oil!

Obviously, organically grown fruit, vegetables and grain would be most desirable for pregnant and breast-feeding women. But these foods are either difficult to obtain or are very expensive. Therefore we have to try to get the poison out of ordinary foodstuffs. Any fruit or vegetable which can be, should be peeled, the dangers from chemical ON the skins outweigh the benefits of the vitamins UNDER the skins. Any other fruit and vegetable should be washed thoroughly under running warm water.

Fresh foods should always be preferred to processed foods, which usually contain a lot of chemical additives.

Finally, something about fats. Sheila Kitzinger recommends that a diet low in animal fats should be eaten during breastfeeding, (i.e. skimmed milk, cottage cheese, etc.). This is a good idea, if at the same time there is an adequate intake of good quality plant fats, (i.e. cold pressed oils, etc.) so that the release of body fats is avoided.

Obviously, we would rarely go into such detail when advising mothers on diet, but basic hints like the avoidance of weight loss, too much meat, offal and animal fats might be a step in the right direction. At the same time I feel that this information is a useful guide for our own diet: "to keep the Radical Midwives healthy"!

Although most of the material and information I have been using is in German, I include a list of English books and articles on this issue.

1. La Leche League Information sheet No. 78c. & 78d "PCBs. and Mothers milk" (Feb. 1977)

2. Sheila Kitzinger: The experiment of Breastfeeding. Breastfeeding in a Polluted World. (both Pelican paperbacks)

3. D.B. & E.F.P.Jelliffe: "Human Milk in the Modern World" O.U.P. 1978

Suzanne Roberts. 1982.

Snippets

Epidural tape banned.

The cassette tape distributed by the manufacturers of the drug mainly used in epidural anaesthesia has been banned by the Association of British Pharmaceutical Industries. This followed complaints by AIMS that many statements in the tape were inaccurate and misleading, that they failed to discuss adequately the risks to mother and baby. It was also shown that the taped interviews were almost pure propaganda aimed at encouraging mothers to seek epidural births.

The pharmaceutical company, Duncan Flockhart, sent the tape to many doctors up and down the country, and they in turn had prospective labouring women listen to the tape, in some hospitals it was a pseudo-official explanation of what epidurals are all about, and what the procedure involved.

AIMS is now pressing for all of the tapes to be withdrawn, and is also lodging a complaint with the BMA's Ethics Committee.

Tap, Tap, Tap!

West African women, through generations, have passed down a method of preventing leaking from the other breast when suckling their babies. They tap the nipple!

Taken from T.A.L.C.'s Tape-Slide lecture on Breast-feeding by David Morley.

(T.A.L.C. = Teaching Aids at Low Cost, from the Institute of Child Health, 30 Guilford St. London WC1 Tel. 01-242-9789.)

Feto-placental Assays.

Does anyone know of any specific research done on the HPL & Oestriol blood tests taken during the latter months of the antenatal period?

A recent mistake of taking blood twice one morning from a number of women in our antenatal clinic resulted in variations of as much as 20 - 30

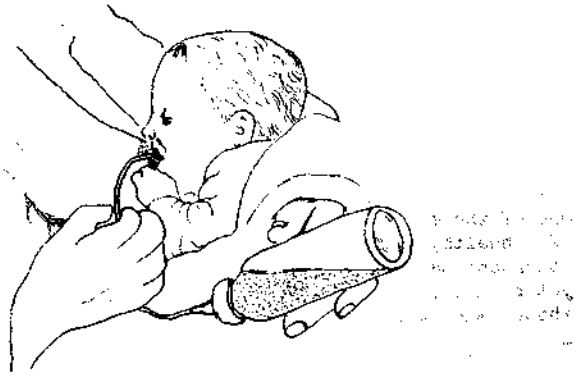
These blood tests should only be assessed serially, but unless the blood is taken at the same time every visit the results may vary greatly.

In the particular maternity unit where I work, a low reading may be the only reason to induce labour when all other clinical signs of well-being of mother and fetus are good, (i.e. weight, B.P., fundal height, relative fetal growth, movement, etc.)

Isn't this just another example of misinterpreted intervention by obstetricians over which the midwives have no control?

American labour suites; now being called "foetal intensive care units"!

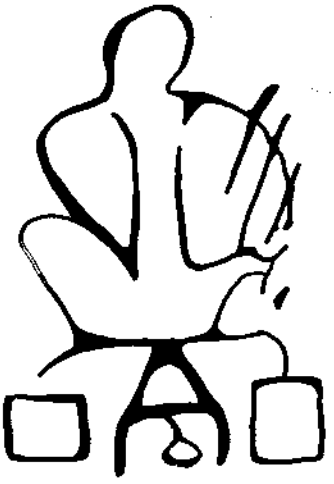
Lactaid Supplementer



This was discussed at the last National meeting in Cumbria. It is used to help in relactation, and to induce lactation in adoptive mothers. It consists of a long thin plastic tube connected to a bottle or plastic bag containing milk. The end of the tube is placed besides the nipple, and the baby sucks the tube at the same time as sucking the nipple. Eventually this suckling stimulates the breast to produce milk, the baby taking less and less milk from the bottle as the mother's milk comes in. It can be bought as a kit from USA, but can be easily home-made.

Tea (strainers) for two!

An easy way to treat sore or cracked nipples:- Expose to sunlight or bedside lamp to harden and dry, and keep exposed to the air as much as possible, and put tea strainers in your bra!!!!!



The Radley Case.

One of the main aims of the midwife - the delivery of a healthy baby from a healthy mother, and the attendant care before and after the birth have not yet been found to be incompatible with home births, though many would have us believe it is so.

This is not a discussion about home v. hospital births, but the recent prosecution of a Wolverhampton man for delivering his own child without notifying the authorities which raises many issues.

It is not possible, nor is it my part to judge the apparent negative attitude of the AHA to the wishes of the parents. Whatever the circumstances, the parents were so unsure that their needs would be met that they did not call the maternity services until after the birth. Surely, somewhere, there was a sympathetic midwife who could have been allowed to compromise to such an extent that she would have been present at the birth, which is all the letter of the law requires.

Perhaps it is indicative of prevalent mood of the authorities that they chose to make an example of this man, in an effort to frighten women into hospital for deliveries. The prosecution brought out many points, and the midwifery profession did not show up so well. However there is a world of difference between a planned home confinement and one where there is no trained birth attendant. So often we hear "there is nothing to it", i.e. delivering your own baby, but this underplays the very real skills of the midwife, who often may not appear to be "doing anything", but who is actually practising those very skills by her apparent inactivity, her observations and experienced calm manner.

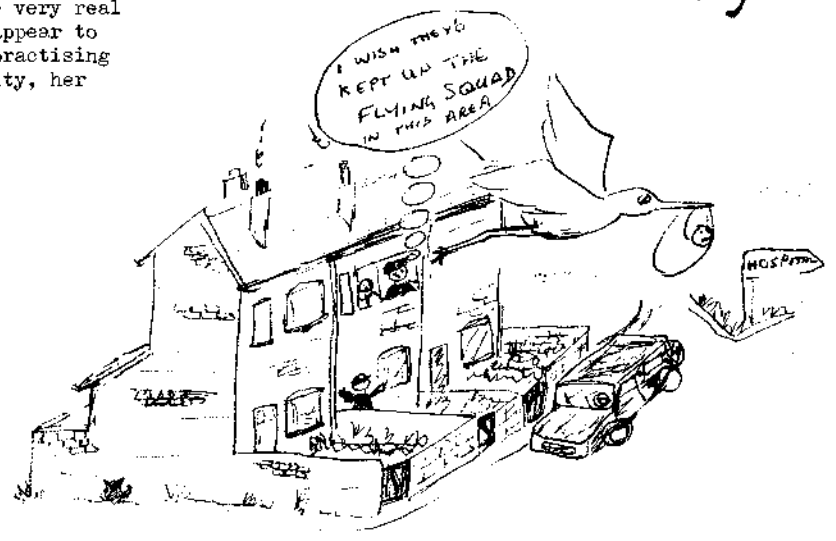
However, many midwives have little experience of home confinements, (or physiological labour for that matter!) - how many comparatively recently qualified midwives have even witnessed a home birth in the course of their training and afterwards? It is not surprising that many community midwives do not wish to attend them.

The policy also means that the skills needed for home confinements and the confidence which goes with such skills are rapidly disappearing, as fewer and fewer midwives operate in urban areas, where such skills were traditionally acquired.

We should not be afraid of voicing our fears - perhaps the ideal is for two midwives to attend, thus drawing on each other's experiences, this may not seem very cost effective, but compares well with the numbers of midwives and doctors a woman may see during her labour in hospital.

The clamp-down on Mr. Radley is symptomatic of a policy to get all women, regardless of criteria, into hospital for delivery. Policies which treat all women alike tend to encourage staff to do the same, giving credence to the complaints of the consumers, that they are not treated as individuals.

Joyce



For your info... Events Jobs

BIRTHRIGHTS - BIRTHLAW

A one day conference on Parent's rights and the legal aspects of Birth, including the responsibilities of Health Care Professionals, to be held by the Birmingham Birth Centre on Saturday 15th November. at the Albany Hotel, Smallbrook, Queensway, B'ham.

Speakers: Beverley Beech - Chairman of AIMS

Jean Robinson - Researcher, one-time chairman of Patients Assoc.

Tickets £6.50 (includes lunch)
Creche £1 per child

Cheques and P.O.s to: The Organiser,
18 Mackenzie Rd.
Mosely,
Birmingham B11 4EL
and made payable to Birmingham Birth Centre.

Please enclose S.A.E.

Telephone 021 449 3747 (urgent enquiries only)

Lesbian Health Workers Weekend 10th - 12th Dec.

Horton Women's Holiday Centre, Horton in Ribblesdale.

Space to break down the isolation many of us feel at work. A chance to share our fears, our experiences and the ways we work things out. Maybe even a step towards building a network of support?

Contact:- Lis, 67 Langdale Rd., Liverpool 15
Tel. 051-734-3404

If possible by early November - we need to know numbers. Wheelchair access is unlikely to be ready by this weekend, unfortunately.

POST NATAL DEPRESSION SUPPORT GROUP

By Mothers - For Mothers. If you are feeling lonely isolated, frightened with your new baby, do not wait but join us in our weekly informal self-help group.

Every Tuesday from 11 am. to 1.0 pm. in the Sheffield Centre against Unemployment, Bridge Street, Sheffield 3
Tel. 24866 (Near A.B.C.Cinema)
Free creche available.

Further information: Barbara Tel. Sheffield 330381
Agnes Burns, 4 High Hazel Mead
Handsorth, S9 4NU

MIDWIVES IN THIRD WORLD PRIMARY HEALTH CARE

Experienced midwives are needed to train local birth attendants, whose skill are vital in making home births safe in rural communities. These women play an important part not only in midwifery, but in preventing sickness for mothers and children, as well as in helping women to understand and improve their social position. So teaching them basic skills and knowledge to add to their years of practical experience can make big changes in the lives of women and their communities.

NORTH YEMEN

Two midwives are needed to join an integrated health project based in Abs, a town on the coastal plain between Yemen's mountains and the Red Sea. The CIIR midwives will be working in the villages surrounding Abs training local birth attendants, who have provided the only midwifery service for generations; they will also be training local staff at the clinic in Abs to provide mother and child care.

NICARAGUA

The Government has started a pilot project in the northern Estli region, to provide a basic service for mothers and children. CIIR needs two more midwives to join a team working throughout the area, training midwives and health auxiliaries, introducing preventative measures such as improved sanitation and vaccination.

PERU

A nurse/midwife is needed to join a tem of agricultural, educational and health workers serving Indian communities in the highland Cusco region. The CIIR midwife will investigate local midwifery, child-care and health practises, and develop training courses for women and local midwives in community health.

ZIMBABWE

Nurse/Midwives are needed to start new training programmes for traditional birth attendants, as part of Zimbabwe's new Government national health programme. CIIR midwives will be based in rural hospitals and clinics.

In all these posts, CIIR midwives will be training others, rather than practising as midwives themselves. So a real confidence in their own skills, as well as a desire to share them and train others is vital. Experience overseas or in community based work in U.K. would be useful. But before taking up overseas posts, all CIIR workers receive a full orientation to their job and the country, additional training if required, and an intensive language course.

Terms: All CIIR overseas workers have minimum two year contracts and receive basic salary, insurance, return air fares, equipment & resettlement grants, and other allowances. For more information please write with details of your experience, enclosing a large A5 SAE and quoting reference AMW/9 to:

CIIR Overseas Programme, 22 Coleman Fields, London N1 7AF

MIDWIFERY IN AMERICA

I've just returned from a three month visit to the States, where I spent most of my time in California. I can't pretend to have a very detailed knowledge of the midwifery scene in America, the situation varies so much from State to State as regards the legality and feasibility of practising as a midwife, that a much longer visit would be necessary to really understand it.
There are basically two kinds of midwife:

1. Certified Nurse/midwife(CNM) who has done midwifery training as a form of post-graduate advanced nursing. the CNM is a recent innovation.

2. The lay midwife, who does not have a formal training in a recognised school. She may be one of the original "granny" midwives, (some of whom were granted a State licence several years ago), or a younger woman, often a mother or a nurse, who has apprenticed herself to a practising midwife, and taught herself from books. There are now also many alternative colleges for training lay midwives, e.g. in El Paso, Texas, though these do not give a legally acceptable qualification.

Basically however, most women still have their babies delivered in hospital by doctors.

Legal Situation.

The situation regarding the legality of lay midwives practising varies from State to State. There are six models which seem to apply:

1. States where lay midwives are recognised by law, and lay midwifery is clearly legal, e.g. New Mexico, Texas, Washington.

2. States where the situation is more vague - lay midwifery is not prohibited nor is there a specific law governing midwives. These States are usually tolerant of lay midwives, e.g. Alaska, Oregon, Nevada, Wyoming.

3. States where it is legal only for granny midwives licenced before a certain time to practise, e.g. Kentucky, and Virginia.

4. States where the situation is not legally defined but is prohibited through judicial interpretation, e.g. California, Colorado, North and South Dakota.

5. States where midwifery is legal, but licences are not issued, e.g. Arizona, Arkansas, Florida and Mississippi.

6. States where lay midwifery is clearly prohibited, and only CNMs can practise, e.g. New York, Pennsylvania Ohio, North Carolina.

Problems of being a CNM

It may sound as though there really is no problem - a lay midwife needs only to undertake a formal training and become a CNM to practise freely. The picture is far from being so simple however.

The American CNM is very different from a British Midwife. She is much less of a practitioner in her own right, (although many of us feel that we are not wither, at least we are still legally given this status, and can work independently if we want to).

The CNM, in most areas, must practise under the supervision of a doctor. This means that they are very rarely able to attend home births, as most doctors refuse to provide home birth backup. Hence most CNMs work in hospitals and birth centres, and home births are usually attended by lay midwives.

CNMs are controlled by Boards of doctors or nursing administrators, and this has far reaching political implications as, without a national health service, doctors and midwives are in economic competition.
In many States CNMs are not allowed to carry emergency equipment, or perform "medical" procedures, e.g. episiotomies. They are far from fulfilling the W.H.O. definition of a midwife - as can be seen from this quotation from a pamphlet published by the American College of Nurse/Midwifery:

"The American Nurse/Midwife always functions within the framework of a medically directed health service, she is never an independent practitioner."

There is no direct-entry form of training, a midwife being seen very much as an advanced nurse practitioner. This means that a lay midwife would first have to undertake nurse training, much of which would be irrelevant to her eventual practice as a midwife.

Problems of being a Lay Midwife

So - why bother to train to be a CNM, when it seems to be very little more than the obstetric nurse status already available? Many lay midwives don't undertake a formal training, and each State seems to have a group of them, either practising openly or covertly.

But, except in the one group of States in which it is legal for them to practise, these lay midwives are in danger of prosecution, for "practising medicine without a licence". In California at present, it seems that there is one of these cases every 6 months. This usually follows a neonatal death, or some kind of obstetric problem; even if the problem in no way is attributable to the midwife's care, and if the parents have no desire to bring a case against her, the State will still use this as a chance to prosecute.

I was told of a team of lay midwives who booked a woman for a home birth. They gave her all her antenatal care, and when she was at term, and called to say she was in labour, they went along to her home. When they arrived the house was surrounded by police, and the midwives were arrested. The pregnant woman and her partner were police informers, and the whole situation had been set up to catch the midwives on the job.
It's frightening to think of the premeditated callousness behind such behaviour, and it makes one thankful that the situation here is more pleasant. (Or is the legal control of midwifery just more subtle here? The recent memorandum sent to D.H.A.s by the N.W.Thames R.H.A., on how to prosecute unqualified people who help with childbirth at home, is far from sympathetic in its attitude.)

Annie: A Lay Midwife.

The lay midwives I met greatly impressed me by the extent of their knowledge and dedication to their work. (Although I realise that there are some who are maybe not as diligent, just as there are qualified midwives who are not.)

To give you an example of one that I met:

Annie works in a single handed practice with an apprentice midwife, and goes to 4-5 births a month. She charges about 600 dollars for antenatal care, the birth and two days postnatal care plus 6 week check-up. (This 2 day postnatal care is standard practice in U.S.A. for home birth follow up - visits are done on day 3 and day 7. After hospital births, women are discharged home on day 2 and have no further follow-up visits. When I explained our system, and how midwives here often continue visiting after 10 days, the American midwives were truly astounded! Although one or two said, "What on earth do you find to do every day?" (!!!!), most of them were impressed with the amount of care, and felt that their system was sadly lacking.)

Annie holds a weekly "drop-in" clinic where pregnant women come along for their antenatal checks, and those who have had their babies return to share their experiences. The women's casenotes are long and detailed, (for a similar type see those in "Heart and Hands. A Guide to Midwifery" by Elizabeth Davis.) They are usually sent home to complete and then brought to the first visit for the midwife to discuss and go over with them. I was particularly impressed by the emphasis on good nutrition, and the midwife's working knowledge of this. (Could you glance through someone's diet for one day and assess the relative amounts of protein, carbohydrate, calcium and vitamins available?)!

She knows a sympathetic doctor who enables her to have lab. work done, blood tests etc., but does not work with him as, for example, independent midwives and G.P.s work in collaboration in this country. Because women must pay for their maternity care, they have to choose between midwife and doctor care.

Annie practises fairly openly, and yet is constantly aware of the threat of prosecution hanging over her. there are many problems inherent in the way that she has to practise - e.g. should a woman have a post-partum haemorrhage, a lay midwife will probably have ergometrine available and will give her this. However, it is in fact illegal for her to possess and administer any drug. Should she need to transfer the woman to hospital, she will then be faced with the dilemma of either having to admit to her illegal behaviour, or else be forced to give false information.

The relationship between CNMs and lay midwives is often difficult, many lay midwives feel CNMs have a superior attitude towards them and are not happy to share their knowledge and work together. This is possibly peculiar to California, where there are many midwives practising and hence there is some competition and rivalry.

Recently there was an attempt to pass a Bill in California that would enable lay midwives with experience through apprenticeship to take the examination for midwifery and become licenced. Most lay midwives I spoke to were very much in favour of this although a few didn't like the idea of their work being regulated in any way. However, the Bill was scrapped and it seems unlikely that it will be successful for some time yet.

Meetings with CNMs.

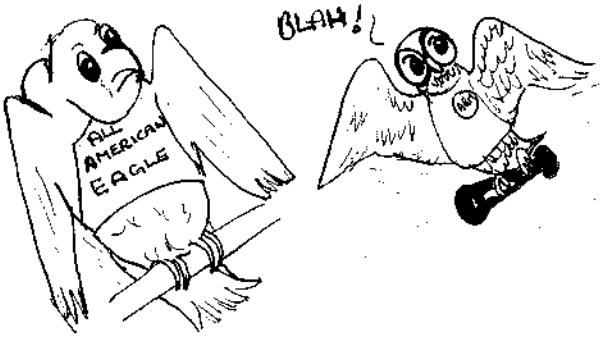
The CNMs I met showed me the other side of the picture. Many were sympathetic to the problems of lay midwives and regarded them as complete equals, whilst others did show the superiority I'd been told about. Most were very articulate about the role of the midwife being different from that of the nurse, but even so they are still controlled by official legislation as to how they can actually practise. I did meet some doing home births, with doctor back-up, but most work in CNM schemes within maternity hospitals. This means they work alongside a team of doctors, and the women choose to have CNM or doctor care. (The doctors attend normal as well as abnormal births). Because they are actually employed by the doctors, there is always an element of unequal status.

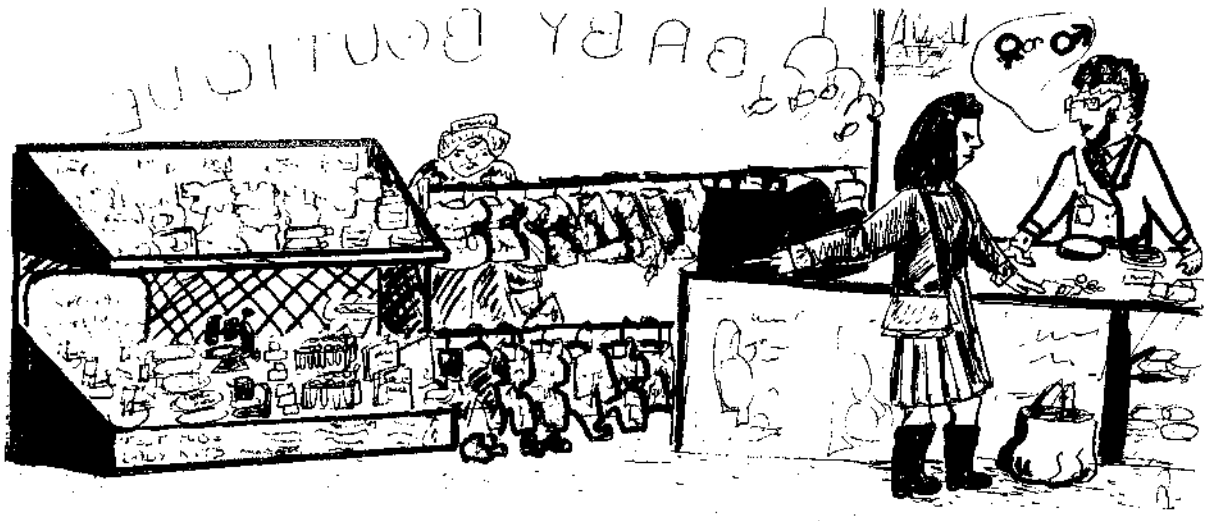
As a generalisation, most CNMs I met were very competent particularly in the field of general physical examination and assessment; they are also able to listen to a woman's heart and lungs, feel the thyroid, test reflexes, examine eyes, etc. Maybe not an essential part of midwifery, but I feel it would be very nice not to have to refer to a doctor for such check-ups.

I did feel however, that quite often there seemed to be little difference between the CNM and the doctor. In the hospital the labouring woman is often looked after by an obstetric nurse, and the CNM appears at the last minute to catch the baby. This doesn't seem to be very different from the behaviour of an American doctor! The obstetric nurses provide emotional support, perform VEs, and do the observations of pulse, fetal heartrate, etc. Following the birth the baby is cared for by nursery nurses, and the women by obstetric nurses until going home on the 2nd day. It seems a shame that the introduction of CNM schemes, a new and daring innovation in many States which had 100% doctor assisted births, seems to have missed the essential and unique role of the midwife altogether.

The American situation has important lessons for us to learn, at a time when the British midwife's role is being threatened. Initially the traditional birth attendants, (Granny midwives) were outlawed by the medical profession, largely for financial gain and power. There was then a period where nearly 100% of births, normal and abnormal, were in the hands of obstetricians. Now at last, some of the normal births are being restored to the care of their rightful attendants, the midwives. It is very illuminating to notice however, in what ways the midwife's role has now been changed and controlled in order to comply with the wishes of the medical profession, who through legislation ultimately still have the real control over women's access to midwives.

Billie Hunter, 1982.





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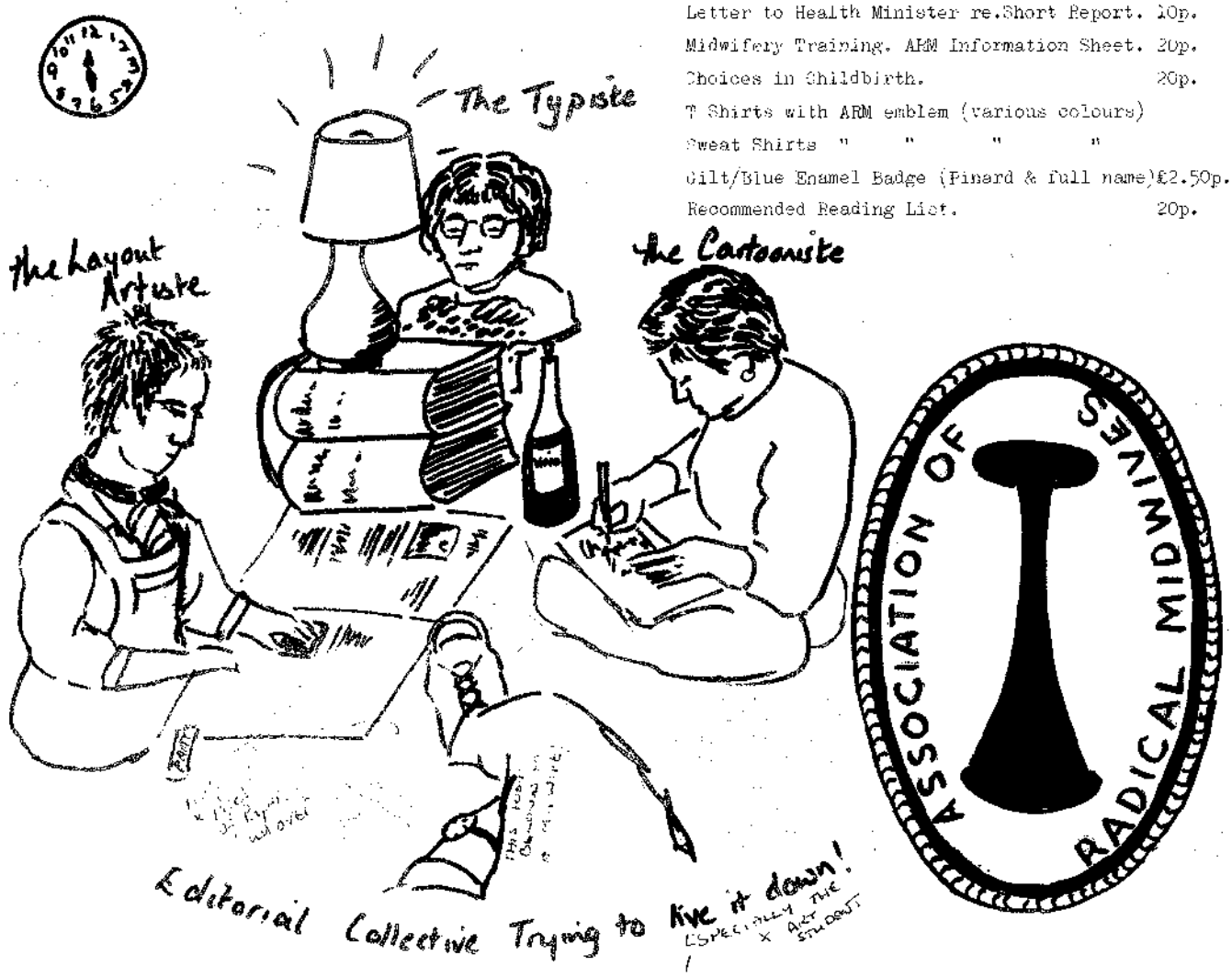

Why a newsletter?

The Association of Radical Midwives has been growing rapidly. We have received a high response from midwives and others concerned about the erosion of the role of the midwife and the consequent lack of choice for childbearing women. So we decided it was time to provide a place to share information, news, and to help us organise ourselves to achieve our objectives.

We will attempt to bring out the newsletter four times a year and it'll cover more ground than the minutes from our six-weekly meetings. It will include an editorial, articles, book/film reviews, lists of useful books, addresses etc., and sections on midwifery abroad, organisations and technical information.

Each issue of the newsletter will be put out by a different regional group. Please send all information, comments, letters and graphics to: PIPPA McKEITH, 71 FOREST RD. EAST, NOTTINGHAM. . We'll be very happy to hear from you and to receive any news, views and information you have to share.

Why radical?

After much discussion about a suitable name for our group THE ASSOCIATION OF RADICAL MIDWIVES was finally agreed upon. We realised that the word "radical" may alienate many midwives who might otherwise be sympathetic with the aims of our group. We believe "radical" expresses in its original sense the essence of our group, i.e. relating to roots and origins.

Our overall aim is to restore the role of the midwife for the benefit of the childbearing woman and her baby. We don't see this as going back, but rather as going forward.... Our objectives are:

1. to re-establish the confidence of the midwife in her own skills.
2. to share ideas, skills and information.
3. to encourage midwives in their support of a woman's active participation in childbirth.
4. to reaffirm the need for midwives to provide continuity of care.
5. to explore alternative patterns of care.
6. to encourage evaluation of development in our field

CONTACT ADDRESS:

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Please make cheque or P.O. payable to Association of Radical Midwives and send with an A4 size envelope to Isobel Hargar, 62 Crosby Hill, Ormskirk, Lancashire, L39 2LT.

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Contacts needed for all areas not co vered. Break the ice, start a regional group in your area and enjoy your own meetings!