ISSN Nº 0961-1479

ISSUE Nº 56 SPRING 1993

Beta Endorphin and Stress in Pregnancy and Labour

Massage and Midwifery

A Charter for Care

Reclaiming Our Heritage: Creating Our Future

ASSOCIATION OF RADICAL MIDWIVES

# ASSOCIATION OF RADICAL MIDWIVES

## 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 women's active participation in birth.
4. To re-affirm the need for midwives to provide continuity of carers.
5. To explore alternative patterns of care.
6. To encourage evaluation of development of our field.

## IMPORTANT

**Read the label on your *Midwifery Matters* mailing envelope before you throw it away, and check your subscription renewal date. Unless you have an active standing order, the date shown indicates the end of your subscription. This may be your last magazine unless you renew before the next issue comes out.**

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. ARM 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. 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.

## 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 the 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 £10 for non-members and £8 for members, to include lunch and light refreshments during the day. Paid-up ARM members can claim a refund of travel expenses ovar *£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).

## MEMBERSHIP

UK and Europe – £22 pa.
Unwaged (optional concession) – £11 pa.
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(See Subscription Form inside this magazine)
Please do not send foreign currency, since bank charges and exchange rates reduce the final payment, and make this method unacceptable.
£ Sterling only please!

## 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!

## 1993 NATIONAL MEETING VENUES

The following members volunteered their region for the National Meetings in 1993:

**20th March** – Birmingham – Sarah Montagu
**19th June** – Hexham (Northumberland) – Shona Kerr
**18th September** – Manchester AGM – Sue Cripps
**18th December** – Bristol – Jane Tucker

# CONTENTS

**Editorials** 2

**Features**

Beta-Endorphin and Stress in Pregnancy and Labour – *Margaret Jowitt* 3
Massage and Midwifery – *Frances Whittey* 5
A Charter for Care – *M. Moran and P.D. Carr* 7
My Pregnancy with Lydia – *Sally Titterington* 11
Lydia's Patient Passage – *Sue Cripps* 13
Reclaiming Our Heritage: Creating Our Future – *Debbie Garrod* 15
Them and Us – *Carol Komaromy* 17
Women and Work 18

**Business**

Winter National Meeting 19
Regional Meetings 27
Local Activities 28
Letters 30
Gleanings 34
Book Reviews 36
Events 37
Summer Meeting 38
Subscriptions 40
How to Get in Touch 41

Designed by Argraff • 0222 664031
Cover photo by Mary Giles / Argraff
Typeset by Pia • 0222 222782
Printed by Reprint • 0222 497901

**Cover:** Sandra Arthur / Midwife. Frances Sloan – gave birth at home to baby girl Nina on 26.1.93

**ISSUE No 56**
**MARCH 1993**

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| **CopyDeadline** | **Publication** |
|---|---|
| Apr 15 | Jun 1 |
| Jul 15 | Sep 1 |
| Oct 15 | Dec 1 |

**Regional Content:**
Spring 1993 – **Manchester**
Summer 1993 – **Overseas**
Autumn 1993 – **Merseyside**
Winter 1993 – **Birmingham**

The views expressed in this magazine are those of individual contributors and are not necessarily those of ARM as a whole.

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

Advertising is accepted at the discretion of ARM. We are unable to accept inserts, all other enquiries should be directed to the Magazine Group.

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# Editorial

The start of a new year and a new look for *Midwifery Matters*. We have now employed the skills of Argraff, a graphic design company based in Cardiff, to illustrate, design and print the journal. We would like to welcome Penni, Andy, Mary and Andrea to our team, and hope that you our readers appreciate the end result.

1992 was a good year for women and midwives due to the publication of 'Maternity Services', the Select Health Committee Report. After years of struggling to make the voice of ARM heard, we finally achieved credibility when invited to submit written evidence to the Select Committee.

ARM's 'The Vision', far ahead of its time when first published in 1986, was a proposal for maternity services in 1996. Even two years ago one could not imagine that its targets would be met. But 'The Vision' has almost reached maturity with the publication of 'Maternity Services' where many of its principles were adopted by the Health Committee.

The facelift of *Midwifery Matters* could not have come at a better time, not only to greet the new year but to provide ARM with a new professional image for the next ten years. We hope the new look will attract a wider readership and increase membership, as well as attracting submissions of a high standard that are both provocative and topical promoting the philosophy and professionalism of ARM.

There is much to achieve in 1993. At an individual level midwives will move into areas they have never dared to venture, and will need support from friends and colleagues. On a wider scale ARM will need to continue to promote the recommendations of The Maternity Services Report to benefit women and midwives, so use *Midwifery Matters* to inform each other of your progress. *Midwifery Matters* does find its way onto the desks of influential planners of maternity services. Comments have been made on how valuable the journal is in informing non-midwife managers of current midwifery practice.

Remember anyone can contribute to *Midwifery Matters*, this is your journal and we hope you enjoy it.

SANDRA ARTHUR
POLLY FERGUSON
*January 1993*

# Regional Editorial

It is a pleasure to be invited to write this on behalf of the Manchester Group. The group meets regularly on the second Tuesday of the month in each others' homes. Our programme is varied and stimulating, and we have a couple of social events that have become a tradition, the July Barbecue and the Christmas Party. Food is important to our group, as those who have attended National Meetings we have hosted will testify.

The Group draws its members from Greater Manchester, Stockport and Cheshire, it is a stable group in terms of numbers, usually about ten people, with as many again who ebb and flow as the requirement takes them. This is the strength of ARM and in particular its local groups, they are always there when you need them, they are not offended when you do not go and they care about you whatever you do.

For many years I, like others, have drawn strength from ARM, for it is a comfort to be among those who accept you just as you are and are happy to share, rejoice or commiserate as appropriate. ARM has no hierarchy, each member is valued for themselves not for what they symbolise. In such a non-threatening environment people bloom, information, knowledge and skills are shared, everyone has something to give and to learn. There is the opportunity to become involved in and influence local and national issues affecting midwifery, women and society. Our personal and professional lives benefit, we may not know all the solutions but through ARM we can find a woman who does. May I recommend you to try your local group and if you have not got one then start one, make new allies and renew old friendships.

Best wishes from

ANNE JACKSON-BAKER,
*on behalf of the Manchester Group.*

# Beta-endorphin and Stress in Pregnancy and Labour

"The midwife must remember that in the antenatal clinic, the woman's anxiety levels are raised." Lois Bowman wrote this statement in the Winter 1992 issue of *Midwifery Matters*. It implies that it is a self-evident truth that hospitals are stressful. If a woman is anxious at an antenatal appointment, how much more anxious must she be when she goes to the hospital in labour itself? Even obstetricians recognise that hospital birth is intrinsically stressful; Derek Llewellyn-Jones (1990) writes: "Maternity hospitals became increasingly 'clinical' and impersonal and the expectant mother, on admission, has been subjected to procedures which 'depersonalise' her. She became the passive recipient of the skilled care of the obstetric team, who delivered her baby and cared for it, without her involvement to any significant degree." He has written this in the past tense but I think most people will accept that the situation has changed very little. Perhaps hospital birth is a little less stressful now, but not much. Does hospital birth allay anxieties or does it cause yet more distress? Does a mother's anxiety level affect the way that she labours? I suspect that nearly everyone reading this article will say instinctively "Of course it matters" but at the same time they will not know why it matters. Neither do the doctors. Llewellyn-Jones (1990) writes: "It must be confessed that although it is agreed that emotions may affect uterine activity, the mechanism of their effect is not known." Pregnant women have been encouraged to go to relaxation classes as a preparation for childbirth ever since Grantley Dick-Read presented his fear/tension/pain explanation of pain in childbirth. By definition relaxation is the opposite of stress. Obstetricians are willing to admit that stress may affect the efficiency of labour but are not convinced enough to want to look further at the question and remain sceptical. No one seems to be researching into the causes of stress in hospital childbirth because no one knows why it is so important. The better quality and safety of home birth becomes instantly understood once one realises that labour is meant to be slowed down by stress hormones. Both Marjorie Tew (1990) and Michel Odent (1986) have come to the conclusion that childbirth should be a natural instinctive event and that medical treatment tends to cause more problems that it cures.

## Beta-endorphin in Pregnancy

Scattered about in the vast medical literature are a few articles which together show that beta-endorphin, a stress hormone, is at the very heart of both pregnancy and labour itself. Pregnant women have so high a level of beta-endorphin that at one time it was thought only they secreted it. But it is now known that secretion is also raised during stress (Carlson, NR, 1991), and pregnancy is a unique kind of stress, imposing all sorts of new burdens on to a mother-to-be. Beta-endorphin is secreted in parallel with ACTH, the hormone responsible for increased cortisol secretion. It was first found in the body in 1975 (Hughes et al., 1975) and contraction suppression was one of the criteria used for its identification. Beta-endorphin also suppresses the immune system and this effect is needed at the uterus itself which contains the foreign body of the feto-placental unit. My thesis is that beta-endorphin keeps women pregnant, and a fall in beta-endorphin leads to the onset of normal labour at term.

Beta-endorphin has both physiological and psychological effects. As well as suppressing smooth muscle, it relieves pain and enhances memory mechanisms (Bohus and de kloet, 1979), it leads to the euphoria typical of other natural and artificial opiates such as opium and pethidine. It also regulates secretion of other hormones such as growth hormone (GH), prolactin, gonadotropin releasing hormone (GnRH) and consequently luteinising hormone (LH) and oestrogen, and oxytocin (e.g. Devorshak-Harvey etal, 1988; Laati kainen 1991; Russell etal 1989; Vetes etal 1986). Its role in oestrogen and oxytocin regulation is very important for pregnancy and labour. Oestrogen 'wires up' the uterus for labour and oxytocin is the first step in a biochemical reaction that leads to the co-ordinated contractions of labour.

## Beta-endorphin in Labour

The large quantities found in labour seem paradoxical. If oestrogen and oxytocin are suppressed, then labour will last longer. In labour a woman cannot decide to have a rest if she is tired, she cannot stop contractions by an act of will if she wants a break. Her brain regulates her labour according to her ability to withstand both physiological and psychological stress. Beta-endorphin regulates labour according to the physiological and psychological stresses encountered by the labouring woman. Moreover, labour is an explosive hormonal situation – more and more of the uterus becomes 'wired up' by oestrogen to act as a whole during labour and, for the second stage only, oxytocin supplies are increased on a nervous signal given to the brain by the baby's head stretching the cervix and the vagina (Steer 1990). Externally given oxytocin can lead to uterine rupture and so, theoretically, can naturally secreted oxytocin. Beta-endorphin rations labour hormones according to both physiological and psychological stress.

High stress hormones increase the chance that instinctive behaviour will take precedence over 'rational' behaviour and during labour a woman needs to follow her instincts as never before, she must follow the dictates of her own body to birth her baby, pain leads to pain avoidance behaviour, and even cues from her baby may make her change her position, experimenting with different positions until she feels as comfortable as possible.

## Implications

Stress hormones are secreted in an attempt by the brain to lead to behaviour likely to increase chances of survival. They are secreted in circumstances of helplessness, hopelessness and lack of control. They are secreted as a response to authority figure pressure, peer pressure, self-inflicted pressure, and also performance pressure, the pressure induced by fear of failure that makes examinations and the driving test so stressful. If we cannot manipulate our environment – and the people within it – to resolve these stresses then stress hormone secretion soars.

Hospital childbirth seems to me to be a classic example of a stressful situation, women are often helpless, physically and psychologically. Control of the environment and indeed their own body is often taken out of their hands completely. The beta-endorphin secreted in these circumstances prolongs labour by preventing oestrogen from 'wiring up' the uterus and by reducing oxytocin secretion. Beta-endorphin turns what should be a natural event into a medical emergency that requires the awesome technology of modern hospital-based obstetrics. If psychological stress can be relieved then labour can proceed as nature intended. However, the physiological stress will remain, no one has ever found a better word than 'labour' to describe childbirth.

Even after the birth beta-endorphin has a job to do. It switches on learning mechanisms (most women remember their labour in uncanny detail) and leads to a feeling of euphoria. The baby has also come through the enormous stress of birth and has high levels of beta-endorphin (Csontos 1979). Both mother and baby have a natural 'high' and are ready to learn all they can about each other. Beta-endorphin is the biological explanation for bonding. The stress of vaginal delivery primes mother and baby to 'fall in love' with each other at first sight. Beta-endorphin could explain critical periods for bonding observed in animals and by some researchers in mankind. The implications for maternity practice are even more compelling. Rather than there being 'no contra-indications to caesarean section' as is still believed by some professionals, caesarean section will cut out natural bonding hormones and impair the relationship between mother and child right from the start.

## Conclusions

The study of the psychology of childbirth is in its infancy but it shows that the link between mind and body must not be ignored by anyone who cares for labouring women. Once the hormonal regulation of labour by stress hormones is understood then professionals will have a vastly different attitude to labour. The mother will be seen as an active participant once more instead of merely a human incubator from which to extract a new baby. I personally feel that home birth is the best way to ensure that women retain control of their own labours but hospital practice could be improved to take account of the implications of this exciting new discovery of the role of stress hormones in labour.

MARGARET JOWITT,
*Postgraduate Student of Psychology,*
*Shropshire 1993*

*Margaret is researching the physiological and psychological outcomes of home and hospital birth at the University of Keele. Her book Childbirth Unmasked expounds the ideas outlined above in greater detail. It is to be published on 1st March price £8.95 (+p&p) and is available from Wolford lodge, Craven arms, Shropshire SY7 0JT.*

### References

**Bohus, B and de Kloet E R (1979).** 'Behavioural effects of neuropeptides and corticosteroids', in *Interaction within the Brain-Pituitary-Adrenocortical System*, ed M T Jones et al, Academic Press.

**Carlson, N R (1991).** *Physiology of Behaviour*. Allyn and Bacon pp 227-231.

**Csontos, K et al (1979).** 'Elevated beta-endorphin levels in pregnant (labouring) women and their neonates'. *Life Sciences*, 25, 835-844.

**Devorshak-Harvey et al, (1988).** 'Declining plasma progesterone levels eliminate endogenous opioid peptide suppression of LH pulse frequency on day 22 of gestation in the rat', *Neuroendocrinology*, 48, 6, 584-590.

**Hughes et al (1975).** 'Identification of two related pentapeptides from the brain with potent opiate agonist activity', *Nature*, 258, 557-579.

**Lautikainen, T J (1991),** 'Corticotropin releasing hormone and opioid peptides in reproduction and stress', *Annals of Medicine*, 23, 5, 489-496.

**Llewellyn-Jones, Derek (1990).** *Fundamentals of Obstetrics and Gynaecology: Part 1 Obstetrics*, Faber and Faber.

**Odent, Michael (1986).** *Primal Health*. Century.

**Russell, J A et al (1989).** 'Interruption of parturition in rats by morphine: a result of inhibition of oxytocin secretion', *Journal of Endocrinology*, 121, 3, 521-526.

**Steer, P (1990).** 'Endocrinology of Parturition' in *Endocrinology of Pregnancy*, ed Franks. Baillière Tindall.

**Tew, Majorie (1990).** *Safer Childbirth?* Chapman and Hall.

**Vertes, M et al (1986).** 'On the mechanism of opioid-oestradiol interactions', *Journal of Steroid Biochemistry*, 24, 1, 235-238.

# Massage and Midwifery

Massage is sophisticated touch. And touch is a powerful form of communication which effectively crosses the barriers of language, race, age and culture. It is also, let's not forget, very unBritish.

When I started my training as a masseuse I found therapeutic touch very frightening, and yet at that time I was a student midwife, learning how to palpate women's abdomens, assist in breast-feeding, carry out vaginal examinations. I was going to work and touching the most intimate parts of women's bodies yet I was afraid to touch and be touched in a therapeutic way.

So why was it okay to carry out vaginal examinations in labour but not acceptable to assist a woman with back massage? It seems to me that, as a nation, we confuse sexuality and sensuality. We have confined most touch to relationships with sexual partners. The very word massage is associated with seedy massage parlours and prostitution. Vaginal examinations and abdominal palpation are traditionally carried out under clinical conditions which encourage distance between the woman and the professional. Massage by its very nature encourages greater intimacy.

Permission to touch is very important. Do we always gain that permission before palpating a woman's abdomen, assessing her cervix? Or do we assume that a woman, on entering hospital, gives us permission to touch her body? While I believe that it is essential to receive verbal consent to carry out any procedure, from taking a blood pressure to performing a CTG, permission to touch therapeutically is often non-verbal. Intuition tells me which women will be helped by touch and which will shrink from it.

Most midwives have used massage in their practice by rubbing a woman's back during contractions or holding her hand when she is frightened or in pain, without necessarily thinking of it as massage. Massage gives us, as midwives, another way to be with the women for whom we care.

Anyone can perform massage but there are a few contra-indications to bear in mind if you decide to use it in your practice:

1. Don't massage anyone who doesn't want to be massaged.
2. Don't massage directly over bone, it's painful and it puts stress on the joints.
3. Don't massage over a fractured bone.
4. Don't use heavy lower back massage on any woman who is liable to miscarriage or any woman who is less than 36 weeks pregnant.
5. Don't massage anyone who is pyrexial.

6. Be very cautious and very gentle with anyone who suffers from epilepsy.
7. Stop if the woman feels pain or discomfort from what you are doing.

You need privacy for the woman, a warm environment, which in the average hospital is not a problem, clean hands, short nails and if you massage directly against the woman's skin, a medium to prevent friction. Oil is the best medium to use and the best oil is almond oil. It is relatively cheap to buy from Asian grocers and

very expensive to buy in fancy bottles from beauticians and health shops, so be warned. Most women don't carry oil around with them so if you find massage useful for women in labour use something that the woman has in her toilet bag like talc or cream, she's unlikely to be allergic to anything of her own. The woman needs to be in a comfortable position, not so simple with a pregnant abdomen to consider. One of the best positions I've found is to get the woman sitting the wrong way round on an upright chair, well supported with pillows, if you kneel on the floor behind the woman you have excellent access to her back without straining your own back. If you want to lie the woman on her back to massage her legs or face during pregnancy, you need to ensure that her shoulders are well supported to prevent occlusion of the inferior vena cava.

## Massage in Pregnancy

Many women feel ambiguous about their changing body shape in pregnancy. Most of us are influenced by the 'small is beautiful' message of our culture. For a pregnant woman massage can be a way of feeling that her body is worth touching, that her pregnant abdomen is beautiful. Massage encourages veinous return and is an effective prophylaxis against varicose veins. It is an excellent way of treating backache in pregnancy.

## Massage in Labour

Labour is probably what most of us would associate massage with, and most as a form of analgesia. Massage works by boosting the woman's production of endorphins, her own natural opiates, and by helping to prevent the release of catecholamines. I find that the most beneficial use of massage is in the lower back. I use strong downwards pressure on either side of the woman's spine, moving towards the sacrum and working with the woman's breathing. As she breathes out I press down with my hands, as she breathes in I gently release the pressure.

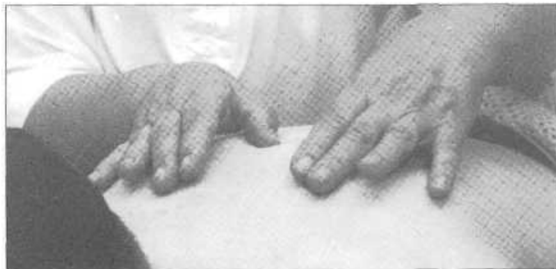
Most of us still work in hospitals where there is no effective continuity of care for women in labour, so if I'm looking after a woman who finds massage useful I teach her partner how to do it. Then if I go off duty, feel exhausted or want a cup of tea, the woman is not left feeling abandoned. A lot of partners feel lost and intimidated in hospital, they want to help their partners but don't know how. The midwife carries the keys to the drug cupboard, knows how to use entonox and how to contact an anaesthetist, seems to have all the power. If the partner can use massage s/he has a way of rubbing it better, s/he is involved and part of the process.

## Massage in the Pueperium

After the birth of a baby, focus often switches from the pregnant woman to the new born child. The immediate post-natal period is very stressful – the parents have to come to terms with meeting the needs of this new person 24 hours a day. Women who breast-feed often develop sore necks and shoulders as they anxiously lean forward, willing the breast into the baby's mouth. Massage can be helpful here, to alleviate aches and pains, to help a mother relax, to remind her that her needs are important too and that if she is to nourish and nurture her child she needs to be nourished and nurtured as well.

The beauty of massage is that it is non-invasive, fun to give and receive and very cheap. It would be nice to see basic techniques of massage taught to student midwives. After all we learn how to give intra-muscular injections and how to top up epidurals. Why shouldn't we learn how to give safe and effective massage? This would also give us all the ability to massage each other. As midwives we get stressed, we get sore backs, aching shoulders, we spend a lot of our time giving to the women we care for and sometimes ignore our own needs. Maybe a little massage for midwives wouldn't go amiss.

FRANCES WHITTY,
*Manchester, 1993*



# A Charter For Care

The "crèche", part of clinic area A

Quality and innovation in the Antenatal Clinic at Fazakerley Maternity Unit, Aintree Hospitals NHS Trust, Merseyside.

## Introduction

The unit is a purpose built hospital, caring for over 4,000 mothers a year, living in South Sefton, Kirkby and North Liverpool.

In July 1990 the newly refurbished antenatal clinic opened, transformed from a dreary impersonal environment to a bright welcoming area, designed to provide appropriate and comfortable accommodation for women and their families.

What is perhaps more exciting is that the system of clinical practice has been improved, enhancing the quality of care given and ensuring proper use of resources as well as clinical midwifery expertise. This was in response to consumer demands, social expectations, Government and other reports and recommendations, and the beliefs of staff of all disciplines.

## Assessing The Need For Change

Reports[1,2] and research[3,4,5] findings continually decry the inefficiency of antenatal care systems in the United Kingdom.

During the 1980s a common pattern consisted of "block" appointments, long waiting times and frequent visits. At one visit a woman could see up to 9 personnel in different areas and yet not see any of them again at following visits.

Both midwives and obstetricians were frustrated that despite their commitment to giving a good quality service, the system made this difficult to achieve.

In 1988 a Community Health Council survey of views of women attending the clinic confirmed their general dissatisfaction with the system and the clinical environment.

## Managing Change

In 1989 the Department of Health invited applications from NHS hospitals for funding to enhance the quality of care in outpatient departments.

Applicants had to submit proposed plans for improvements to standards of care and service which could be done quickly at comparative low cost. The submission by Fazakerley Hospital was successful and the antenatal clinic became one of six demonstration projects within the United Kingdom. Following preliminary discussions it was decided to set up two multi-disciplinary working parties to include representatives of all groups involved.

**Working Party 1**

**Remit:** To plan environment and structural change.

**Members:** Unit General Manager, Estate Managers, Consultant Obstetricians, Director of Nursing and Midwifery,

Midwifery Unit and Antenatal Clinic Managers, Patient Services Manager, and a member of the Arts Council.

**Working Party 2**

**Remit:** To plan changes in the clinical system.

**Members:** Consultant Obstetrician, Midwifery Managers, Midwife Teacher, Antenatal Clinic Manager and midwives, Maternity Records Department representative.

The following criteria were seen to be vital:
- There should be close liaison between both working parties.
- Staff at every level should be given the opportunity to offer ideas, influence decisions and be kept informed of plans so that a sense of ownership would develop.
- The Government reports and recommendations and relevant research findings should be taken into account, with particular regard to efficient and effective use of resources, the proper use of midwifery services and expertise, and continuity of care.
- The changes would take account of a further qualitative consumer satisfaction survey [6] which brought the following comments:

**Waiting times:**
"Too long. First time I waited 4 hours, last time 2¼ hours, nobody explained why"
"On my first visit I sat undressed in a cubicle for 1 hour, waiting to see the doctor"
"Everyone arrives at 9.0 am then people come in later and go in first."

**Systems of Care**
"It's a bit like a cattle market, getting moved about from one room to another."
"I'd like to see the same midwife each visit."
"You explain the same thing to a different one each time, it's a waste of time."

Photo: Ron Davies

Clinic area A, after change

**Environment**
"Cramped and scruffy, but I suppose that's to be expected."
Adjectives included: claustrophobic, depressing, dull and dingy, uncomfortable, cramped, shabby. No children's facilities, no refreshments.

**Expectations**
"I didn't have any illusions."
"Everyone has such low expectations of the NHS, they settle for second best."
"When you're pregnant you are vulnerable and incapable of standing up for yourself."

**Information**
"I would have liked the information before I arrived."
"They rely on you finding out from family and friends."

**Staff Attitudes**
Descriptive adjectives: helpful, friendly, polite, willing to have a laugh and a joke.

**The following recommendations were made by the independent consultants who carried out the survey:**

There should be provision for:
- Continuity of care by midwife, client allocation
- Environment improvements to decor, heating and ventilation.
- An efficient appointment system.
- Child play facilities.

Working parties met on a regular basis to agree the changes that were to be made. In this time the antenatal clinic had to be re-sited on to an unused ward while the structural alterations took place.

## The Clinical Environment

When comparing the new clinic with its predecessor it is difficult to believe that the tranquil yet efficient environment was brought about with only minimal structural alterations.

The Estate Manager and the Director of "Arts for Health", in consultation with clinic staff agreed that a Spring theme was ideal. Local artists were involved in depicting this in the numerous pictures and mosaics on the internal pillars.

The original black vinyl chairs, black floors and stark changing cubicles were replaced and refurbished using carpeting and soft furnishings in pastel pinks, blues and greys which complement the relaxed atmosphere of the clinic. A striking entrance mural, quiet background music and decorative door panels complete the effect.

A receptionist greets mothers on arrival and refreshments are available in the foyer. An Ultrasound Scan room, Phlebotomy room and CTG room are sited in the area. Children are welcomed at the clinic and are cared for by a qualified Nursery Nurse in a well equipped

Above: Clinic area B, after change. Below: Before change

crèche. The modern and brightly coloured design of the crèche with its range of good quality safe toys attracts the children's attention and interest immediately. Divided from the clinic waiting area by clear Perspex, the children and parents feel at ease as both can see and be seen by each other. This enables the mother to get maximum benefit from her visit, knowing her children are happy in a safe environment.

The offices of the clinical midwife manager, parent education co-ordinator and social worker are sited in or adjacent to the area, improving communication and accessibility to mothers and staff alike.

## The Clinic System

However, all these efforts would have been in vain if the clinic organisation was not structured and efficient enough to sustain this relaxed atmosphere.

Firstly, the appointment system needed a radical reform. Much work went into evolving a system which would be controlled by the midwife, and was personalised, adaptable and structured to the individual needs and obstetric requirements of the client. The system is monitored by a master plan which allowed the flexibility to cater for unforeseen delays and extra clinic visits.

Maternity Records Department staff altered their working practices in order to accommodate the changes.

Consultation between midwives and obstetricians resulted in agreed guidelines for the pattern and minimum number of clinic visits. This resulted in an overall reduction in the number of visits and a shift of some care into the community, while retaining a flexible approach.

The system now allows midwives to make proper use of their skills and expertise by carrying their own caseload and delivering all antenatal care to mothers with uncomplicated pregnancies, while still sharing the care of at-risk pregnancies.

The women receive all care in one of the 8

midwives' consulting rooms. On booking, she meets her named midwife who will care for her at subsequent visits according to her individual needs.

The system enables the consultant obstetrician and his team to spend more time with women on first visits and those whose pregnancies are at risk. A unique custom-built call system in each room indicates when the obstetrician is required.

In response to women's criticism of the information available, all relevant information is collated and presented in an attractive booklet which is sent out with the first appointment.

## Evaluating The Change

Almost 2 years after the clinic opened there is no doubt that the project has been even more successful that envisaged.

In 1991 there were 18,600 attendances. The reactions of mothers, families and staff are revealed in a post-project qualitative survey 7 carried out in the first year:

**Waiting Times**

General satisfaction was expressed by clients. "So far I've never had to wait more than 20 minutes."

"It's dead quick."

An audit of waiting times in September 1992 showed that 70% of women were seen within 15 minutes of their appointment time, 90% within 30 minutes and 98% within one hour.

**Continuity of Care**

Client: "The benefits to me are less waiting time, less rooms to go in, you go to the same midwife each time, which is great – you get to know her."

**Environment**

Adjectives used to describe the environment commonly include: relaxed, friendly, lovely decor, bright and cheerful, doesn't seem like a hospital, crèche is great.

**Information**

"Very efficient information sent in the post, last time I was 2½ hours giving details. Now I filled most of it in at home."

**Obstetrician**

"It is a better working environment for doctors and midwives, less feeling of stress". "The responses I have had from patients show they appreciate the changes."

**Midwife**

"I like the fact that midwives have been given an opportunity to use their expertise. It is a vast improvement that we have our own caseload. We see the girls from booking to delivery."

**Clinical Officer**

"It's a very pleasant environment, much more personal now."

Of course there have been problems. Nobody should underestimate the work involved in decamping a clinic to another area while alterations take place

Doctors and midwives were subject to considerable change to previous working practices. The appointment system, giving 45 minute to first visits and 15 minutes to re-visits is the maximum allowable to cope with the number of clients attending, which means everyone must keep to a tight schedule.

- There was an initial increase in the number of follow-up visits, but this quickly improved as midwives became more familiar with the revised pattern of clinic visits and gained confidence in their own clinical judgements.
- Referrals to the clinic increased shortly after the changes, which may have been due to heightened local awareness of the new system and facilities. This necessitated an increase in staff to maintain previously agreed staff/client ratio and quality of care.
- Whilst the new furnishing materials are as durable as those previously used, it was soon obvious that the old methodical cleaning routine was inadequate, and a new, more vigilant approach was required if the new pastel shades were not to be marked by incidental day-to-day staining. It is thanks to a dedicated domestic staff that this has not happened.

However, there is no doubt as to the success of the venture. One major reason for this success has been the manner in which staff were involved in the planning and decision making concerning the change.

It is thanks to the support, commitment and continuing enthusiasm of all who work in the clinic, in whatever capacity, that the project has been successful.

M MOHAN RGN RM
*Antenatal Clinic Manager*

P D CARR RGN RM ADM MTD Cert.Ed
*Deputy Head of Midwifery/Community and Antenatal Services Manager*

April 1992

## REFERENCES

1 MATERNITY SERVICES ADVISORY COMMITTEE 1982. "Maternity Care in Action: Part I Antenatal Care". London HMSO

2 MASON Val. 1989. "Women's Experience of Maternity Care A Survey Manual" London HMSO

3 JACOBY Ann. 1988. "Mothers Views about Information and Advice in Pregnancy and Childbirth: Findings from a National Study". Midwifery 3:117-124

4 HALL M, MACINTRYE S, PORTER M. 1985 "Antenatal Care Assessment" Aberdeen

5 ROBINSON S, GOLDEN J, BRADLEY S. 1983 "A Study of the Role and Responsibilities of the Midwife" Nursing Education Research Unit, Chelsea College, University of London

6 COMMUNIQUE 1991 "Post Project Qualitative Survey of the Antenatal Department, Fazakerley Maternity Unit". The Communique Organisation Ltd

# My Pregnancy With Lydia

This was my fourth pregnancy. Something I had wanted and wished for, for what seemed to me a long time. It was New Year's Eve 1991, and symbolic that I had missed my period, ready to discover my pregnancy in the New Year of 1992.

I was elated and excited even though it was going to be a traumatic time for myself, my family and friends. As in February 1991 my third pregnancy ended disastrously with an emergency caesarean section and a beautiful baby boy who was stillborn whom I called Sam.

My other two children at the time were 5 and 6½. They were devastated, I realised that by having another baby they were going to be anxious and possibly upset. We all knew there would never be a replacement for Sam, but it would be nice to complete our family with another baby as we were fortunate enough to be able to have one.

Rachael and Joseph were both normal deliveries and normal pregnancies as was Sam's. Despite some raised blood pressure with my first pregnancy with which I was admitted to hospital.

This time I was eager that things should go smoothly and well for my baby and myself. Choice was very important to me. Who would be giving my antenatal care? Would I be able to trust them? Would they understand my anxieties without making me feel as if I was neurotic? Could I rely on them to be sensitive?

With our present day system of meeting so many professionals in one spell of nine months, so many people giving different opinions in antenatal care, I felt it was necessary to choose.

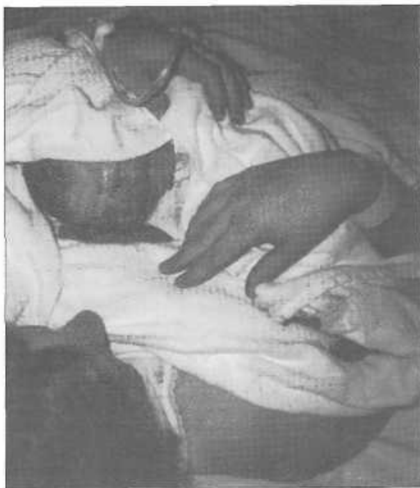
As I am a midwife myself I was more fortunate than most women who pass through, in that I was more knowledgeable about the system and that I did have 'rights'. I am also an unassertive person and find it difficult to exercise these 'rights'. Therefore I knew I needed a midwife who would be strong for me when and if necessary. I needed someone that I could put all my trust into to make the right decisions. So I chose Sue. Of course she had to be willing as I was probably no easy task.

We worked at the same place and had trained together as well as being friends. Paul my partner was in agreement. Bravely Sue agreed to be my midwife.

I booked with one of the consultants at the hospital who was also very supportive and was aware of my last experience of having a baby. We all agreed that Sue should do my antenatal care but I could see the consultant whenever I wished.

Antenatal care was fairly 'routine'. I had the occasional urinary tract infection which I was treated for with antibiotics.

My expected date of delivery was 11th September 1992. It was now June and I was almost ready to finish for maternity leave. I had had my blood pressure checked and it was found to be elevated. This continued. I was 27 weeks pregnant and was admitted for the first time with hypertension. Sue had been round to my house to take it daily and twice this day. Sue arranged my admission for closer observation with the consultant. Routine blood tests were taken, my urine was clear of protein. I did have headaches, but I was very tense and anxious especially about my blood pressure being raised at this gestation. The blood tests (urea and electrolytes) came back normal with the exception of the serum calcium and corrected calcium levels. These were high. I had no knowledge of what this meant and thought that I had probably eaten too much cheese or milk in my ignorance.



Lydia was covered in vernix, but, none the less, looked beautiful to me

I was discharged as my BP seemed to stabilise. Sue continued to check it at home.

Three weeks later however it was raised again. Now I had a diastonic of 110. Panic set in. Having a knowledge of the changes of high blood pressure I was convinced I was going to lose another baby. I was reassured by Sue who

did not panic. I was referred by the consultant, to the physician re my blood pressure, having been admitted again.

After a brief interview with the physician about my BP and calcium levels it was thought I had a parathyroid adenoma or Sarcoidosis. Needless to say at this point I felt distraught, confused and as though someone was definitely pointing 'the proverbial finger'.

Sue and I laughed rather than cried, both were easy options. I was commenced on an intravenous infusion of saline, four litres in 24 hours. An ultrasound scan of my neck was arranged. I did 24 hour urine collections for creatine clearance and urinary calcium levels. Whilst in hospital Sue contrived to care for me daily. She provided me with the confidence and reassurance and exceptional support which I needed. The ward staff were all very good too. Somehow I always felt cushioned by other people around me.

Sue and I were able to discuss changes in my care. For example we were both wondering now how and when I would deliver and what was to come. She liaised with all the other relevant people. Parathyroid adenoma was diagnosed by ultrasound scan. Sue discussed with the obstetricians and physicians my care and the plan for the remainder of my pregnancy.

After five days of infusion and low calcium diet which was very difficult, I was allowed home. To maintain a low calcium diet was hard as the main dietary source of calcium is water and I now had to drink three to four litres of fluid per day. The water in our home is very hard which means there is a higher level of calcium despite filtering. Ideally I had to have distilled water. I also had to have calcisorb sachets on my already low calcium meals to make the remaining calcium indigestible.

By now our family felt thoroughly miserable. Rachael and Joseph were frightened and often showed their anxiety by being angry with me. Paul was very worried for me as well as the baby and found it difficult to handle the situation which sometimes made me feel that he didn't care as I felt at times he wanted to isolate himself from all these problems. I felt extremely guilty because I wanted so much to have another baby, it felt as though I had done this at all costs, especially at the expense of my children and family.

Joe and Lydia

Rachael and Lydia

This was helped as Sue visited daily, she included the children. They listened to the fetal heart and helped to palpate the baby. They also knew Sue and she spent time explaining and discussing things with them.

There were about two more admissions to hospital as the pregnancy progressed. All appeared well with the baby. Fetal movements were good as was the fetal heart rate.

It was decided that it was better to deliver me by caesarean section at 38 weeks. This was because the consultant didn't want me to go post mature and it would be difficult to induce me as it would complicate matters with having had a section 18 months previously. The 25th August had been decided. The other reason was as I had such high calcium levels, the baby's parathyroid would not be functioning temporarily after the delivery. Therefore if she was not closely observed the baby may have an attack of tetany.

I went to visit the neo-natal unit where the baby would go as she would have to have an umbilical catheter in situ in order to administer intravenous calcium if necessary.

Rachael and Joseph both had a visit so they could be more familiar with it, as it is a frightening place.

I was finally readmitted with a diastonic pressure of /120mmHg. The consultant came in (as he was on annual leave) and decided to deliver me the following morning by caesarean section, Friday 21st August. This was arranged.

Sue prepared me for the operation which was to take place at 9.00am. A paediatrician was arranged. Neo-natal unit was informed. I was at this point quite relieved. Paul had to arrange to be there and for the children to be looked after, although they didn't know that their sister was going to be born.

I was anxious to breastfeed. Sue liaised with neo-natal unit and made it clear that the baby was to be breastfed only.

The next day it was a lovely sunny day. It felt strange that this was an end to the pregnancy which despite everything had gone very quickly for me. Sue arrived early, she was going to 'take the baby'. Paul and I were nervous. I had decided on a spinal block as anaesthesia.

In theatre the atmosphere was happy. I was reassured and everything went smoothly for the delivery. Lydia was born at 09.23. She appeared more like 36 weeks than 37, but cried spontaneously. She was covered in vernix but none the less looked beautiful to me.

Lydia came back to the ward with me and had a breastfeed which she did very well. Following this she went to the neo-natal unit, where I visited as frequently as I possibly could at the time. I mainly went just for feeding initially as it was quite painful. I was always made comfortable and was given a full explanation what was happening. Lydia was commenced on oral calcium and never needed the umbilical catheter to be used. Sure enough her calcium level dropped but soon regained a normal permanent level. She could stop taking it after a couple of weeks.

The next event was to be a parathyroidectomy some time in the near future.

I was fortunate to have such a resilient daughter. I also realised that even though I was an 'obstetric case' I was more than grateful to have the support of a good midwife, because the most important thing to me was having a live healthy baby and it was a great consolation to have someone to bring normality to this process when I felt everything would go wrong again.

SALLY TITTERINGTON
Dec 1992

# Lydia's Patient Passage

It was with great joy at the beginning of 1992 that my friend and colleague Sally told me she was pregnant. This would be Sally's fourth baby, at the time it wasn't yet 12 months since the emergency caesarean section and stillbirth of her son Sam.

This was going to be an anxious nine months for Sally, Paul, Joe and Rachael, and the rest of the family.

Sally took her time to make decisions about this pregnancy and the type of care she wanted. Last time she had planned a home birth. She had received a lot of support and care from her midwife but her GP was more grudging in his and this had taken its toll during the time after Sam's birth.

In the end Sally wished to have complete consultant care with no GP involvement. But she also wanted a named midwife, continuity of care and a low key affair. By seeing as few people as possible and learning to trust those people involved in her care, whatever the outcome Sally, Paul and her family would then have the strength to cope.

So Sally asked the consultant who had performed her caesarean section and me to look after her. We both humbly accepted and got on with the job.

I knew Sally and Paul were embarking upon this pregnancy with little self confidence and my aim was to give them a lot of tender loving care and support as well as professional dedication throughout the next nine months.

Sally booked in at around eight weeks. She had already had some spotting which had now settled down and a scan reassured us that all was still well.

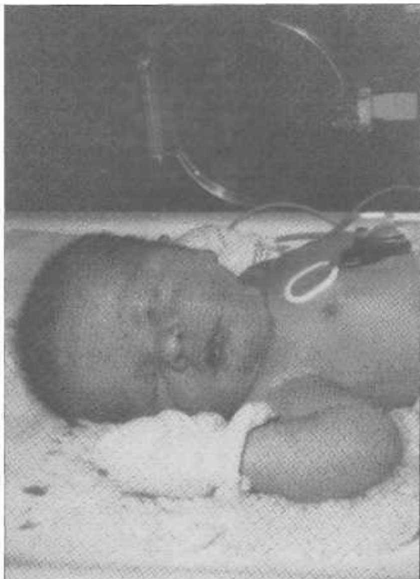
She is rhesus positive and her booking blood pressure was 140/80. Her first pregnancy was induced at 41 weeks with an ARM and IV Syntocinon for a raised blood pressure. The outcome was a normal delivery of a little girl, Rachael. Her second pregnancy was of spontaneous onset again at 41 weeks with a normal delivery of a baby boy, Joe. Her third pregnancy was an emergency section at 41 weeks for fetal distress and reduced fetal movements not in labour, and the stillbirth of son Sam.

Early on in the pregnancy and again later Sally was plagued by a urinary tract infection which was eventually cleared with antibiotics.

At about 26 weeks Sally's blood pressure also began to rise although otherwise she was asymptomatic.

We planned just to observe her blood pressure closely which I did.

I also became concerned about Sally's uterine growth which seemed a bit sluggish and requested a scan just to check growth. After liaison with the consultant I also took a routine blood sample for antenatal profile particularly uric acid to check for renal impairment. The scan was okay, all measurements at the 50th centile with normal liquor volume. The blood result showed that all the urea and electrolytes were within normal limits but that Sally's serum calcium level was very high.



Lydia

This was unusual and we decided to repeat the test in one week. Meanwhile the consultant liaised with a physician with regard to Sally's blood pressure management and serum calcium.

Sally saw the physician who cares for women with hypertension in pregnancy and was started on some medication to be reviewed in one month.

Sally was by now on maternity leave and anxious to stay at home with her family. I visited frequently checking her blood pressure and her diastolic stabilised to about 90mmHG with no other symptoms. However, Sally was suffering a lot of anxiety because of her hypertension, worrying about the effects on her baby. She

constantly complained of tiredness, lethargy and headaches which were partly due to stress and poor sleeping habits.

Myself, Paul, Joe and Rachael worked hard at supporting Sally at this particular time. It was a very special time when I prepared to examine and palpate Sally's abdomen. I got to know her baby from very early on. I always spoke to the baby and it would gently wriggle and move in acknowledgement of my tender prods. With great care, Joe's help and my ARM Pinnard we would listen to the regular reassuring beat of its heart.

At no time did the baby ever give me cause for concern for its well-being. I had a feeling all the way through that it was going to be a girl and the baby stayed calm and secure in its womb world strong and patient awaiting its time unruffled by all the events going on around it.

Despite medication Sally's diastolic blood pressure did not stay stable and at 27 weeks Sally was admitted with a BP >100 for four hourly assessment. Something else that was causing concern was the serum calcium which were still shown to be abnormally high.

Normal range: 2.10-2.65 mmol/L
Sally's level: 3.42 and rising.

The hypercalcaemia had to be investigated. It was thought to be unconnected with the pregnancy but had been detected because of her antenatal hypertension.

That day in July was a busy and anxious time for us all. Sally had lots of blood samples taken and the physician suggested that the cause of the raised serum calcium was probably due to a rare malfunction of her parathyroid gland possibly caused by a benign tumour.

This was indeed confirmed by ultrasound scan and Primary Hyperparathyroidism was diagnosed. Because of her pregnancy the plan was to maintain the well-being of mother and baby and surgically remove the tumour after delivery.

Hypertension is one symptom of hypercalcaemia. Sally's blood pressure was monitored closely. She was seen by a dietician and commenced a low calcium diet and was flushed intravenously with normal saline to reduce the serum calcium. Sally would have to take in at least three litres of fluid per day and twice weekly I took blood samples to check calcium levels, our aim to maintain the level below 3.0 mmol/litre.

Mode of delivery had not been properly discussed. We all hoped for a vaginal delivery. Neither Sally nor the consultant wanted the pregnancy to go post mature and by now Sally just wanted to have a live, healthy baby.

Over the next few weeks she stayed at home and I visited her daily liaising with the consultant and the physician constantly.

However at 36 weeks +5 days Sally's blood pressure rose her diastolic at 120mmHG and we immediately came into hospital. The next 48 hours would be critical, if her diastolic blood pressure stayed >100 then the consultant was going to deliver Sally and Paul's baby by caesarean section. Her blood pressure did stay high and we prepared for an elective section under spinal anaesthetic.

Paul was marvellous, when I saw him that morning he was very pale and anxious but had remembered to bring the camera and kept us going with his quiet calm sense of humour. Joe and Rachael had gone to school unaware that when they came home they would have a new brother or sister.

Whilst Sally was prepared for her spinal I stayed with her and then prepared myself to take the baby.

At 09.23 hours on 21.8.92 Sally and Paul saw the birth of a little girl weighing 2kg 740g with apgars of 9/1 9/5 and all her fingers and toes. Her name was Lydia Beth and as far as we were all concerned she was perfect and beautiful. Because of Sally's hypercalcaemia Lydia was at risk of hypocalcaemia within the next 24 hours and would have to go to the neo-natal unit for observation and blood tests.

After much excitement and photographs Lydia travelled in Sally's arms up to the ward and Sally and Paul were able to have some time alone together with their daughter. After Lydia had then had a good breastfeed I took her down to the neo-natal unit.

Lydia had an umbilical catheter inserted in case she needed an infusion of calcium gluconate, fortunately Lydia's condition did not deteriorate to that level and only required oral calcium as a maintenance dose for a couple of weeks. She made such good progress that she was transferred out of the neo-natal unit after four days.

Eight days after her caesarean section Sally and Lydia were discharged from hospital. A referral was made for Sally to see the surgeon urgently about her hyperparathyroidism. And other follow up appointments were made for them both.

At home at last they both quickly blossomed and flourished, Lydia gaining weight and staying as patient as ever.

Eight weeks on Sally was admitted with Lydia to a side room on a children's surgical ward and had the adenoma surgically removed from her right lower parathyroid gland.

All is now well. Sally is regaining her strength and self confidence and well-being. Lydia is growing and ever changing. Paul has lost his worry lines but like me has gained a few grey hairs. Joe and Rachael are enchanted by their new sister, and the rest of the family can't believe their good fortune.

Sally, Paul, Joe and Rachael shared their experience and time with me and made my participation a wonderful experience. Continuity of care was the key. Continuity of care enhanced its quality for all of us. I wouldn't have missed any of it for the world and thank my lucky stars that I am a midwife.

SUE CRIPPS
*December 1992*

# "Reclaiming our heritage: creating our future"

## Report on the Second International Homebirth Conference in Sydney, Australia, October 1992

Early one Saturday morning in late September 1992, my family drove me to Manchester Airport and waved me off to fly to Australia to attend the Second International Homebirth Conference in Sydney, where I represented the National Childbirth Trust (NCT) and gave a paper on their behalf. Hugs and kisses all round; walking away from them and seeing their dear familiar faces recede, my mind full of doubts and anxieties, I would gladly have returned and called the whole excursion off! Would the plane fall out of the sky? I hadn't flown for 20 years, and then only to Northern Europe, and I hadn't enjoyed flying then! What would happen if one of our four children became seriously ill? I had never left them for so long, and two weeks seemed an eternity.

As I experienced the rare pleasure of reading the whole front page of the Guardian uninterrupted, while waiting for my flight to be called, I realised there were benefits to solo travel! And when the plane roared into life and soared off, my doubts and worries evaporated instantly! The whole trip was the biggest adventure of my life – travelling alone to the other side of the world, attending such an exciting, *inspiring* Conference, *meeting many* many different people and sharing ideas, hopes and experiences, visiting maternity hospitals and getting a taste of how midwives work there.... I was hardly pining for home and family!

The Homebirth Conference lasted for three days, preceded by a one day workshop on 'Spiritual Midwifery' with Ina May Gaskin. Each day began with two addresses from keynote speakers, to all 600 delegates. It was good to hear Kitzinger, Odent, Savage and Balaskas again, and have the opportunity to hear Elizabeth Davis and Marsden Wagner for the first time. Each day then continued with a wide variety of concurrent sessions.... the range of topics and speakers offered a tantalizing choice!

The richness and diversity of ideas and experiences continues to inspire and stimulate me; I'm keen to share some of these – the problem is, where to begin and how to select. Eventually I've decided to focus on sessions led by five midwives, three American, one British and one Australian. Although this was a 'Homebirth' Conference, it seems to me that their ideas and suggestions can be explored by midwives wherever we're working, although home is obviously more private and peaceful than any other environment.

Ina May Gaskin's one day workshop was attended by about 50 midwives and students. Ina May is a storyteller par excellence; the morning was spent with us listening enthralled to her fund of stories; in the afternoon we split into groups and were given 'case histories' with problems highlighted – these we discussed, then 'fed back' to the whole group. I liked this way of working, especially the opportunity to listen to midwives from many different cultures sharing their ideas.

Ina May is a memorably warm, practical woman. She started working as a lay midwife in 1970, on 'The Farm' in Tennessee, where to date almost 2,000 babies have been born at home. To precis the content of her workshop is hard, because its significance lay in the presence and being of this modest, strong, earthy woman, whose sense of humour, beautiful smile and wealth of stories and experience remain as my strongest memories of her.

Describing (Western) homo sapiens as "the only species that doesn't know how to give birth", she sees the practices that have developed around our Western way of birth as a reflection of the alienation and fragmentation in our society as a whole. Fear, she says, is used to keep women down, and being scared means we forget how to give birth! The challenge before us is to release this "spell of fear", to rekindle women's knowledge and memory of how to give birth. How to do this? As women and midwives, we must relearn how to listen, to dream, to fantasize and become animal – for birth is an earthy business. Our attempts to sanitize it and sterilize it crush what she describes as the "delicate birth energy". One of our roles is to protect this energy, by creating a safe place, a sense of shared ancestry, "herstory" and connection with all other birthing women, past, present and future.

A sense of humour and the ability to laugh are vital in a midwife. Remaining sensitive to the atmosphere in labour, keeping adrenalin levels down, using laughter (as the best antidote to fear), will all encourage endorphin release. Ina May suggests that laughter is especially helpful as the baby approaches crowning, because it allows the woman to "open big". She describes a woman's ability to "get phenomenally big" in birth, and encourages us to pass this reassurance on to our daughters, (whose current predominate image of the adult female form is probably Barbie!)

Midwives should acknowledge all of a

woman's body as beautiful and powerful, to honour, respect and admire the pregnant woman: Ina May says the labouring woman needs to be treated as a goddess. She encourages us as midwives not to focus on negative experiences, but to pay more attention to the positive. I have often wondered why horror stories are so enthralling! And have resolved to share more of the good times in future.

The central theme running through the 'Spiritual Midwifery' workshop was that recognition of the mind-body link is vitally important – in ourselves, and the women we care for. In this way we can reconnect with women's knowledge of how to give birth.

Jane Harwicke-Collings, an Australian independent midwife, led a practical workshop entitled 'Realising the potential of birth through ceremony', in which she reiterated the importance of helping women to reach what she described as the "spiritual-material interface". She explored how the ceremonies (both conscious and unconscious) around central life events – birth, marriage, death – reflect the beliefs of our time and place. Jane asked us to consider what the current ceremonies around birth tell us about our time. I became sad as I did so..... much of what should be ceremony and celebration seems to have been replaced by rituals which serve our institutions. Jane suggests that as midwives we can consciously create ceremony that facilitates the birth process by moving women towards the spirital-material interface. Ways to do this include acknowledging the woman's intuition and empowering her; having the right people present at birth; paying attention to mood, to stimulation of the senses, and to how we communicate.

One of the high spots of the Conference for me was the opportunity to hear Elizabeth Davis, Californian midwife and author of 'Heart and Hands: A Guide to Midwifery' – a wonderful book that I read and re-read. Her keynote address was on 'Women's Intuition: its role in birth and childrearing'; she explored ways to access our intuition and use it to complement our technical expertise and knowledge. We need to learn to distinguish between what we can know through intuition, and fear/desire which may give rise to feelings that prompt us to action, inappropriately. Elizabeth strongly advocates listening to women in labour, in particular to what they say about their progress, and the baby's condition: this will tell us a great deal.

Elizabeth puts the woman at the centre of all the care the midwife gives. For example, using a 'match-pacing' approach, at every contact from the antenatal booking onwards, creates a safe space in which she can share. 'Match-pacing' the woman involves letting her set the pace, then matching it. This allows her to be the centre of attention, to lead us and set the agenda. The midwife validates what the woman shares, and values her knowledge and intuition about herself and her baby. I felt instantly drawn to this approach; but how to reconcile it with the sheaf of notes and paperwork with which we are armed at booking!

Elizabeth suggests that when leading antenatal classes, the midwife/facilitator becomes a 'hypnotic role-model'. By being relaxed and open herself, she can generate a 'body-centred focus'. The woman will absorb – intuitively – as much about relaxation from a relaxed role model as from more formal teaching.

Turning to midwifery training, Elizabeth advocates community-based apprenticeship: an integrated model of learning and doing, with thought, feeling and knowledge in a continuum. Learning in the community context leads to awareness of the needs of its population. This has certainly been my experience on a three year midwifery course that starts in the community and returns twice more and involves a detailed environmental study carried out concurrently. The community placements have been the high spots of the course for me.

Elizabeth suggests midwifery training should consciously incorporate personal growth elements, involving three 'strands'. Firstly: self scrutiny – of our expectations, biases, prejudices, beliefs, birth experiences, using guided journal work, discussion and sharing in a trusting atmosphere; secondly, she says the student must be "validated as early and as often as possible", individual skills and expertise recognized; and thirdly, the development of self-confidence and leadership qualities should be nurtured and affirmed as they grow. She feels that only by educating a student in this way can we encourage her to become a midwife who can meet the international definition, be a practitioner in her own right; a midwife who can handle a crisis without separating her human qualities from her technical skill. This is what Elizabeth Davis describes as her dream; she closed her session with the words – "I am dedicating my life to a vision of midwives working with dignity, class, grace and pleasure." She is certainly one such midwife! I felt like standing up and cheering (but being British, just clapped very hard).

Nicky Leap's vision is of a future where midwives are visible in the community, working autonomously in our own premises, with caseloads. We would be the first point of contact for a newly pregnant woman. Midwifery, she says, has always attracted individualists, and our different styles and skills and approaches give rise to richness, diversity and, potentially, increased choice for women.

When caring for women and their families, we should be sensitive as to when to act, when to inform and when to withdraw. In labour, the woman chooses her helpers and the midwife should let them help! She is there as an encourager and 'safety net' presence. Her statement "The less we do, the more we give" has returned to me many times in recent weeks.

Californian midwife Marina Alzuguray Kurstin led a participating workshop entitled

'Primal Birth Dance' on assessing progress in labour through observation of the woman's sounds and movements. We explored the sounds that accompany normal, physiological labour – becoming comfortable with these sounds seems a terribly important part of being with the woman. Moaning, groaning, grunting, crying out are all seen by some as signalling distress and loss of control. Whose distress and whose control, I wonder! Marina distinguished between these sounds and the terrified high-pitched 'up in the head' screaming stimulated by fear or obstructed labour. A woman who is truly free to move around as she chooses in labour will demonstrate the progression of her labour by the positions she chooses, as well as by her sounds. We practised 'catching' babies in different positions taking turns to be mother, midwife and assistant.

All too soon the packed days of the conference were over. I returned full of ideas and plans; memories of conversations during coffee, over meals, on walks and in hospitals and birth centres, as well as stimulated and enriched by the conference itself. The flight home seemed interminably long! But the sight of my lovely family at Manchester Airport was just beautiful! While everyone else stood patiently waiting, they (the children at least!) were leaping up and down, shrieking and waving their arms about! I felt that just as I had grown and matured through the experience, so had they, and I shall always be so thankful to have had such a truly marvellous opportunity.

DEBBIE GARROD

*(Debbie Garrod lives in Manchester with Ken and their four children. She has been an NCT teacher for ten years, and is currently two and a half years through a three year 'Direct Entry' midwifery training course at Stepping Hill Hospital, Stockport.)*

## "Why Do You Want a Child?"

Why do you ask?
Is it so strange
To love a child?
Unconceived.

I think of you,
My unborn child,
In all my plans,
In all I do,
I'm thinking of you.

I pop the pills,
My breast aches,
The red flow floods;

My heart breaks.

LORRAINE,
*'Issue' magazine, Autumn 1992, p.16*

# THEM AND US

Twenty two years ago, I stood in the sluice of a gynaecological ward staring at a twenty week fetus in a stainless steel bowl. The mother, I remember her beautiful sad face, was not allowed to see her baby. I didn't know why, and I still don't.

It was a boy, perfectly formed, nothing apparently wrong with him. I was told to place his body in a black plastic bag and ring for a porter who would take "it" to the incinerator.

I was a student nurse. I stood staring at this baby for what seemed like hours, experiencing an incredible mixture of emotions, mostly shock, at how whole and perfectly formed he was.

I was then challenged by the aggressively efficient staff nurse.

'Well, haven't you got rid of it yet?'
'No,' I protested, 'I can't.'
'Why not?' A smug, "I've seen it all before" tone crept into her voice.
'Because it's wrong and I can't do it.'
'Right, I'll do it then,' she said, angrily and callously.

I think she really wanted to make me do it.

In those days, people used coercion in many forms to get students to do as they were told. It was not that I was especially rebellious, but everything about the situation was wrong. The mother silently crying and empty, in all senses. The father feeling responsible because he had taken hard drugs. Was he? Who knows?

I knew that the baby should be with his mother so that they could say goodbye, but mostly so that she could just see him. I suppose she could firstly say 'Hello'. I was also aware of the father's terrible pain, and that I had left him out. Hospitals separate people in many ways. They have no right to do this. It disgusted me then, and it still does.

What does help is to realise that being alongside women removes the "them" and "us" barrier, the barrier which protects professionals from emotional involvement and maintains their position of power in the relationship.

Being with woman means acknowledging what they feel. For that woman, twenty two years ago, being "with" her would have meant having the courage to listen, and to help her meet her son. I will always regret that I was unable to do that.

CAROL KOMAROMY
BA(Open), RMN, RGN,
Student Midwife

# Women In Work/ Childminding In The 1990's

The Berkshire County Childminding Association (BCMA) is one of a number of groups throughout the country overseen by the National Childminding Association. It is a totally voluntary organisation and currently only receives small grants from the NCMA and the Berkshire County Council. This lack of funding means that only those childminders with the ability and the financial means to attend meetings either countrywide or local have access to a termly newsletter. This is discriminatory and contrary to our aim at equal opportunity.

Childminders are often the only childcare resource available at reasonable cost to single parents and low income families and childminding is the largest form of childcare used in the country. The onset of the 1989 Children's Act has accelerated the path towards professionalism in childcare. Childminders are now registered with the County Council Social Services Department and in certain cases are seen by Social Services as being a prevention of taking children into care. Childminders do not have the same stigma compared with perhaps attending a family centre or Social Services care. In order to ensure that all Berkshire Childminding Association members are kept advised and informed of new ideas, training facilities, information and interpretation of current legislation it is essential that they receive a newsletter.

The need to ensure that children receive professional care whilst at work is essential.

Without your support the achievements I have outlined cannot be maintained.

*If any midwife wishes to support the Berkshire County Childminding Association, financially or otherwise, please contact:*

*Helen Westhrop*
*5 Clarendon Road*
*Early*
*Reading*
*RG6 1PB*

## 'Avec Femme'

I see the essence of midwifery as being with Women.

I see through midwifery the essence of Women.

Every day I see through pregnancy, childbirth, and motherhood the release of an energy that is female, and I believe intrinsic within all women.

I see this energy like a trickle of fresh water that bubbles from deep within a rock pool.

As a midwife I try to follow that source as it ebbs and flows along its journey;

Sometimes overwhelmed by its Strength and other times by its Gentleness and Calm.

As a midwife I learn to know its path.

I do not try to Dam its flow, or Tap its Source. I simply follow its energy and nurture it so that women from within themselves can follow its power and gain strength from their natural resource.

The midwife exists to protect that Natural Spring and empower women.

I am the midwife. It is a transference of Energy.

SUE CRIPPS

## The Aims Of The Berkshire County Childminding Association

To promote high standards of childminding in Berkshire.

To standardise, develop and promote training for childminders across the county.

To provide up to date information, advice and support on childminding for both childminder and parents in Berkshire.

To promote the provision of facilities for the daily care, education and recreation of young children.

To identify sources of information, support, expertise and FUNDING.

To liaise closely with Social Service Departments and collaborate with Day Care Advisors.

To arrange study days, meetings and other training events for childminders and parents and other interested bodies.

To hold an annual county conference to which all relevant parties are to be invited.

To conduct research and publish the useful results and to produce a Newsletter for childminders, parents and interested bodies in Berkshire.

To collaborate with all under 5's groups in Berkshire and to share information and resources.

To promote the ideals set out by EPOCH (End Physical Punishment of Children).

To maintain and foster links with NCMA.

# Winter National Meeting

12TH December 1992, Chesterton Hospital, Cambridge

**BUSINESS**

## A Debate – Men in Midwifery

Jane Grant chaired this session, and minutes were taken by Penny Beere.

Six panellists had been invited, and each had five minutes to put forward personal views and arguments for or against the subject, after which the debate began.

**FOR** Sally Herbert (Midwife in Liverpool)
Jo O'Connor (Senior Industrial Relations Officer, RCM, and non-practising midwife)
Joe Schneider (Midwife in London)

**AGAINST**
Sue Cripps (Midwife in Manchester)
Garry Saunders (Nurse in London)
Sandar Warshall (Secretary of Association for Improvements in Maternity Services)

**SALLY HERBERT** – She felt that it was a personal issue, related to how one feels about men in general. She had been a senior student midwife when the first male student midwife started his training at her hospital, and said that at first there was uproar. Then having worked alongside the man she built up a good rapport with him, and now finds the argument about men in midwifery a difficult one to cope with. She says he had exactly the same training as his female colleagues, all of whom were very positive and complimentary about him, and apparently the women he cared for also felt well supported by him. She was unsure of how she would feel about having a male midwife if she was in labour. (She has three children, the youngest 9yrs old).

Sally noted that of approximately 100 men who had qualified, only 34 were in practice. She said she could see both sides of the argument, and can understand how women may feel. She felt that we should give male midwives space; the first of any of the opposite sex coming into a one-sex profession are scorned and resisted. Working beside the male midwife, Sally said she did not feel embarrassed, he is a good person to work with, equally comparable with other midwives on her unit.

**JO O'CONNOR** – She felt she should address the issue of equal opportunities. The current legislation allows people of both sexes to work in most occupations, including midwifery. The time to change legislation such as this is at the time it is being set up, not now. It is now actually illegal to discriminate against male midwives. There is no research to date to show that the contribution of men in midwifery has been detrimental. In the units where male midwives are employed they seem to fit in well, and have neither taken from nor added to the role of the midwife.

Jo said that as a woman she would have no objection to being attended by a male midwife; but she added that she trained at a time when there were no men in midwifery. In her present professional capacity Jo felt unable to agree with the empathy issue. In fact, there are many female midwives who have an attitude problem and are not suited to midwifery, or any other job dealing with the public! Male midwives do not seem to have a problem acquiring the skills they need to do the job. Jo noted that there is no research to date showing how women react to male midwives, and remarked that "Midwife" means "with woman", but doesn't say **who** with woman. ARM is about empowering women to choose, therefore we should give them the latitude to choose anything, not just what we think they should choose.

**JOE SCHNEIDER** – He made the decision to become a midwife during his General Nurse training, feeling that caring for sick people wasn't for him. He enjoyed working with healthy people, i.e. working in partnership with them. He joined the panel to support "Men in Midwifery" because he is a man, a midwife, and working in a job that he loves doing and feels he does well. He appreciated the problem of male midwives rapidly rising to the upper levels of management. As far as the issues of women's choice and sub-conscious influences were concerned, Joe admitted that he did not have any answers to those questions.

**SUE CRIPPS** – She felt that this was a very personal and emotional issue, and her presentation reflected this. She felt that the essence of midwifery was **being with women**, and that it was about the release of female energies. All women have this energy within them intuitively, and it is the midwife's role to learn the path of this energy and to follow it, not to block it. The midwife exists to help channel the energy and nurture it. Where men have become involved in childbirth they have tried to divert the energy, to tap its source. Women are right to be suspicious of men; they are strangers, they have power, and women have a lot to lose. Women wishing to have a male midwife have to seek one out, it should be her own choice.

Sue felt that as a midwife she should provide continuity of care from a group practice and provide a real choice. She had not yet read anywhere of a woman choosing a male midwife, which indicated that women did not yet feel comfortable in choosing to be attended by men.

**GARRY SAUNDERS** – He told us that he was on the panel as a man who had chosen **not** to become a midwife. During his 8 week maternity care module while training in General Nursing *he had been struck by the power and intimacy of* labour. He appreciated that the women were well and that childbirth was a normal event. As a nurse he felt that he was not coming from the same viewpoint. He felt he would be able to develop the required skills, but was blocked by the inequality of power. Prior to the module he had been involved in a COHSE campaign to get male nurses onto female wards, and had noted that in a rota system there was, in fact, no choice for the women, because there weren't enough staff.

He had considered the position and power of men in society, and cited Soo Downe's example of sensitive men crossing over to the other side of the street if they find themselves following a woman, at night or in isolated places. He had watched his partner in labour and felt that women needed to be able to concentrate on their labour, not on sexual politics. He found the Equal Opportunities argument strange, since caring for women in childbirth is not the same as fighting fires or crime; it is about dealing with women. He felt it was important that men should appreciate the reality in women's lives: that most women are afraid of men. Considering the way some men behave, Garry said he was sympathetic to that fact.

**SANDAR WARSHALL** – She was talking from the experience of many years dealing with complaints from women about their maternity care. She said we should perhaps have to change the name midwife to "midhusband", "midperson" or perhaps "delivery boy"! She said midwifery had arisen from a very female dominated area historically, one surrounded by natural healing methods. When medicine came along it was male dominated and excluded the healing power of women. Women passively handed over their bodies to these medical men, divorcing their heads from their bodies, and had to cope with men looking at their genitals and interfering with the instincts of childbirth. Research by the Women's National Commission showed that 87% of women preferred to be with other women during childbirth. It is a personal, intimate time, and this tends to be overlooked by medical men. Do women really want men to help them postnatally? Women are socialised not to say "No" to men. Sandar had this nightmare of a woman completely surrounded by men during childbirth, (consultant, registrar, SHO, midwife and husband!). Women are taught to grant men authority and men are taught to take it.

How would we identify men sensitive enough to take on the role of midwife? How have these *men learnt to be so sensitive*? The obstetric structure is already set up to be beneficial to men; there is no allowance for continuity of care, thus proving that most men are totally insensitive to the needs of women. The system already disregards women's intuition, so why add more men? However, Sandar remarked that if women had real choice she would be more than happy to reconsider her position.

## THE DISCUSSION

SALLY:
Women have more choice when there is a male midwife around, they are able to say, "No, I don't want you".

CAROL:
The speakers "FOR" took a personal view of the issue. It is a personal dilemma and we want people to believe we are tolerant and accepting. The "AGAINST" speakers took a more political stance. Personal is political, especially in labour. Women are conditioned to accept men, therefore there is no choice if they are offered a male midwife.

JACKY (to Joe):
In your community practice, how do you know if the woman is happy to have a male midwife?

JOE:
I do not ask everybody, because it's like saying, "there's basically something wrong with me, but do you mind if I care for you?". In hospital there is a much more realistic choice. Before I took up my community post, I put out feelers via the community midwives to see what the response would be. If I visit anyone who appears to be anxious about my presence, I broach the subject and get a female colleague to take over.

HEATHER (to Joe):
Has anyone ever said "No!", without being aske

JOE:
Not often, but it is easier to say "no" when you are on home ground, than when you are in hospital.

HEATHER (to Sally):
(The same question)

SALLY:
I feel that women in our area would get quite abusive if they didn't want a particular person to care for them. They are generally very accepting of our male colleague. It could be his own personality.

SOO:
This illustrates the power that men have. If he had been a woman then he would not have been so significant. To a woman who has been abused, the very worst female midwife is better than the male midwife. Women will willingly hand over power to men. Men and women are seen as very different in the same situation. Men's skills are seen as superior, even though they are the same. Incidentally, the larger proportion of nurses struck off for abuse are men.

JULIE:
Is it possible that because male midwives do have to struggle, we are going to get the cream of men in midwifery? And women will learn more about choosing, about stating their views and about thinking about their choices.

ANNE:
To focus on the question of choice, it is important to recognise that women who have been sexually abused have a very low self-esteem, which makes it difficult for them to make a choice. They are so vulnerable and it's too much to even ask them to choose.

JO:
It is probably easier to refuse to be attended by a student, and more difficult to refuse a qualified practitioner since most women would choose to be cared for by a qualified practitioner.

JOE:
As time went by I began to feel more useful as a student, but at the beginning I felt like an intruder. Of course, it is more difficult for male medical students to observe labour and delivery than for their female colleagues. Women have more choice with students, because they know they don't have to be there.

MEG:
I don't recognise this maternity unit everyone is talking about, where women have a choice of midwife!

Childbirth and sexuality are very much connected, I had two homebirths myself because of my fear of being inhibited in hospital. Birth is a sexual act, and not one to be performed in a public hospital, with strange men around.

SOO (to Meg):
If the male midwife had been known to you, would it have made any difference?

MEG:
I don't think so.

JO:
If the male midwife was gay, would it make any difference? And if we talk about this, we must also consider gay female midwives!

SUE (to Meg):
As a woman making choices about your delivery, did you ever think about seeking out a male midwife?

MEG:
No.

SOO:
In Derby a study has shown that a small percentage of women would choose to have a male doctor.

JOE:
A female midwife who had trained with me asked me to deliver her.

ROWENA:
How often do women know how to contact a midwife, female or otherwise? It is also important how well you know and trust your midwife.

PETER:
As a student midwife, I am randomly assigned women to care for, and one woman said she was more able to trust a man.

SOO:
The issue is that there are excellent male midwives, but what happens at the extremes of care, where a woman has been abused?

JANE:
What women value most is trust and communication.

ALI:
The element of choice is dependent on numbers. If the number of male midwives was so divided to allow for choice there would be two per unit!

SOO:
It is important how you choose the men.

SANDAR:
I feel the system is changing; women are changing. They should be seen as healthy individuals.

CELIA:
We are only looking at the male midwife in the labour ward. What about the other parts of the job? We are trying to involve male partners in labour.

JO:
Historically in some societies, no men are involved at all. How is it that we selectively let them into one area but not another?

JANE:
Women can make that choice for themselves.

JO:
Most women are worrying about real life issues at present.

AMANDA:
How many of you have actually worked with a male midwife?

(About 14 of those present said they had).

CLAIRE:
When women first entered the medical profession they had to be better than men, not equally skilled. Now male midwives have to be better than their female colleagues.

CELIA:
How many women see childbirth as a normal event? Men may make it abnormal.

GERALDINE:
Important points are – personal, intimate and private. The only way to achieve these is in teams.

(When asked how many mothers present had been attended by a male midwife, nobody raised a hand)

## Summing up – Jane Tucker

It would be useful if the six panel members would write up their presentations for the next issue of *Midwifery Matters*, to include the Equal Opportunities legalities, and any recorded incidents of discrimination. It was good that everyone had looked at the issue from the aspect of the present day, and were open to change. On behalf of the meeting, Jane thanked the six panellists for their presentations, and Jane Grant for chairing the debate.

(Comments after the meeting indicated that a vote at the end of the debate would have been useful).

## Arm business

**ELECTION CAMPAIGN GROUP** – The group, (nicknamed the M62 Group), completed their first task by getting UKCC election campaign posters printed and posted to ARM Local Contacts, RCM Branch Secretaries and every Midwifery establishment. The mailing was well timed, arriving only one day after the Ballot Papers. Deb Hughes, link worker for the group would like all members to consider potential nominees for posts on such bodies as RCM Council, UKCC (20 places still to be filled, by appointment of Health Secretary, after election is completed), RCM National Boards, etc. These vacancies often arise with short notice and the function of the Election Campaign Group is to have a selection of people who have agreed to be nominated should the need arise.

**ARM ROADSHOW** – At the AGM Sally Herbert was given approval for the purchase of a display stand, which she set up at this meeting. She volunteered to travel around the country, on invitation from local groups needing a boost to their activities and attendance, (e.g. setting up the ARM display during the day, perhaps in antenatal clinic, and attending an ARM meeting in the evening). There are already several requests for this service. Sally says she could give 10 hours per week at her present E grade salary, (she works part-time). Shelley, (the Treasurer), confirmed that we could afford this, and the meeting voted unanimously for Sally to run the Roadshow for 1 year initially, and the future of the project would be decided after a review of the results, in terms of increased membership, more viability of local groups, increased sale of ARM items and general widening of awareness of our aims. It was accepted that some of these objectives will be difficult to assess, and the decision would also depend on ARM's state of finance at the time.

**MIDWIVES JOURNAL** – It was rather significant that fewer than ⅓rd of those present knew that ARM edits this quarterly supplement in the Nursing Times. This shows a need for us to give greater publicity to this fact in our own publication. At present Claire Flook and Hannah Hulme are our editors, though Hannah left UK several months ago, and has not been replaced. Claire is looking for a replacement for herself also, after editing the Journal for two years. She told us that N.T. has a circulation of 250,000, and invited members to submit articles and study-reports for consideration. The question of conflict between *Midwifery Matters* and MIDWIVES JOURNAL was brought up, but this does not seem to have been a problem over the 7 years since N.T. first invited ARM to edit M.J., commissioning work which reflects ARM's philosophy. Articles between 900 – 1500 words are needed, and are paid for. A recent issue had carried advertising, which had been unacceptable to ARM, for which we received an apology, with reassurances that similar adverts will not be placed in future. N.T. already respect our firm ban on adverts related to artificial feeding of infants.

**LETTER TO THE HEALTH SECRETARY** – Ishbel reported that she had recently drafted a letter to Mrs Bottomley, and following consultation with members of the Steering Group and others, the final draft will be posted in January, and at the same time a Press Release will be sent to the Press Association. The letter reads as follows:

Dear Mrs Bottomley

We are most concerned that some General Practitioners are misleading women who attend them for maternity care, by giving inadequate and sometimes incorrect information.

The majority of phone calls and letters to our organisation are from women who feel they have not been treated fairly by their doctors, many have been told that homebirth is not allowed,

others feel they were ignored when decisions about their maternity care were being made. Examples of the statements being made are:

*"For a homebirth, the midwife must have the backing of a GP, and none of us in this practice will agree to it."*

*"Homebirth is not allowed for first babies."*

*"Mr X, (the consultant), does not allow homebirths."*

*"Just sign here, Mrs A. You'll get an appointment in the post to see Mr X at the City General Hospital."*

The Patient's Charter advocates freedom of choice and encourages people to become more aware of their rights in health care. A firm directive from your department to all GPs will inform these doctors of the distress which they are causing and the risks they take. We request that you issue such a directive as part of the Government's policy of widening the choices for consumers of the National Health Service. The result must surely be a more responsive and enhanced Maternity Service.

We would like the Directive to remind doctors of the following:

**1 Access to maternity care does not depend upon referral from her GP.**

Although at present most women apply in the first instance to their GPs, there is no legal requirement for GP referral in order to obtain maternity care.

**2 The GP must inform pregnant women of the options in maternity care, including pattern of antenatal care, choice of consultant and place of birth.**

Too often, a woman choosing or needing hospital birth is denied any choice as to which hospital to attend and which consultant to see, this decision having been taken by the GP without discussing the matter with her.

**3 Women must not be coerced into signing any paper during the initial visit, but must be given time to consider the options before making any decision.**

Every pregnant woman must be informed that signing a "contract" for maternity care does not preclude any subsequent change of plan, and that her signature merely enables the GP to claim payment for yet another maternity case on his list.

**4 A doctor unwilling to support a woman's wish for a homebirth must not allow personal opinions to dictate a course of action to women seeking maternity care.**

There is sufficient research data available to show that birth at home is no less safe than in hospital for the majority of healthy women with normal pregnancies. While GPs are within their rights to decline routine support for a booked homebirth, they have no right to give false information, and are behaving unprofessionally if they do so. They have a duty to refer the woman to the Senior Midwife at the local Maternity Unit, and to advise the woman of her right to register with another GP for maternity care.

**5 It is not permissible to tell a woman that she is not ALLOWED to give birth at home.**

The decision on place of birth belongs to the woman and her family. Professional advice may be given, and most women will modify their plans when convinced of a genuine need to do so. However they have the right to reject advice, however well-founded, and the maternity services still have a legal obligation to provide the best possible care in the circumstances.

**6 It is the duty of the doctor to inform the woman that expert assistance (the Obstetric Emergency Service), is available to her midwife, AT ALL TIMES, REGARDLESS OF PLANNED PLACE OF BIRTH.**

This service is provided for all obstetric emergencies outside the consultant unit. No doctor should seek to frighten a woman against homebirth by a refusal to attend a birth at home. This raises the spectre of the midwife frantically phoning around all the GPs in the area for help, and is often the deciding argument for many women, who then abandon the planned homebirth, and subsequently nurse a long-term resentment at having been manipulated against their will.

We hope you will accede to our request. A Directive on the above lines from your Department would underline the Government's commitment to enhancing the standard of care offered to pregnant women, and would be in the interests of everyone concerned with maternity care in the UK. As you are no doubt aware, many of the Health Service cases reaching the Courts concern misinformation.

In order to increase the awareness of women concerning the issues discussed above, we have sent copies of this letter to several National Newspapers, in the form of "An Open Letter to the Health Secretary". We have also sent a copy to Baroness Cumberledge for consideration by the Expert Committee on Maternity Services.

On behalf of the Association of Radical Midwives,

Yours faithfully,
**Ishbel Kargar SRN, SCM**
*(Admin.Secretary)*

**MIDWIFERY MATTERS –** Nobody will be sorry to learn that we have finally changed our printers! It was heartening that people were still complimentary about MM, apparently ignoring the constant typesetting errors, and judging by the content! The new company will help with design and layout, making Sandra's work much easier. They are based in Cardiff, eliminating our previous communications problems. Sandra only has Polly Ferguson helping her, and they would welcome more input, especially from local

members. Sandra emphasised the importance of all ARM member treating MM as their own journal, and not as a remote publication which arrives on the doorstep from somewhere "out there"! Please, send her all your news, what's happening in your area, write about your problems, how you solved them, etc.!!!

**INTERNATIONAL CONGRESS OF MIDWIVES** – We have two representatives on ICM Council, (elected at the AGM three years ago). They are Caroline Flint and Soo Downe. Council meetings are held during the week before the Congress, which of course involves extra expenses for accommodation, etc. Last time, ARM gave a donation towards this extra expense, and the Steering Group has agreed to do so again. (Caroline will not be able to attend the Council meetings this time, but ARM's two votes can still be used by the remaining delegate). ICM also offers the opportunity for each member organisation to send Observers to the Council meeting, but as space may be limited we have to send names in beforehand. We already know of several ARM members who are planning to attend the Congress, and it was agreed that Ishbel would send a circular to local contacts, asking if anyone is able to spend an extra week in Vancouver and would like to attend Council meetings as an Observer. (Apparently, as Council procedures are rather hard to grasp, this is an opportunity for potential delegates to learn the ropes!) If more than one or two people ask for this facility, a ballot will be held for priority listing.

**CHILDBIRTH ISSUES ON RADIO AND TV SOAPS** – Julie Steer reported having spoken to Graham Hardy (script-writer for The Archers), about the lack of discussion of current issues in childbirth. The result was not encouraging, but our meeting resolved that everyone should write and comment on this issue, when the situation arises in their own favourite TV or Radio programme. This is one way of raising awareness.

**WEST CUMBRIA H.A. POLICY ON CARING FOR RELATIONS/FRIENDS** – There had been several responses to this item in the last issue of MM, but it was pointed out that the RCM had already dealt with the matter satisfactorily. Such policies are unlikely to be drawn up elsewhere in future, but we must be ever vigilant.!

## Workshops/Discussion Groups:

Listening Skills for Midwives – led by Pat Ingham
Viewing and discussion of two videos by Nicky Leap – Antenatal Groups, and Homebirth.
Father's role in childbirth – led by Nick Ingham
Caring and Sharing – led by Rowena Richards

**Surprise closing session:** A most enjoyable group session of relaxation, chanting, singing and movement in which everyone "let go". – led by Sue Parlby

**HUGS AND HOME** – The meeting was quite successful, and was enjoyed not only by ARM but by the old people who's premises we were borrowing. They enjoyed seeing the small children around, and the strange sounds coming from our room during the final session brought quite a few curious people to the door. Many thanks to the Cambridge/Huntingdon members for a really well organised and enjoyable day.

**"CHOICES IN CHILDBIRTH" LEAFLET** – Ishbel reported that this leaflet is now out of stock, and the Steering Group decided that instead of reprinting as it is, it will be completel[y] revised first. Four members of the Steering Group have agreed to take this on, and hopefully will have the new leaflet ready for distribution in February. They are Jane Tucker, Amanda Moult, Sarah Montagu and Hilary Mathieu.

**THE VISION DOCUMENT** – This is also out of stock, but because it is on the required reading list for various courses in Midwifery an[d] related subjects, we decided to reprint as it is, with an explanatory foreword which will state our intention to set up a new Working party at the 1993 AGM, to prepare a new "Vision". Recent titles (since 1986) will be added to the bibliography. The price, which has been £1 sinc[e] it was first published in 1986, is to be raised to £2.

NB. If you have a supply of Vision booklets which you are not using, please let Ishbel know

**ACCOMMODATION AND CRECHE AT ARM MEETINGS** – Our hostesses had asked that the following problems be aired during the meeting: ARM has always offered overnight accommodation on the evening before National Meetings, because of the long journeys some members have to make. These members are invited to sit in on the Steering Group meeting, which always takes place at this time. This of course involves the provision of food as well as sleeping arrangements. However, lately we seem to have become a little casual about letting the Hosting Group know we are coming. This has begun to cause problems with catering, as guesswork is useless if people turn up in greater numbers than were expected. The same applies to the meeting itself, and although we have nev[er] demanded prior registration, it is only courtesy to let people know you intend to come. If everyone remembers to do this, then the few people who suddenly find they are able to come after all can be catered for without any problem. The Creche is a little different, as it involves workers wages and insurance fees, both of whic[h] have to be paid whether the creche is used or not. For this reason it is essential to book crech[e] places in advance. Guidelines for Hosting Groups are being revised to reflect these points.

## Evaluation

Evaluation forms were used for the first time at national meeting, so we have included a brief

analysis of the feedback.

Midwives and student midwives attended the meeting, of these, 24 out of 55 returned the forms.

The majority of the comments were very favourable and most people had enjoyed the day. "The meeting had a real buzz to it". Only one person replied that they had not gained much from the day. Two people felt that the day could have been better structured and there were three comments suggesting that business matters overran into lunchtime leaving people "hungry and fidgety". Several others commented on the importance of time-keeping and using time effectively.

Six midwives said this was their first ARM meeting, six their second, one their third and 11 members had attended "lots"! All said they would attend another.

It was acknowledged that the facilities had been cramped but that the meeting had been friendly and relaxed. Several people had not been able to find loos. The creche was very popular. Two said it was the first time they'd used one; were impressed and would use it again. Everyone commented that the food was delicious, albeit a bit sparse for those at the back of the queue.

There were a few positive comments on the panel discussion on male midwives. The workshops evoked little comment (it needs a specific question on the form), except that the father's role in childbirth had initiated some angry and divided responses. We felt this could have been suppressed reaction from the morning's panel discussion.

The 'surprise' chant session was commented on by many to be a wonderful end to the meeting.

One person summed the day up as "energy, enthusiasm, solidarity and support".

I have sent a copy of the evaluation form used – with improved amendments! – to Ishbel, for anyone hosting future meetings who would like to use it.

SARAH WERRELL,
*Cambridge, December 1992*

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D O N ' T F O R G E T

## SPRING NATIONAL MEETING 20TH MARCH 1993, 9.30 – 4.30

KINGS HEATH COMMUNITY CENTRE, HEATHFIELD ROAD, BIRMINGHAM

Midwifery implication of Female Genital Mutilation

Plus workshops on many other aspects of midwifery practice

£8 members, £10 non-members

**Please notify your intention to attend – this helps with catering.**

Telephone 021 444 2257 or 021 449 2326

Julia Allison currently Chair for RCM Council will hopefully stand for President

# President For The Royal College Of Midwives *Nominations Invited*

The current President for the Royal College of Midwives will retire in December 1993. Members fulfilling the criteria set out below are invited to nominate themselves for this position supported by ten sponsors, four of whom must be serving on council.

**Criteria:**

- Fully paid up member of the College.
- Served on council for a minimum of three years within the preceding ten years.
- The term of office will be three years commencing in January 1994. Thereafter she will be eligible to stand for re-election for one further three year term of office.
- The closing date for nomination forms to be returned is Friday 13th March 1993. Nomination forms available from:

**The Administrative Officer**
**RCM Headquarters**
**15 Mansfield Street**
**London W1M 0BE**

**BUSINESS**

# Joint ARM/RCM/ASM Meetings

Resumé of the meeting on 7th December. Frances Black attended on behalf of ARM, Jane Grant was unable to attend.

In the Chair: Ruth Ashton
(Next meeting – May 1993 – to be chaired by Rosemary Jenkins)

ARM had received a copy of a document from South East Thames H.A. entitled "Midwives Arrangements for Supervision". Frances took it to the meeting, and asked the rep. from the Association of Supervisors of Midwives if they knew of any plans for it to be used as general guidelines throughout the NHS. Their response was that as far as they are aware there are no plans to use the review in this way.

There was a proposal to formulate a joint statement concerning the demise of Head of Midwifery posts throughout UK, to be targeted at NHSME and MPs. Frances added that the question of competencies of the named Head of Service should be included in the letter, as they need to be people who are capable of representing Midwifery issues at Board level. In general ARM is in agreement with such a statement.

Concerning our request for co-signing our letter to Mrs Bottomley, (see page 22) RCM was not keen to support us, saying that since it was ARM's problem, we should deal with it. Eventually the Supervisors thought something should be done and agreed to send the letter out for consultation with members. ("Good Practice" Guidelines to be published early in 1993, which may address the problem).

Frances says the meetings are very useful in keeping open channels of communication. ASM and ARM representatives have often asked for a representative of RCN Midwifery Section to be invited to the meeting, but this has not yet been agreed.

About the meetings in general, Frances believes there should be a more structured approach, perhaps identifying specific objectives in order to get more positive returns. She herself has twice raised the issue of RCM bidding for research monies from sources other than the Government, in order to further midwifery research. She says she will continue to push for this.

**NB**. These meetings were initiated by ARM in 1988, and have been held infrequently since the first one held in September 1989, and Jane Grant was one of our first representatives. She now wishes to step down and we are therefore looking for someone to take her place, in partnership with Frances Black. (See advert "Can you fill this gap?" see below).

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# CAN YOU FILL ONE OF THESE GAPS?

**EDITOR FOR MIDWIVES JOURNAL** – Since 1985 at the invitation of Nursing Times, ARM has provided a succession of commissioning editors for this prestigious quarterly supplement. Claire Flook has done the job for the last two years, assisted by Hannah Hulme. Claire would like to stand down this spring, and Hannah is no longer in UK. This is an exciting and rewarding job, offering an insight into the world of publishing. The editor has the responsibility to commission features from colleagues and others, and may also submit her own writing. The Journal contains topical issues in midwifery from an ARM viewpoint, including short research studies and opinions. Approximately two editorial meetings per quarter are held at the Nursing Times office in London, travel expenses refunded. In addition to the post of Editor, two or three assistants are needed, in different regions of UK, who can canvass locally for people to write for the Journal, and provide a wider geographical input. It will not be necessary for these assistants to attend editorial meetings on a regular basis.

**I.C.M.** – ARM has two seats on the ICM Council. At our AGM in 1989 we elected Soo Downe and Caroline Flint to represent us on ICM Council. Caroline is no longer able to fulfil this role, and we are therefore asking for nominations to fill her place. If there is more than one candidate, we will make the selection by voting at the September AGM in Manchester.

**JOINT MEETINGS ARM/RCM/ASM** – We have two representatives attending these meetings, which are very useful, and enable an exchange of ideas to take place between ourselves, the College and the Supervisors. Frances Black and Jane Grant have attended on our behalf so far, but Jane needs to stand down. It is essential that we have a replacement. The group meets about every three months, usually in London.

**ARM STEERING GROUP** –
There are now three vacancies on the Steering Group to make the full complement of 12 elected members. Also Sally Herbert will be standing down at the end of her first term, (she is eligible for re-election if she so wishes).

Please consider joining us on this dynamic and influential group. The Steering Group has a responsibility to respond to suggestions from the membership concerning the directions taken by ARM, and is also able to initiate action. Four regular meetings per year, (the Friday evenings before National Meetings and AGM), plus occasional extra-ordinary meetings when necessary. Travel expenses for official Steering Group Meetings are re-imbursed.

**If you would like to take any of the above jobs, please contact me as soon as possible,**
**Many thanks.**

**Ishbel Kargar**
**(Secretary),**
**62 Greetby Hill,**
**Ormskirh,**
**L39 2DT**
**(0695 572776)**

# REGIONAL MEETINGS – A NEW VENTURE

Although ARM has always tried to rotate the venues for the quarterly National Meetings in a way which gives as many members as possible the opportunity to attend at least one or two each year without a long journey, this has not always been possible. The venues for these meetings depend entirely on local groups offering to host them. I mooted the idea of several local groups holding an occasional Regional Meeting, with the same ARM support which is available for National Meetings. This idea has been taken up by the Poole and Bournemouth members, whose offer to host the 1993 Summer National Meeting was unfortunately overlooked.

The notice below gives details of this inaugural ARM Regional Meeting. Members in the South West are particularly invited to attend, though of course people from elsewhere in UK will also be welcome. (For obvious reasons the usual travel refund facility will not be offered). Another "first" will be the opportunity to pay a reduced registration fee by booking in advance. The organisers feel this will help with catering and planning venue facilities.

## SOUTH WEST REGION ARM MEETING

9.30 – 5.00 SATURDAY MAY 8TH 1993
POST GRADUATE CENTRE, POOLE GENERAL HOSPITAL, LONGFLEET ROAD

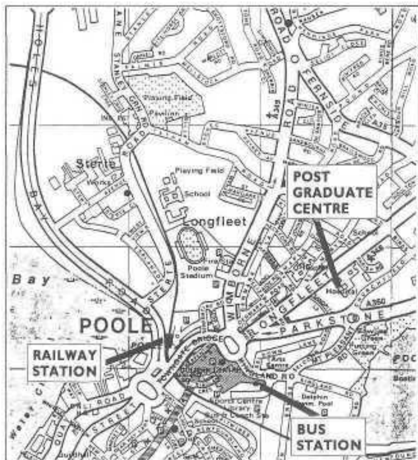
THEME FOR THE DAY:

## MIDWIFERY LED UNITS

TWO MAIN SPEAKERS:
ONE FROM BOURNEMOUTH MIDWIFERY-LED UNIT
ONE FROM THE ROYAL COLLEGE OF MIDWIVES

PLUS VARIOUS WORKSHOPS AND DISCUSSION GROUPS AFTER LUNCH.

COST: £5.00 IF BOOKED UP TO 1 WEEK IN ADVANCE, £7.50 AFTERWARDS AND ON THE DAY.




**HOW TO GET THERE:**
From Poole Railway Station, ½ mile walk. From the Bus Station, numbers 101, 102, 103 stop outside the hospital. By Car: A31, A348 then follow signs to Poole Town Centre, (this road goes past the hospital.

**IMPORTANT:** PLEASE NOTIFY US BEFORE 3RD APRIL IF CRÈCHE FACILITIES ARE NEEDED.

FOR FURTHER INFORMATION CONTACT: GLYNIS RAWLINGS C/O BOURNEMOUTH MATERNITY UNIT, CASTLE LANE, BOURNEMOUTH, OR AUDREY WAREHAM – 0202 479953

## Are you going to Vancouver?

Several members who are planning to attend the ICM Congress in Vancouver have rung in to ask if there are any other ARM members going, and whether there would be a chance to meet each other. If you are planning to go, and would like to meet up with other ARM members from UK or overseas, please contact me as soon as possible, then I can put you all in touch with each other via a circulated list. Some have suggested sharing accommodation and car-hire costs.

Ishbel Kargar, 0695 572776

# LOCAL ACTIVITIES

Below are the reports from local contacts based on the latest questionnaires. Some reported "no change" since October 1992, and these are listed under "Meeting times & venues". (*For a more detailed account of these groups please refer to Midwifery Matters issue no.55 – Winter 1992*) For addresses and telephone numbers of contacts please see inside back page.

## BRISTOL
**Ceri Evans**

Regrouped in July 1992. Meeting every 4 weeks in members houses. Average attendance 10-16. Advertised by posters in both maternity units and in health centres for community staff. First few meetings rather free-form.

## EAST YORKSHIRE
**Linda Allen**

The area covers York, Scarborough, Whitby, Malton, Bridlington and Beverley. Meetings are held occasionally, in Scarborough Hospital or members' homes. Significant local changes include movement for waterbirth facilities at Scarborough, Team Midwifery at York. Fax machine for domiciliary fetal monitoring at Whitby and Malton. The local contact reports difficulty in arranging meetings, but feels that local practice reflects ARM philosophy, also educational/ professional updating is good, leading to a general awareness of new ideas.

## HERTS
**Alison Heywood**

The area covers Watford, Hemel Hempstead, St Albans, E.Herts Q.E.II Hospital, and Lister Hospital. There is a small group of about 6 members, hoping to meet more frequently in future. Topics discussed so far include: Changes arising from Trust Status; new General Manager; Midwives Journal (ARM's voice in Nursing Times); failure of public campaign to prevent St Albans Maternity Unit moving to Hemel Hempstead. Significant local changes include restrictions on part-time posts – bank work offered instead; poor staffing levels generally; new Maternity Unit at H.H.; clinic service only at St Albans, but home delivery rate is rising, and not discouraged, due to enlightened community midwives and their supervisor.

## CORNWALL
**Linda Greenstreet**

The area covers Treliske DGH, the GP unit at Penrice, St Austell and DOMINO unit at Bude, (N.Cornwall). At present no meetings are held, and Linda would welcome help in getting a group started. There are around 11 ARM members in Cornwall. Significant local changes include: 1. Community midwives come under Community Healthcare Trust, hospital midwives under a separate Hospital Trust, which is at present having financial difficulties, one postnatal ward has been closed. 2. A review of services in St Austell is imminent. There is a feeling that Penrice is under threat as a GP unit and may become a DOMINO unit. Linda feels that women in Cornwall get a generally high standard of care and continuity, having good access to their community midwife, with few visits to consultant clinics.

## SHEFFIELD
**Mavis Kirkham**

Area covered: Jessop Hospital and Northern General Hospital. The group of 6-8 meets in members' homes, either evenings or daytime, no fixed day. Non-members welcome. Recent topics include hypnosis for childbirth; birth in Cuba; Vitamin K. Significant local changes are that both units are starting Team Midwifery, but with large "teams". It is still too soon to see the effects.

## SCOTTISH HIGHLANDS
**Victoria Wall**

Area covered includes Raigmore Hospital and Highland Health Authority. Some local resistance to ARM, problems with the concept of "RADICAL", equating it with "bra-burning", obstinacy for the sake of it, etc. Consequently a "Journal Group" has been initiated, to stimulate interest in research, questioning routine practices and changing some aspects of care, as well as offering support to each other. The Journal Group meets monthly in the Staff/Student's Common Room in the College of N.& M. at Raigmore, Inverness, from 7pm to 9pm. The day varies, meetings advertised by posters. The inaugural meeting was held in November, topics planned are: January – "How to carry out a literature search" (into Vitamin K), led by a local librarian; February – A discussion on the use of Vitamin K, using literature.

## KENT
**Diane Garland**

Area covered includes Canterbury & Thanet H.A., Ashford, Maidstone, Medway. Meetings are held every 2 months, usually on Mondays, from 8pm, average attendance is 6-14, with no restrictions. Recent topics include Direct Entry (Pre-Registration) Midwifery Training; Midwifery "USA" style; Parentcraft Tips.

## PORTSMOUTH
**Donna Williams**

Meetings changed to 1st working day each month at 7.30pm in room B27 at St Mary's Maternity Hospital. Topics during last three months: Possible closure of GP Unit; Midwifery in Third World; Meeting local UKCC candidates (joint mtg with RCM). Involved in fund-raising for TENS unit for hire to local women. Significant recent changes: GP Unit transfer to Consultant Unit is "on ice" at present.

## LANCS (EAST)
**Yvonne White**

Significant recent development: Fairfield General Mat.Unit, (near Bury) have stopped weighing antenatally.

## W.GLAMORGAN
**Claire Rees**

Meeting monthly, last Wednesday at 7pm, venues vary, (members' homes). Recent topics: Role of the midwife; Continuity of Care; Pre-registration Midwifery Training.

## LEAMINGTON SPA/ COVENTRY
**Val Hollier**

Still meeting monthly, on Wednesdays 7.30pm. Topics since last report: Teenage pregnancy – report from MIDIRS Study Day, (Val Hollier); Aromatherapy, (Vicky Halliday); Bereavement counselling, (Karen Walker). Significant recent changes: Informed choices and involvement in decision making; Use of Domiciliary Fetal Monitoring.

(some without GP medical cover); Midwives discharge women from Unit, including Labour Ward; Clients' self-administration of some drugs.

**NOTTINGHAM/DERBY**
**Amanda Moult**
The day varies to accommodate those with regular commitments on a particular day. Meetings held in the evenings at 7.30pm in members' homes unless larger venue needed. Topics since last report: Winterton Report; Pros and Cons of Breast feeding. Significant recent changes – waterbirths more available at both Nottingham Hospitals, "Genesis" scheme in Mansfield, i.e. more midwife-led care. Planned meetings: February – Alternative Therapies.

**FARNBOROUGH AREA**
**Helen Kennedy**
Still meets monthly, 2nd Monday 8.0pm, in members homes. Recent topics: Syntometrine, when & whether to give it; Men in Midwifery; Management of prolonged rupture of membranes. Recent changes: Triple Test; increase in routine scans; "temporary" ward closures.

**WEST MIDLANDS**
**Sarah Montagu**
Area covered: South Birmingham, East BHA, West BHA, Solihull, Dudley. Meetings held monthly, on 2nd Tuesday, at 7.30pm, at varying locations. Recent topics: Midwifery in Zanzibar (Marian Millington); Acupuncture in Midwifery; Caring/Sharing. Events organised for fund-raising: Baby sitting service (on-going); Car Boot Sale.

**GLASGOW/WEST SCOTLAND**
**Mary Kennedy**
Health Board areas covered: Greater Glasgow, possibly Argyll & Clyde, Ayrshire & Arran, Western Isles, Lanarkshire, umfries & Galloway, and Borders. No regular meetings yet, but first one planned for Paisley in March. Please phone for details. Recent deveopments: new Midwife Development Unit at Rottenrow (Glasgow Royal Maternity Hospital) is getting underway in January 1993; Ruthergien Maternity Hospital is under threat of closure, (local women & midwives campainging to save it); rumours of further closure in Glasgow, so watch this space!

**DORSET**
**Glynis Rawlings**
Area covered: Poole, Bournemouth and surrounding areas. Monthly meetings on 3rd Wednesday, in members' homes, starting 7.30pm. Recent topics included a discussion of the non-midwives' interpretation of the expressions used by midwives. Future topics: Suturing, is it always necessary?; Preparation and emotional support for women undergoing emergency procedures; Caring & Sharing Sessions, (by popular request).

**YORKSHIRE (LEEDS) BRANCH**
Next meeting will be on Thursday 18th March, 7.30pm, at 37 Springbank Crescent, Gildersome, Morley, Leeds. Phone 0532-539087. Rosemary Derby will tell us how her local unit instigated Team Midwifery. Non-Members very welcome.

The following meeting will be on Thursday 20th May, 7.30pm, at the same venue. Olga Parker will discuss her trip to Canada's International Congress of Midwives.

Meetings are to be quarterly, between ARM National Meetings.

**Other groups – meeting times & venues**
(Previously reported. Local Contact details inside back page)

**CAMBRIDGE**
Monthly, 1st Wednesday, 7.30pm, venues vary.

**NOTTINGHAM/DERBY**
Monthly, evenings, no regular day.

**GRAMPIAN**
Monthly, 1st Thursday 8pm in A/N Clinic at Aberdeen Mat. Unit.

**SOUTHAMPTON**
Monthly, last Wednesday, 8pm, Kate Walmesley's house.

**GLOUCESTER**
Every six weeks, usually in members' homes.

**MANCHESTER**
Monthly, second Tuesday evening, in members' homes.

**FARNBOROUGH**
Monthly, second Monday at 8pm, in members' homes.

**LONDON (NORTH)**
Monthly, 2nd Monday, 8pm, Holland Street Clinic, 9-11 Holland Street, London W8.

# LETTER

## Midwives Interest Group

The monthly meetings are not ARM meetings but a 'Midwives Interest Group' which came about by means of a support group for local midwives, some two and a half years ago.

It has since expanded and evolved and each meeting now consists of about 6-30 midwives attending depending on topic or speaker. The main aim of the Interest Group is to share information and also for support for each other.

We follow a 'loose' agenda and a roaming chairperson is responsible for drawing up the agenda. We meet in midwives' homes and find this a relaxed meeting place and generally there are lots of offers for 'housing' the next meetings!

At most monthly meetings we have a speaker who is usually one of the local midwives who will present a current topic she may be researching or report back on a Study Day she attended.

The group has discussed the Winterton Report at some length and during October, we invited our local MP, Gyles Brandreth, to come and meet some Chester midwives to discuss The Maternity Services Report. Our comments were noted and hopefully taken back to Parliament.

Other areas may wish to set up a group like ours in their districts and anyone who needs guidance or advice, please telephone.

Hope this may be useful for further ARM magazine.

JANE GRANT
*Regional Contact – Cheshire*
*Tel. 0244 319577*

# LETTERS

## Unlawful Discrimination

Further to the recent seminar/discussion on 'Men in Midwifery' at which I was one of your guest speakers, as stated by me the position with regard to Employment Legislation is quite clear. The Sex Discrimination Act 1975 is intended to render discrimination on grounds of sex and/or of marital status, unlawful as regards those areas of employment not dealt with by the terms of the contract to which the Equal Pay Act applies.

It should be noted that it is possible to seek an exemption under the Act on the grounds that being a man or a woman is a "genuine occupational qualification". Section 7 of the Act provides for this.

However, being female is not an occupational qualification that is required for Midwifery training and in addition it is difficult to see (following a decade of men entering midwifery training) how such a case could be made retrospectively, particularly as there is no evidence available which suggests that their involvement has in any way been detrimental to the interests of mothers and babies.

Finally, I would just say that I do agree with the sentiments expressed by Soo Downe that in cases where women have been subject to abuse by men in the past, that it is conceivable that such women would have difficulty in being looked after by a male midwife. However, since difficulties are not peculiar to midwifery, the Police Department for instance allocate women only officers to female rape victims, I am sure that with a little imaginative management at Local Level, such difficulties could be overcome in Maternity Units.

Yours sincerely,

JOSEPHINE O'CONNOR (Miss)

## A Matter of Choice

I have been a 'sleeping' member of ARM for many years and have been tempted to write on more than one occasion, never quite managing it before the next magazine is published! I am, however, not going to let the directive from West Cumbria Health Authority beat me.

If women are to be allowed choice in any aspect of their care, surely those who have friends or relatives who are midwives, should be allowed to choose to have them to care for them if that is their wish! I feel it is a privilege to be asked to care for someone during pregnancy and/or labour, particularly if I have cared for them before, and I will make myself available to them, if it is at all possible. I have delivered several of my ex-students, at their request and am currently caring for one now in her third pregnancy.

We are professionals and should be able to make the correct decision in any situation, whether the woman is a close friend or not.

Yours sincerely,

KAY GREENISH

## Reply to Lorna Tinsley, Issue No.54, p.9

*Midwifery Matters* is certainly a challenging read! I enjoyed very much the last issue and found plenty of food for thought. I have great admiration for midwives and midwifery skills. As an NCT Antenatal teacher I find *Midwifery Matters* a valuable forum for discussion of the issues and a source of support for both midwives and mothers.

I was disappointed that Lorna Tinsley saw the publication of someone's (unhappy) birth report in an NCT Newsletter as an attack on midwives. I understand that as the woman felt betrayed by her midwife, anaesthetist and the 'delivery', that those concerned would feel upset that despite caring for this woman to the best of their ability, and within the restrictions of the system, they were unable to provide what she wanted, with unhappy consequences. I also understand that they would feel distressed for the woman concerned.

But why direct hurt and anger at the NCT for publishing this woman's experience? Should we only publish glowing and grateful birth reports? Or none at all? Would this be fulfilling our aims of 'Education for Parenthood'? Should we be sworn to secrecy about less than positive experiences?

Birth reports are popular among the readership of NCT Newsletter. When our local newsletter doesn't have one available to publish, it is missed! All over the country local NCT groups and branches publish birth reports in their newsletters. These tend to be either very positive or very negative, and it's these extremes of experience which motivate women, (and in some cases their partners), to write them and send them in. Most editors ensure that the reports don't mention names, and they are usually published some time after the event. A selection will provide a range of experiences, and editors usually try to achieve a balance of positive and negative reports over each year. (If we published only good reports we would be reinforcing the (mistaken) idea that NCT is idealistic!) Both good and bad are a stimulus for discussion.

I feel the role of birth reports in any publication, (including *Midwifery Matters*), is to:

- give a woman/couple an opportunity to debrief their experience, which can help them to accept and come to terms with it;
- give other people (including midwives) an opportunity to learn,

from another's experience, how labour might feel, what might happen, ways to cope, things to avoid;

– give an insight into options available locally, to enable others to make informed choices;

– give an insight into the emotional side of giving birth.

Birth reports are obviously not published with the aim of upsetting midwives!! I can understand Lorna's desire to protect herself and others from unwanted criticism but although it is unpleasant, we should be able to learn from negative feedback. Reading negative birth reports can enable midwives to understand how medical care is perceived from the parents' point of view, and how some parents can feel absolutely devastated by a 'bad' experience. The psychological effects can of course last a long time.

In the case of the birth report in question, a pregnant woman reading it might well have felt swept along by the author's distress. Don't you think she can stand back and say, "that was her experience – not mine". I don't think any pregnancy is free from fear – aren't we all afraid, deep down? Surely accepting our fear is healthy, but denying it is not. I don't think reading others' birth reports causes fear, but it may increase fear, especially of the 'system' that does not allow women to make reasonable choices.

If I were having a breech baby and had read that report, I might have been forewarned enough to look around for an alternative place of birth, where external cephalic version and natural breech birth are acceptable options. Of course, the end result could still be the need for technology to "lend a helping hand to ensure mum's and baby's health". Perhaps having been able to opt for the choices I'd wanted initially, might help me feel positive about the overall experience, regardless of the loss of my ideal birth. I would have been more in control of the decisions, which is essential to my mental health.

Lorna does not attempt to justify the unit's policy on breech births. Nor does she challenge it. Instead she apparently prepares women in her classes to comply with the policy. Is this informed choice? In Kate Isherwood's article in the same issue, she asks if midwives are "with woman" or "with policy". From what Lorna says there seems to be some justification in the mother's feeling of anger, disappointment and being cheated. This mother wanted options which were not available at the hospital where she was booked. She was prepared very well by the midwives' classes for what was available, but this was not what she wanted. How can you "negotiate with a caring team", when the options you want are denied to you!

It is surely inappropriate for Lorna to direct blame at NCT. Perhaps her feelings of frustration should be directed to challenging and changing the system? And to providing debriefing and support after the birth.?

The NCT and midwives are natural allies and can work well to inform and support parents and each other, and to improve the service. Are we really battling against each other? I think not!

Best wishes,

STEPHANIE KEENAN

## Natural allies

Thank you for your response to my article on 'A Birth Story' in a contact magazine. I feel that you have missed the point. Rather than an attack on NCT my article was a plea that midwives (the people who are there at delivery) recognise the many facets that make them whole and use them to the women's advantage.

I was concerned that this particular article was published. The customer is always right and..... perceptions of her labour and care is as she described. The midwives, my own and the obstetrician's perception was very different. I have no desire to protect myself from just criticism as I want to be a better midwife.

This woman was prepared through parentcraft for the options available in this hospital, the NCT provided information on alternative ways of delivering a breech. As an ARM midwife I tried to give the alternative viewpoint but we failed her because we did not do it together. The point of my article was that NCT, ARM, and midwives are natural allies but this time we did not work together. We did not help this woman.

On 16th March the RCM, NCT and the Maternity Alliance will be working together to hold a conference and rally. We are all here to improve things for women and their families. This rally is part of working together. My article and your responses are also playing their part in helping communication between the many groups who are supporting women today.

Thank you for your reply.

LORNA TINSLEY

## Information Wanted

I am undertaking some work on the use of frameworks, theories and models in midwifery practice. Frequently people express the view that no models or theories are used in midwifery practice but I am sure that there are many midwives who have given this issue a great deal of

thought. I would be interested in hearing from anyone who has developed and is using their own model or framework or who has adapted a model from nursing, health promotion or other fields which they are using. What are the benefits of having a framework; what were the difficulties of developing the model?

I would also be interested in hearing from anyone who has any views on this rather contentious topic!

I am currently working in the area of primary health care with Teamcare Valleys but still think, at least in relation to the topic of individualised care in midwifery, that I can describe myself as a research midwife!

*Midwifery Matters* is always very thought-provoking and informative and has been my main means of keeping in contact with what is or what should be going on in midwifery!

Thanks for your help.

Yours sincerely,

ROSAMUND BRYAR
***Teamcare Valleys***
***Whitchurch Hospital***
***Whitchurch***
***Cardiff***
***CF4 7XB***

***Tel. 0222 520750***
***Fax 0222 520814***

## Safe Childbirth for Travellers

I am writing to introduce the Safe Childbirth for Travellers Campaign (Scotland) with a view to you helping us gather information.

Following the publication of the Maternity Alliance report on the health of Traveller mothers and babies, a group of Travellers and non-Travellers began meeting in London to consider ways of campaigning to improve conditions for Traveller mothers and babies.

The main aim of the London Safe Childbirth Campaign is to establish standard procedures with all public and local authorities whereby they inform themselves of the health circumstances of Traveller families on unauthorised sites and take the needs of pregnant women, mothers and babies into account before considering eviction. Traveller women around London often experienced difficulty in securing access to maternity services and many have been evicted from sites close to birth or with a newborn baby. Save the Children Fund in Scotland, who have initiated the campaign here, feel that there is evidence to suggest that a similar situation may exist here.

The initial meeting of various health professionals, SCF workers and Travellers was held in Dunfermline, Fife on 31st August and a contact list of possible groups and individuals who might become affiliated with the campaign was drawn up.

Could you send any information which you may already have, e.g. Traveller women who may have contacted you for help in arranging a homebirth or who may have experienced difficulty in gaining access to her local maternity services, you can send to me at the enclosed address.

I look forward to your support.

Yours faithfully,

CAITLIN P. HEAVEY
***Association for Improvements in the Maternity Services***
***Fife Branch (Scotland)***
***10 Back Street***
***Freuchie***
***Fife KY7 7EJ***

***Tel. 0337 57040***

## VBAC

Some time ago, I contacted you for information regarding achieving a vaginal delivery after my first child was born by caesarean. To jog your memory, my son Alex was born at 28 weeks following premature rupture of the membranes. He was breech and was delivered through a vertical incision (although the skin incision was horizontal). Thus it was termed a 'low vertical' lower segment caesarean section (LSCS). However, due to the premature time of delivery, the lower segment had not formed properly, making the incision more of a midline classical. Alex had to be delivered quickly due to acute fetal distress even though my contractions were still mild. At delivery, it was found that the placenta was pale and unhealthy and had been coming away before the birth.

All this was traumatic and frightening, but I had no reason to suspect that these events would repeat themselves. So when I am 'told' I cannot deliver any further babies in the normal manner because of the risk of scar rupture – I am devastated. I had hoped that next time would be better. Another caesarean did NOT appeal!

This is where you came in (apologies for this circular letter, but I wrote to a lot of people!). I contacted you for information – any information on VBAC after a classical incision. Everybody I contacted helped me with some snippet of information or referred me to someone else who they thought could help. AIMS, The Maternity Alliance, Active Birth Centre, Association of Radical Midwives, NCT, Special Delivery, Marie Wren, Mr. Yehudi Gordon, Linda Howes, Ann Dally, Jenny Fraser, Mrs. Wendy Savage, and the book 'Silent Knife'; these are most of the people who helped me in some way, large or small. Thank you all so very much.

After reading Linda Howes' story in the AIMS journal (on VBAC), I decided to contact Mrs. Wendy Savage in a last ditch attempt to avoid an unnecessary repeat section. I was over thirty weeks by this time.

Well I did it! My baby daughter, Sally Christine, was born at the Royal London, Whitechapel on 28th October 1992 after an eight hour labour. The whole experience was better than expected. There was no continuous monitoring, no drip, no 'interference', and I managed on entonox – if 'managed' is the right word, with the amount of noise I made! I tore on delivery, but those stitches were nothing to a caesarean. The third stage was also physiological – Sally's cord being left alone until it had stopped pulsing. She never left our side once and we were home the next day. The statistics for rupture of classical scars performed at 28 weeks have not been computed, but the risk must be very small indeed, and as we all know, all pregnancies, labours and births carry some element of risk.

My recovery from Sally's birth was rapid with none of the depression present with Alex's. I can now get on with life, enjoying my family to the full. My caesarean scar healed three years ago but it took Sally's birth to finally heal my mind. I never thought I could do it.

but I did and if I can, ANYONE can! Please help spread the word that a classical section does not necessarily mean a repeat section. Providing the next pregnancy is normal and none of the problems that caused the last section re-occur then anyone who wants to try for a VBAC should be able to, even with a classical incision. It really is worth all the effort!

Thank you once again for your kindness and support. I couldn't have done it without you. Best wishes.

Yours faithfully,

MRS. JACQUELINE GEORGE

### Who to Believe?

What is our profession coming to?

I have just been to see a woman in my care after discharge from hospital.

At first sight, it seemed all had gone well, *normal* delivery, only entonox for pain relief, lovely healthy little girl. Her husband wasn't so sure.

Should it really have been his responsibility to argue with the midwife as to when the last examination was carried out? It seems there was a change of shift following a vaginal examination and the midwife forgot to document this. We're all human I hear you say and yes it would be forgivable if the next midwife had taken the woman and husband's word for it, but that's where the argument came into it. She would not accept that the woman had been examined one and a half hours ago and not longer as the notes said and that the husband knew his wife's cervix had dilated to 5cm. I really don't think they would have made up something like that just to make more progress (if only it was that easy).

It makes me so angry when tales like this are told and I know it is not that unusual.

By writing to *Midwifery Matters* I am preaching to the already converted but the more we are aware of this the better our practice can be.

Yours sincerely,

LYNNE COE

*PS She also had a 1200ml PPH and manual removal with no explanation of cause but that's another story.*

### Continuity

I have followed the debate about male midwives with interest and like, I suspect, many, I find myself unable to be completely decided on my views.

Without a doubt, the comfort of the mother is paramount and, unfortunately, in our society the historical struggle of men and their power over women does go a long way to reducing a woman's feeling of control and could lead to an unnecessarily difficult labour.

I also believe, however, that there must be many men who would make very good midwives and it is a shame that their skills and compassion should be wasted.

We may not be able to change thousands of years of male domination over women, but if we can look at the issue and follow the principle – I believe to be fundamentally important, even essential, but alas rare, in the care of pregnant women – CONTINUITY, the problem could resolve itself. If the INDIVIDUAL woman got to know the INDIVIDUAL midwife, male or female, over the months prior to the birth and came to trust them completely the issue of fear of domination should not arise.

Any comment gratefully accepted.

Yours sincerely,

JENNY CARTER

### Women in Need

After reading the article about the West Cumbria Health Authority and their policy for caring for friends/relatives in labour I feel I must comment.

In the last few years as a hospital and more recently community midwife I have cared for six close friends, one cousin and a couple of colleagues in labour. More importantly I have cared for them before and during pregnancy and post natally up to this day. This care has included support during and after two miscarriages, one termination for abnormality, home deliveries, a caesarean section and numerous other 'normal' hospital deliveries. There have also been many other friends and acquaintances who have requested my care and one friend who chose not to know the midwife who cared for her in labour.

All these cases have been tremendously rewarding, tiring, emotional, created special bonds between friends, lasting memories and are still a joy to me.

SO WHAT ELSE IS NEW? ISN'T THAT BEING A MIDWIFE?

My points are these:

All women should be given the best possible care. Ideally women should have the choice of a midwife that they know, who is a 'friend' and ally to them.

Midwives must be confident to give professional and competent care, make the right decisions and take the correct action to benefit the woman.... any woman.

If the parents have confidence and know their midwife, difficult decisions can be made, well laid plans may not materialise, occasional disasters may happen but how much better it is to have a caring friend with you and hours/years afterwards to talk things through.

Stop yourself sometime during the day and say....

"If this lady was my best friend how would I treat her, am I giving the best care?"

Real job satisfaction comes from doing just that.

ROSIE PARKES

# GLEANINGS

## Breastfeeding

Researchers at Newcastle Polytechnic are developing a way of predicting which women are most likely to give up breastfeeding..... Once out of hospital, it seems, women are at the mercy of their own mothers, who had babies in the Sixties, when bottles became big business....."We've discovered that the most important question is, 'How often do you see your mother?' The more they do, the less likely they are to breastfeed".

Grannies aside, much of the blame can be laid on the infant formula manufacturers, which supply their products free to maternity wards. Farley's, for example, recently offered hospitals £18 for every baby fed on Ostermilk, and a lump sum of £24,000 if all were fed on it and mothers were persuaded to continue when they left.

The Government is examining ways of legislating to end such practices, but their impact is clear: the number of babies being fed on formula milk at four months has almost doubled since 1985, despite mounting research demonstrating its inadequacy.

From "*MAKING BABY HIT THE BOTTLE*", by Tessa Thomas, in THE INDEPENDENT, 29.12.92.

## Vitamin K

Until recently it was believed that vitamin K prophylaxis at birth is essential for the prevention of haemorrhagic disease of the newborn (HDN), which is potentially fatal to the newborn. A recent British study by McNich & Tripp (BMJ *1991; 303:1103-1109*) has quantified the risk of HDN. They found that the risk of the disease was 4.4 in 100,000 if no vitamin K were given, 1.4 if oral vitamin K were given and only 0.11 if intramuscular vitamin K were administered.

Professor Golding used these figures and her own study to do a risk-benefit analysis of vitamin K use. She found the following per 100,000 newborns:

– if no child received any vitamin K then there would be about 30-60 cases of HDN.
– if all received oral vitamin K there would be 10 cases of HDN and no extra cancers.
– if all received intramuscular vitamin K there would be one case of HDN and 980 extra cancers.

.... it may be prudent to use oral rather than IMI vitamin K.

.... Professor Webster of University of Sydney's Anatomy Department, who has studied vitamin K and birth defects, explained that the normal pregnant mother and fetus have very low blood levels of vitamin K. He explained that there must have been some evolutionary advantage in being relatively vitamin K deficient, which overrides the risk of HDN. The advantage is as yet unknown.

From: *The Communique* (Journal of the Australian Society of Independent Midwives), page 22, Vol.4 no.4 (Winter 1992)

## Electronic Fetal Monitoring

A report issued by the Senate Committee on Human Resources estimated that in 1978 the costs of fetal monitoring added up to over 80 million dollars.... and that the hazards of using the technology added up to over 300 million dollars in unnecessary caesarean sections resulting from misreading information from fetal monitors and in risks to the mother of death and pelvic disease..... Electronic fetal monitors were introduced into American maternity care 20 years ago without objective verification of their value. Initially developed as a technique for closer observation of the high-risk delivery, it became the standard of care for all births.... established despite prospective, randomised studies which found fetal monitors to be no better than intermittent auscultation in preventing neonatal problems..... However the story of the use and misuse of electronic monitoring in USA is not surprising, for we are a society which looks to technology for the solutions to our problems, and pours countless dollars into new machines to monitor and regulate deliveries, while allowing thousands of children to be born to mothers without adequate nutrition and prenatal care.

From: "*A CRITICAL LOOK AT ELECTRONIC FETAL HEART MONITORING*", by Elizabeth Graninger, in BIRTH GAZETTE, Fall 1992, page 23.

## Tobacco Advertising

**Norway:** Smee carried out the first full econometric study of the 1975 Norwegian Tobacco Act, testing two models. One suggested a long-run cut in consumption of 9%, the other 16%, with the great majority of this effect due to the advertising ban, since other measures in the Act were minor.

**Finland:** A detailed study of the Finnish advertising ban has found that it produced a 6.7% reduction in cigarette consumption.

**Canada:** The ban in January 1989 has already produced a 2.8% drop in consumption.

**New Zealand:** Of the 7½% immediate drop in sales in the six months following the December 1990 ban, Smee attributes 5½% to the ban and the rest to other factors.

From: A.S.H. Newsletter, "*WHAT THE SMEE REPORT SAYS*", November 1992.

## KY Jelly

"I personally don't use KY jelly; it contains chlorhexadrine gluconate, which the Physicians Desk Reference warns is not for use on mucous membranes."

From: the letters page, *MIDWIFERY TODAY*, Autumn 1992

## Herpes Simplex Virus: Some Facts

- HSV is as common as chicken pox (Varicella Zoster Virus).
- At some time in their lives almost everyone comes into contact with HSV, and are infected with either type I or type II, or both – with or without symptoms.
- If you have type I facial infection, you cannot contract a type I genital infection later.
- HSV is contracted through direct skin to skin contact with an active infection.
- Once you have the virus you cannot re-infect yourself. For instance, you cannot transfer infection from mouth to genitals, genitals to mouth, mouth to fingers, etc.
- You cannot re-infect your partner if the two of you have the same type of HSV.
- It is possible to have the first noticeable infection of HSV many years after contracting the virus. So the sudden appearance of symptoms during a faithful relationship does not mean your partner has been sleeping with someone else.

From: "*HERPES – THE REALITY*" by Alison Innes, in WOMEN'S HEALTH NEWSLETTER, no.16, 1992

## Unwanted Pregnancy

The British Pregnancy Advisory Service (BPAS), in attempting to dispel the myth that no one using contraception correctly need become pregnant, state that the price for perpetuating this myth is paid for in the guilt and shame felt by women in need of abortion. Women, the report suggests, are now expected to be efficient, organised and in control of their fertility.

The BPAS try to help women come to terms with these feelings and "live in peace with themselves".

Most women do use some form of contraception, but the 'responsible' 70% are not immune from pregnancy. 16% of women requesting abortion are on the pill, whilst a further 36% are using condoms.

Although there will inevitably be some user error, the BPAS suggest that instead of 'blaming' women, we should "question the almost inhuman standards of perfection expected of women in this most embarrassing, risky and confusing area".

**Taken from: Women's Health Newsletter, No.15, 1992.**

## Images of Infant Feeding

A member of the La Leche League, writing in LLL GB News, comments on her disappointment at the contents of a children's book 'Visiting the New Baby'. On opening the book at the page where children visit the hospital to see their new baby, she discovered that the illustration showed a mother bottle feeding. She wrote to Mothercare – the sellers of the book to express surprise at Mothercare unwittingly promoting the image of bottle feeding, as the philosophy of the store is to support breast feeding. Mothercare's response was to confirm that whilst it was appreciated that breast milk was best milk for babies, the decision on how to feed the baby lies solely with the mother. Because of this Mothercare offer a range of products to "complement natural feeding". However, in light of the negative comments, Mothercare's marketing manager was informed.

**Taken from: LLL GB News, July/August 1992, No.71.**

## Softgut – Condemned But Still Being Used!

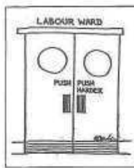
In the mid-1980s... many midwives acquiesced in the promotion and introduction into their practice of a persuasively marketed new suture material to repair perineal trauma (glycerol-impregnated catgut, "Softgut"). Had Jennifer Sleep and her colleagues not conducted a randomised controlled trial to compare the new catgut with an existing, standard alternative (chromic catgut), it probably still would not have been recognised that glycerol-impregnated catgut results in a substantially increased risk of pain and discomfort, which was still detectable three years after suturing. (Table 2, Grant et al 1989).

Unfortunately, in spite of the fact that these findings were published several years ago, it appears that this suture material is still being used in some British maternity units. How would the midwives working in those units defend themselves if a woman who had been sutured with glycerol-impregnated catgut explained that her relationship with her partner had broken down because sexual intercourse had proved intolerably painful? Even if midwives had not been responsible for ordering or using the suture material (and in many maternity units they are), could they really abdicate all responsibility for the adoption of this harmful practice by other professionals working with them!

From: "*EFFECTIVE CARE IN MIDWIFERY*" paper given by Iain Chalmers at RCM Annual Conference, July 1992, reported in MIDWIVES CHRONICLE, January 1993, page 4.

## "New" Way to Check Dilatation

One of the marvellous advantages of working abroad is the great techniques and tricks we can learn from other cultures. When Molly Lasser was in Russia, she learned a trick for checking dilatation externally, but hasn't had time to test it. We hope you will try it and let us know your results. Apparently Russian midwifery textbooks state that just above the




From: *PRIVATE EYE*, 4 December 1992

symphysis a ring forms in the muscle as labour starts. This subtle ring, (not Bandles ring), moves upwards with dilatation. One finger above the symphysis indicates a cervical dilatation of about 4cm, and two fingers indicates about 8 cm. Measurement is taken during a contraction. If this technique is accurate, imagine the wonderful ramifications for premature rupture of membranes, for sexually abused women and just for general respect of the labouring mother.

From: Sent in by "Jan", for "*TRICKS OF THE TRADE*", in MIDWIFERY TODAY, Autumn 1992.

### The Safety of Ultrasound

In America the Food and Drug Administration (FDA), have advised against 'frivolous' use of ultrasound in pregnancy. They suggest that scanning should only be used if there is a history of bleeding, birth defects or some other specific medical reason can be identified.

**Taken from: The Complete Mother, Fall 1992, Vol.27.**

### London's Museums of Health and Medicine

A leaflet produced by the London Museums Service lists a fascinating array of museums that are open to the public, (although some are by appointment). The Royal College of General Practitioners and the Royal College of Obstetricians both have extensive collections of medical objects, instruments and medical folios on display, whilst there are regular 'tours' of Britain's oldest surviving, purpose built, operating theatre, in the roof of a Christopher Wren church, once the chapel of St. Thomas's Hospital.

**For more information contact London Museums Service.**

### NB

Perhaps ARM members should consider reviewing children's books related to childbirth and inform publishers of the inaccuracies that appear in them. Many of these books refer to birth attendants as nurses, and give the impression that it is either the nurse or the doctor that assists at the birth.

## BOOK REVIEWS

### The American Way of Birth

**JESSICA MITFORD,**

Victor Gollancz Ltd., 1992

In a recent review, Wendy Steiner criticised this new book by Jessica Mitford as being "tame and self-serving" (London Review of Books, 17th December 1992). Tame, in that it tells us nothing new about the system of care in the US; and self-serving, in that it is too personal. It could be considered neither a useful consumer manual nor an incitement to social reform, says Steiner.

But the beauty of this book is precisely that it is neither a consumer manual nor an incitement to social reform. It is simply a well written and entertaining perusal of the history of midwifery in the USA (and UK) from medieval times to date. Though highly anecdotal, it is also well researched and written with great conviction and enthusiasm. Mitford, who is British but has lived for many years in the United States, was prompted to write the book after her own experiences of childbirth (1937-44), both here and in the US, and from a curiosity about the anomalous situation for midwives practising in the USA. Her curiosity took her all over the States, visiting practising midwives and interviewing mothers. Her conclusions, which will come as no surprise to most midwives, is that the increasing domination of childbirth by male obstetricians has led to an alarming increase in the medicalisation of childbirth, particularly in the caesarean section rate.

As Steiner says, this book is no exposé. However, it does take a critical look at the effects of the increasing medicalisation of childbirth and the demerits of a system of care governed by profit rather than quality. The comparison of the American system and the British one leaves Mitford in no doubt that midwives on both sides of the Atlantic can and do deliver a quality service which is well worth defending. Rather like a tonic, this book refreshed my enthusiasm for midwifery, whilst reinforcing some unpleasant facts about the current state of our health care system.

FRANCES SLOAN

### Homoeopathy For Midwives (and Pregnant Women)

**PETER WEBB,**

published by BHA, 1992

This 44-page booklet has been commissioned by the Homoeopathic Association in response to a growing interest in homoeopathy by many midwives. It is intended as a complement to conventional midwifery skills from the beginning of pregnancy to the end of the post natal period and has been written in consultation with midwives from the John Radcliffe Infirmary, Oxford.

Set out like a consultation manual, this booklet is easy to read and consult. The introduction explains about the remedies and how to identify the constitutional picture of the client. Subsequent chapters cover a homoeopathic history taking, and common problems in the three trimesters of pregnancy, such as miscarriage, anaemia, vaginal discharge, hypertension, Braxton Hicks, and malpresentation. A chapter on labour deals with remedies for preparation for labour, uterine inertia, and PPH. The last two chapters of remedies deal with breastfeeding difficulties and common problems in the neonate, colic, septic spots, and night crying. For any midwife who feels confident in the use of homoeopathy, this is a useful booklet with which to advise women.

FRANCES SLOAN

**NB.**

Midwives wanting to use homoeopathy in their clinical practice should take heed of paragraph 39, p.34 in 'Standards for the Administration of Medicines' (UKCC, Oct. 1992), and also make sure they have read 'The Scope of Professional Practice' (UKCC, June 1992).

# EVENTS

The prices for advertising in the Events column are as follows:

**£20 – profit making ventures**
**£10 – voluntary organisations and charities**
other prices on application

*Please contact:*
Sandra Arthur
(0222) 711765
*or send details to*
71 Plymouth Road
Penarth
S. Glam
CF6 2DD

*STUDY DAY*

**11th March.**
NATURAL MIDWIFERY
An ENB approved study day at Hinchingbrooke Hospital which will include topics such as natural/active birth, water for pain relief in labour, nutrition in labour and aromatherapy in the ante and post natal period. **Cost £15**, please bring your own packed lunch. For details please send SAE to
*Miss I. Milner, Maternity Unit, Hinchingbrooke Hospital, Huntingdon, Cambs., PE18 8NT.*

*ROYAL COLLEGE OF MIDWIVES, WEST BERKSHIRE BRANCH*

**Thursday 18th March 1993**
THE MIDWIFE AND THE LAW
A one day conference
*Kingsclere Suite, Hampshire Stand, Newbury Racecourse*
*Chairman: Margaret Brain, President RCM*

"A Defence Lawyer's Perspective"
*David Mason and Peter Edwards, Solicitors*

"Launch of the RCM Booklet"
*Rory Murphy, Director Industrial Relations, RCM*

"Professional Conduct"
*Sarah Roch, Director of Midwifery Education, Southampton*

"The Patient's Perspective"
*Jean Robinson, Lay Member GMC*

"From the Case Book"
*Andrew Andrews, Freelance Solicitor*

*ENB APPROVED STUDY DAY*

Registration Fee (to include all refreshments) £37.50 (inc. VAT)

Organised in collaboration with the
*SMA Nutrition, Department of Postgraduate Education*

For further information please contact:
*Mr. G. Rivas*
*SMA Nutrition*
*Huntercombe Lane South*
*Taplow*
*Maidenhead*
*Berkshire SL6 0PH*
*Tel. 0628 660633 ext. 4330*

*J.B.I. STUDY DAY*

**11th May, 1993**
"INNOVATIONS IN BREASTFEEDING FOR MOTHERS AND HEALTH PROFESSIONALS"
*With:*
*Michael Woolridge* – Physiology of Breastfeeding
*Mary Smale* – Meanings of Breastfeeding
*Cynthia Ricketts* – Developing and Introducing a New Breastfeeding Policy
*Pamela Eaton* – Breastfeeding in Low Priveleged Areas

To be held at Mid-Staffordshire Post-Graduate Medical Centre, Stafford
Cost £30 includes refreshments and lunch
E.N.B. approved
For booking and further information please contact either:
Janet Manders – (0785) 43481
Fiona Beckwith – (0785) 212592

*BIRTHDAY*

**6th March 1993,**
10th Birthday Celebrations, Women and Childbirth.
**Reading Birth Centre,**
Sheila Kitzinger and Janet Balaskas
Phone for Tickets – £15
0734 478728
0734 421342
0734 698275

*MIDIRS STUDY DAYS*

**25th March 1993 –**
Feeding preterm babies
**Radcliffe Infirmary, Oxford.**

**21st April 1993 –**
Alternative therapies: embrace or reject
**Reading University.**

**18th June 1993 –**
Water birth
**Ninewells Hospital, Dundee**

**7th July 1993 –**
Quality of care
**Sheffield University**

ENB approval has been applied for for all events. Further details from
*MIDIRS, Institute of Child Health, St. Michael's Hill, Bristol, BS2 8BJ.*

# STOP–PRESS!

One hospital in England is offering its first set of qualifying pre-registration midwifery students, posts on a D-grade for 6 months, rising automatically to an E-grade after this time. The reason given is that they will not meet the criteria to hold an E-grade post upon qualification, because they will not have had the necessary management experience to take charge of a ward. This will be provided during the 6 months on a 'D' grade.

What do you think of this decision?

Do you know what is happening in your area?

Write to 'Midwifery Matters' and tell us

# STOP PRESS

A group of Independent Midwives in South East London have been asked by Baroness Cumberlege to try to assess how many midwives think case load practice is a good idea. (See Midwives Chronicle Jan 1993 letters page). The response so far has been poor so please write even if it is only a few lines so that we don't miss this wonderful opportunity.

PLEASE RESPOND NOW
to South east London Midwives practice group c/o Nicky Leap
79 Halesworth rd,
London
SE1 B7TL

# STOP PRESS

UKCC Midwifery Elected Candidates

| | |
|---|---|
| England | Mary Clark<br>Sarah Roch |
| Scotland | Johanna Mathew<br>Helen Campbell |
| Northern Ireland | Mary Uprichard<br>Margaret Unice Foster |
| Wales | Alison Scouller<br>Pam Hughes |

# Notice

If anyone wishes to purchase greetings cards as illustrated in Winter issue no.55, please write to
Maggie Guillon
The Old Farmhouse
Oaks Farm
Moore Green
Nottingham NG1 63QW

# SUMMER NATIONAL MEETING
## *Hexham, Northumberland*

# Saturday 19th June 1993

*Venue*
*Priory School, Dene Park, Hexham*

*Time*
*9.30am – 4.00pm*

Agenda

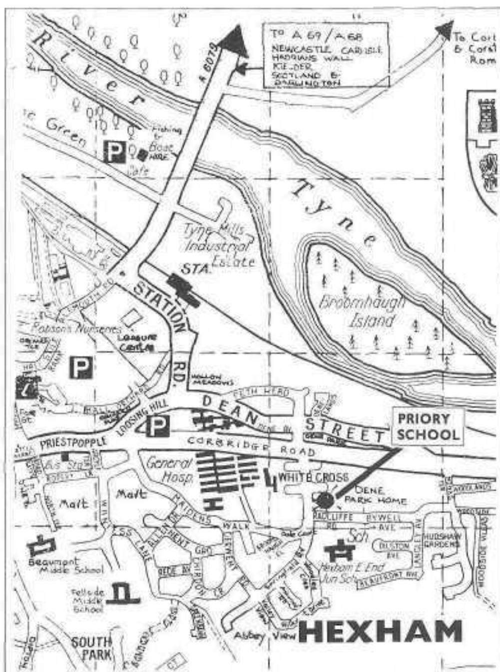
*Saturday AM*
*Coffee and cake*

*Business*
*Post Winterton – Speakers and discussion, including Sue Blennerhasset (CHC and Midwifery), Jean Davies (Cowgate Project) and many more!*

*Lunch – Delicious local delicacies (what is stotty cake?)*

*Saturday PM*
*Workshops around 'choice', 'continuity' and 'communications'*
*Coffee, tea and more cake!*

*Sunday*
*Hadrian's Wall walk*




Parking available outside school

Access for wheelchairs

Hexham is 18 miles from Newcastle and 35 miles from Carlisle. Good train service. The bus takes forever.

Please let us know in advance if you plan to attend. Registration on arrival includes lunch and refreshments – £10 non-members, £8 members.

Crèche available but please book by 31st May.

Accommodation available but advance notice essential. (Bring sleeping bag.) Good local B & B's.

Travel expenses over £10 available to members.

Contact:
*Shona Kerr – 0434 604439*
*Pauline Grainger – 0434 681838*

SUBSCRIPTIONS

## PERSONAL SUBSCRIPTION FORM

(Other organisations, groups, midwifery schools/colleges, etc. please write for details)

Subscriptions may begin at any time of the year, to cover 4 issues of MIDWIFERY MATTERS, beginning with the most recent. Members are entitled to reduced entrance fee at all ARM meetings, refund of expenses over £10 for travel to National Meetings, (not AGM), and free use of ARM Lending Library.

NAME & ADDRESS (please print clearly): ______________________

______________________

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______________________ Tel. ____________

**MIDWIFE** (Please circle relevant status): Community Hospital Team Tutor Student (pre-reg./post-grad.) Research Manager Independent Not Practising Retired

**NON-MIDWIFE:** (Occupation) ______________________

IS THIS YOUR FIRST SUBSCRIPTION TO ARM? YES/NO (IF "NO", PLEASE NOTE ANY CHANGES SINCE LAST SUBSCRIPTION) PREVIOUS NAME & ADDRESS: ______________________

______________________

**SUBSCRIPTION:** UK and Europe ............. £22 p.a.

All other countries (airmail) .......... £30 p.a. (UK£ only please)

Optional half-price concession, unwaged, grant-aided students, etc.,(UK only): ..... £11 p.a.

Please make cheque/P.O. payable to ARM, and post to 62 GREETBY HILL, ORMSKIRK, L39 2DT. **(NB! If you are paying by Standing Order, please fill in both sections, and send the whole form to ARM)**

Introduced by: (name & address) ______________________

______________________

## ASSOCIATION OF RADICAL MIDWIVES STANDING ORDER FORM

To: (Please print clearly the full name and address of your Bank)

______________________

______________________

______________________

Please pay £ ______ ( ____________ pounds) on ________ 19___ and **ANNUALLY** thereafter until further notice to:

**THE ASSOCIATION OF RADICAL MIDWIVES**
Account No. 08783756
National Westminster Bank (01-02-69)
Wilmslow Road Branch
Manchester M20 0RE and debit my account number

**N.B. THIS ORDER CANCELS ALL PREVIOUS ORDERS IN FAVOUR OF THE ASSOCIATION OF RADICAL MIDWIVES**

Signed Date ______________________ Date ____________

Name & address ______________________

______________________

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## INTRODUCE A FRIEND – GET TWO FREE CAR STICKERS !

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# ARM STEERING GROUP (AGM SEPT. 1992)

# HOW TO GET IN TOUCH

### ELECTED MEMBERS

(There are three vacancies still to be filled. Come and join us!)

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**Sally Herbert**
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**Hilary Mathieu**
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**Sarah Montagu**
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### CO-OPTED MEMBERS

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**Soo Downe**
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### EXECUTIVE MEMBERS

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**Sandra Arthur**
(Magazine)
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### ARM WORKING GROUPS

Please join any group which interests you!

| | CONTACT | |
|---|---|---|
| **Election Campaign** | Deb Hughes | 0422 368659 |
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| **Lending Library** | Sally Herbert | 0704 894258 |
| **Midwifery Legislation Group** | Beverley Beech | 0753 652781 |
| **Regional Group Support** | Ishbel Kargar | 0695 572776 |
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| **Student Midwives** | Jo Hindley | 021 449 2326 |
| **Winterton Report** | Frances Whitty | 061 861 0812 |

### ARM REPRESENTATION ON OTHER BODIES

**NATIONAL COUNCIL OF VOLUNTARY ORGANISATIONS**
Suzie Bonifant, 3 North Court, Clevedon Road, Twickenham, TW1 2HS
(081 891 4152)

**JOINT MEETINGS – RCM, ASM & ARM**
Frances Black, Pantyronnen, Aberarth, Dyfed, SA46 0LA
(0545 570117)

(One other representative needed)

**MATERNITY ALLIANCE**
Jane Grant, 54 Panton Road, Hoole, CH2 3HX

**INTERNATIONAL CONFEDERATION OF MIDWIVES** (Council members)
Soo Downe, 34 Larges Street, Derby, DE1 1DN
(0332 294876)

plus 1 vacancy

**MIDWIVES JOURNAL** (ARM's quarterly supplement in Nursing Times)
Features Editor: Clare Flook, 8 Lodge Drive, Hatfield, AL9 5HJ
(0707 262869)

**JOINT COMMITTEE OF PROFESSIONAL ORGANISATIONS**
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ASSOCIATION
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**IS THERE A REGIONAL CONTACT NEAR YOU?**

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