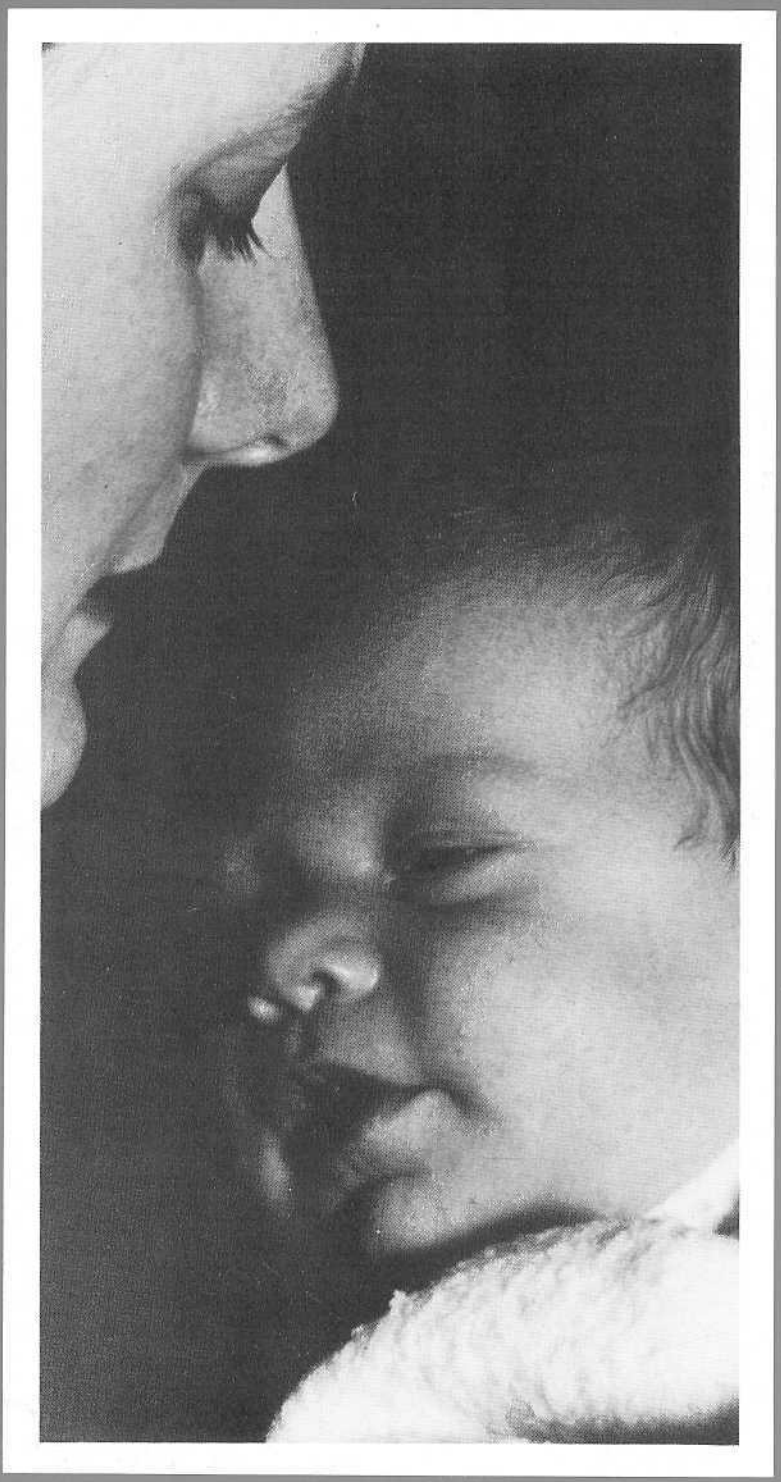
ASSOCIATION OF RADICAL MIDWIVES

MIDWIFERY MATTERS



- *A Matter of Feelings*
- *Male Midwives*
- *Midwifery & Nursing in Search of Commonalities*
- *Unusual Delay in 2nd Stage*

ISSUE NO.52
SPRING
1992

ASSOCIATION OF RADICAL MIDWIVES

The Association was formed in 1976 by a small group of student midwives from different training schools, who were alarmed by the apparent trend towards 'maternity nurse' status in their training. With growing support from other student midwives, qualified midwives in all fields of practice, and from the women themselves who are consumers of maternity services, that undesirable trend is at least being challenged. A.R.M. can feel justifiably proud to have been part of the movement towards a more caring attitude in midwifery, and to have been instrumental in helping alert our colleagues to the threatened loss of our professional independence. The word 'Radical' is used in its literary meaning of relating to roots and origins, and best expresses the hopes of that early group, that midwifery could find its way back to a position where midwives' skills were used to the full, while still taking full advantage of the benefits of modern technological advances, where these are seen to be in the best interests of the woman and her child. In other words, the hope that the true meaning of midwife ('with woman') will once more be realised in practice.

OBJECTIVES

1. To re-establish the confidence of the midwife in her own skills
2. To share ideals, skills and information.
3. To encourage midwives in their support of womens' active participation in birth
4. To reaffirm the need for midwives to provide continuity of carers.
5. To explore alternative patterns of care
6. To encourage evaluation of developments of our field

OUR QUARTERLY MAGAZINE

MIDWIFERY MATTERS is our line of communication between members, and also from ARM to others concerned with maternity care. In principle it will be published quarterly and will include reports from meetings during the last three months. Although the actual publishing and editing is lodged with the South Wales Group, the Regional Groups take turns in providing the main features, which may sometimes illustrate a common theme. The rota for this input is made up at the Annual General Meeting from volunteer Regional Groups.

Regular inclusions such as letters, book and film reviews, forthcoming events and other items of interest are always needed. Artwork is always welcome, as are good photographs. We can return originals.

This is YOUR magazine, let us hear from YOU!

MEMBERSHIP

UK and Europe — £22 pa.
Unwaged (optional concession) — £11 pa.
Overseas (airmail) — £30 p.a.

(See Subscription Form inside this magazine)

Please do not send foreign currency, since bank charges and exchange rates reduce the finaly payment, and make this method unacceptable.

£ Sterling only please!

NATIONAL MEETINGS

We meet regularly to exchange views, hear of developments in maternity care and share our skills with each other. Members are encouraged to bring along non-member colleagues and friends. Meetings, which are open to all who are concerned about maternity care, are held every three months, on the third Saturday of March, June and September, and the second Saturday in December. (One of these meetings will be the AGM). Venues vary around UK to give everyone a chance to attend during the year, and will be announced in MIDWIFERY MATTERS, together with directions and map. The registration fee is £8 for non-members and £6 for members, to include lunch and light refreshments during the day. Paid-up ARM members can claim a refund of travel expenses over £10 based on the most economical transport, funded mainly by the registration fee. Overnight accommodation is always available, usually in local members' homes, (bring sleeping bags if possible).

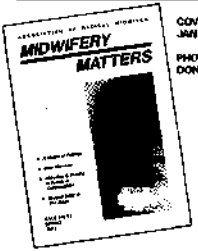
1992 NATIONAL MEETING VENUES

The following members volunteered their region for the National Meetings in 1992

March 21st	LEEDS/WEST YORKS.	Olga Parker
June 20th	CARDIFF	Sandra Arthur
September 19th	ORMSKIRK (AGM)	Ishbel Kargar
December 12th	CAMBRIDGESHIRE	Sarah Wernell

IMPORTANT

The Association is self-supporting, financed by membership subscription and sale of literature and other items. It is run by its members, who give of their time and effort voluntarily, by co-ordinating and editing Midwifery Matters and by joining the Steering Group and working parties. The only paid worker is the secretary, who receives the equivalent of an E grade post salary for approximately 25 hours per week.



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Oct 15	Dec 1

Regional Content:
Spring 1992 – **Nottingham**
Summer 1992 – **Stockport (students)**
Autumn 1992 – **Cardiff**
Winter 1992 – **Ormskirk**

Information on the events page will be confined to basic details only. Any further elaboration will be charged the usual rate.

Advertising is accepted at the discretion of ARM. Some inserts accepted. Enquiries should be directed to the Magazine Group or Secretary.

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Association of Radical Midwives Magazine

Contents

Issue No. 52 **Spring 1992**

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Editorial

Nottingham A.R.M. have been together now for about three years. We were initially encouraged to set up by various midwives such as Pippa Mackeith, Sue Skyrme, Ishbel Kargar and many others.

Over the years we have become a strong and dedicated group always willing to stand up to a challenge. Looking back, one of our highlights was in April 1990 when we organised a conference called "Women, Birth and Freedom". This event was a huge success and we hope to enjoy many more in the future.

We try to meet regularly in each others homes. The aim of these meetings are purely to act as a support to each other. The business side of the meeting is always kept to a minimum. Several times a year we arrange larger meetings at a hall, community centre or hospital to discuss various topics of interest. Past topics have been positions in labour, water births, third stage of labour, yoga and relaxation and aromatherapy.

The articles submitted to the magazine from Nottingham are all personal accounts of labour experiences as, over the last year many of us have had a baby and so it reflects our group well. A special thank you for sharing their experiences. We always welcome new ideas and new faces, so if you live in Nottingham or nearby why not come along to our meetings?

Amanda Moult
Nottingham Regional Contact
January 1992

STOP PRESS

At the House of Commons Select Committee on 16th January 1992, Virginia Bottomley, Minister of Health said "The Department of Health has no objection to midwives having admission rights to maternity units". When asked if the Department will inform those responsible of their views, she replied, "I have written to Ruth Ashton, Secretary of the Royal College of Midwives. If clarification needs to be made we will do so".

Footnote: If midwives want action they should raise this issue with their Health Authority, Virginia Bottomley and the Royal College of Midwives.

Steering group meeting in December. Left to right, Sally, Ruth, Ishbel, Nicky, Kate, Shelley.

FALSE ALARM!

No, it was the real thing. Alison's birth experience was not what she expected.

My labour took me totally by surprise, being a primigravid community midwife. I had convinced myself that my baby would be postmature, so at 39 weeks into my pregnancy, mild contractions commenced. I choose to think they were a "false alarm".

The contractions continued for 3 hours, in the meantime I sent my husband Mark out for a take-away and left him to carry on decorating our bathroom, in between back rubbing.

After 3 hours I tried to call a friend — I was unable to contact her, so my second friend came to examine me. To my amazement I was 3 cm dilated. My husband went to fetch a TNS set which was marvellous pain relief.

Four hours later I had a bloody red show and an urge to push whilst walking back from the loo, my friend examined me again and I was 9cm dilated, she asked Mark to phone an ambulance and this totally panicked him.

I was astonished, as I thought I would be experiencing excruciating pain. I waited for it but it never came. I then desperately tried not to push while I waited for the ambulance.

I remember praying that I didn't deliver in the ambulance on the way to the hospital. At the next examination I had an anterior lip which took ages to disappear.

Entonox came into use at the hospital and 3½ hours later I had a Neville Barnes Forceps Delivery with a pudendal block. My baby was a 9lb 3oz, girl and I was delighted to have her in my arms at last.

Lauren breastfed well from day one, with initial encouragement and was a contented lovable newborn baby.

The experience has helped me as a midwife. The practical experience has given me much more confidence and belief in women's ability to cope with labour, and the immediate postnatal period, and an insight into the small problems that I may have missed before I became a mother.

Alison Snape
Community Midwife, Mansfield.
Jan 1992

MY HOME DELIVERY

This time I decided to deliver at home.

My youngest daughter was born safely at home on January 18th 1991. It was the most relaxed of all my deliveries and I enjoyed it all.

My husband, Ian, supported me throughout the delivery although he hadn't been totally confident in my decision but afterwards wouldn't have changed it and would, if we have another, (unlikely), do it again.

My two elder daughters were born in hospital, Elizabeth by forceps after a quick (5hr) induction, Catherine a normal delivery, slower but more satisfying, by a friend, Beverly.

Early in my pregnancy I decided this time I would deliver at home and was supported by colleagues and friends.

Early in the evening I began having contractions which gradually increased in strength and frequency. By about 10.15 pm I called for the midwife who arrived about ½ hr later. I was 5-6 cms dilated and quite pleased. I quickly progressed and by 11.20pm Rebecca had arrived, very quiet but alert.

My two daughters came through and enjoyed a cuddle with their new sister. Eventually we all settled down and slept well. Rebecca was a content and placid babe, perhaps a little more so than my other daughters, but makes up for it now with her temper.

I feel my experience helps me support other women who are having their own home delivery.

Jacqueline Smith
Community Midwife, Nottingham.
Jan 1992

JESSICA'S BIRTH

Sue describes her very long labour and the arrival of baby daughter Jessica.

March 8th One or two weeks post dates (depending on the interpretation of my rather irregular menstrual cycle) — shame about the loss of postnatal maternity leave .. The baby still feels compact, and I don't quite feel whale-like, but the nights are getting sleepless. All is ready for delivery at home, though I refuse to use plastic sheets on the bed — far too uncomfortable! I still have some word processing to finish, but at least all the cupboards are tidy. I am convinced that the baby is waiting for Mother's Day to arrive.

10th March, Mother's Day — no baby. I am running out of enthusiasm for word processing, and I am running out of enthusiasm for being pregnant, though I have enjoyed it hugely, and I am sure I will miss it when, (or if), it is eventually over...

11th March. I visit the GP. I experience acute cramping pains while waiting to see him — Is this it? He is convinced enough to assume I am on the verge of labour, but books me an appointment for March 14th (term + 2 — or even 3 weeks). I am hopeful.

March 12th, my birthday, and another milestone comes and goes — nothing. Gloom descends on me — am I going to have to sacrifice my much wished for home delivery? Where is this child? Martin and I decide to try everything we can to get labour going — breast stimulation, sex, castor oil (NOT recommended!) jasmin essential oil, ginger, curry, gallons of raspberry leaf tea, and bach flower remedy for depression March 13th dawns warm and balmy, and I spend a peaceful day pruning roses and *winter jasmine, and regretting the castor oil.*

March 14th. I can't believe it has come to this — I see the GP, and he decides that it is time I was referred. I am unable to disagree with him. I ask to be referred to a particular consultant, and I prepare all my requests, arguments and demands — already my happy, if nervous anticipation of labour is fading fast. However, as it turns out, the consultant is completely sympathetic, relaxed and understanding. He actually asks me if I want to set a date for induction — I find to my great surprise that I do. We agree that I will come to the consultant unit on the next Saturday, in the evening for a prostin pessary, that we will try to complete the induction with prostin, and that, if she is willing, my community midwife will conduct the labour and delivery. We will go home at 6 hours post delivery if all is well. We also agree that, since I am now at least 14 days post mature, and probably in fact 21 days, I will attend the hospital even if I labour in the interim. I have a CTG, which is fine, and go home. I begin to feel that my wish for a home delivery was an impossible dream...

That night, at midnight, to my incredulity, I began to experience firm, regular tightenings, 1:3. It took me a while to believe it! I decided not to wake Martin, just in case. I did the ironing, cleaned the kitchen floor, did the washing up, chatted to the cats, who were curious to see me wandering around at that time in the morning, but pleased to be having an extra feed. At 0300 I was fairly convinced that we were in business, so I woke Martin, and asked him if he fancied having a baby at last. He did....

0530 — the tightenings were still 1:3-5, and felt strong to me, but I knew that my cervix was still posterior, long, and uneffaced. At 0600 I called Eryl, my midwife, to tell her what was going on, and that there was no need to come immediately. She arrived in ½ hour. I assumed (though I greatly regretted it) that I would labour at home for as long as possible, and then go to the hospital — it appeared that Eryl's ideas were somewhat different. She calmly continued with the original plans for a home delivery, and saw no reason why we should do otherwise. I was anxious, not about the place of delivery (which I was delighted about,) but about the reaction of the consultant and GP. To her eternal credit, such matters of power and control did not bother her one iota, and, to his eternal credit, when we finally did phone the consultant later that afternoon, when I was in the middle of labour, he merely said "you two are cooking up a home delivery between you aren't you — ok, call me if you need me...

For the first few hours after Eryl's arrival, we chatted, she palpated the baby and listened in, and, after some hours, did a VE — as I had thought, not much seemed to be happening. I drank orange juice, raspberry leaf and ordinary tea, and ate toast. Labour (like pregnancy) made me sick. I found rescue remedy to be a great help. As far as I am aware, I was never ketotic, despite what turned out to be 23 hours of hard work.

Mid-morning, I called my friend and midwifery colleague, Claire and she came and went throughout first stage. I called *my mum in Bristol at about the same time and* asked her if she wanted to come up to Derby to join in, warning her that it would probably still be some time.

For most of the labour, I found I could handle the contractions fairly well — as long as someone massaged my back and applied hot water bottles to my belly, since the pain was both abdominal and in my lower back throughout labour. In retrospect, it was a good thing that I was attended by so many people, since they all joined in with the massaging. The burden on one person would have been excessive. We used essential oils, and regular hot water bottles prepared by Martin. Frequent baths were also important, and the walks around the house and to and from the bathroom meant that I was followed by a procession of people carrying various accoutrements of the labour — very amusing at the time.

Mid-afternoon, mum arrived, amazed to find me undelivered. I decided I wanted jelly to eat. Martin was dispatched to get it. The first attempt was too runny, which was in retrospect a good thing, because, when the labour got a little too intense for her, my mum would wander off saying she was going to supervise the progress of the second attempt. I never ate it — I wonder if anyone did?

At about 1830, the contractions were beginning to get tough, and it was less easy to wander around chatting — I found I needed to concentrate hard, and I needed my back rubbing more than ever. About an hour later, I was suddenly aware of warm fluid running down my legs — my

membranes had ruptured. Immediately, the contractions got stronger. Eryl checked me — 7cms. I tried Entonox, but it just made me feel sick. I find it hard to remember the next few hours clearly — I know that we tried a number of different positions, and, when Eryl checked me again, at around 2100, I was 9 cms. A couple of hours later, I was the same, and I was beginning to get desperate. I had no desire to push. Although I was not able to converse with people, I could sense that Eryl and Claire were beginning to get a little concerned, and I was finding it very hard going. I remember thinking that if they wanted me to move I trusted their judgement absolutely. I thought longingly of an epidural, but could not face the idea of going downstairs, getting into a car, waiting for the epidural to be sited, and to work... Eryl suggested a bath.

I am in the midwives' hands — I trust them totally. The bath helps, but pain still makes me scream at one point, and swear continuously. I visualise steps, and a smiling face, and I count to ten — sometimes I have to start counting again before the contraction peaks. It is agony.

Suddenly, I start pushing (although when the midwives get excited, I gasp that I don't feel like pushing). However, the feeling (which I still remember as not being an overwhelming urge, just very painfull intensities, and I stagger back from the bath to the bedroom, trailing the others after me, stopping a few times to push HARD en route. It doesn't feel better than the first stage, to my surprise and dismay. A supported squat feels awkward, despite having practised it antenatally. I try various positions, none of which is comfortable. The backache is worse with each push — a check to my desire to get it over with. As I push, Claire holds my hand and says 'you're nearly there' — I know this is midwife talk. I can feel that the baby is high. Through all the effort, I am aware that there is meconium. The midwives now urge me to push longer. It is very difficult — the perineal pain is excruciating, and the backache is not much better. I find myself in left lateral position on the floor. Part of my mind registers the fact that all the pressure IS rectal, and none vaginal (despite the perineal sensations). I hear Eryl say she will want me to pant soon —

one more huge push —

the baby is out!

Thank God!!!

Did it cry? — I am too elated to notice. Martin is in tears, I am shaking uncontrollably, laughing with relief — but I am aware that the baby is very small, and I have seen that it has a cleft lip.

Somehow I am not surprised. I ask what we have got. Claire tells me gently that she is a girl, and that she has a bad cleft lip and palate. I don't care!! I am so glad she is a girl. I hold her. She is very small, very alert, with big, calm, bright eyes, wide open, and she is called Jessica. She is in good condition, despite her size (when she is eventually weighed, she just tips 5lbs). I am aware of the need to transfer to hospital in view of her size and defect, and I do not mind — I feel amazed that I have done it. I am still trembling uncontrollably, and I am full of relief. I am conscious of Eryl giving me Syntometrine, which I had not felt strongly about one way or the other, and I realise that it is because she did not want to transfer me with a placenta in situ. I feel so good! I have crossed the abyss! Both midwives remain totally calm and efficient. Time of delivery was 0055 on Saturday March 16th, well passed her dates, whichever way they were calculated.

Both midwives transferred with me, despite a long, very tiring day (Claire had been working the night before, and Eryl only left me for an hour or so all day). Martin followed the ambulance, feeling rather unsteady, and relieved that the journey is only five minutes long. My poor mum, left amid the mess, later recounted to me that she was in a state of shock for some hours — I suppose, for her, a cleft lip and palate was a completely unexpected outcome, although, by the next day, she had accepted the situation, and Jessica, totally.

The consultant came in to see me, despite the late hour, and was perfectly happy at the management of the labour, as far as I could tell. Jessica was eventually transferred to the NNU, mostly due to her small size, and inability to suck at first. I was not unduly bothered by this and, finally arriving on the postnatal ward, I fell into a sublime sleep.

Jessica went on to experience a string of problems, some of which are still not completely resolved. I have reflected for a long time on whether not having a scan, and going ahead with a home delivery were right things to do. In retrospect, the delivery experience has been a very positive memory in some dark times, and there were some very definite risks to Jessica of being scanned (not least early induction and, possibly, even section for her small size, on the assumption that it revealed IUGR. In fact, it did not — she was symmetrically small for gestational age, a distinction which I now know to be vital). As it was, despite structural problems, including a cardiac defect which required open heart surgery, she has been physically very well generally. She never showed signs of distress during delivery or afterwards, despite the meconium at the end of labour. It may be that six months of expressed breast milk has helped her in recovering from her various operations, and I now realise how important it is that women should be supported in long term expressing.

I would be scanned for possible heart defects in future, so that action could be taken sooner rather than later. If they existed — but I would not otherwise change the management of a future labour, unless there were clear evidence of IUGR or some other such problem. Both my midwives, and my consultant, agree with me — and I could not end this account without recording my heartfelt thanks to them for supporting me throughout, and in particular to Eryl for giving me a service which could hardly be equalled by even the very best Know Your Midwife scheme. I was immensely privileged in this respect, and very aware that the vast majority of women are not able to have anywhere near such complete continuity of care. I am also extremely grateful to my mother, for being there, and, most of all, to Martin, for all his support, encouragement, and for all the heartache he has shared since Jessica was born.

I still ask myself why she has had so many problems, and I still search for something I did in my pregnancy which may explain it, despite knowing that, at least with the present state of knowledge, it is unlikely that anyone could pinpoint anything. All I can say in conclusion is that I learnt a great deal from the whole experience, and I am not averse to doing it again — but perhaps not for a little while yet!

Soo Downe
Dec 91

MIDWIFERY: A MATTER OF FEELINGS

A discussion on the nature of a midwife's relationship with women, asks whether we have the balance between professional and friend right.

I was travelling home by train one evening when the gentleman in the seat opposite leaned forward and looked at the papers I was reading. "Midwifery" he said. "Now what is Midwifery today? Is it all epidurals and intervention?"

"Oh no", I replied "At it's best it's 80% feeling and only 20% technology."

He laughed and proceeded to describe the birth of each of his four children. Some it was true, involved slightly more technology than others. One birth was, he said, more of a plumbing problem but easily solved with a pair of obstetric forceps.

He then went on to talk about his feelings. He described in detail each of the midwives who were involved in the care of his wife and his family at the birth of each of his children. He said "Only some of the midwives could feel, others were very efficient".

He leant back in his chair and said "80% feelings and the richest experiences of my life". What a privilege to have been there, I thought to myself.

This whole business of feelings has been on my mind for some time now.

I have recently read a non midwifery book called, 'Nursing as Therapy', edited by McMahon and Pearson. In the preface, the authors say that Nursing is beginning to rediscover some of its basic truths. It describes one of these truths as "intelligent, sensitive nursing does make a difference to consumers of health care."

They go on to describe how many nurses have become increasingly aware of a commonly held view that "getting better" or even "staying healthy" is largely dependent upon initiatives by medical practitioners and medical therapists, with nurses merely carrying out the orders.

The book uses the analogy of an air journey, the aim being to get from A to B. Success is largely dependent upon the aeroplane and the cockpit crew. The aeroplane can be seen as technology and the doctor as the pilot, the para medicals as co pilots. The nurses in this analogy are the cabin crew. Flight attendants who can make a journey more comfortable, but who have little to do with achieving the overall aim.

The central theme of the book argues that nurses are in fact more than cabin crew. When nursing actually becomes therapeutic, and not just the task orientated activity which is so familiar, then the benefits to the consumer can really be seen.

I could not help but reflect on both the similarities and differences between nursing and midwifery. In 75% of births the midwife is the pilot, not just the cabin crew. She has the ability to fly the plane and to provide the care that is 80% feelings and sometimes on 20% technology. I like to think of the woman as the plane, the source of the power, capable of flying on auto pilot, sometimes needing the knowledge and skill of the pilot.

Yet like nurses, we still have problems.

McCrea and Crute (1991) set out to explore midwives' understanding of the factors which affected the development of a therapeutic relationship with clients. Many midwives will recognise themselves in the subjects of this small study and will relate to the midwife who is reported to have said "the best comes out in me when I can feel with the mothers".

The midwives in this study highlight the dilemma of what they describe as the conflict between being 'a professional' and being a 'friend'.

I shared the authors' assessment that there is indeed still a lot to be learnt. Are we still working at 80% technology and 'just in case' intervention? Are we still frequently locked into the traditional nurses' mode as the co-ordinator rather than the giver of direct care? Do we still wait for instructions from the most junior of house officers?

Is the feeling aspect of care or the therapeutic relationship too painful? Are many of us really too uncomfortable if we are too close or too involved? There are certainly ambiguities that surround the appropriate extent of our emotional involvement as professionals.

The midwife who grieves following the birth of a still born baby is encouraged to develop 'professional detachment'. There often exists a strange combination of the English stiff upper lip and the belief that emotional involvement may in some way prevent the task from being accomplished. The task and its efficient completion form the basis of the individuals ability to be a "good, efficient" midwife. This leaves very little room for feelings or the therapeutic relationship. Disclosure and openness often lead to embarrassment and discomfort.

There is, I am sure, much that can be learnt through 'shared learning', yes, even with nurses. When nurses and midwives begin to really learn what is a true therapeutic relationship, care will improve.

So what of the future?

In this area, the first cohort of Pre-registration Midwifery students have recently begun their course. Another example of "a privilege to be there". Their refreshing view of the world of midwifery is uncontaminated by the illness model of care and what I now see as the cabin crew mentality.

As they take their first taste of clinical midwifery in a community setting, they are encouraged to write a reflective diary. They are advised to write briefly under the following headings.

EVENTS: REACTIONS: RELEVANCE:

One student, with her community midwife, visited the home of a new family. Her description in the events section was clear. The mother was checked, her uterus was involuting at the required rate, lochia and micturition

normal. The baby was checked, cord on, sticky eyes improving. The midwife had recorded that all was well.

The student's next heading was reactions. She began by describing her difficulties in writing in this section. She wrote that it was true that 'all was well', but somehow she was concerned about this new mother. She wrote that she knew that after only four weeks in midwifery she lacked the knowledge and experience to discover what this new mother's problems really were. However, she felt that it was something about the sadness in the woman's eyes or the way she spoke. She discussed this with the midwife outside in the car. The student said she felt the mother seemed almost resigned to artificially feeding the baby. Should professionals intervene, asked the student? Was there really something wrong, not life threatening but not right? The experience of becoming a mother is not easy but can a midwife improve on it?

The student's diary explained what happened next.

The midwife and student returned to the house. Together they listened carefully to the parents of the new baby and advised the mother how to recommence breast feeding her baby. The baby's father also listened carefully, he wanted to be sure of his role in the plan for breast feeding.

Two days later the student concluded her diary triumphantly! Mother, baby and father were doing well. The baby was feeding well at the mother's breast. The student's diary section headed Relevance said: *I think this is what midwives do best, it seems we need to listen to our own feelings as well as to the women in our care.*

This very new student and her mentor had grasped what I see as the very essence of midwifery care. The relationship had gone beyond the norm and had become special. This is the relationship that the text books describe as 'the therapeutic relationship'.

This is what I see as one of Midwifery's basic truths. 80% feelings and sometimes just 20% technology.

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Sheila C Hunt
Midwife Teacher, Swansea
December 1991

SOME THOUGHTS ON LABOUR — ONE YEAR ON

Angela confirms the importance of midwives to labouring women.

As my son approaches his first birthday, I find myself looking back over the past year and inevitably recalling the events of the big day itself. I vaguely remember most of what happened, but only a few things are still vivid in my memory.

I remember most of all the care and support of the midwives Kathy, Sue and Kate: who comforted encouraged and even bullied me, (when I needed it!). I hadn't realised just how important midwives are to labouring women, until I was on the receiving end.

I remember feeling strangely calm when the baby's heartbeat began to "dip", as if it wasn't happening to me at all. I had total confidence in my attendants and I knew that they would make sure that everything was alright. I assume that most mothers must feel like this, and it reminds the midwife in me of the enormous responsibility we undertake when caring for labouring women.

I can remember that it was painful but I cannot describe how unspeakably awful it was! The relief when I had an epidural was wonderful. I now have tremendous admiration for women who rely on their own natural ability to deal with the pain.

I was surprised that the placenta was not the soft slippery thing that I had always imagined. In fact it was rather hard and bulky to deliver. Guess who never tells women that this bit doesn't hurt?

One of the comments made by a midwife sticks in my mind. As I nursed my newborn son she said that he was "born to breastfeed". That comment sustained me, to a degree, through some of the difficult days.

Worryingly, I remember that I was not in the least bit bothered about who came in and out of the room while I was in labour. I was to busy to care. It is clearly up to the midwives to protect a woman's dignity as she is often unable to do so herself.

The midwife in me feels more confident that I am giving women relevant and accurate information about pregnancy, labour and afterwards; the mother in me still calls the doctor out for the slightest snuffle!

Angela Jackson,
Midwife, Mother
Jan 1992.

"SEE ME IN MY OFFICE"

Although this article was written and first published in ARM Newsletter No.23 (1984), it is still pertinent today, so we thought we would reprint it.

"See me in my office", words that can turn knees to jelly and put even the strong-hearted on their guard. Many of us in the past have accepted this order without question and then found ourselves in a difficult and vulnerable position. Learning the hard way can be a traumatic experience with drastic consequences and it is certainly not everyone who emerges unscathed.

Many of us have come to realise the importance of belonging to a Trade Union, not only for its ability and knowledge in negotiating pay and conditions of service, but perhaps even more important — individual representation for the member.

It is not unreasonable to want to know the purpose of such a meeting, so if one is called to the office, it is essential to find out the reason beforehand. Politely but firmly, insist upon knowing the reason and do not be "fobbed off" with phrases like 'nothing in particular', 'you'll find out when you arrive', and 'just a chat about this and that'. No manager would dream of going into a meeting unprepared, so why should you?

Once the subject has been established, the next step is to gather one's thoughts together — easier said than done once the 'panic' button has been pressed. Never attend a meeting on your own, always take a colleague or preferably, a staff representative. It is very important that someone attends and is able to produce a written account to avoid future misunderstanding, and is there to speak up on your behalf, where necessary. If the member of staff does not belong to a Union at the time, the Confederation of Health Service Employees is prepared to represent the person whilst the membership application is being processed. Disciplinary action may be taken by the employing authority if working procedures in the hospitals have been contravened.

Types of Disciplinary Action

Counselling: A manager may wish to have a 'word' with the employee in a genuine attempt to solve a problem. This should be accepted in the spirit in which it is intended, bearing in mind that if there is no improvement following counselling, disciplinary action may be taken a step further.

Verbal Warning: A manager should state that a verbal warning is to be given to avoid being confused with counselling. It is up to the discretion of the manager whether this is entered on the individual's personal records.

It takes a more serious meaning if it is entered and should be appealed against if the circumstances warrnt it. More than one verbal warning may be given before moving onto the next level.

Written warning:

It is usual practice for a manager to make full enquiries and be convinced of the offence before issuing a written warning as these are only given for serious misconduct. Under these circumstances the employee should have the right of say to the investigating manager in the presence of his/her Trade Union Representative. It would be appropriate at this level for the person to be the Branch Officer. However, the full time Regional Officer should be informed by the Branch Officer of the relevant facts and information as they are a valuable source of advice and support. It may be necessary to ask the Regional Officer to intervene if it is felt the employee is not getting a fair deal. It is usual to receive two written warnings before dismissal, but that obviously depends on the seriousness of the alleged offence.

Suspension:

No employee may be suspended unless on full pay. This should not be interpreted as disciplinary action, merely part of an overall disciplinary procedure. However, one has to be realistic, and suspicion is naturally aroused when this type of action is taken. Management would certainly lose credibility were it to be used 'willy nilly'. There are two types — Pending Further Investigation or Pending A Full Disciplinary Hearing.

In addition to the aforementioned categories of Union Representation, a Union member may also seek assistance should he or she be accused of a civil or criminal offence outside the working situation.

I hope that this article has helped to make clear the steps of disciplinary action. I should also like to think that it has heightened the awareness for the members of staff, who have been led like lambs to the slaughter.

Always ask the reason why someone wants to see you, and then if necessary, take a **colleague** — preferably a staff representative.

See you — but hopefully not in the office!!!

Christine Wilde
Jan. 1992

THE COLCHESTER HOME-BIRTH SUPPORT GROUP

A local home birth support group outlines its aims and activities and explains why there is a need for such groups.

ORIGINS

The group was initiated around the needs of local women who were planning, or had planned, home-birth. Our first gathering at the home of NCT teacher, Jan Holden, indicated that most of us had met with sustained resistance from medical and health professionals. We resolved to support each other in the face of this mountain of misinformation and conceptual rigidity.

First, we wanted to offer to each other, pastoral care by setting up informal networks and by talking and exchanging our ideas and experiences of childbirth. Second, we wanted to offer tangible support during and after the birth. On request, a member will be present at a birth to act as advocate or attendant. After the birth, we attempt to provide household help.

We also realised that helping people within the group would not counteract the enormous tide of opposition to homebirth which is propagated by the bulk of the medical profession. We resolved to become a political body under the auspices of the National Childbirth Trust. The NCT, we acknowledged, would be able to provide a nationally-networked and institutionally-respected umbrella to carry out our aims. These are as follows:

AIMS

1. To support, emotionally and practically, women wanting a home-birth. Support is offered from mothers who have experienced the joy and freedom of home delivery.
2. To provide accurate up-to-date information about home-birth so that women can make informed choices based on fact rather than conjecture.
3. To inform women of their legal rights regarding home-birth.
4. To publicise home-birth as a responsible and safe choice for childbirth.
5. To carry out dialogue with midwives in order to improve continuity of care. It is believed that women should develop a close relationship with the midwives who will attend the delivery of the baby. It is also believed that the attending midwives should be fully supportive of the woman's choice of birthplace.
6. To liaise with other home-birth support groups, health professionals and maternity-care related organisations to further the concept of home-birth as a safe and responsible alternative.
7. To provide post-partum counselling and political advocacy, as required.

ACTIVITIES

A number of activities were launched to further our aims.

1. We have written to GPs in the Colchester area advising them of our existence as an information-source and support group.
2. We are compiling a register of doctors who are willing to provide medical back-up should women desire GP assistance. This list is very modest.
3. We have written to maternity and related organisations advising them of our existence
4. We have advised the Director of Community Midwifery Services at the Colchester Maternity Home of our aims and functions.
5. We have designed a poster for distribution to various outlets in the community so that women are made further aware of our existence. These venues include mother and toddler groups, libraries, chemist retailers, health clinics, community centres and post offices.
6. We have written an information leaflet which sets out the full range of options available legally to women and how they might persist in their efforts to get their personal needs fulfilled. This leaflet also deals with issues like safety and risk. It includes some anecdotal evidence from parents, midwives and doctors.
7. We have canvassed local organisations for financial support. We also plan to hold a public lecture to raise money for promotion purposes.
8. We have collected a library of books on various aspects of birthing. These are available for borrowing.
9. We have given press and radio interviews in the Essex area.
10. We are also planning Assertiveness Training seminars for pregnant women. The seminars will run in tandem with NCT antenatal classes. These sessions will help women to identify what kind of option best suits their personal and domestic needs. The seminars will impart to women the skills necessary to negotiate with health institutions and professionals in the pursuit of their choice.
11. The group is currently involved in a research program to ascertain what women in the Colchester area desire form the medical and maternity/hospital systems. Interviews are being conducted with women who have experienced both home and hospital births. Further research will focus on those women who have used only the Colchester Maternity Home. This program will try to identify what kind of services and conditions women themselves require for joyous birthing. Obviously, it will pinpoint undesirable practices as well. The results will be presented to local and national medical authorities and to all political parties.

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"I'LL BE A DAD TODAY..."

Empathy and sympathy from a new father.

There we were, two weeks post-mature. I had visions of drips 'n' sections 'n' things, you know how you get when you can't be objective. Well it's actually happening to us now, Mr and Mrs gravida-one-para-nil-forty-two-weeker as I'd probably have described us in my student days.

Strangely enough a "thirty-six weeker" friend had visited us the day before and said, "you'll go off soon now". Does a mother always know or was it just statistically highly probable? It was difficult to be sure, but a mother certainly knows something — I couldn't laugh off the prediction that day for some reason like I had done the previous fourteen!

At 04.30 hours the missus awoke with slight cramp-like abdominal pains. "What had we eaten yesterday?", I asked, "a dodgy piece of chicken?" At 07.00 hours it was clear that the sensation originated not from the hind-gut but the genital tract. At last this was it I thought, the beginning of a process where the two physiologically related parties in the matter come into potentially moral conflict for a brief few hours of their lives. It nearly always works out alright. I reassured myself, but the objectivity of the past couple of weeks was already deserting me.

Being a midwife the missus knew what to do; stay at home where it's nice to let the first stage get under way properly for they laugh at you on labour suite apparently when you go home after a false alarm!).

After numerous baths and back-rubbing the afternoon arrived and I was sure this was it. The missus was still unsure as to whether it was a "false alarm" or not. Probably a result of having dealt with so many at work I guessed.

Anyway, we decided to take the uncertainty factor out, I especially wanted to ease the burden of this on her mind as it was obviously cramping her style. The old training came in handy and I found the os to be at about 5cm with membranes intact, indicating to her with a "V" sign the precise findings! A surprisingly objective investigation I thought at the time. The veil of doubt was lifted, clear thought and practicality crept back into me.

At around 16.45 hours we decided to go to the labour suite and two of the wife's trade friends welcomed us and made us feel well at home. The perks of this trade can't be measured in material terms — you can keep your company cars lads, no offence intended.

Things started to hot up at around 20.00 hours and various positions were tried in and around the delivery room. Seemed to make little difference by the looks of things. Initially my support was gratefully received but I began to feel a little discarded as the pains became much worse. Its a strange thing pain, isn't it? You can sympathise all you like but you can't share the sensation, you can never feel how bad it is and how it can alter your priorities, loyalties and outlook on life. This is just for a few hours I thought, and look at the difference in her. It was then that I considered the plight of chronic pain sufferers remembering my rheumatoid arthritis stricken grandmother and others — patients I'd seen as a student whilst struggling to get my clerkings right. Why had it taken until now for me to ponder matters such as these?

I was snapped from my thoughts. Things were beginning to happen, "fully!" they exclaimed, and epidural had been given. This was good I thought as she and baby had been fighting for a long time and exhaustion was setting in with a lot of work still to do. She got her breath back, the second stage went like clockwork and I heard the first sound.

I shed a tear then but I have to tell you it was not so much over the miracle of birth but that Julia's pain and toil was over. Even though the process is a physiological one not pathological I was more worried for her wellbeing than I'd anticipated I would be. What about when we're older and she does suffer from a pathological process? What will it be like then?

We'd got a lovely daughter who stared quietly up at her mother for most of that first night. The end result was a fairy-tale. The oedema subsided, mum lost weight, made milk and began to return to full strength. Again I stopped to think about others who have not been so lucky. The rest of the hospital is full of them; injured or ill in some way usually through no fault of their own. I thanked mother nature for safe passage of the two I love.

It was such a short journey from inside to the outside world, only a few inches, but mechanically so complex, a system honed by millions of years' evolution. For me it was a very thought provoking and valuable experience so little of which I seem to have outlined above. Childbirth and parenthood I know, have strengthened me, made me happier and increased my confidence in life. I'd recommend it.

Martin Heywood
Student at Nottingham Poly.
Jan 1992

MALE MIDWIVES?

Sue Cripps explores her feelings regarding male midwives in this challenging personal viewpoint.

I am sure there are many midwives out there who have already addressed this issue, but I have not until now. That is not to say that I haven't been aware of the fact that there are men who do practice as midwives. I am, I just haven't yet met any.

I won't beat about the bush. This article is an attempt by me to openly explore how I feel as a women and a midwife about men in midwifery and generate some discussion about an issue that I think is important.

Quite honestly I have uneasy misgivings about them. Deep down I don't really understand why some men would want to become midwives, what I would like to do is understand what I am really feeling.

Fundamentally I believe there are a great many differences between the sexes. This sounds like a cliche it is not meant to! But the uniqueness of the differences between men and women does not become apparent very often, most of the time it can be ignored. Just occasionally, and I think this is one of them, it is of significant importance.

Don't get me wrong, this is not an anti-men article. I believe they are important within the complex matrix of conception, childbirth and parenthood for most women, to a greater or lesser extent. That is not the issue here.

The point I am trying to make and explore is the role that the midwife plays in all of this. Her role is unique. From the very beginning the centre of her focus is the woman who is pregnant.

The midwife is there primarily for the woman. She has to empathise with her throughout this time, through whatever situation and whatever point in the physiological process that she meets her.

The relationship between the midwife and the woman is as much emotional and intuitive as it is professional and clinical. I would say more so. The understanding and awareness required can only, I feel, be fully appreciated if the midwife is a woman.

For example, as a woman and a midwife I am very aware of my body. I am very aware of my emotions and my hormonal make up. I regularly experience those changes my body undergoes to prepare itself for conception and childbirth, of my breasts becoming tender, my senses becoming heightened, my emotions becoming muddled and my secretions changing. I know that men do not experience any of these.

As a midwife when I am with a woman in labour I am attuned to the subtle changes both physical and emotional that her body makes as labour progresses. I am acutely aware of her levels of pain, and her primeval needs are so obvious to me. I do not believe any man could be as aware or as understanding.

There is also the question of power and control and the struggle men and women have coping with this power both consciously and subconsciously. Women at some point when pregnant, in labour, or as a parent, may need the support and understanding of other women. Could any man truthfully fulfil this need on an equal footing? I think not. Just as I might like to romanticise about my equality with men the reality when challenged is often so very different.

Women who are with midwives are women undergoing necessary changes that are both physical and emotional in order to allow the normal physiological process to continue. I believe they need the empathy of female midwives who will nurture and enhance this process and so bring out the very best from every situation for all women whom they care for. I do not believe men can fulfil this position as well.

Finally, there are the illogical, purely emotional fears deep down that conjure up concerns of suppression, control, management, and dominance, within the psyche of conception, pregnancy, and childbirth.

Forgive me if this article reads as extreme and emotional. It has been written without malice but with honesty and courage. It is meant as a public exploration and discussion of very private female feelings and hopefully will provoke constructive discussion and criticism about an issue that will have to be addressed again and again.

Sue Cripps
Midwife in Manchester
Jan 1992

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Preliminary survey results indicate that women demand four requisites for adequate birthing in addition to the basic requirements of excellence in medical care. The four elements are:

1. Continuity of care from mainly one or two professional carers.
2. Control over the procedures and conditions of childbirth.
3. Peace and security in the birthplace.
4. Privacy in the space where they deliver their baby.

Our contention is that these conditions are rarely met in a busy hospital setting. They are easily achieved at home. However, our wider brief is to ensure that women should be armed with a full range of informed options about choice of birthplace. Government policy states that women should have informed choice, but in reality women are rarely informed about all options and they are rarely counselled in the indisputable and massively greater safety of home birth. Ultimately, our aim is to ensure that women are able to make informed choice

We would be pleased to hear from other home-birth support groups, or maternity-related organisations. Please contact the Co-ordinator, Sally Petts, at 14 Hawthorn Road, Layer-de-la-Haye, Colchester, Essex CO2 0LN or tel. 0206 34537.

Midwifery and Nursing: in search of commonalities

Elaine explores why nurses endeavour to gather midwives into the nursing profession.

Recently I have been privileged to be invited to joint validations of pre-registration midwifery courses. At these events I was amazed to find both nurse educationalists and lecturers from higher education spending considerable amounts of time interrogating midwives as to the rationale behind not joining in with Project 2000. I was amazed because in my naivety I thought that since midwives unanimously rejected the concept of midwifery as part of Project 2000, it should be clear to the whole world that midwives obviously do not consider this model appropriate to meet the educational and training needs of the next generation of midwives. I am now totally convinced that Soo Downe is right when she asserted that that non-midwives may not have understood the issues involved (Downe 1990).

The argument for midwifery to be part of Project 2000 is getting stronger and more and more midwives seem to be swayed towards this idea. It would appear that the powerful tool of ideology is at work again.

The fundamental premise for midwifery to be part of Project 2000 is that there is a common feature which a curriculum planning team could grasp as a unifying focus for a pre-registration course which takes account of the needs of both midwifery and nursing students (McFarlane 1985). This implies that there is a system of knowledge, values, beliefs and assumptions common to both the midwifery and nursing profession. Indeed, Akinsanya (1987) argues that there are significant aspects of the knowledge and values which are central and common to nurses and midwives. The latter would include nursing theories and models of nursing, informed and safe practice and the application of knowledge derived for other disciplines (Akinsanya 1987).

However, he went on to state that in his view, at a time of strict economic stringency, the nursing and midwifery profession should present a unified and concerted front in bidding for scarce resources (Akinsanya 1987). He has just provided me with an answer to my long standing question: why must nurses endeavour to gather the midwives into the nursing profession? I also suspect that the claim made by almost all midwives that they are not 'specialist nurses' but practitioners in their own right tends to infuriate the nurses. The latter is like adding salt to a wound as the long term aim of nurses is to be practitioners in their own right and to establish nursing as an autonomous profession. Akinsanya (1987) argues that the diagnostic and prescription rights of a midwife are functions sanctioned by medical practitioners and such functions would also be granted to nurses as their quest for increased knowledge base is fulfilled. In fact the possibility of nurses being given prescription rights in the future is now real. (Crown 1989). A midwife could argue that the very fact that Professor Akinsanya saw the diagnostic and prescription rights of a midwife as being 'medically sanctioned' is proof of his ignorance of the midwifery profession.

The question that I am interested in exploring is: what are the commonalities, if any, in the values, beliefs, assumptions and knowledge base associated with the midwifery and nursing profession? Perhaps as a starting point we may ask the question: what do nurses do? Does this differ from what midwives do?

McFarlane (1976) suggested that caring is the essence of nursing. Akinsanya (1987) argued that care is a common feature of what nurses and midwives do. A dog or cat that is unwell could be provided with care, the person assuming such a caring role is taking on a nursing role but would not necessarily be classified as a nurse or midwife. This appeared to be supported by Akinsanya's next statement "caring is a feature shared by nurses with other professionals and even professionals without professional education..." (Akinsanya 1987). Hence to classify midwifery as a branch of nursing based on the notion of 'caring' is not very convincing.

In order to search for commonalities between the midwifery and nursing professions, it is necessary to analyse more than just the activities of a midwife and nurse. The activities of these individuals are encompassed within their role. Most midwives hold a fundamental belief that their role is that of an advocate and 'being with the woman who is going through childbirth'. Indeed in the code of professional conduct it states that:

> Each registered midwife is accountable for her practice, and in the exercise of professional accountability shall:—
>
> 1. Act always in such a way as to promote and safeguard the well-being and interests of clients.
> 2. Ensure that no action or omission on her part, or within her sphere of influence is detrimental to the condition or safety of clients.
>
> (*Code of Professional Conduct* 1984)

The above statements emphasise that the interests of the client reigns supreme. However, embedded in the statements are key beliefs, values and assumptions which form the foundation of the midwifery profession. We now need to address the question: does the nursing profession also share this set of beliefs, values and assumptions? Let me take the argument further by illustrating the difference between the role of the midwife and the nurse. An obstetrician may give an order and a maternity/obstetric nurse would be responsible for carrying out the order because the role of a nurse is to aid recovery, (that is to give the appropriate care), following medically ordered intervention (Downe 1990). However, if an obstetrician gives a midwife an order, the midwife must not carry it out unless, using her own clinical judgement, she decides that

the instruction is in the best interests of her client. Moreover, she must be able to explain and justify, (that is be accountable for), any action or omission of action on her part.

To assume such a degree of accountability the midwife would require a level of knowledge that allows the consequences of alternative action to be assessed. Nurses may well argue that they too are trying to achieve a level of knowledge which would encourage doctors to give them the same degree of accountability. The loophole is that the degree of accountability that midwives exercise is not medically sanctioned but incorporated in the Nurses, Midwives and Health Visitors Act (1979). Therefore with an increased level of knowledge, nurses may be given more responsibility to carry out procedures such as the siting of an intravenous infusion, (that is the extended role); but the nurse is not in a position to overrule a medically ordered procedure nor be held accountable for such an action.

Downe (1990) argues that the whole premise from which the midwifery and nursing profession originate is completely different and she further expresses concern that the application of a philosophy of one profession to another profession would be detrimental to the care given in either case.

The hallmark of a profession is its ability to regulate its own practice (Berlant 1975). The primary legislation in the statutory control of midwives is the Nurses, Midwives and Health Visitors Act 1979, which has a built in safeguard to allow the midwifery profession to take responsibility for matters directly related to the control of the practice of midwives. If midwifery is a branch of nursing such safeguard would not be necessary as nurses could be considered as part of the peer group and in the position to judge midwifery practice accordingly. But if Downe's (1990) argument that the two professions work from a different premise holds true, what would be the implication of a group of nurses disciplining a midwife with alleged misconduct?

Let us take the case of a midwife who, in spite of a doctor's order, refused to perform an episiotomy on a woman who is having a normal labour. The midwife's refusal is based on her clinical judgement that such a procedure is unnecessary as the delivery is progressing normally. The doctor ordered this procedure to be carried out because he believed that routine episiotomy was better than a second degree tear. A panel of midwives should have no problem understanding that the midwife was acting in accordance with the code of professional conduct. Would a panel of nurses have such similar understanding if their role is to 'aid recovery following medically ordered intervention' (Downe 1990)? If not, what could be the implication? Would midwives change their practice to conform to the expectation of their new found peers? If this occurred I envisage that the self fulfilling prophecy would come true and midwifery would legitimately be a branch of nursing.

Conclusion:

In this paper, I have asked many questions and have provided few answers because I believe that midwives need to continue to ask questions as a way of dispelling ideology. Remember, no one (not doctors, lawyers or nurses) could say we are one of them unless we believe that we are. Only midwives know the intrinsic value and reward of being an advocate of childbearing women and practising as an autonomous practitioner. Hence we are in the best position to empathise with the nurses for seeking to assume such a status. We can afford to be encouraging and supportive of the nurses' mission but we cannot, as a consequence, lose the true nature of our profession.

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Elaine Ho
December 1991

EUROPEAN MIDWIVES' CONGRESS
Brussels, May 31st-June 1st

Eva-Maria reports back on the European Midwives congress in Brussels during the Summer.

Perinatal Mortality Prevention in the EC and the Professional Practice of Midwives

I went with high expectations to this congress

a) because it was an International congress, but in view of 1992 was Europe-centred
b) almost to the day I had passed my midwifery exams 30 years ago in Brussels at the "Free University" and St. Pierre Hospital, and thought that was a happy coincidence
c) I had taken along two colleagues from former East Germany and was eager to show them the "big wide world"

Well, the whole thing was, measured by its announced aims, a big flop.

For a start, although announced as officially bilingual English/French, French was the overpowering official means of communication. The translations were absolutely disastrous (listening at home to the underlying speech of M Wagner, for instance on the video), one realised that at some stages he has been translated wrongly, giving a different view to what he had said!

A big francophone doo-da — held in Paris, would have been OK, but not in Brussels!

The Round-tables weren't round, so to speak. In that there was hardly any possibility for exchange, again due to the fact that there were no translators in the small rooms.

Lunch break too short, the cheaper area over-crowded, the restaurant too expensive. There were many private people who took lodgers home, that was very nice, of course — thank you, good people of Brussels — but some groups were in hostels up to 30 km outside town and no bus service at night.

Personally, I was very disappointed that although the Conference was well attended, neither a member of the Royal family, nor of the Brussels town Council, nor of the EC Parliament was there to open the congress. Does this show how important we are?

Still — the EC Green Party had sent a nice French lady to say a few words: we were told that the Greens "had been the only political group to have helped and assisted, financially and otherwise, right from the beginning". Maybe we should remember this at the next European election!

Still, in spite of all, it was worthwhile having been there. Such a big crowd of midwives in one place — 1300 of them from over 20 different countries, absolutely heart-warming!

There was a very interesting and positive presentation on the role of the midwife by a french historian, M Gelis. It was good to hear how important we've been for centuries. As M Gelis says: if you want a perspective for the future, you must know your past, your links from knowing who his ancestors were, to build up self-esteem and pride. I liked his picture of midwives completing the circle of life — they helped the children into this world, took them to the church, and cared for the dead and accompanied them to the cemetery. Thus she was there, from the beginning to the end — another way of "continuity of care", isn't it? Personally I like this idea, because, what do people fear most? A child bearing women, and the dead. We weren't afraid of either, and we still are not, are we?

M. de Reu, a Belgian, in the NL working well — male midwife — conferred about better training for 1992 and beyond "It's now or never" he said, if we don't want to be trampled under.

A Signora Lloria from the EC Parliament spoke about the "Charter of the childbearing woman" — was one ever heard about? It's the document B-2-712-86 conform to the article 47 and voted for in 1988 in Strasburg. Try to get hold of it!

And then — there was the darling of the midwives of this world, M Marsden Wagner, of the WHO. If ever we were to choose a patron saint... some key sentences: Bringing women to the place where the technology exists means that it is almost certain that all of this technology will be used on her whether she needs it or not. There is no scientific evidence that the hospital is safer than the home as a place of birth for a woman who has had a normal pregnancy — and so on. (See WHO report: Having a baby in Europe).

Very clear and in tune with the theme of the conference was the presentation of "Know your own midwife" scheme from the UK. There were videos and slides of babies, midwives, home deliveries — funny, one never gets tired of them!

Absolutely awful — Nestlé everywhere and their cups (plastic!) of coffee. This must not be, not at a meeting of midwives. And apparently the lady who was to distribute leaflets of the ICM was kindly asked to pack up. This I only heard afterwards from the A.I.M.S. delegate from Ireland Marie O'Regan. As it was a sunny week-end, I would have put up my table outside and told everyone in a loud voice that I'd been thrown out!

A sociologist from Ireland, M. Th. O'Connor with a well-documented research about childbearing in and out of hospitals had been refused permission to speak (after having been asked to!) because it was supposed to be a conference "for midwives by midwives". But then — what about our German contribution — Mgt Lehmann, Arch Bishop of Nallez? What on earth was he doing there? The Catholic Church is not specially renowned for protecting midwives and women over the centuries (Inquisition). He was given ample time for his utterances. An American midwife was refused for lack of time, on the other hand...

But, fortunately, the nice thing about conferences is — the people one meets! I had a lovely evening with Marie-Therese O'Connor, after having missed the German

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REGIONAL GROUP NEWS

CALLING ALL REGIONAL GROUPS

We know that some groups are really active, holding regular meetings with interesting topics being discussed, action being taken, etc. But we rarely hear about it in MIDWIFERY MATTERS! To try to remedy the situation, we are starting a regular REGIONAL GROUP NEWS page, which will look rather bare if there's nothing to put in it, so please let us have your news! Tell us what your meetings are about, who came to speak to you, what was discussed, what films you've watched, what the group has done about local situations which needed changing, etc. etc. Even if you only send in your schedule, i.e. what day of the month, what time, where, etc. this is useful information for new members and casual readers of MIDWIFERY MATTERS in your locality. At your next meeting, find a volunteer who will make a commitment to report to MM about your activities, or fix a rota so everyone gets a chance to write a few paragraphs! Do your best to make the new page stimulating and interesting. It may turn out to be the first page people read when they open their magazines!

GRAMPIAN REGIONAL GROUP is now up and running! Meeting at 8pm the first Thursday in every month. As it is a large region we try to vary the venues to allow everybody a chance to attend. We're a small, young but hopeful group, (about 10-15 people usually attend meetings), and we try to keep things informal. We've had some good meetings so far. At our first meeting Jean Lyall, community midwife from Aberdeen, gave a talk about a study tour to the Faroe Isles and Sweden. Last month we hosted the meeting in Peterhead and the subject was Aromatherapy (from conception to colic!), given by a local fully qualified Aromatherapist, and this month we will be entering the world of Hypnotherapy.

Further details from Regional contact: Liz Quinn, tel 0779 82609.

HAMPSHIRE REGIONAL GROUP holds regular meetings on the 1st Monday of each month. Topics so far have included Infant resuscitation, midwifery legislation, prostin research, T.E.N.S., etc. For details of future meetings and venues please contact Donna Williams, 0705 826720.

WEST MIDLANDS REGIONAL GROUP meets on the 2nd Thursday each month at Thorne House, Sorrento Hospital College of Midwifery, 7.30pm. For further details contact Jo Hindley, 021 449 2326 ext. 241.

NORTH LONDON REGIONAL GROUP meets monthly on the 2nd Monday at 7.00pm at the Holland Street Clinic, 9-11 Holland Street, London W8. For details contact Jo Bishop 081 579 8519.

WEST MIDLANDS REGIONAL GROUP, THORNE HOUSE, SORRENTO MAT. HOSP., BIRMINGHAM 13.

March 12th: Jane Coomber on Independent Midwifery
April 6th (N.B. this is 3rd, not 2nd Thursday, note also change of venue) at the Lecture Theatre, Birmingham Maternity Hospital, Caroline Flint 'A New Midwives' Act'.
May 14th: Jo Hindley, an Introduction to Co-counselling. Ring Sarah (444 2257) or Jo (449 2326) for further details — we look forward to seeing you!

Do you live near FLEET, HAMPSHIRE? (SOUTH BERKS, WEST SURREY, NORTH HANTS). If so, Helen Kennedy would like to hear from you.

She works part-time in Reading and is in touch with ARM Midwives there, but would like to set up a Regional Group closer to home.

Please contact her at
21 Holland Gardens,
Fleet,
Hants. GU13 9NE.
Tel. 0252 625144.

LIBRARY UPDATE

PLEASE PLEASE. Anybody returning books to me in the Mail MUST get a Certificate of posting from the Post Office. In the event of me not receiving the book/s I can at least then get compensation from them. If I do not receive the books, then I shall ask you for the Certificate of Posting. If for some reason you have not retained it, then I am afraid you will be liable for the cost of the book/s plus 50% as printed on the invoice I would send out to you. There have been a number of recent book/s that have gone missing, none of which I can claim the full price for and books are very expensive as you already know!

If anybody has any of the following books from the library then please can they be returned to me as above.

TITLE	AUTHOR
Babies, Breastfeeding, Bonding	Ina May Gaskin
Freedom and Choice in Childbirth	Sheila Kitzinger
Midwives in History & Society	Towler & Bramhall
Minds, Mothers & Midwives	Prince & Adams
Politics of Breastfeeding	Gabrielle Palmer
Sensitive Midwifery	Caroline Flint

All these books are missing. As you can see some of them are quite new publications, and would be very costly to replace, so please remember the Certificate of Posting when returning books.

Sally Herbert
Librarian

NEWLY ELECTED STEERING GROUP MEMBERS

I joined ARM in 1989 when I started my post-registration midwifery training.

I try to go along every 2nd Tuesday of the month to my local branch meetings which I enjoy very much.

Midwifery is very important to me. I am constantly questioning and challenging both my own practice and that of people around me. Being an ARM member I believe, has enabled me to get better and better at this: as I always feel well supported which boosts my self confidence.

I am a grassroots midwife. I rely heavily on my instincts and intuition as well as my academic skills and knowledge. I gave it a lot of thought before offering my services as a Steering Group member but I hope to bring to the meetings some grassroots insight. Also some of my personal time and enthusiasm in what ever way I can to preserving midwifery as a profession.

Other hobbies – gardening, making and drinking wine! Walking with my dogs and just recently trying to master the game of golf.

Sue Cripps
Midwife in Manchester **Jan 1992**

As one of the first direct-entry student midwives on the new pre-registration diploma course in Birmingham I am a tangible product of the ARM vision of educating non-medicalised midwives for the future. I am now nearly half way through the course which lasts three years. Prior to beginning my training I did a degree in Human Sciences at Oxford, worked in the Middle East and India, and in Geneva with the Quakers at their United Nations Office.

ARM's radical philosophy underpinned my intentions to become a midwife right from the start. I wanted to work as a midwife in the true sense of "midwife", to be "with woman", and I wanted to develop my skills so that I could work independently, possible in a less technologically developed country.

I have been active in coordinating national meetings for pre-reg students and in the Student Midwives Forum, and I have helped to get the West Midlands ARM Regional Group going again after a few quiet years. Now, with my election to the Steering Group I am enjoying having the chance to learn more and be involved more in ARM business, as well as contribute my perspective as a student.

Joanna Hindley
Birmingham **Jan 1992**

Thumbnail sketch of Olga Parker

After leaving An School I became the mother of three children, one of whom has honoured me with two grandsons who are now at secondary school. No prizes for guessing my age!

As for my background, I have done a variety of jobs, from chamber-maid to delivering the post.

Then I entered midwifery as a direct-entry student and became a midwife in 1974, moving into the community nine months later.

I found time hanging on my hands as there was little in the way of on-going training in those days for a district midwife, so I joined the Open University and graduated last year.

With Deborah Hughes I was instrumental in setting up the "Midwives Journal" the quarterly supplement in Nursing Times.

To keep myself aware of the midwifery scene world-wide I have been lucky enough to be able to attend many midwifery conferences.

Olga Parker
West Yorkshire **Oct 1991**

I work as a community midwife in Sneinton, an inner city area of Nottingham. I completed my SRN in Watford, then my Midwifery here in Nottingham. Since qualifying I have worked in hospital then from May 87 on community. I have had 3 breaks for the deliveries of my daughters Elizabeth, 6, Catherine, 4 and Rebecca, 1.

I have worked as a relief community midwife since returning to work after Catherine was born. I have seen many areas which have all been different.

In Sneinton we have several booked home confinements which are well supported by a GP practice. Although as yet I have not been involved in many it is an area which I have a special interest and feel one which should be more widely and more freely available to women.

I have been a member of ARM for about 2½ yrs. Nottingham holds regular house and branch meetings. As a group we hope to provide a supportive side as well as an educative side for women and midwives.

I feel I would like to mention that I would not be able to be as involved if it were not for my husband, Ian, who is so supportive. Encouraging me to attend as many meetings as I can and caring for the children when he himself is not at work.

Jacqueline Smith
Community Midwife
Nottingham Jan 1992

I was born in a mining town called Kirkby-In-Ashfield, Nottinghamshire and have worked in and around that area both as a nurse and a midwife. In 1988 as a student midwife I attended various meetings which lead to the formation of the Notts ARM.

As a student I gained much from meeting midwives from neighbouring areas and enjoyed the support given to each other, comparing midwifery practice in different hospitals/communities and a whole range of new ideas.

Once I qualified as a midwife I felt able and willing to "deliver" the special service I had been trained for. However, doom and gloom struck! No vacancies in Nottingham. After eight weeks of unemployment I decided to diversify my skills at a Mother and Baby Home called St. Joseph's (owned by the Catholic Children's Society). For a whole year I cared for pregnant teenagers, assessed their parenting skills and bonding, boosted their confidence as new mothers and finally visited them in their new homes giving additional support.

However, the need to work as a midwife returned and I finally started to work at a large teaching hospital (Queens Medical Centre). I occasionally care for the lonely teenager from St. Joseph's at the hospital and usually they feel much more relaxed when we start talking about the home.

The Notts ARM sometimes was my only contact with midwifery whilst I worked at the Mother and Baby Home and for that I am extremely grateful.

Sadly the number of active people who attend the Notts ARM meetings are diminishing and I would love to see more gaining the support that I have had over the years.

Amanda Moult
Midwife in Nottingham
Jan 1992

cont from page 14

speaking group which met to air its anger and bring it to paper — which wasn't read, the panel censoring in a dictatorial way what was to be announced and what not.

Anyhow, Marie-Therese and I had a good meal and truly fantastic conversation in a Turkish restaurant (incl. belly-dancer!) and finished the evening in the one and only "real" Irish Pub in Brussels.

Next day — the last one — at lunch time we met Marie O'Regan, and 3 fantastic Dutch midwives — Tina, Thea and Tommy. We continued our heated discussions at 4 pm, when all was over, in the pub over the road, and it was a wonderful good-bye session.

After the second pint we agreed that this conference, or rather, the organiser, wants to build up a francophone counterpart to the I.C.M. (typical, these French!) and after the third pint we all agreed that a) midwives are a class of their own, and b) that women in any case and anyhow.....

Eva-Maria Müller-Markfort,
Midwife
Germany
Dec 1991

WORKSHOP — A CHARTER FOR MIDWIFERY

The Midwifery Legislation Group has, during 1991, held a series of meetings to discuss and develop a Charter for Midwifery. The ARM National Meeting offered an opportunity for a group to examine the third draft.

The purpose of the Charter is to draw attention to the problems in midwifery eg. the changes in midwifery education, the failure of the National Boards to act upon the midwifery Committee's recommendations, and the domination of the profession by doctors.

A number of people commented that they were unhappy with the word "Charter", they believed it was an over-used term and did not adequately describe the document. It was agreed, after some discussion, that "Manifesto" would better describe the proposed leaflet.

The leaflet's objective is to canvass support from individuals, other groups, and the midwifery profession itself. The Manifesto is divided into six sections. The first section "A Midwifery Service Fit for the Future" deals with the crisis in midwifery, explaining how this occurred and goes onto identify the effects this has had on clinicians, education, and women and babies.

The section canvassing support for the Manifesto asks for help and details on how individuals and organisations can join the campaign. A list of potential supporters has been draw up and a strategy will need to be developed for approaching them and enlisting their support.

The Manifesto sets out the principles of a new Act of Parliament and what the Act would achieve. The final page of the document asks for subscriptions.

It was felt that while the Manifesto sets out the issues, briefly, there is a need for a supportive document which would review why the changes set out in the Manifesto are not being achieved.

Following the workshop at the ARM National Meeting in December, comments and alterations were incorporated. A final copy was agreed on 21st January 1992. A copy will be sent to all members of the MLG and supporters. If you would also like a copy of the manifesto please write to: Midwifery Legislation Group, 34 Elm Quay Court, Nine Elms Lane, London SW8 5DE. Please send an sae.

Beverley Beech
Administrator, M.L.G.
Jan, 1992.

NATIONAL MEETING

Report of the ARM National Meeting combined with the Midwives Legislation Group.

Held in London Women's Centre on 14th Dec. 1991

Attendance: 38

The South London regional group hosted the meeting, arranging venue and providing lunch and refreshments. They had agreed that the Midwives Legislation Group could set the agenda, a wide discussion of legislation issues in midwifery, while retaining the ARM format for National Meetings.

MIDWIFERY LEGISLATION: Following introductions, Soo Downe gave a potted history of midwifery legislation in UK, from the abolition of the Central Midwives Board and other professional bodies under the 1979 Nurses, Midwives and Health Visitors Act which brought the UKCC and National Boards into being. That legislation had been opposed by many midwives, including ARM, who foresaw loss of autonomy due to the built-in majority of other professions on these bodies. The protests were instrumental in getting statutory midwifery standing committees at both board and council level, with the requirement that all matters pertaining to midwifery were to be referred to them. Unfortunately statute did not give the recommendations of these midwifery committees the force of law, and as we have seen, they are easily ignored.

One well publicised example of this is the action of the English National Board, which decided on a cost-cutting exercise of scrapping the requirement for education officers inspecting/validating training schools to be practitioners in that particular specialty. The new regulation provided for any education officer of the board to visit/validate training schools regardless of professional background. The midwifery committee was not consulted, and when they objected were told that it was not a midwifery-related matter, but an issue of management.

The midwifery committee nevertheless gained a small concession — that generic education officers would be accompanied by a midwifery advisor when visiting midwifery training schools. This has not proved such a valuable move, though, as much depends on the vigilance and awareness of this midwife, and changes have slipped through which are not beneficial to midwifery education or practice. Midwifery tutors instead of having direct access to their ENB midwifery education officer now have to refer to their allocated G.E.O. who may not be a midwife, and may not understand the issues involved. The system was reviewed after 12 months, and although many problems were identified and objections were raised, there was a majority vote to retain the new system.

The Government engaged a consultant firm, Peat Marwick McLintock, to review the workings of UKCC and the National Boards, and their report recommended some sweeping changes to the structure. In February 1991 the Government put forward a Bill to amend the existing legislation, taking in many of the PMMcL recommendations. Chief among these are the way the council and boards are chosen and funded. The UKCC will be a large body, with maximum 60 members, two thirds elected by the professions, the remainder appointed by the Secretary of State. There is a requirement that all three professions should be represented, but no minimum number for each. The National Boards will consist of 9 or 10 members, all (including chairperson), appointed and paid by the Secretary of State. The majority shall be nurses, midwives or health visitors, (i.e. 1 or 2 midwives maximum!). No provision for veto.

The Bill was introduced into the House of Lords in the Autumn, and has now completed all three readings. It will be presented to the House of Commons early in January, and this is where we may usefully lobby our MPs to be vigilant on our behalf. There will be no drastic changes however, and midwives will still share legislation on a very uneven basis with nurses and health visitors. The only way midwives will ever gain professional and educational autonomy will be through new legislation designed with midwives in mind, i.e. a Midwives Act.

QUESTION TIME: Soo answered many questions, and a lively discussion followed. Many points were brought out, including RCM's "**LEGISLATION WATCH**", inviting members to write in with comments on the workings of midwifery legislation. We suggested that everyone in ARM make use of this invitation, so that RCM will have evidence of midwives' concern when meeting with MLG in the new year.

We decided to urge everyone to send off the letter which was inserted into **MIDWIFERY MATTERS** Winter Issue. This is an initial step which will alert MPs to the fact that midwives are not happy with the Bill, which can be followed up with a more informative document listing the actual clauses needing attention. Unless MPs are aware that the Bill needs

careful scrutiny, it will be rushed through onto the statute book unchanged.

OTHER ITEMS FOR DISCUSSION: Caroline said that a TV programme is being prepared, called "Taking Liberties", which is looking at injustice in the workplace. They have asked for instances of victimisation etc., write to Caroline for details.

Jill Demilew expressed concern about the large proportion of Independent midwives being investigated, and is looking into this.

Joan Cameron told us of the new guidelines for practitioners who are HIV positive. She checked with RCM who welcome them. Among the recommendations are that affected midwives may perform normal non-invasive procedures, but if, for example, an episiotomy is required, another non-HIV positive colleague must be called to do it.

Soo told us about the problems of getting midwifery representation on the Central Research Development Committee.

Beverley added that AIMS had written to complain that the Clinical Audit Committee has no clinical midwife. However, Rosemary Jenkins is a member, which could help keep clinical midwifery issues alive.

ASSERTIVENESS: Nicky Leap introduced the next session, and Jane Grant read out four personality examples from a book called "A Woman in your own Right", by Ann Dixon. We then formed pairs and were talked through a series of exercises recalling a traumatic event, re-living it with different scenario, and expressing how the various methods felt. Each member of the pair took turns being "subject" and "listener". The whole session took almost 90 minutes, and in the discussion afterwards people told the group how it had felt. Some were surprised at the strength of feelings brought back by events which had happened, in some cases, many years previously.

LUNCH BREAK: (During which Sally Herbert opened the Lending Library and held a raffle which raised £20 for library funds).

AFTERNOON SESSION — WORKSHOPS: 1. Midwives Charter — putting in the final touches following the comments received. **2. The Draft Midwives Act** — finalising the draft in response to comments. **3. Publicity and Fundraising** — ways and means. **4. Awareness raising in Parliament** — drawing up a fact sheet of actual clauses in the 1979 Amendment Bill which need scrutiny, and suggesting changes. **5. Caring and Sharing** — letting your hair down and the tears fall. (This last workshop attracted the most attendance and report-back was enthusiastic!)

PLENARY: Due to the bad weather and some public transport problems, the agenda had been shortened to allow people to get away early, and several had already left when we got back together, but it was a useful session, bringing together the events of the day, and recapping on action decided upon.

The meeting closed with enthusiastic thanks to Nicky Leap and the South London Regional Group for their warm, friendly welcome, the delicious lunch, and a really enjoyable and useful day.

Report from Caring and Sharing Workshop — facilitated by Caroline Flint

We started by going round the room telling everybody our names and why we were at the Workshop.

The reasons that women were there was because they did not know where to go to next in their career. They wanted to be able to support women better and improve their relationship with women. They wanted to feel less isolated in their clinical perspective and they felt at a low ebb. They wanted to know how to care for each other. They were feeling helpless and they wanted to know how to be brave and strong. And one woman wanted to say goodbye as she felt that she would be unable to come to any more ARM meetings because of her personal situation.

In the Workshop we explored individual situations, we all cried a lot; we all hugged each other a lot and we finished off by doing a belly laugh which made us end up laughing. It was a very cathartic experience for everybody there and many of us felt energised and stronger after we had shared our anxieties and concerns with a sympathetic group.

ITEMS FOR SALE

Help yourself and ARM funds by taking advantage of the following:

MIDWIFERY MATTERS (previously ARM MAGAZINE)	£ 2.00
ARM Lapel Badge (blue enamel on gilt, Pinard Logo)	£ 3.50
Pinard Stethoscope (wooden, p+p 50p)	£ 6.00
Choices in Childbirth (comprehensive information leaflet)	£ .50
Squatting Birth Bar: Steel bar adaptation for most labour beds. (incl. p+p)	£55.00
Wall Poster "Did You Know" (facts re midwife's role, for clinics etc.)	£ .50
Sheaffer "No-Nonsense" pen, (black ink), with ARM name, address and logo.	£ 3.00
White 100% cotton T-shirt ("Midwifery Matters" and Pinard logo in blue) (Extra large and medium — please state size required)	£ 5.50
Car Stickers "Midwifery Matters" with Pinard logo in red on white	£ .50
"What is a Midwife?" information leaflets for clients & colleagues	Free

p+p £1.50 for 100; £2.50 for 200; £3.50 for 500; £4.50 for 1000 leaflets

All items from ARM, 62 Greetby Hill, Ormskirk, L39 2DT. Please add 50p for post and packing except where otherwise indicated. Overseas postage is variable, please write for details.

ARM DOCUMENTS AND REPORTS

From time to time the Association of Radical Midwives has produced reports, memoranda and other submissions to various bodies undertaking enquiries or research into midwifery-related topics. Most of these documents have been subsequently published in MIDWIFERY MATTERS, for the information and/or consultation of ARM members. Photocopies of the documents and/or articles can be obtained from ARM, 62 Greetby Hill, Ormskirk, L39 2DT. Prices quoted include p+p.

SUBJECT	DATE	PRICE
Proposals for the Future of the Maternity Services. (The Vision).	Autumn '86	£1.50
Professional Conduct Machinery, some necessary changes.	Spring '89	£3.00
"Working for Mothers & Babies" (Response to NHS White Paper 1989)	Autumn '89	£ .50
Response to Peat Marwick & McLintock report	Dec. '89	£1.50
Midwives Legislation (Draft of new Midwives Bill)	Spring '90	£3.50
ARM's evidence to House of Commons Health Committee enquiry into the Maternity Service.	Summer '91	£2.50

NEW POTTERY MUGS FOR SALE!!

We have had some beautiful hand-made stoneware mugs made specially for ARM. They are a lovely shade of brown, with really comfortable handles. The ARM badge is printed on the side in black. They will be on sale at National Meetings and other events around the country for £4.00 each. They will not be available by post, however, because of the difficulty of packing to avoid breakage.

UNUSUAL DELAY IN THE SECOND STAGE

Jennifer describes a puzzling delivery she attended.

Tracy, a twenty-year old single woman was admitted, unannounced, to the delivery suite late one Saturday afternoon. She was accompanied by her father. The ambulance men, realising that delivery was imminent, had brought Tracy straight into us and we moved directly into a delivery room.

Saturday afternoon — no clerical staff around — a midwife would have to go and hunt for the notes in the antenatal department. Meantime Tracy was in urgent need of attention.

Her labour had started the previous night and intermittent pains had been thought to be a 'tummy upset' as she had also vomited. She'd stayed in bed during the morning but was feeling no better so made the two mile bus journey to her parents' home to stay there till she felt better. She'd hoped to find her mother at home but she was out shopping. Fortunately her dad had realised that this was no ordinary 'tummy upset', had phoned an ambulance and, leaving a message for his wife, had accompanied Tracy to the hospital.

Tracy was offered entonox for pain relief and she began using it with contractions that were coming strongly every two minutes. From Tracy's breathing patterns it was clear that she was already wanting to push. On palpation I realised that this was to be a premature baby — the fundal height was thirty weeks size. It was a cephalic presentation with the head deeply engaged in a favourable anterior position. I was having difficulty locating the fetal heart with the Pinard's — and the external monitor registered only 100 which matched Tracy's pulse rate and Tracy, herself, could not remember feeling any fetal movements today. I needed to know if this baby was alive. The paediatric team had already been alerted and the neo-natal unit was on standby — but would their presence be needed?

Gentle vaginal examination revealed full dilatation of the cervix as I'd expected. The fetal head was directly occipito-anterior and at the level of the ischial spines. The membrances were not present and blood-stained liquid was evident. I attached a fetal scalp electrode which showed a fetal heart rate of 110. The fetus was alive. Tracy was encouraged in her pushing efforts for the next twenty minutes and very slowing the fetal head advanced. The head was well visible and would soon be on the perineum. The paediatric registrar and assistant midwife had prepared a warmed incubator and the overhead heater was warming the resuscitaire.

The head was advancing slowly — but was it my imagination or was there distortion of the external genitalia? I washed Tracy ready for delivery and encouraged her efforts. The fetal heart began to decelerate ominously — down to 60-70 with contractions and a slow recovery to a baseline of only 100. I felt that the premature baby should deliver very soon but asked for the obstetric registrar and a forceps trolley to be at the ready just in case.

The head did advance a little but the perineum did not appear to be stretching as it should. Instead the left hand labia minora was stretching and seemed to be receiving all the impact of the fetal head. The clitoris was definitely moving sideways — to Tracy's right! This was distinctly odd. The fetal heart continued to dip and so I infiltrated the perineum with 1% lignocaine in advance as I decided that an episiotomy would be advisable. Why wasn't the fetal head pressing more on the perineum? The labia became more and more taut as Tracy pushed her baby. I performed the episiotomy with the next contraction, expecting that this would relieve the labial pressure. It did not. The labia stretched and stretched as the baby advanced and then suddenly I realised that this was not the labia minora that was now stretched, forming a 3 inch wide band across the fetal head, but a vaginal septum. I asked for the obstetric registrar to advise me. She'd never encountered this either!

But what were we actually looking at? If the vaginal opening, as the head advanced, were a clock face the septum covered the fetal head from 10 o'clock to 5 o'clock but now the fetal head was also visible at the septum's upper margin between 1 and 2 o'clock. I needed to cut through this septum. But what of the blood and nervous supply to the septum? I could only guess and hope. I infiltrated quickly and cut through the septum. The effect was magical. The clitoris sprung back to its correct position and the fetal head was suddenly on the perineum and being gently delivered. Tracy's baby girl weighed 3lb and had an Apgar of 7 at 1 minute and 9 at 10 minutes and after an initial cuddle was transferred to the neonatal unit.

The perineal repair was performed by the registrar — surprisingly the cut septum did not bleed excessively. Before delivery the septum had extended inwards from the lower end of the vagina — slightly to the left — for at least four inches. The impact of the fetal head on the upper margin of the septum had caused it to be deflected downwards, twisting it so that the upper septal edge presented as the lower border of the observed obstruction stretching from 10 o'clock to 5 o'clock.

It was of course not replaced after delivery but the cut edges were basically oversewn to prevent any future obstruction.

Writing the notes afterwards — and only then did I have time to read them properly — I noted that a scan early in pregnancy had additionally revealed a partial uterine septum which predisposes to premature labour.

In discussion with Tracy afterwards she admitted that she sometimes felt something in her vagina and occasionally had trouble inserting tampons. Her doctor had examined her and, like me, had missed the septum and told her not to worry. An obstetric colleague tells me that it is easily missed as before the baby begins to distort it is floppy and appears to be the vaginal wall. Examining fingers or a speculum deflect it to one side. He added that a breech delivering vaginally could advance astride a septum! Now that's something to bear in mind!

Jennifer Kelsall
SRN, SCM, MTD.

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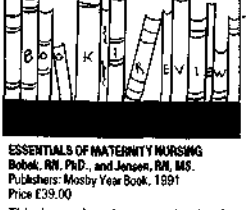


ESSENTIALS OF MATERNITY NURSING
Bobak, RN, PhD., and Jensen, RN, MS.
Publishers: Mosby Year Book, 1991
Price £39.00

This is an American text book of almost 1000 pages. It is a comprehensive, up-to-date work, covering the wide range of information needed by modern maternity nurses and midwives.

The presentation is good, making it easy to read, proceeding in a logical sequence conducive to learning and retaining new material. An excellent teaching package and reference.

It is unfortunate that the title may not appeal to midwives, since human reproduction and related issues are covered extensively. Current investigations and treatments specific to human fertility and the neonate are dealt with in detail. Teenage pregnancy, drug abuse in pregnancy and AIDS are included, as are the legal aspects of maternity and neonatal care. A useful inclusion is the discussion of the importance to quality control and other management topics.

The pregnant woman is regarded throughout as an individual who's psychosocial, cultural and family background are kept in mind, as she is helped to make informed decisions concerning her own health care and pregnancy progress.

I find American textbooks on nursing and midwifery very useful for defining terms and concepts, and also for linking theoretical knowledge to practical aspects of care.

D. Howard, SRN SCM.
December 1991.

MEDICAL DISORDERS IN PREGNANCY
William M Barron
Marshall D. Lindheimer
Wolfe Publishing, London.
Price £57.00.

This book is written by thirty co-authors and edited by two Professors of Medicine and Obstetrics within the United States. The book provides a wealth of information about its subjects. The major aim of the text is to equip doctors with the knowledge they require for the effective management of Medical Problems in Pregnant women. This is particularly important in the 1990's since more women are delaying childbirth until their 30s & 40s and, as a consequence, an increasing number of pregnancies are complicated by medical problems. The 19 chapters describe in detail the more familiar and the most rare medical disorders which doctors and midwives may encounter in the course of their practise, e.g. Cardiovascular, endocrine and immunological disorders, drug abuse, mental illness and even a chapter on the effects of fetal exposure to radiation. The authors present detailed descriptions of the pathology relating to each disorder. They discuss ways in which the disorder might effect the pregnancy and they propose a plan of management for the Ante, Intra, and Post Natal care.

The Medical terminology is quite un-inspiring for most "non-medics" and this is definitely not a book recommended for a little light reading! However it provides a detailed and well referenced account of Medical Disorders in Pregnancy and deserves a place in the Midwifery library as a useful source of information for midwives, doctors and nurses.

Mary Byrne R.G.N. R.M..A.D.M. 1991

ANAESTHETIC AND OBSTETRIC MANAGEMENT OF HIGH RISK PREGNANCY
Sanjay Dalia
Published by Wolfe Publishing, London. 1991.
Price £3.00

This is a text to "dip into" out of interest, as opposed to a standard reference work or an examination aid. This is because, although it is laudably up to date, it has to be read with a constant awareness of what is acceptable practice in this country.

I cannot comment on the obstetric management (I am an obstetric anaesthetist not an obstetrician). From a general point of view I would say that the American style of obstetrics seems to be very "interventionist". This is certainly the case with American anaesthesiology compared to British anaesthesic practice.

This book covers a large range of possible obstetric and anaesthetic problems in commendable detail. It provides excellent background reading into the path-physiologicy of diseases in and of pregnancy. The American influence is also evident in the choice of topics. I doubt whether an equivalent British text would present some of the chapters in this book (teenage pregnancy, morbid obesity, substance abuse) with the same prominence. Having said that, however, it may well be that this is one area in which we are in the wrong!

The overall impression one is left with after reading a chapter of this book is the unremmittingly "high-tech" approach to labour and delivery that is regarded as the norm. This is of course inherent in a book looking at high risk pregnancy, but there do seem to be many instances of intensive care practices being advised in the delivery room. Considering the failure of American obstetricians to avoid litigation over the last ten years it could be argued that the case for this type of approach is not proven.

The most startling difference from British practice is the fact that almost every chapter advocates epidural analgesia for labour, anaesthesia as a last desperate measure to be used only under extreme circumstances. There are occasional mentions of general anaesthesia for vaginal delivery, an anaesthetic intervention (virtually) unknown in my unit.

Overall the most important and most impressive aspect of this book is the integration of obstetric and anaesthetic problems and their management within each chapter. The need for this level of inter-specialty communication and the multi-disciplinary management that this can produce are constantly stressed and recommended; clearly this is desirable in this country. The notable absence of the midwife from this team approach reflects the difference in the nursing of obstetric patients in America. This is one of the most obvious faults of American obstetric practice and this book sadly reflects it.

In conclusion: buy this book for your library, but do not follow its recommendations without expert British guidance.

Dr. N.P. Mercer
Consultant Obstetric Anaesthetist
Aintree Hospital, Liverpool.

Briefly...

45 COPE STREET.
YOUNG MOTHERS LEARNING THROUGH GROUP WORK.
AN EVALUATION REPORT 1991

This is a project, like the well known Sitehill project, that I think we will be hearing a lot about in the future. The findings of this project may well influence our practise in the care of young mothers.

The team of workers include one part time health visitor, one part time midwife, two part time nursery nurses and one full time midwife/health visitor. Other local workers such as midwives and adult education tutors are invited in on a sessional basis, with Cope Street being used as a placement for some students.

Cope Street, according to their press release, is a preventive health project working with young mothers aged between 16 and 25, and their children, based in a small house in the inner city of Nottingham. It aims to work in partnership with parents to improve child and family health, primarily through the use of group work methods.

It is the sort of project that is often talked about theoretically but less often put into practise. Difficult to analyse statistically, it would not go down well with the money minded managers of today's health care trusts. The workers methods have been reviewed by means of confidential evaluation forms filled in during and after the groups sessions. They have often changed their practise after analysing these and talking to group members.

Their results show changes in the women's self esteem, from having a low self esteem at first contact to achieving college places and employment for many after attending the centre. The creche, which is available when the groups run, means that for the duration of the session the mothers are not distracted by their children.

They do not shirk questions of why some women do not come to the centre and poor uptake of services by the black and Asian women. Indeed the problem has been addressed and as well as improving the publicity, using leaflets in the relevant languages, two black team members have been employed.

The report makes fascinating reading, especially as the workers have gained special skills in working with groups, and have expanded this into running courses on "Changing parentcraft" (to less of a formal class to more of group led subjects) and "Working with groups". Personally I could do with going on one of their courses to put more "zip" into my classes.

There is lots more in the report to make it worth reading, especially for all of us who work in this field or is involved in running groups of any sort.

There is a copy in the ARM library or get your own personal copy:—
Cost £5 inc. p&p.
Cheques made payable to
"Nottingham Community Health".
Available from — "45 Cope Street Evaluation Report"
Sector Office
Old Basford Health Centre
1 Bailey Street
Nottingham
NG6 0HB Tel: 0602 420323.

Joyce Pemberton
Community Midwife
Manchester

MIDWIFE TO MIDWIFE

The Birth Traditions Survival Bank

The Birth Traditions Survival Bank is a collection of information from all over the world about the traditions associated with conception, pregnancy, birth and the neonatal period.

It is being set up by Jacky Vincent Priya who first thought of the idea after talking to a number of traditional midwives in various parts of Southeast Asia. She found that in many cases the valuable work they were doing was discounted by the medical establishment: their traditional skills and knowledge were not being passed on and was being forgotten. It seemed ironic that this was happening at a time when in the west large numbers of women are disenchanted with the care which they receive from 'modern medicine' and are looking for the kind of holistic alternatives provided by these traditional practitioners.

The aim of the Birth Traditions Survival Bank is to bring together existing information about birth traditions as well as carrying out research on traditions which would otherwise be forgotten and lost forever. An important subsidiary aim is to make this data accessible to everyone — from the pregnant woman wanting to know about her own traditions to the politician wanting to integrate traditional practitioners into a woman centred health service for women and children.

At the heart of the collection is a computerised data base consisting of information from a wide variety of sources about the traditions associated with every aspect of birth. So often such material is collected as a sideline to some other line of enquiry and is therefore scattered through a diversity of material ranging from academic research reports to travellers' tales. Jacky Vincent Priya is especially interested in hearing from anyone who has any experience of birth traditions, whether this involvement came about individually or professionally. She hopes that a large amount of the data in the Bank will consist of such personal reports and individual experiences. Eventually the collection will also include a photographic picture library, literary and artistic works as well as new empirical data collected specifically for the Bank.

Ongoing empirical research will be an important feature of the Bank as it is through this that original material will be systematically gathered. Traditional birth practices are an important aspect of giving birth in many developing countries where most women may give birth with the help of their female relatives, friends and traditional birth attendants rather than a biomedically trained doctor. In developed countries such traditions have often been relegated to the position of 'folk law' but it will be interesting to see what remains and if there are any new traditions developing. In all places where such information is obtained it is expected that the women who participate will also benefit. By sharing their knowledge and experience of childbearing they will hopefully become aware of and appreciate their own traditions and to understand, in the context of local changes and conditions, the implications this has for their own reproductive choices.

Those who would like to support the work of the Bank are invited to subscribe to the Birth Traditions Survival Bank Network and to receive a quarterly Newsletter which costs £20 per year. At present the Bank has no external financial support so relies entirely on such subscriptions and donations for its continued existence. Anyone who has information for the Bank, who would like to subscribe/donate or who would like more information can write to Jacky Vincent Priya at:

BIRTH TRADITIONS SURVIVAL BANK
Private Bag 2
Mtunthama
MALAWI
CENTRAL AFRICA

FAX NO. 253586

Letters

Dear Ishbel,
This letter finds me in a much better frame of mind than when I last wrote.

The prospects of work look much brighter than at the beginning of the summer although the legal paperwork looks as though it might take till the end of the century. The problem has been that although the British qualification is recognised here, they also require me to have worked for a year in Britain after qualification. This is where the problem stems from as I only qualified on March 10th and had only 6 weeks post-reg experience before coming out here. It couldn't face the prospect of being separated from my son and husband for practically a year). I have suggested to the Ministry that they allow me to do a year's experience (supervised) here and the nearest hospital, Figueris, is prepared to support my petition. Hardly surprising as all this year would be unpaid and b) there is a chronic shortage of midwives here. They suspended midwifery training here four years ago whilst they prepared the new two year curriculum (previously it was only a year) and have yet to implement it. What's worse is that there is no sign of it being implemented within the next two years. What with natural wastage ie. retirement, people leaving to have families or to return to general nursing, the country has half the minimum of midwives deemed necessary by the E.E.C. Action has been taken by the E.E.C. in the form of two official sanctions, but lack of public awareness and general apathy within the profession have hardly helped. There is no official college exclusively representing midwives but recently I attended a meeting held by the Catalonian Association of Midwives who seem to be getting their act together ie. petitions signed by the public and lobbying local M.Ps.

Apart from all this I've just about decided that if they won't let me practice legally I'll practise illegally. There are already plenty of lay midwives doing so.

I've started a small Childbirth class in Olot (50 miles away) and have 5 prospective women for home delivery and one who has already done so with great success. I've chivvied another midwife into doing the deliveries (with my physical and moral support) as I of course couldn't sign all the necessary papers. Our first delivery was a real race against time. Blanca has a history of speedy deliveries, so as soon as we got her call Sofia and I set off, hell for leather. 50 miles doesn't seem far but the mountain roads were badly surfaced and quite hair-raising. Needless to say we got there in time. Blanca delivered a beautiful girl in the twilight of an autumn evening.

Both Sofia and I want to buy some more equipment. We have a Sonicaid but only on loan and we would like to have a paediatric ambubag, as all these women live some distance from the nearest hospital and ambulance service is practically non-existent.

Have you any idea of any companies that send out catalogues with price lists? Everything is very expensive and I'm sure we'd find it much cheaper to buy equipment in England when I next come on holiday. I had hoped to come in December to coincide with the A.R.M. meeting in London but the weekend previous to that there was an 'International Research Conference here in Barcelona and I didn't think I could afford both. When and where are you having the Spring meeting?

I certainly won't be attending the Summer meeting as I've a more important appointment to keep — I'm expecting my second child at the beginning of July! There'll be a twelve year gap between the two. I think it's going to be a bit of a shock to the system after so long.

It was lovely to meet Penny Dungworth. If anybody else is coming out this way do let them know where I am, everybody is welcome.

Regards to all.

Joanna Reid

Dear Ishbel,
It has been a good week from the midwifery literature point of view. A few days ago an excellent Midwives Chronicle centred round the Joint Breast Feeding Initiative, yesterday M.I.D.I.R.s filled with goodies, and today nicely rounded off by Midwifery Matters no. 49, as good as ever with its own special qualities of somehow catching and expressing moods and feelings, movement and change, and of being an instrument of change because of its "vision".

And so on to the subscription. I am a member of RCM because it gives me insurance cover etc, and because its magazine is very good. If it wasn't for its magazine I might have found one of the other Unions. RCM costs nearly £60 a year. M.I.D.I.R.s is more than worth its subscription. My feeling about A.R.M. is the same as M.I.D.I.R.s. A.R.M. is important — my way of supporting it is by paying my money. Is the Midwives Legislation Group perhaps not one of the most important things of the present? My heart tells me yes. My heart tells me that a lot of the little acorns that have come from A.R.M will ... I will happily pay a subscription of £20 if it helps to keep 'the vision' going.
Yours sincerely,
Maureen Carroll

Dear ARM members,
In April 1991 I visited Zanzibar, a small island off the coast of Tanzania in East Africa. I am a student midwife and I won 2 free return air tickets from British Airways for one week. One aim of my week's holiday was to visit the College of Health Sciences on the island and meet the student midwives there. The female nurse students study for 4 years and their final year is a compulsory midwifery course. Their native language is Swahili but all the teaching at the college takes place in English and all the books are in English.

The students earn approximately £1.50 a month! The college is an impressive new building, donated by the Sultan of Oman, but there is a chronic problem of funding. I took with me a tenth edition of Mayes Midwifery amongst a few

other hastily thrown together items and this was received with interest by the tutors there. The most recent edition that they had was the seventh edition.

Myself and two other student midwives from the Dorset and Salisbury College of Midwifery and Nursing are fund raising for teaching equipment for the Mbweni College of Health Sciences in Zanzibar as part of our celebration of International Day of the Midwife in May 1992. If anyone has any midwifery text books they no longer need or would like to make a donation to the equipment fund, these would be gratefully received.

Please send to:— Sally Millar, Student Midwife, Dorset and Salisbury College of Midwifery and Nursing, Maternity Unit, St. Mary's Road, Poole, Dorset.

Thank you, we will report back later

Yours,

Sally Millar

Dear Editor,

The article on Supervision of Midwifery by Chris Warren and Caroline Flint (MM Issue No51) was interesting and I agree with many of the sentiments expressed.

However, I feel alarmed by the statement; "she (ie, the supervisor) would not discipline me or threaten me with the UKCC but I would expect her to candidly tell me if my practice appeared unsafe".

I would expect a supervisor of midwives, as protector of the public, to ensure something is done about her unsafe practice; not just to tell the midwife — however candidly.

Although they referred to a "woman-led service" Caroline and Chris want to choose their supervisor. This could surely lead to charges of favouritism — do we wish to establish some sort of "old girl network"?! What is in the best interests of the users of our service?

Unfortunately (to answer the request for opinions on supervision) I feel that the present threat to midwifery in legislation means that strong supervision — actively used by midwives — is essential if midwifery is to survive. When the midwifery profession is truly autonomous and self-regulating, we may no longer need supervisors.

Yours,

Kate Isherwood

Dear Ishbel,

Sheila Nuttall is not alone in her approach to "dissolving" perineal sutures. It has cheered me up reading her little piece, because regularly cut, like her, with scissors, not a stitch cutter, perineal skin sutures, when I believe they are the cause of pain. As Sheila says, this provides instant relief to many women. Like Sheila, I believe much pain after the first few days is suture related. Unfortunately, one cannot gain access to overtight muscle sutures! Earlier this autumn I ended up investigating and cutting an episiotomy suture (catgut) which turned out to be the culprit for "agony" at 14 days post delivery. Fortunately dealing with the skin sutures only usually helps. One also cannot gain access to a "sub-cut" skin suture. A nurse, who had had a forceps delivery, had one of these a few months ago. The physical agony from her perineum was evident on her face — dreadful suffering. To the eyes her perineum looked OK. I do not believe there was infection/abscess etc. One could feel a *taut line* running straight down the episline, pulled tight. How one wished she had had interrupted visible sutures which at least could have been removed or cut. Yet, many midwives are loathe to undertake this task. Women are frightened too, that their wounds will burst if stitches are cut and fear leads the occasioned one to decline the offer to cut her stitches to try and relieve pain. Obviously, I only cut stitches if pain is being complained about.

I am grateful to the midwife who told me tight stitches prevent healing by causing necrosis. Physiological glues are in position and functioning rather soon after a wound occurs, and if there is infection stopping healing the presence of sutures will not prevent breakdown of a wound. Sutures having served their brief function become a "foreign body".

If an episiotomy is gaping, healing speeds up if catgut/other suture material that is often seen "lying about" is removed. Better no perineal sutures at all but yes if present and giving pain, remove them.

All good wishes for 1992.

Regards from

Maureen Carroll

Dear ARM,

I have a problem with men in midwifery which I want to share.

At an intellectual level I acknowledge that some men can be more sensitive and and caring than some women. But I have a strong 'gut' feeling that midwifery is, and should stay, female work.

Birthing is women's business.

It is all very well pussyfooting about, getting worried about discriminating against men in midwifery: I am concerned about the possible damage to women of the assumed acceptability of a male birth attendant.

How many women will be confident enough to say: "I do not want a male midwife, thank you". The very presence of a male birth attendant can change the dynamics and power at a birth so profoundly that it may threaten the natural process.

Can men empathise or understand enough to be really "with woman"? I think not.

Anon.

Dear Ishbel,

A friend of mine lent me a copy of 'Midwifery Matters' and I breathed a sigh of relief whilst reading. I'm not the only one who feels like this! If had begun to think I was a bit peculiar).

You see, I am a Student Midwife and whilst on my allocation to the Labour Suite I learnt that I wasn't being taught the skills I need: The CTG machine wasn't available (I'm ace at putting these on) and I was told to feel for contractions — I didn't know how to do this. Imagine my feelings if you can. I began to wonder what other skills I wasn't being taught. So I did some reading and I now feel I need the support of like-minded people to teach me what birth is really like. So I'd like to join A.R.M. please.

Student Midwife

Nottingham

Dear Midwifery Matters,
At the last meeting in London we were trying to think up a slogan for "badge wearers". The reason being, that the idea of a slogan could only be understood by those of us who are aware as midwives to what is needed, and serves as a talking point to those who are not.

Anyway how about these?

IS YOUR VISION CLEAR?

I'VE SEEN THE VISION, HAVE YOU?

NICHOLAS (WINTERTON) MAY WELL HAVE SEEN THE VISION? I AM ARE YOU?

Any other ideas?

Sally Herbert

Dear readers,
In reply to a comment by a member recently, we do not publish the writer's address on the letters page because of lack of space. However, we are very happy to forward a reply to individuals if a stamp addressed envelope is enclosed.

The size of each journal reflects the content sent to us from each group and very rarely do we need to hold over articles until the next issue, however, on this occasion we have done so.

With regards

Sandra

Dear colleagues,
I refer to the book review by Peter Jones of "Anecdotes of German Midwives in Bygone Days".

I share his opinion that this book is a real treasure, almost a valuable document. I also feel it is high time that some researcher in the UK started interviewing "old" midwives, in order to preserve precious information about traditional midwifery.

What I found irritating — and I would like to rectify this point — is his generalised judgement on midwifery in Germany.

It is **not** true that the "craft of midwifery ... is almost unknown"! We are not as downtrodden as it might seem to you. In theory, the German midwife has very much the same responsibilities and abilities as her **colleague** in Great Britain. I admit that hospital practice often does look very grim, but there are many of us striving for improvement and change. There is an extremely important law in Germany which states that there has to be a midwife at every delivery. This is something like the anchor of our profession here.

Outside hospital, midwives can choose to go into free practice (paid by the woman's health insurance) or even to do private work (i.e. ante-natal classes, post-natals) in addition to her hospital job.

I feel competent to judge the situation in the UK and in Germany, as I trained in England and now practice midwifery in Germany. I work part-time in the local labour-ward and also do private work (birth preparation/education, post-natals, especially domino deliveries). I am too busy these days to write articles, otherwise I would have liked to have produced something on the situation of the German midwife.

Yours sincerely,

Susanne Roberts

Why ARM is still needed

Help,
I am 4½ months pregnant, and need to find someone who will help me with a natural birthing. I feel like I am constantly at war with doctors, midwives and people in hospital over what kind of birth I want. It's as if they want to take my pregnancy away from me and do it for me.

It's very rare that I consult Western medical practitioners. I prefer more holistic approaches such as Chinese medicine, homoeopathy, etc. I don't like the Western attitude of seeing the part rather than the whole, and believe childbirth should encompass emotions and spirit, not just a physical process.

I'm sorry if all this seems garbled, I am feeling desperate at the moment. I feel intimidated by never being able to talk to any of these people alone, and without being treated like a child who doesn't know any better. I feel like I'm abnormal at times, like every other mother to be is quite happy with machines and monitors and being shot full of painkillers.

My mother asked why I always have to fight things, why can't I just go along with them, but I'd rather fight now than when I'm in labour. I have the support of a few friends here, which is good. The father wanted nothing to do with me when I got pregnant. I'm happy that we split when we did, and I'm happy about having a baby.

According to all the blood, urine and smear tests, both the baby and I are fit and well. I got a flat 'no' when I asked about a home birth, 'not for a first baby', they said.

If I can't find anyone to help me in this area, I would be willing to travel. I don't have a lot of money, so I would be grateful for advice on charges for midwives outside of the NHS.

Hope you can help me.

Replied — help offered as usual.

Events

MARCH 7 & 8 — **WOMEN IN MEDICINE 1992 CONFERENCE — "OUR RESPONSIBILITIES"** at The Staff Club, Cardiff University Park Place, Cardiff.
Cost:— according to income — food and creche included. Contact Sally Keefe, 42, Heathfield Road, Heath, Cardiff. Tel: 0222 619 711.

MARCH 18 — **NATURAL MIDWIFERY** — A study day at Hinchingbrooke Hospital which will include topics such as natural/active birth, water for pain relief in labour and aromatherapy in the ante and post natal period.
Cost £10, please bring your own packed lunch. For details please send S.A.E. to Miss I. Milner, Maternity Unit, Hinchingbrooke Hospital, Huntingdon, Cambs. PE18 8NT.

MARCH 27 — **"VIOLENCE IN PREGNANCY: The Tip of the Iceberg".** Venue: Post Graduate Centre, Chase Farm Hospital, The Ridgeway, Enfield, Middlesex EN2 8JL. Fee £25. Details and application forms from: Deirdre Nugent, Whittington Education Centre, Whittington Hospital, Highgate Hill, London N19 5NF. Tel: 071 288 5054.

MARCH 31 — **"EMPOWERING MOTHERS AND MIDWIVES"** E.N.B. Approved Workshop with Caroline Flint. 10am-4.30pm at Harborne Hall, Birmingham. Fee: £30.00 inc. lunch.
Further details from Mary Nolan, Birmingham Childbirth Seminars, tel: 021-445 1005.

APRIL 7 — **FEEDING PREMATURE BABIES.** Which milk is best? Current thinking on milk banks. Is supplementation necessary? Venue — Sheffield University.
The cost will be £25.00 for students, £30.00 for MIDIRS subscribers and £35.00 for non-subscribers, per day.
Details from: MIDIRS, Institute of Child Health, Royal Hospital for Sick Children, St. Michael's Hill, Bristol, BS2 8BJ. Tel: 0272 251791.

APRIL 10 — **"PRENATAL SCREENING".** ENB Approved Study Day. See March 27 for details.

APRIL 23 — **CHALLENGING POLICY;** making change happen. How to achieve change; improve practice; change course etc. Venue — Bristol University. See April 7 for details.
INFORMED CONSENT IN CHILD AND THE WOMAN'S HEALTH ARENA. "The right thing for the wrong reason".
Venue: School of Midwifery. Contact: Dora Opoku — Head of Women and Family Health Education, The Royal London Hospital, Whitechapel, London E1 1BB. Tel: 071 377 7268.

MAY 14 — **"CONTINUITY OF CARE"** — A Study Day for Midwives at Prince Philip Hospital, Llanelli, Dyfed, South Wales. Cost: £20 inc. lunch. Speakers: Beverley Beech, Gill Hawksworth and others... workshop sessions... Full programme/application form from:
Midwives, Amman Valley Hospital, Ffolland Road, Glanamman, Ammanford, Dyfed, SA18 2BQ. Tel: 0269 822228.
Closing date for applications: 23.4.92.

MAY 21 — **"EXERCISES FOR CHILDBEARING AND ALTERNATIVE THERAPIES IN LABOUR"** E.N.B. Approval Pending. See March 31 for details.

JULY 7 — **NATIONAL CONFERENCE ON RESEARCH IN MIDWIFERY** — to be held at the University of Reading. This conference will offer a forum for the presentation of studies relevant to midwifery.
Speakers: Ellen Hodnett, Nurse/Midwife researcher, University of Toronto.
Josephine Green, Psychologist, Child care and Development Group, Cambridge plus 9 research papers presented in parallel sessions. Fee: £45 to include all refreshments. ENB approval anticipated.
Please contact: Sue Cammerloher, 61, Tamar Way, Woosehill, Wokingham, Berkshire RG11 9UB. Tel: 0734 793294 (evenings).

SUMMER NATIONAL MEETING

CARDIFF

Saturday June 20th — 9.30am-4.30pm

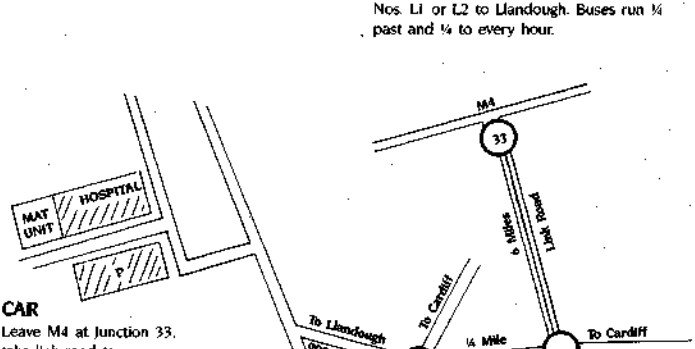
Venue:— Llandough Maternity Unit
Llandough Hospital, Penarth

TRAIN

Take train to Cardiff Central Station.

BUS

Bus station is opposite Railway station. Take Nos. L1 or L2 to Llandough. Buses run ¼ past and ¼ to every hour.



CAR

Leave M4 at Junction 33, take link road to PENARTH. Stay on link road to the end (6 miles) (Roundabout at the end). Turn right at the Roundabout to Penarth (¼ mile). At the next Roundabout go straight on to traffic lights and turn right. Up hill (200 yards). Turn left into HOSPITAL. The road bends to right, turn sharp left, drive to end. Parking on left. Hospital on right. Parking 20 pence.

Ring **Sandra 0222 711765**
Polly 0222 228392
Let us know by MAY if you need accommodation or creche facilities.

cont. from page 21.

Further reading:
STANLEY G. CLAYTON, DONALD FRASER, T.L.T. LEWIS: Obstetrics by 10 Teachers — (Chapter: Congenital abnormalities of the uterus and vagina) — 14th Edition — Edward Arnold 1985
GARREY/GOVAN/HODGE/CALLANDER: Obstetrics illustrated — 3rd Edition (Congenital Abnormalities) Churchill-Livingstone 1980.
R.R. MYERSCOUGH: Munro Kerr's Operative Obstetrics — 10th Edition 1982, p 183. Balliere Tindall.

Fundraising

Frances Whitty will walk 270 miles of the **Pennine Way** on behalf of ARM on 20th June 1992.

Regional Contacts will receive a sponsor form. Please try to obtain as many sponsors as possible for Frances and collect the money after Frances has told you how many miles she has walked.

If you would like to sponsor Frances please ring 061-861 0812.

FOR SALE

Entonox Machine: recently serviced — £100.
Contact: Antoinette Ward, The Green, Caldbeck, Wigton, Cumbria CA7 8ER. Tel. 06998 220.

Huntleigh Sonicaid — Fetal Dippler D520. As new £175 o.n.o. to good home!
Tel. Maggie Bonner 0884 820749. 10% to ARM funds.

NOTICE
Did anyone leave a T-shirt at Nicky Leap's house after the London National Meeting "Midwives Help People Out".

NOTICES

NB!! ANONYMOUS SUBSCRIPTIONS NB!!

Although standing order subscriptions are a great boon, the banks pass the payment to our bank with very little supporting information, which makes it impossible for me to update the relevant member's records. The mailing list then shows an overdue subscription, so the member gets a reminder instead of a magazine!

I always query these entries with our Bank, and they can often give me a few more details which help me trace the origin of the payment, but sometimes they can't help me. I used to chase up the scraps of information available, by phoning around to the various originating banks, but this became too expensive and time-consuming, so I now rely on members contacting me when their supply of journals dries up in spite of having paid their subs!

Sometimes the name on the Bank statement doesn't correspond with any of my membership records, which makes me wonder if some members may have changed their names after setting up the standing order, and forgotten to give me the new name. I have a backlog of such credits into our account, and I'm hoping that if you recognise the name, or the account number in the following list you will contact me.

Many thanks, Ishbel. Tel: 0695 572776.

Date on Statement	Details on Bank Statement	Further details obtained	Amount paid in
3.3.91	N.M. McCoogan	none available	£15
5.4.91	S	Nat. West., Gloucester	£15
17.4.91	S.A. Mantle	Yorkshire Bank, Clitheroe	£15
3.5.91	Smith L P P & C P	Nat. West., Yeovil	£15
17.7.91	Starkey W	none	£10
28.8.91	M. Turner	Automated transfer, no details	£15
4.9.91	J & H Ashbridge	Nat. West., Cardiff	£15
4.9.91	Lucas D M & R T McLachlan	Midland, Notting Hill	£15
20.9.91	NABS 50762708191I	none available	£15
16.10.91	Ingram A J	none available	£10
21.10.91	NABS 23562308923	none available	£15
30.10.91	R & P Hanna	Bank of Scotland, Inverness	£15
5.11.91	Gordon D N & W J	none available	£15
5.11.91	Jones H T	none available	£15
6.11.91	Daly A	none available	£7.50
5.12.91	Payroll	none available	£15
12.12.91	Cash and/or cheques	none available	£15

PERSONAL SUBSCRIPTION FORM

(Other organisations, groups, midwifery schools, etc., please write for rates)

Subscriptions may begin at any time of the year to cover 4 issues of Midwifery Matters beginning with the most recent issue. Members are entitled to reduced entrance fees at all ARM meetings. Plus free loans of books from the lending library.

Name and Address (please print clearly). _____

_____

_____

_____ TEL: _____

MIDWIFE: (please circle relevant status) Community Hospital Team Student (Pre reg — Post Grad)
Tutor Research Management Independent Not practising Retired

Non-Midwife (Occupation) _____

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ARM Working Groups

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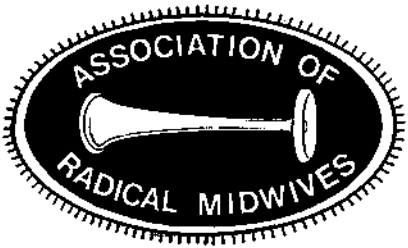
IS THERE A REGIONAL GROUP NEAR YOU?

Some regional groups cover a large area, and other areas have no regional group at all. If your area is not covered by the list, or if there is no regional group close by, why not get together with one or two colleagues to start your own group? Contacts are needed in all areas, to provide information on the local midwifery care situation. Write to Ishbel Kargar, 62 Greetby Hill, Ormskirk L39 2DT.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