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Regulation Revisited

The Editorial Group decided to concentrate on two topics for this issue: first, a case brought by a woman to the NMC regarding the blatant denial of her wishes during her birth. Jane Ashwell was unhappy with the way she had been treated on transfer from a home birth. In an email to the ukmidwifery list she wrote:

"My complaint was heard by fitness to practise. They closed it with no case to answer (or so I have just been told over the phone) So..."

- It is perfectly acceptable practice to forcibly put a labouring woman on her back despite being told no.
- It is acceptable to inject her with syntometrine despite her saying no and having it written in her birth plan as no, and discussed twice in labour and been refused both times.
- It is acceptable to do a ventouse for FTP when baby's head is visible after three pushes, and second stage recorded as 6 minutes
- It is acceptable to grab a woman by her hair and yank her head forward to make her comply with Valsalva pushing which she doesn't agree with and knows is not in her or her baby's best interests.
- It is acceptable to put someone in stirrups despite them screaming no.
- It is acceptable to do cord traction against written and spoken wishes.
- It is acceptable to refuse a couple access to their baby until woman has had a shower – by physically blocking their path to baby.
- It is acceptable to stand by and do nothing while a woman begs you to get a doctor's hand out of her vagina because he is causing her so much pain while VE-ing without consent.
- It is okay to pass a catheter when woman clearly states she does not consent – ditto the ventouse and the local anaesthetic....

"The fact that I was completely comatos mentis and had my partner as a witness to the whole lot is not sufficient. No wonder so few women complain."

"Where do I go now? Court for assault? Please don't tell me to let it go – if I do I will feel personally responsible for every woman coming out of that hospital with the same story."

Advice on the back of a postcard gratefully received.... JaneA

Members will be aware that this type of behaviour is all too common in some hospitals. In other contexts it would go by the name of bullying, harassment, even torture and, if it happened to a prisoner of war, the soldiers concerned would be hauled up before a court martial, but because it happens to a woman in childbirth somehow it becomes acceptable practice, so acceptable that the NMC said that there was no case to answer because it was “Unlikely to lead to removal from the Register”. Now it seems, bullying is officially condoned by the NMC.

This type of care is given by health care professionals who are so brutalised by the NHS system that they have lost all sense of humanity. It brutalises staff, parents and babies and causes untold mental harm, leading directly to conditions such as post natal depression and PTSD (see MM no. 103, p40), maternal suicide, (now the leading cause of maternal death) and traumatised, depressed mothers unable to bond with their babies. The mental scars carried by that family will persist for years. I would also suggest that the high wastage from midwifery is a direct result of such practice. There comes a time when crying in the sluice, letting off steam at ARM meetings, and long term sick leave is not enough to process the grief and guilt that comes from being an unwilling participant in such a system. The only answer is to leave the profession or to go independent and those who leave are those we can ill afford to lose. The NMC does no favours to registrants if it condones forced intervention. I would go so far as to say that it has brought midwifery itself into disrepute and should no longer include the word in its title. The white-washed midwives in this case were certainly not ‘with women’, they were with doctor, with hospital, with guideline. They must have seen the woman as an object to be manipulated at their convenience.

I would like to think that the NMC’s decision was simple expediency – if failing to support women and failing to prevent abuse meant removal from the Register the NHS staffing crisis would become even more acute – but I fear that such a culture is far more deep rooted. I would like the case to be taken to the European Court of Human Rights, if only to establish that labouring women have the right to be treated as human beings.

Midwifery regulation

If not to protect women, what is the point of midwifery regulation? Not to protect midwives. In this issue, Louise Park describes its history, showing that composition of the various regulatory bodies governing midwifery has rarely favoured midwives. Only at one point in their history have midwives regulated midwives; the Central Midwives Board had only just achieved a majority of midwives when it was abolished to make way for the UKCC; the current NMC has a paltry four midwives. As was reported at the Marsden Wagner day (MM 103, p42), independent midwives are far more likely to face regulatory hearings than those working in the NHS. The undeclared purpose of regulation is not to protect women — if it were Jane would have proved her case — it is to keep midwives under control.

Locally, midwives are kept under control by management and sometimes the statutory instrument of supervi-
Good supervision can protect midwives from dictatorial management but it is often used as a method of making sure that midwives toe the management line. We have a new column from Matilda the Madwife entitled ‘Double Vision’ which allows members to let off steam about unsatisfactory supervision that is getting them down. Do join in the debate.

What is a Midwife?

The price midwives in the developed world paid for their continued existence in the face of competition from doctors was outside control – professional regulation by non-midwives, at first mainly doctors and in more recent years the State itself. The price midwives paid in the developing world for the regulation of the developed world is a very denial of their calling, they were downgraded to ‘traditional birth attendants’, a term approved by ICM and FIGO. Some members of ICM are calling for this degrading term to be abandoned and the term ‘traditional midwife’ to be used instead. These traditional midwives work how we used to work, without the backup of well staffed hospitals, safer surgery, modern technology – and most significantly – transport infrastructure. Read the letter from Edna, a midwife in the Philippines on page 22 of this issue, reread the article on Mexican midwives from our Winter issue. These women are scapegoated for shortcomings in their health systems but they are with women, they are midwives.

Midwifery is the most ancient of professions. Women have been helping other women give birth since time immemorial, and the English language word for such a woman is a midwife, one who is with women. Midwifery was a profession long before the advent of regulation. If anything regulation has demeaned the professional status of midwives – professions are regulated by their peers, midwives are not. Midwives who have the benefit of a professional education have no right to dictate to the rest of the world who else can be labelled ‘midwife’, particularly when some of them have forgotten how to be ‘with women’.

Following that NMC landmark case of ‘no case to answer’, I feel inclined to think that those who will not or cannot be with women should stop calling themselves midwives.

To end where I began, with Jane’s case. It is patently obvious that Jane was denied any autonomy whatsoever in the birth of her baby – but in mitigation – she was oppressed by midwives who are themselves oppressed.

Midwives and women must work together to claw back control over birth from the patriarchal nanny state which is scared to death of strong women. The joint ARM/AIMS conference advertised on page 36 has been organised for just this purpose. We have dared call the day ‘Do Women want Midwives or Obstetric Nurses?’

I know the answer for me at least – Women want Midwives.

Margaret Jowitt
Natural Birth in Germany - an Option for the Future or a Delusion?

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I LIVE IN WESTPHALIA and although we are bordering the Netherlands, things couldn’t be more different on our side of the border as far as the situation of pregnant and birthing women is concerned.

Two to three years ago we had an average caesarean rate of 25%, and it will be even higher now. There is a rumour going about a small clinic in the northern part of Germany and a gynaecologist with a caesarean rate of 15-20% and another one of about 60%! But nobody seems to worry. The hospitals in this country boast of having curtains at the windows of the labour room, cheerful paintings, machinery that is hidden out of sight, candle-light, a “cuddle labour-room”, even big bathtubs — but there is no real decrease in induction, artificial rupture of membranes, epidural anaesthesia, injection of pethidine or psychodrugs, delivery via Ventouse extraction or forceps. In our local hospital, mediolateral episiotomies are performed as a matter of routine as is, of course, endless monitoring. A few years back we thought that things might improve (with the said candle-light and music and so on) but I have the feeling, and all the homebirth midwives I know share this feeling, that things are rather getting worse, albeit, in a subtle way.

For years I have looked after women, watched them, talked to them, but I have one question that has not yet been answered — Why do women agree to all this? Why do they suffer, heroically and in the true sense of the word, what the system is doing to them and to their children? I was not satisfied with the answers I was first given — indoctrination, fear, habit, lack of insight, unwillingness to take responsibility, immaturity, and so on.

Now the perinatal psychologists have added to those explanations — The memories of our own antenatal life and birth are engraved in our unconsciousness forever. So, I started thinking — In which way were today’s mothers born? But, of course, they were born in the seventies and eighties at the height of medically assisted birth, including a wide “choice” of all kinds of drugs! And what about their mothers in the fifties and sixties? ...

I began to realize that there was more to solving all these questions. I started talking to older midwives, looked for old obstetrical books, and found a first answer:

Ever since the twenties women have been treated with all kinds of drugs during birth. That means there are up to three generations of children who were born under the influence of morphine, quinine, Entonox, meprobamates, spasmytics, spasmoanalgetics, psychopharmaceuticals, i.e. valium, analgesics, i.e. pethidine, and so on.

No wonder women have less and less feeling, intuition about the state of a baby, its needs, its fears, its loneliness.

No wonder there is less and less breastfeeding — just consider how a baby feels the difference between a warm, living, pulsating breast and a hard, lifeless bottle? Is there a relationship between getting a bottle in times of need of closeness, love, understanding and taking to the bottle in later life?

No wonder we have more and more juvenile addicts to tobacco, alcohol and all kinds of drugs. But why was there no outcry when two Swedish studies show that most of the juvenile drug addicts were born under the influence of drugs? How can we fail to see the relationship between the Entonox sniffing mother in her moments of despair, pain, and loneliness and the kids sniffing, inhaling whatever it is in their plastic bags to find a moment of oblivion?

For years, many books, articles, conferences have presented these problems but nothing happens — not anywhere! Prevention seems indeed to be an unknown word because it would mean casting doubt on the medical establishment.

The same applies for the ever increasing rate of premature babies. Medical solutions have failed so far, on the contrary, apparently 50% of all premature babies were actually cut out of their mothers’ wombs, i.e., by caesarean. I just wonder how many of those poor children would have stayed inside, maybe even until close to term?

Right now I’m looking after a young woman who was sent to hospital because of preterm contractions. After one week she was reminded by her body that she hadn’t been to the toilet during that time — she asked for a laxative. Thereupon, the nurse called the midwife, the midwife said “monitoring first” and called a doctor, the doctor looked at the strip of paper and said, “We must get it out urgently”, and half an hour later the baby was out of its mother’s womb in the operating theatre — after 24 weeks of gestation! And without a vaginal examination to measure dilatation! Three days afterwards the mother asked “Why?”
and finally got the answer “You had a severe infection” - which they discovered suddenly - at 10 p.m. The baby had to stay in the hospital NICU for 4 months, 25 miles away from home. The child is one year old now and somehow retarded, it still gets different treatments three times per week. The mother will have her second baby next month and the word “caesarean” has already been uttered several times. She very much hopes to have a normal birth this time. Unfortunately, I couldn’t convince her that she would have a better chance if she had the baby at home. She won’t. She’s much too afraid.

I want to finish with a story with a happy end. Little Leo was born 6-7 weeks before term after spontaneous rupture of the membranes. We had planned a homebirth and I was rather disappointed when the father rang at 6 pm. All our dreams seemed to crumble. At first, the mother had no contractions which allowed me to hope that the baby would wait a little longer. To find out where best to take her, I rang four hospitals up to 40 miles away to hear what they could offer. After having explained the situation - primi-gravida, broken waters, baby in breech position in the 34th week, I got the same answer four times: Of course, a caesarean!

I called my friend and colleague Anna, a midwife and doctor, who lives in the same town. She is very experienced in breech and twin deliveries and after careful, painful consideration and the parents begging “Let us stay here” the baby was born in two pushes at 2 am after four hours of contractions. His birth weight was 2020 g, he was very sleepy but well and suckling at the breast. We injected mare’s milk on top of mother’s milk with a syringe - i.e. the father did and he did it excellently! Leo’s weight went down to 1820 g – all of us were concerned – but he was always “well”. Then, he started gaining weight and all of us were relieved and hugged each other.

At times, we were three midwives looking after mother and child as I live 25 miles away. It was a round-the-clock business sometimes and there were moments of fear and doubt. The father was just great at supporting his wife who did nothing but breastfeeding, pumping every two hours at the beginning. This shows it can be done when parents and midwives are prepared to take responsibility.

Afterwards we said: Wouldn’t it have been nice if we had found a hospital saying “You just come and we’ll let the baby come by itself” as we didn’t know how the baby would get along after birth.

In that case, however, we would not have been able to take the baby home after birth - just imagine! The transport back home in December! It was better to be at home and for Leo to lie quietly between his mother’s warm, soft breasts as a first impression of life on this earth!

All in all, I think it was the mother’s very strong belief in herself and her baby, her confidence in being the best person to look after him, her faith in her baby - that little man - that really did it. In addition, there was a father supporting mother and child selflessly for weeks and assuring her he would be there at any time.

When I recall the situation I’m very sure – I dare say – that it was my very close, intensive relationship with and care for the parents – especially the mother during pregnancy – that helped to take the decisions as we did.

In my opinion it is time to think “midwifery” over and to re-establish our talents, knowledge, and wisdom in the community where they belong.
In November 2002 I felt I needed a change from the NHS and a new challenge. Boy did I find one! Accepted for Voluntary Services Overseas, I was offered a placement in the Highlands of Cameroon, West Africa in a health centre on a large cattle ranch which in due course was to become a tea plantation. The change of environment was unexpected; it was cold, wet and windy. I needed wellington boots and thick jumpers and my umbrella was useless. People were friendly and helpful but the isolation and slow pace of life was too much of a contrast to the hectic shifts I had experienced in recent years. As a midwife there was little demand for my skills and many of those consulting me had diseases I had only read about. I had to get down to serious study to understand malaria, schistomiasis, filaria, hookworm, syphilis, gonorrhrea and sickle cell crisis. Although consultations probably averaged three people a day, some days no one came and on others 15 would arrive. Those who were sick expected to be given at least five drugs and hopefully an injection or drip. Typically health personnel treat symptoms not underlying disease and also earn a living from the medicines they sell. More was spent on drugs than on tests to make a diagnosis. My husband Roger had agreed to accompany and support me during this two year placement but having fallen down a pit latrine (fortunately used only for urinating) he developed footdrop and had to come back to the UK for investigation. Eventually the tedium of few patients, loneliness and too little to occupy myself started to undermine my emotional stability and my feeling of self worth. I decided that this was not what I had left everything behind for. I had come to share knowledge, skills and learn about another culture, believing I could perhaps make a difference. For the first time in my life I experienced signs of depression and was determined I had to leave this placement; but I was not ready to come home. Some new friends, my VSO colleagues and their local contacts supported me through this difficult period.

VSO agreed that if I found an appropriate placement I could stay in Cameroon so I embarked on a search in the province for a suitable position. Fortunately I was directed to a Catholic Mission Hospital to be warmly welcomed by the matron who felt that, although she did not have a post for me in the hospital, there might be an opportunity to work in the nearby private nursing school. I left my CV for her to pass to the school’s directress and returned to my temporary accommodation to await a call. My efforts were not in vain.

In December 2003 I joined the staff of the School as a tutor for nursing and midwifery both in the school and clinical setting namely the Mission Hospital. Roger returned from the UK and my life resumed in a positive mode.

The School was started by five sisters of the Franciscan order, in 1954, when they realised that the need for health care and health care personnel in Cameroon could not be met by missionaries alone. Students come here from all over the country and, although many choose to come, many are allocated a place here after passing the Government entrance exam for nurse training. The school offers three year diploma courses for general nursing, laboratory technology and a one year course for nursing assistants which can also serve for in-service training for health care personnel who do not have the qualifications to enter Government Certificate exams. The majority of students board here and we currently have over 150 students in training.

Chalk and talk teaching is the norm and much of it given at dictation speed! Classroom teaching is not really my forte and certainly I had no intention of dictating notes for students to learn by rote. I firmly believe nurses need enquiry based learning but I have had to adapt to the limited resources available. Getting 50 students to do group work involves lots of planning, explanation and then allocating people to groups, otherwise the whole period is wasted as the students try to decide which group to be in and where to sit! They now know after a year that I do
not spoon feed information and that they are going to have to think in my classes. I have improvised for practical teaching and have found balloons amongst other things wonderful resource for demonstrating palpation (when filled with water plus objects) lung expansion, and changes in the uterus (retraction, formation of lower segment, effacement). First Aid even saw me doing chest compression on an under inflated football and breathing on some false lips and balloon lungs before I discovered some wonderful teaching aids in a bag in the store.

Although there is a good library in the school compound, the convent has recently gone on-line and students can access the internet. Sometimes the skills are lacking, but more frequently money is short. I do not only cover midwifery, I was scheduled to teach geriatrics (which being over 50 and a grandma, I have found very revealing), health and safety, first aid, management and sense organs. I had to revisit many topics that I have not looked at in such depth for decades.

The working day starts with teaching or clinical duties from 7am and continues until noon when all staff meet for a meal of local dishes. We break for an hour and then continue until 4 or 5pm (occasionally later) except on Saturdays when we close at 12. There is always plenty to do; preparation of lessons, supervision of clinical experience and group instruction, lectures, practicals and examinations, staff meetings, administration and so on.

In addition I have been:
- working with local women’s groups to share health information
- helping students produce a newsletter
- applying for funding/computers for the school
- holding study days to update qualified midwives
- collaborating with hospital staff to introduce new style records
- working with a group to develop HIV follow up focused on MTCT
- trying to see and enjoy Cameroon’s culture/nature with my husband
- and of course keeping my hands on!

There are so many challenges here, some invigorating, some frustrating. Knowledge is the main need and because of lack of resources, opportunities, priorities and expectations most nurses/midwives have not looked at a textbook since qualifying. Life is very much day to day and centred on what to eat and where and how to get it. Women work from dawn till dusk farming, cooking, raising their families and earning a living where possible. If only I could say the same for men.

Women certainly suffer and their health bears witness to poverty, disadvantage, subservience and tradition. Grand multiparity, severe anaemia, sexually transmitted infections (particularly HIV and syphilis) tuberculosis and sepsis are common diagnoses. The example of a jumbo jet full of women dying every day from pregnancy related causes is now crystallised in my mind, having experienced first hand the sorrowful maternal and fetal losses met on a daily basis. Not a week seems to go by without a stillbirth, IUFD and or a maternal death. Some women arrive at the hospital too ill to cure and we are helpless. Others come but the outcome of their pregnancy is negative. Congenital abnormalities that I had seen only in books occur but there is little hope of treatment here. However, it is not all negative. Twins are plentiful, breech is seen as a ‘normal’ presentation, the caesarean rate is very low, we do not need to spend hours convincing women to breastfeed, everyone helps everyone else as community spirit is high and people say thank you! Hands on skills are excellent, every nurse can use a Pinnard’s, there is no defensive practice and nobody is employed to deal with complaints. Low birth weight babies are very common due to malaria (endemic mainly Falciparum), multiple pregnancy, anaemia (often 7 g/dl when it should because of altitude be 16g/dl) and malnutrition. Surprisingly even babies weighing only 1250-1500g are doing well with good care. We have started giving dexamethasone for lung maturation, we can administer oxygen nasally, we can keep them warm and we are feeding them expressed breast milk by naso-gastric tube or cup until they can suck. As as long as babies can breathe without assistance and we can prevent infection they have a good chance of survival. I have seen very few varicose veins, no DVTs and there is little pre-eclampsia in this area. West African men and women seem to be able to tolerate higher blood pressures than we in the West.

Delivery care still needs to improve but Rome was not built in a day.
- Women are still lying flat to deliver – I seem to be banging my head against a brick wall on this one
- Fundal pressure is common, patience is not! A second stage rarely lasts 15 minutes.
- Episiotomy is routine for primips as the perineum does not stretch quickly enough
• Deep suction with stiff catheters seems obligatory – except when I’m there!
• Babies are suspended by their ankles at birth all wet – bang goes my head again!
• Babies often get glucose for 24 hours as ‘there is nothing coming out of the breast’

I have succeeded in stopping the practice of bathing newborns at delivery. After the suspension with neck extended, then cord cutting and suction babies were usually subjected to a tepid bath, whether resuscitation was needed or not! I have convinced them it is neither appropriate nor safe; we had a spate of cross infection with Staphylococcus that helped persuade them of the risks.

I reinforce rationale for change whenever I can and have been persuading the women not to give glucose by discussing exclusive breastfeeding with them in antenatal clinic. If only I could persuade them to insist on telling the midwives that they don’t want to lie down.

The Delivery Room

The students are taught what should be done but intimidation is the norm here, as a student you don’t challenge nurses and as a nurse you don’t challenge doctors. Remember where we were 25 years ago and how long it took us to change.

What has made the experience is the warmth of the women here and their gratitude for even the small things like:
• Explaining what I am writing in their antenatal card
• Telling them why their baby is not well or why they had a caesarean
• Helping them to breastfeed
• Encouraging them to touch their baby in the incubator
• Valuing their vast experience of breastfeeding.

I have never had such wonderful hugs from strangers and felt so appreciated even relatives show great gratitude for my efforts.

Looking back, my first placement taught me a great deal. I can appreciate distances as I had to walk three hours to a main road and in wet weather vehicles could not climb the hill. I know how little people have to live on, how hard they work and what their living conditions are like. It helped me appreciate their priorities and reasons for attending late for clinics or when very sick. Using public transport while living here rather than having a vehicle illustrates the meaning of access to facilities. Bush taxis only go when full (or over crowded), frequently breakdown and are very uncomfortable, in addition they are slow and are repeatedly stopped by road blocks. Twenty kilometers can easily take two hours.

The School is run by a very forward thinking Sister who has been to America to study and believes she needs people to come from the West, in order to update nursing here. I know there is so much we can do to help and it’s not about donating money and goods, it is about sharing knowledge and skills. The hospital is regarded as one of the best in Cameroon and the School’s graduates are much sought after. If anyone is interested in sharing knowledge and enthusiasm in midwifery with another culture then I can recommend working here.

Graduation of Students 2004

There are many here who have become my friends and I will be sad to leave. I know that we can keep in touch and I hope we will come back sometime in the future to visit them all. It has certainly been an experience for Roger and me, we have learned much about each other’s strengths and weaknesses and our bonds have grown stronger. I owe him a great deal as he has been a magnificent support in often difficult circumstances. He too has had a great adventure exploring Cameroon its culture and its wildlife. It will be wonderful after two years absence to come home to my enlarged family (we have three grandchildren to meet whom we have not seen) and our friends and colleagues. We have been able to keep in touch through the wonders of technology, so home has only been an email or phone call away but we look forward to physical and face to face contact.

The countryside surrounding Shisong

The Cathedral at Kumbo
Who’s Regulating Whom?

Louise Park

This article considers the composition of the first Central Midwives Board (England and Wales) and the Central Midwives Board for Scotland, and examines the level of control that was given to midwives and non-midwives over midwifery education, registration and practice. It will consider the balance of gender, profession and class within the Boards, and explore the differences and similarities between these and the current composition of the interim board of the Nursing and Midwifery Council.

Background
Throughout the 19th century there was demand, mostly from numerous medical professions, for legal control over the practice of midwifery. Various societies attempted to take control of the education and certification of midwives over the years, but without notable success. Many doctors were disgusted by the practice, and regarded it as an affront to society (due to it being a traditionally female activity and, particularly during Victorian times, associated with female sexuality), though this did not prevent them from wanting control over its practice (Donnison 1988, Ridgway 2002, Towler and Bramall 1986). In 1825 with the formation of the Obstetrical Society doctors finally claimed midwifery practice as a medical specialty in its own right, and the Society attempted to bring about regulation of the practice in an effort to exclude those who were unskilled and potentially dangerous to the women in their care. In this, they included other medical practitioners (usually from rival societies, such as the College of Surgeons and the Society of Apothecaries) who claimed to have knowledge of midwifery, but were often ignorant of basic facts of anatomy and physiology pertaining to midwifery.

After a number of attempts by other societies to offer certificates in midwifery (usually to men only), midwifery education finally came under a degree of control by the Royal College of Surgeons in 1872. However, when several members of the Ladies Obstetrical College applied to undergo examination in 1875, the Board of Examiners resigned in protest, despite the women meeting the criteria for examination. During the latter part of the 19th century, there was a gradual relenting of medical opinion, and midwifery certification was offered by the London Obstetrical Society to young ladies of good moral character who underwent specific training and education (Towler and Bramall, 1986).

Some of these midwives went on to form the Matrons’ Aid Society (which became the Incorporated Midwives’ Institute, and eventually the Royal College of Midwives), and campaigned for women’s right to safe midwifery care and for professional regulation of midwifery (Cowell and Wainwright, 1981). There followed a protracted campaign, lasting over twenty years, to introduce legislation for the training and registration of midwives, which led eventually to the passing of the Midwives Act 1902, which applied only in England and Wales, and subsequently the Midwives (Scotland) Act 1915 which regulated Scottish midwives. The implementation of these Acts resulted in the formation of the Central Midwives Board (CMB) and the Central Midwives Board for Scotland (CMBS), which were to govern midwifery education and practice until the Nurses, Midwives and Health Visitors Act 1979 abolished them in 1983 establishing the UKCC (Towler and Bramall 1986).

Composition of the Central Midwives Boards
Membership of the English and Welsh Board was initially restricted to four medical practitioners (representing the Royal College of Physicians, the Royal College of Surgeons, the Society of Apothecaries and the Incorporated Midwives’ Institute), one representative of the Association of County Councils, two nursing representatives and two appointees of the Privy Council. Of these members, only one (appointed by the Privy Council) was required to be female and the midwifery representative had to be a doctor, thus excluding women (who were still barred from medical practice) from this crucial role, though in total three women were present on the first board (Cowell and Wainwright 1981, Jenkins 1995). All of the members were of high social status and thus could not be considered representative of the majority of the midwives whom they were to govern, as midwifery at that time was mostly the province of the poorer women in society, midwifery being likened by the upper classes to domestic service of the lowest sort (Morrin 1992, Warriner 2002).

In comparison, the Scottish board was to consist of two practising midwives and another person appointed by the Lord President of the Privy Council, five registered medical practitioners (appointed by the universities and various medical associations), one public health representative (another registered medical practitioner) one nursing...
representative, and two other members appointed by the Association of County Councils and the Convention of the Royal Burghs of Scotland. This was a more eclectic selection of backgrounds, and though still dominated by the medical professions and the upper and middle classes, the presence of practising midwives on the Board was very progressive for the time (Mander and Reid, 2002).

However, midwives were unable to sit on the first CMBS at its inception, due to the requirement that the midwife member be registered on the Roll of Midwives, and this could not exist until the Board created it. This situation was resolved when appropriate midwife representatives became available, though there was some delay while rules were drafted that would establish the Roll and allow the Board to function initially. Two midwifery representatives finally attended their first Board meeting in July 1916 (Reid 2003, Cowell and Wainwright, 1981).

Out of a total of twelve members, six members of the first CMBS were medical practitioners, so there was the possibility for the medical profession to exercise substantial control over proceedings. However, it does show a certain regard for their profession and ability that midwives in Scotland were regarded as having some contribution to make to their own regulation and education (Mander and Reid, 2002). The other four members of the board were lay members, and of these, two were ladies who were reputed to have a good understanding of the working conditions of midwives, though what this means in practice is unclear (Cowell and Wainwright, 1981). Thus, the total number of women on the board was four.

The Nursing and Midwifery Council Today

In contrast to the situation in the early 20th century, the current Board of the Nursing and Midwifery Council (NMC) is made up entirely of nurses, midwives, health visitors and lay members who are considered to have experience of value to the NMC (Dimond, 2002). There is no statutory requirement for the involvement of members of the medical professions though, as discussed below, there are a significant number involved as lay members.

At present, the Council consists of three midwives (one position being unfilled), four nurses, four health visitors and eleven lay members. There is also a group of alternate members who can attend meetings if their equivalent registrant member is absent; this consists of four midwives, four nurses and four health visitors (NMC, 2004). This group appear to have little influence on the Council, in effect it is there purely to maintain a professional majority for voting purposes (Lewis, 2002).

The professional backgrounds of the lay members are of interest considering the determination of the medical profession to control midwifery in the past (and arguably the present). There are at present four members who are professors involved in medicine, three National Health Service executives, three who are involved in independent health-related organisations and only one member who has declared a midwifery interest (NMC 2004).

Taken as a whole, therefore, only four members of the main council have any declared interest in midwifery out of a total of 22. This is strikingly similar to the proportions that were present in the CMBS in 1916, and demonstrates the continuing reluctance of the establishment to allow midwives properly to regulate their own profession, which was particularly signified by the merging of the regulatory bodies of midwifery and nursing by the Nurses, Midwives and Health Visitors Act 1979 (Jowitt 2004, House of Commons 1979). This abolished the CMB and CMBS, and established a Midwifery Committee with advisory powers (similar to that which exists today), which was easily ignored by the regulatory committees.

The gender balance on the Council is interesting, particularly in the division between the registrant and lay membership. The registrant membership consists of one man and ten women, whereas the lay membership has six men and only five women (NMC 2004). While the registrant gender balance reflects of the gender balance in the nursing and midwifery professions (though not of that in midwifery alone), there appears to be a determination by ‘laymen’ to have a significant influence on their regulation, despite there being relatively few men engaged in these professions and lower health service usage by this group (Office for National Statistics 2004).

Although the class system has undergone substantial change, and in the eyes of some, disintegrated entirely, it can still be said that the NMC is dominated by those who have substantial social, political and economic power. Of the registrant members, the majority are managers, and all are in senior posts; and of the lay members, the majority are professors and managers (NMC 2004). It is clear that this is a significant theme, which is apparent from the earliest attempts to govern midwifery (as discussed above) right through to today.

Discussion

It is seen by some that the main aims of the 1905 Act were to make midwifery a profession to which, like nursing during the same period, young middle class women would aspire, and also to eliminate the traditional, mostly uneducated midwife by making registration difficult for her (Mander and Reid 2002, Heagerty 1996). This difficulty in registering was due to many midwives being unaware of the existence of the Act (whether due to poor communication or deliberate withholding of the information by Medical Officers), and of those who were aware, many could not afford the ten-shilling registration fee (Towler and Bramall, 1986).

Many women were also unable to pay for midwifery training, which became a requirement for registration by the CMB for those who were not already in practice, though when the Midwives (Scotland) Act was brought in, provision was made to allow the Local Supervising Authority to cover the cost of midwifery training when necessary. The authorities by 1915 obviously realised that the greatest need was to ensure that practising midwives were edu-
cated, rather than to exclude from practice those who, through no fault of their own, were not (Mander and Reid 2002, House of Commons 1905).

The status of the midwife went (and continues to go) through a spectrum of change. In the late 19th century, she was seen as a domestic servant dealing with a necessary but unmentionable chore. She has since progressed through a stage akin to that of the manual trades (controlled by the authorities, and being certified rather than registered) to the near-professional stage of the present time, with midwives being registered practitioners governed, if not by themselves, at least in conjunction with health professions having a similar status (Morrin 1992, Fleming 2002).

It could be said that this changing status reflects a parallel change in the role of middle class women in society, as during the same period they went from being ‘mere’ housewives to having a substantial contribution to make outside of the home. It seems probable that there is a substantial connection between the progress made in nursing and midwifery and the role of middle and upper class women generally, with change in all these areas being largely driven by reformers such as Emily Pankhurst, Florence Nightingale, Ethel Bedford Fenwick and Rosalind Paget.

There is still much demand for change, with many midwives actively campaigning for the removal of the new requirement for midwives to provide evidence of good health (presumably by means of a certificate from a medical practitioner), and to have their own governing body rather than one dominated by the nursing profession, or at least an advisory committee within the NMC with substantially more powers than at present (Dimond 2002, Woodford 2001, Privy Council 2002). There is also a campaign to gain recognition, through the wording of the Nursing and Midwifery Order 2001 (which currently uses the pronoun ‘he’ throughout), that the majority of nurses and midwives are female (Association of Radical Midwives 2001, Privy Council 2002).

It is ironic that the vast majority of campaigning midwives of the late 19th and early 20th centuries, such as Rosalind Paget, rather than being practising midwives, were upper class matrons, superintendents and managers of charitable organisations who were unlikely to have put their nursing and midwifery training (if they had any) to any real use, but who used their social standing to gain control of the profession for their class rather than their gender (Heagerty 1997). They ensured that the practice of midwifery did not impinge on that of the doctor, and created a new profession which dealt only with ‘normal’ labours, and which was of suitable social status for upper and middle class ladies to practise (Mander and Reid 2002).

It is clear that these women were not feminists – they did not fight for liberation for all women, but they did ensure that there was a new outlet for middle class ladies who wished to do something useful outside the home (Mander and Reid 2002). Midwifery is still governed largely by those who do not practise midwifery themselves. Despite the passage of one hundred years since the first Midwives Act, grassroots midwives still have little or no control over the regulation and practice of their own profession, and many practise in constant fear of breaching policies set down by doctors and managers, which are not necessarily in the best interests of the client (Warren 1988).

The reformers of the early 20th century have succeeded in turning midwifery into a profession for the middle classes, due largely to the inexorable rise in the level of education required for entry to the Register. This is reiterated by the recent vote by the Royal College of Nurses, which hopes to see a requirement for the degree-level education of all new registrants (Edwards 2004), and is a strong theme running throughout the history of midwifery regulation. It would appear that class, rather than gender, is the stronger influence in the campaign for the regulation of midwifery.

Conclusion

Although there have been significant advances over the last century in women’s rights, there is still a long way to go before the people most affected by the regulation of midwifery practice, namely working midwives and women, will be able to claim that they have control of their own profession and the service it is allowed by law to provide. In order to have that degree of control, the profession needs to be governed by midwives from all levels and areas of practice, with a significant input from the women whose health needs they are trying to meet. It is difficult to see how this can be achieved while midwifery is governed alongside nursing and health visiting under the control of a single statutory body, and largely by people who are distant from grassroots midwifery practice. The needs of women, and of the midwives who support them, would surely be better served by a regulatory body whose sole interest is the education, registration and standard of practice of midwives, and which is governed by those most affected by these issues. Perhaps this should be the aim of the campaigning midwives of the 21st century.

REFERENCES


Nuffield Council on BioEthics

‘The ethics of prolonging life in fetuses and the newborn’

The Council’s terms of reference are:
1. To identify and define ethical questions raised by recent advances in biological and medical research in order to respond to, and to anticipate, public concern.
2. To make arrangements for examining and reporting on such questions with a view to promoting public understanding and discussion; this may lead, where needed, to the formulation of new guidelines by the appropriate regulatory or other body
3. In the light on the outcome of its work, to publish reports; and to make representations, as the Council may judge appropriate.

The Nuffield Council on Bioethics is considering the complex and controversial ethical and legal issues that arise when deciding whether or not to prolong life in fetuses and the newborn. Midwives may want to take part. The Council is an independent body and would welcome your comments on these and related issues.

Contact the Council at:
http://www.nuffieldbioethics.org

Closing date for responses 9 June, 2005
WHEN I MISCARRIED my first baby, Frehel, I was cautious about building hope that I would conceive again, but we had crossed a Rubicon, and my body and all the people that Frehel's tiny life had touched were changed (Midwifery Matters, no 102, Autumn 2004). Frehel opened the way, for me, for John, for my family, for our journey from death to life.

Frehel’s due date coincided with the May Day bank holiday weekend. John and I headed out to Herefordshire to spend the weekend with friends on a meditation retreat. It was bright and sunny and the grass was very green. I had not come across the Buddhist practice of ‘touching the earth’ before. I prostrated myself flat on my front. The grass smelled good. A few sobs welled up from inside me. The earth took them; it earthed my residual grief. The months that would have been Frehel’s gestation were complete and I could move on, lighter. My period came on the Monday. Later in May we were on holiday in Devon. As I came out of the rough sea a big wave invaded sand under my swimsuit and into every crevice and orifice of my body. My nipples were unusually tender and I wondered if I was pregnant again. A test in early June confirmed I was.

I was well and fit through my pregnancy and my belly grew which it hadn’t with Frehel. At 11 weeks I asked a colleague to do a scan to check the presence of a heart-beat. I calculated by menstrual dates that the baby would come some time in February. I decided against other scans or tests for foetal anomalies. When people asked “Do you know what you’re having?” I answered that I hoped I was having “a baby!” When they responded, “Oh well, so long as it’s alright…” I would think and occasionally say “even if it’s not!” Once I recognised the baby’s movements I was reassured by wriggling and hiccupping and later, legs stretching out under my ribs. There is a tradition in John’s family of alternating Theodore as a first or a second name for the firstborn son of the firstborn son. It means ‘gift of God’. John is John Theodore. I thought our baby could be named Theodore, or if it was a girl, Theodora.

I was thankful that, as a midwife, I knew about pregnancy and birth. It meant I felt calmly confident about what I wanted. I booked with Sarah, my friend and colleague. I trusted Sarah completely – with my life. I knew she would be my advocate if I needed her to be. I planned a home birth. I also booked at a neighbouring maternity unit where Sarah would have an honorary contract if transfer was needed. I hired a birthing pool. I invited my sister to the birth.

I handed in the final copy of my dissertation for my master’s degree on the Thursday. On Friday I felt a period-like heaviness in my groin. Saturday morning I went to the toilet to discover I was having a show. On Sunday my Mum and Dad came to visit for the day. They had been keeping out of the way for me to finish my dissertation. I hadn’t seen them since Christmas. They helped bolt together the birthing pool; Dad played Chopin mazurkas on the piano; Mum put her hands on my belly and felt the baby move; John made us scrambled egg. I spoke to Sarah and rang my sister and Jane, another midwife and friend. By 8 pm the birthing team had gathered. Another friend rang from her mobile. She was outside the front door. It was her birthday and she had brought us birthday cake. She had guessed something was happening. “Labour was a piece of cake!” we laughed. We filled the pool and I got in about 9 pm.
From this point I have had to actively seek to remember. It felt like my brain had been tampered with. It seemed like the experience had been wiped. I'm not used to not remembering things. But labour hurt. It was ‘mega’ and ‘excruciating’. It took 23 hours and 17 minutes. I pushed for 3 hours and 27 minutes. I actually need to forget it and that is what my clever brain is ready to do. But although my labour was traumatic it was also a triumph. I want to record it. To write this I have struck a deal with myself. I have decided to remember, and then I can forget if I still need to.

I was in the pool throughout the night. Every time I had a particularly painful contraction I was sick. I also had heartburn. Large pots of yoghurt were the answer and I tried to down a spoonful whenever I could. I examined myself at about midnight and felt the baby’s head was low but my cervix was far back and not open much. I needed to find a way to relax. I asked John to get into the pool with me. The room was dark lit only by nightlights. I didn’t want to be watched so asked if the others could go into the other room. I requested a tape of Celtic harp music. I was figuring out what I needed. “Let’s make love” I suggested. John found points on my back that he could press to relieve the pain in my front. For a while I was pain free.

The night wore on and Sarah took over from John pressing my back. I tried to stay present to each moment, not looking back or forward to the last or to the next contraction. “Present moment, wonderful moment” I intoned. “Here and now”, “All is well”, “I relax the long length of my back” - I could hear the voice of my antenatal yoga teacher. Later my back became more painful than my front. It became so tender I couldn’t bear it to be touched. I asked Sarah to just hover over it with her hand when a contraction came. Before dawn I got out of the pool. I did yoga lunges on the stairs and used the birthing ball. I had been in labour for over twelve hours. I was exhausted and I felt I could not go on much more. I didn’t know what else I could do to help myself or be helped.

John remembered the TENS machine and with it on I lay down in bed to rest. For half an hour I slept between contractions which were still coming every few minutes. I agreed to an ARM. The liquor was clear and my cervix was 6cms dilated. While on my back I had another contraction, had to urinate and was sick at the same time! Sarah suggested music. I needed to loosen up my tense back. Kate Bush’s The Hounds of Love got me moving. Jane left to go to work. Karen joined us in the bedroom. John reminded me I could finish long difficult projects; I had finished my dissertation!

Sarah asked if there was anything psychological holding me back. Sarah’s question gave me space to clear the way forward. I cried with frustration and exhaustion as I named my psychological blocks. I was thinking of friends who had planned homebirths, got to 6-7cm dilatation and stuck there. As midwife I had felt out of resources to help them. I felt guilty for their ending up with C sections. I felt I had no right to move into the birthing mother space when they had not been able to.

Similarly, I felt inhibited about becoming a mother when my sister could not. She had grieved twenty years for a baby she did not have and would now never have since having a hysterectomy. Seven years old when I was born, Karen changed my nappies. She was aggrieved that my mum’s midwife had not allowed her to witness me being born. When I miscarried Frehel, Karen experienced physical symptoms. With this pregnancy she went up a bra size. She had talked regularly on the phone to her ‘nephew/niecelet’ in my belly. I had invited her to be at the birth and she had negotiated special leave from her teaching role to be there. But in labour I found her presence difficult. I wanted her to leave… but I wanted her to stay. Once I named my inhibition it was easier. I didn’t have to be there my big sister but I was also no longer little sister. I could become a mother in my own right.

I got into the bath again and roared. I was banishing old grief—banshees; I was sending family ghosts packing. My grandfather died when my mum was pregnant with me. Irish in England, her grief and isolation far from home flooded round my tiny form inside her. She herself imbibed grief at the breast as my Irish grandmother mourned my mum’s eldest brother who had died. I needed to shift two generations of mother grief. I was performing an exorcism; moving from death to life.

I had to focus on our baby and the present, not on history or other people’s birthing experiences. It was day now; a beautiful day. I sang along to a compilation tape of positive songs: Bob Marley’s Three Little Birds, the Beatles’ Yellow Submarine, and Julie Andrews’ My Favourite Things. I needed John in the pool again. Focusing on the goodness of John I connected with our baby. “I want you.” I told the baby. I felt inside myself and could feel the head well down. My back pain was excruciating. I had no urge to push but I decided I was going to push anyway. It helped with the pain. Sarah didn’t stop me. It was midday Tuesday.
Pushing in the pool I soon felt spaced out. I needed to touch the earth again. I got out of the pool and we burned lavender oil to bring me back. Sitting on John’s lap to push, Sarah said she could see our baby’s head. But it felt a long way away to me. I pushed on the loo for a while. My perineum was tense and hot and tender and I asked Sarah to use oil to ease it for me. I pushed on all fours. I pushed best with my knees together. I could hardly catch my breath, plunge the TENS booster and slurp a swig of water between contractions. I felt my chest would burst. I was pushing to relieve my back pain, rather than to give birth. I was roaring again. “I know what I should be doing, but I just can’t do it!” I exclaimed. I was in mental denial that I was making any progress. I didn’t want to go forward but I couldn’t go back. “I want to be someone else!” I said. I didn’t want to transfer to hospital. Then I decided I was going to do it. Sarah’s praise was measured not effusive. I pushed for Sarah’s praise. “Have you a ventouse in your bag Sarah?” I asked. My labia were burning. I pushed through the burning. Suddenly our baby, Theodore was in front of us attached by his chunky cord which disappeared up into me, the mother - not the midwife.

Birthing the placenta was the best bit. It slipped out satisfactorily. A few days later we buried it beside the apple tree in our garden near to where we had laid Frehel.

I had never properly appreciated what an express train of body changes for mother and baby the first fortnight can be. I simultaneously telescoped in opposite directions like Alice in Wonderland; my wobbly belly shrank while my breasts swelled and went lumpy. For Theo, coping with my triple cream colostrum, every burp, posit, rumble, fart and explosion of poo was like an earthquake and sent him into a panic for which he would accept no consolation. I was ravenous but rarely had a free hand to feed myself. Sarah and Karen spooned nourishment into my open baby bird mouth. When John went back to work I feared I would fade away. After the fullness of pregnancy, I looked down at my wasted legs and wept. I feared being famished. My great grandmother was born in west Cork shortly after the Irish Potato Famine. Friends and family brought round meals to fill the fridge. I gave thanks for health and strength, daily bread and central heating.

John’s mother brought an aconite when she visited the first day. I picked snowdrops when I ventured into the garden to feed the birds on day three. A herbalist friend provided marigold flowers (calendula) and lavender oil for my bath to heal my raw torn labia. I dosed on arnica 1M. Visitors, phone calls and cards piled into our home. I laundered white terry squares stained with brilliant red, yellow and green; my blood, my milk and Theo’s poo. We strung prayer flags with the same bright colours out the upstairs window and down the garden. They fluttered in the wind and flurries of snow as I breastfed.

Giving birth to Theodore David (David after my Dad) was as much an act of will power as body power. Deciding on a homebirth with Sarah made the rest possible. I had time and space to work out what I needed physically, emotionally and spiritually. When I finally gave birth it was a personal and family triumph. Karen witnessed her nephew being born and her special bond with him continues. My mum and dad are proud and delighted grandparents at last at the age of 70. No one has died. With Theodore David’s birth we have moved from death to life.

April 2005
Learning Through Birth

Katherine Hales

In September 2003 I was standing in the kitchen of Ebenezer Chapel on the ARM retreat week when a fellow midwife asked me when my baby was due. “Well actually I am not really sure I am pregnant but possibly 10 weeks?” In denial that I could possibly be expecting a 7th child at the age of 43, and due to a periodic tendency to early miscarriage I had hardly acknowledged the fact to myself despite looking (according to another colleague) “about seven months!” Part of me was thrilled as always to be pregnant but also I was concerned about juggling four grown children, three little ones, a part time midwifery post and independent work with my friend Pauline. Still things have a habit of working out and Pete works part time as a teacher so....

I decided to have an ultrasound scan this time as a sop to my age, though I did not want amniocentesis and, much to my surprise, at 12 weeks there was a small hand waving back from the screen. I have had eight miscarriages so was quite prepared for the: “no fetal heart, baby stopped growing at 6,7,8 weeks scenario.” It still seems amazing that conception and pregnancy happens and I am always surprised when it happens to me, perhaps accounting for my lack of success with contraception!

As usual I was fortunate enough to feel well and happy during pregnancy and the time flew by. My friend and colleague Pauline offered to care for me and I felt confident to know that I could count on her presence. My previous three children were born at home and I had a lovely NHS community midwife who was later a work colleague, but I did not want to be dependent on the chance her being on call on the day.

Towards the end of the pregnancy I began to feel that this baby was lying very much over to my right and possibly tending towards the posterior, this did not really bother me as I had a baby in a similar position before which had resolved to the anterior in labour as had all the others. I was having regular reflexology from lovely local midwife Joan which, though primarily for my oedema, was giving me very strong contractions. As a sop to Jean Sutton I diligently scrubbed my stone kitchen floor on hands and knees, leant forward, sat up straight and optimally positioned at all times! I also bore in mind the fact that the ultrasound had shown the placenta to be anterior.

At around 40 weeks I had the restless emotionality which I felt would soon dissolve into labour, the baby was trying repeatedly and somewhat painfully to position itself in the anterior, rotating on the front right of my pelvis (a new experience!) All my babies were born between 39+4 and 41+3 and I felt he was ready, yet something was not quite right. I had the classic posterior prelabour symptoms of repeated phases of strong contractions never quite turning into labour and by 41+3 I decided to ask Pauline to do a membrane sweep which she did rather vigorously, declaring me to be 4-5cms dilated, stretchy up to whatever you like and why I wasn’t in labour? I do emphasise that I don’t believe that all women should be in labour at this gestation but that I had a strong feeling that this baby should come and that there was a reason for his non appearance. After a repeat sweep two days later I became even more anxious and decided to take homeopathic gelsemium which had an instantaneous contraction inducing effect.

Later that evening I felt that though the contractions were variable in frequency they were strong and I rang Pauline to ask her to come along by midnight when I would be more established in labour. I planned to borrow a birth pool and to experience water birth for the first time. I had a few concerns over my other children as I really felt that there was no one I could turn to for assistance with them – at least no one who could drop everything and come at any time, and who knew them well enough to do every thing that might be necessary. Yet all my other homebirths had started in the evening and finished by early morning so I trusted it would be all right. My son Ralph aged 6 wanted to be there and I had prepared him and his sister with stories and videos water birth however I felt that Imogen aged 2 and 1/2 might be upset and demand that I attend to her needs while I was in the throes of labour, even if Pete were there.

A little while after Pauline arrived I decided to get into the pool though the contractions were of varying frequency nevertheless very strong. The water seemed very beneficial and I’m glad to have experienced its soothing qualities. It was so lovely to float my large body. I asked Pauline to examine me by 1 am because the contractions were sometimes 7 or 10 minutes apart and it seemed odd that they were getting no closer together. She said I was 7 cms dilated, with the head presenting by the parietal bone on the right side and again I could feel the grinding sensation on the front of my pelvis as the baby tried to rotate to the anterior. I took more gelsemium which again had the immediate effect of increasing the rate of contraction but again they died away until eventually I left the pool feeling that gravity was the only way to keep
pressure on the cervix. As 5 am and then 7 am came, I became increasingly aware that Imogen would awaken and demand my attention. Ralph was there and rather bored at wanting to see if he had a brother and not another sister! I asked Pauline to examine me again—only 9 cms after 6 hours! Most of my babies were born within four hours—even my fifth was quicker than this after a 13 year gap. I could feel the turning of the baby’s head being ever more insistent with the contractions which were finally every couple of minutes. I climbed the stairs, rocked back and forth but to no avail. I had a little entonox and bellowed (Ralph remained unperturbed, “When is the baby coming mummy?”) Where was the familiar blessed sensation which would signal that I could push my baby out?

‘Fee Fi Fo Fum I’ll grind his bones to make my bread,’ I kept thinking as the baby’s head tried to rotate.

At this point I was putting on my midwife head, which was insistently saying deep transverse arrest. I was remembering the tale of Andrea, a contributor to the ukmidwifery email list, whose tenth baby ‘got stuck’ at full dilatation, leading eventually to emergency c-section, after many straightforward births of larger babies. I was also dreading Imogen appearing and feared she would be upset seeing me bellowing like a dairy herd. As time continued to pass I told Pauline my fears and that I was frightened. I would be like Andrea. We had a muttered midwife conversation in the loo between bellows. I asked Pauline to call the nearest obstetric unit in Newcastle 20+ miles away and tell them I would go in. I could see her thoughts on her face: ‘shall I persuade her it will be OK or go with her to hospital?’ The baby’s heart rate was fine and she suggested that she rupture the membranes but that seemed wrong to me and I thought that if the baby’s head suddenly came down in the transverse this may cause a challenging situation to worsen and the pain to be unbearable.

The ambulance was called and the hospital informed while I continued to bellow. At around 8.00 to 8.30 I got into the ambulance with two very anxious paramedics who then drove off speedily without Pauline! I told them not to worry but they were very worried— I might give birth! I reassured them that this would solve the problem as the baby was fine and I would let them know if I was going to pop a baby out and then we could turn round and go home! I tried to kneel with my bum in the air to ease the grinding of bones and cervical pressure. They offered me a whiff of entonox but unfortunately the valve did not work.

About 10 miles into the journey in rush hour traffic on a main road roundabout the ambulance stopped and the men informed me that it had broken down—a leaking radiator casing overheating. Very luckily Pauline had guessed the route they would take and pulled up behind. I was not receptive to the idea of waiting for another ambulance so got out into the rush hour traffic in my dressing gown and on to the back seat of Pauline’s car with one man, and the faulty valve cylinder (more knee chest position and more bellowing). This will seem funny tomorrow, I thought and good job I’m not a real emergency, and he’ll be worried sick about his critical incident form.

Eventually we arrived at the hospital, bump, bellow in the wheel chair: “Aahh! Decent piped entonox—I suppose I’ll have to see a registrar.” “No you can’t cannulate, put up synt or give me syntometrine afterwards—well, all right, you can cannulate if you want to, but nothing else.” Fully diluted, waters break, out comes Hamish persistent OP position, ouch, what a relief, I’ve done it myself. Hamish looked to me to be rather thin and indeed though he has the same head circumference as his 9lb 1 oz brother he is only 7lbs 8 oz so I wonder if he was really trying to arrive sooner and has lost weight in the meantime.

Afterwards poor Pete, who was not entirely sure what we’d been muttering about and whether he should worry, arrived with children, Imogen having just woken as I left. Ralph was very indignant that the hospital had got his baby and could he take him home NOW. The placenta appeared after about 20 minutes much to the midwife’s relief, no synt. no bleeding!

Yes, I was disappointed and cross with myself and felt I’d let Pauline down and all the women I’ve encouraged to listen to their bodies—and my sister soon to have her first. Why didn’t I listen to Pauline and have faith and leave my own midwife head off? Why didn’t I get someone to care for Immy? Why did I become so affected by another’s story? But I was so relieved— no section, no instrumental delivery merely the first time I’d been in a maternity ward as a ‘patient’ since 1983.

Now, despite all this, I feel it has been a valuable experience for me of labouring and birthing a baby in less than optimum position, of the effect of water and the storytelling we do and listen to, there is always something new to learn about myself and about birth—layers upon layers with each experience and story. I wish I had had faith in myself and my little girl to rise to the occasion. But then Hamish is lovely and I gave birth to him, I feel very very lucky indeed.
Birth of Jonty

Andrya Prescott

Jonty’s mother was 36 weeks pregnant when he decided to arrive. She had experienced an emotionally very tough pregnancy as her father died just as she discovered she was pregnant. This was to be her third baby with both the others also born at home around term. I have been lucky enough to be her midwife each time.

We knew this baby had not grown as well as the other babies had. The mother declined obstetric reviews as she trusted herself and her baby to grow well enough and birth well enough.

When she went into labour it was sooner than expected but we had plenty of warning with some warming up contractions one evening, I went and stayed overnight as we were both wondering how quickly it would all happen. She had not been long with her other births… The next morning she felt crowded, so her friend took her other children out for a walk and I went into the local town for a while. The father of the babies called me to say contractions were strong now could I come.

She was labouring beautifully, celebrating it all. She had a large enough bath for her to fit in easily and so planned to birth in water in the lovely warm bathroom. We had talked about early, small babies and the importance of heat and
she felt it was the best option for her and her baby and I supported this. We had also talked about her birthing her baby into her hands this time and so she did. The pictures show her holding her perineum and his head as he crowns and then there was a moment where she thought she couldn’t but then she reached down and triumphantly brought her baby up. The father was totally there with her emotionally and physically. It was a very emotional birth— not a dry eye in the bathroom. She nursed her baby soon after he birthed and her placenta came 10 minutes later physiologically.

Once she was wrapped up and warm with her baby their eldest son came in with the biggest smile on his face when her met his newest brother.

Jonty had IUGR and so with “kangaroo” care she stayed in bed with him, skin to skin, and he nursed and nursed and nursed while she was looked after by her husband and anyone who came to visit. Jonty thrived with this care and really quickly gained at about 1lb a week or more.
Spring National Meeting
Ashton-in-Makerfield, Wigan
Saturday, March 19, 2005

Spring had just arrived with sunshine and daffodils when ARM had its Spring meeting in Ashton. It was lovely to see so many local midwives present and I am sure that this reflected the midwifery culture which has been strongly reinforced by the creation of a new woman’s group, the Wigan Homebirth Group which was set up by a local woman, Jayne Halton, following her struggle to get a home birth.

After the usual round of introductions – extended somewhat as more and more people streamed in, we started on ARM business chaired by Wendy Blackwood. We discussed the issue of informed consent and informed refusal. Members were concerned at the rejection of a case brought to the NMC by a mother whose refusal of many aspects of her treatment such as vaginal examination without consent, Ventouse without consent, syntometrine and CCT without consent were overridden. The Fitness to Practise Committee ruled that since the case was unlikely to lead to removal from the Register it need not be heard. The meeting agreed that there should be a series of articles on women’s rights in the magazine.

Jane Munro had sent an update on the Evidence Based Midwifery Network. Recently this has separated itself from the Foundation of Nursing Studies which previously did all its administration work. By becoming independent the Evidence Based Midwifery Network now has to charge a fee for membership. It asked ARM for a reciprocal relationship whereby it could put a call for abstracts and an advertisement for its conference in Wales March 26th, 2006 in the next Midwifery Matters in return for ARM having a free stall at the conference. EBMN also wants reciprocal links on each other’s websites although the EBMN one has not quite gone live yet. These were agreed.

Mary Cronk and Jane Evans give workshops on Sharing the Skills and their agent is anxious that the business side of this is put on a sounder footing. Sessions are organised all over the country and the usual fee is much higher than that charged at the ARM Gathering last September. It was felt that it would be inappropriate to repeat this concession this year so the session planned for this year will be priced higher so that other venues in the locality are not deterred from booking Mary and Jane. There have already been some bookings for this year’s gathering but the meeting felt that perhaps there were not enough workshops planned – there had been too many last year but not enough planned for this year. Mary and Jane would present A Day at the Breech on the Sunday and Lorna Davies and Sara Wickham could be invited to present a workshop on the Wednesday.

Sarah Montagu informed the meeting that she is moving to Oxford in the summer and thus ARM’s main address and telephone numbers will have to change.

ARM members in Scotland have written to ask for publicity for their campaign for the new Scottish law on breastfeeding in public (in any place where bottle feeding would be acceptable) to be extended to England and Wales.

Wendy reported that the local contacts list on the back of the magazine has been changed to reflect the information that local contacts wanted to give and that details of local groups are now given inside the magazine.

Margaret reminded the meeting that Andrea Martinez had expressed interest in coordinating a new ARM book on ARM wisdom and had met someone interested in publishing it.

At Glastonbury this year the ARM stall will be in the Green Futures area instead of the health area. This means that the stall can include items for sale. The Festival group asked if the ARM range of items for sale could be expanded to include merchandise suitable for such events. A large sheet of paper was put up on a door for people to write their favourite slogan which could be used on a t-shirt, e.g. ‘Midwives Help People Out’.
The Wigan Home Birth Support Group

Jayne Halton founded the Wigan Home Birth Support Group in September 2003 following the home birth of her third child. She would have liked to have had her second child at home but it seemed too uphill a struggle. She managed to get a homebirth for her third child and from a group of five or six the group has mushroomed into about 30. The group is led by the women and takes place weekly in a church hall. Midwives and doulas also attend. Jayne mentioned the problem of funds and Kerri-Anne suggested approaching the PCT as there are funds readily available for user groups, however this group works well because it is woman led and is outside the Trust’s umbrella. There has been a 100% rise in the home birth rate in just 18 months, albeit from a low level to 1.3%. The Government’s aim is a 10% home birth rate and groups such as this will help achieve this objective. Macclesfield also has a home birth group which is led by midwives and the culture is changing such that midwives are telling women about the group, although it is noted that women take more notice of other women than they do of midwives.

Midwifery Outside the Obstetric Model

Judith Kurutac was an NHS midwife from 1973 until 1994 when she went independent. She is now a supervisor with the NW LSA. She believes we must remember what originally drove us to become midwives. She grew up in Wiltshire where homebirth was an everyday occurrence. She came to midwifery in the 1970s and the increasing technology was such a shock that she escaped abroad to Turkey. There while having her own baby, she encountered an obstetrician who believed in her as a woman and connived to give her the birth she wanted, going to the extent of dressing her husband up in scrubs to allow him access to the birth room!

She emphasised that we must have a belief in women and a belief in the profession of midwifery and we must see UK midwifery from a global perspective and start to understand why we are lagging behind other countries, why we have constructed barriers around our original values. Fear restricts us both physically and mentally. We must respect each other, not questioning each other’s decisions which humiliates people, but exploring problems together, by constant questions and audit. Supervision should be a framework of support, midwives can be frightened and intimidated by employment practices and get this muddled up with supervision.

After a break for coffee we were treated to a session of Pilates ably led by Jan Lythcoe and a wonderful display of belly dancing by Sarah Garrish who belly danced her way through her last pregnancy and is now pregnant again and still going strong.

After lunch we had a workshop on independent midwifery facilitated by Leslie Hinton.

Hugs and Home

People left feeling happy and revitalised.

“It’s refreshing to hear positive views of something better out there.”

“You can’t beat the pester power of stroppy women!”
Dear Kerri-Anne,

It's been so long since I've sent you any news/messages about me. It's because I was just too busy after the worst typhoon and flashflood that hit my place. I just couldn't imagine how our life will go on when half of our house was buried with mud and water. But I was so thankful to GOD that he spared my whole family, and also for giving friends who are really friends whom I can turn to in time of need. Thank you with all the help you have sent, it really helped a lot, not only to my family but to my constituents also especially to other midwives whose houses and clinics were also damaged.

Now, were starting our new life again, after I experienced to live and stayed in the evacuation center for 10 days, attending three births that night after the flood hits us with just only a scissor and cord clamp, barefooted and wet half body, with the mother lying in a corner with a piece of dry cloth and a baby with a towel and both were saved safely. Thanks really to GOD. I am now working with the people again, Ogie is still trying to dig and clean his furniture shop hoping to save some of the machines, but I think it's all damage already after it had been buried for almost more than a month. Ogie still hoping he could find some.

I've been in Manila today and send this message to you. I attended a meeting with IMAP Officers as I am now one of the officers. This is the first time that I met them after the flood. We're planning of how we can help and share to work in the rehabilitation of our place with a limited budget of the association. We talk also about the forthcoming ICM Congress in Australia, who are interested to attend, but I think only few can, because of high cost of expenses. I'm planning to do some writing about how I am now, working and serving with people without a clinic now. Our Department of Health now think of helping our area with limited budget also to rehabilitate and reconstruct damaged 42 clinics in Real, Infanta and Gen. Nakar. (Three neighboring towns that were hit by the flashflood)

Till here, I hope that Tata has sent you already some of the pictures I've got. I was not able to take many because everything in the clinic and some in the house were all buried and damaged. I'll try to get more copies and send you. Thank you very much, really, I am very touched with your much help and concerns for me.

Much Love,
Edna

Groveling Corner
Hi Margaret
Can you tell Tessa Dean who wrote the review of Heart and Hands that my edition is a 1st edition published in 1981. She said it was first published in 1987. Not being picky, just thought she might like to know! Thank you for a wonderful magazine yet again, it restores my faith every time.
Yours
Dillian

Midwifery Matters and ARM would like to apologise to The Practising Midwife for inadvertently accepting and publishing an article, ‘Some Diverse Surprises’, by Rosie Kacary which appeared in our last issue.
The Way Nature Intended

In Scotland a law came into force on March 18 making it illegal for a mother breastfeeding her child to be discriminated against. Many women are made to feel alienated when breastfeeding their child by looks and comments from other members of the public and by being asked to leave premises or move to back rooms or toilets to feed.

As mothers, mothers-to-be, midwives, student midwives and fathers we feel the Scottish law should be nationwide. Breasts are seen everywhere in the media, on beaches or even in the street, as sexual objects and no-one gives them a second look. We want to give breastfeeding women the same right feed their child as a bottle feeding mother, in any place where bottle feeding is acceptable. Our aim is to end the stigma surrounding breastfeeding in public places and to promote equity in legislation throughout the UK. According to UK surveys 50% of all women who had breastfed their baby had never tried to breastfeed in a public place. The UK has one of the lowest breastfeeding rates in Europe.

The WHO UNICEF and the NHS recommend that a baby is fed breast milk exclusively for the first six months of life.

What can you do?

• Come and visit us at www.thewaynatureintended.org and learn more about our campaign.
• Write to your local MP in support of breastfeeding in public www.writetothem.com
• Photocopy and distribute the petition below.

Breastfeeding Acceptance in Public Places

By signing this petition I confirm my support for a change in legislation to make it illegal to discriminate against mothers because of the way they decide to feed their babies.

www.TheWayNatureIntended.org

Name or Organisation   Address, city or Email* (optional)   Comment (optional)

* If provided, your contact details will remain confidential and will only be passed to the government to show that this petition in valid and correct. Your name and details will not be recorded by us in any way or passed to any other parties.
The Evidence Based Midwifery Network

The Evidence Based Midwifery Network established in 1998, offers a forum in the UK for midwives to share ideas and experiences of evidence based practice.

The network’s main aims are to encourage collaboration of successful initiatives, influence the direction of local and national agendas and further the development and use of evidence-based practice in midwifery.

The network currently meets three times a year in different locations in the UK. This provides the opportunity for members to share examples of good practice and to provide peer support for implementing change. The network is active in lobbying to raise the awareness of specific current issues, in order to ensure that evidence-based practice within maternity services maintains a high profile.

A database exists for members to liaise with each other effectively, and the network is now developing a website. This will include details of EBMN’s activities, minutes of meetings, presentations, research opportunities, information about conferencees and links to relevant national/international organisations. The website will host resources that members are happy to share with the network such as audit tools, and evaluations of midwifery developments and interventions.

Any midwives interested in identifying best and changing practice, or who have been actively involved in evaluating the implementation and outcome of change are encouraged to join the network.

The network, which previously had administrative support from the Foundation of Nursing Studies, is now independent and therefore has to support itself financially. As a result, there is now an annual membership fee of £20 for midwives and £10 for midwifery students. For more information, please contact either:

Jane Munro tel: 0114 2268552 or email: jane.munro@sth.nhs.uk or
Sharon Mills tel: 0115 969 1169 ext 45193 or email: sharon.mills@nottingham.ac.uk

Call for Abstracts

Celebrating Change: Evidence Led Innovations In Midwifery Practice

Saturday 25th March 2006
University Hospitals of Leicester NHS Trust

Papers are invited for both parallel sessions and poster presentations.

Themes for concurrent sessions and poster submissions are:

1. Public Health
2. Innovations
3. Voices of Women

If you would like to submit an abstract for consideration for this conference, please contact
Ms Sharon Mills
Academic Division of Midwifery, University of Nottingham
Postgraduate Education Centre, City Hospital
Hucknall Road, Nottingham, NG5 1PB
Sharon.Mills@nottingham.ac.uk

The Closing Date for Abstracts is the 30th September
Dear Madwife Matilda,

After attending a marvellous homebirth of someone on my caseload I had to as per usual to submit the records to a SoM. My named one was away so they were sent to a central clearing point. I remember packing them marking them confidential and recording the date and details of dispatch. Not thinking anymore about it I continued in my usual midwifery duties, loving the work I do. Six months later I received a letter to say that the notes were missing and obviously I had not sent them and where were they? It sent me into a stressful tizzy waz. I searched high and low, rang everywhere I could think of that they may have ended up. I rang my SoM and she told me to keep looking and to write an incident form if they were still lost. I thought I would give them a bit longer to turn up in the NHS system, I was coming up to a year of the notes missing so after more enquiries I was about to write the incident form which felt like a confession for something I hadn’t been responsible for. Lo and behold in the next post there was an audit letter for me from a SoM about the very same “lost” notes! No apology, no acknowledgment of the distress I had been going through nothing other than some extremely strange comments about the woman’s progress in labour!

The very same wonderful home birth was a five hour labour of a 4 times already experienced healthy woman who liked to nip out for a cigarette now and then as her normal outcome at home, mother and baby and rest of family very happy. In the notes I was reprimanded for only taking the blood pressure once in four hours and therefore “how did I know the labour was progressing normally”? I was flabbergasted and probably feeling very sensitive about the missing notes issue but my response to the SoM’s letter was to feel rather angry to the point that I no longer enjoy my job and have started to think about leaving the NHS. I was attending the woman as an experienced midwife. The woman was a normally labouring woman who had never had blood pressure problems. On the only pre-birth check her BP was 110/60 her usual baseline and her post-birth check before I left a few hours later was 105/60. I judged that once before the birth was enough as I did not feel the need to disturb her unfolding labour. What do you and others think? Am I over-reacting? I look forward to all comments. Thank you,

MW Flabbergast.

MW Flabbergast is waiting to hear from us and from you. Madwife Matilda will reply in the next issue of MM and if any one else has thoughts on this situation please feel free to send them via e-mail or letter to the editorial group. Please feel free to share with editorial group your own experiences if you are seeking feedback from Madwife Matilda and ARM

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**Double Vision**

by Madwife Matilda

This section of the mag is a new addition to Midwifery Matters. It has been inspired by no less than a combination of terrible Supervisors of Midwives (SoM) and an epidemic of having to write incident forms in the NHS. Now, of course, I’ll make the usual sensible disclaimers that: a) we all know one or two wonderful Supervisors of Midwives whose shoulders we may have cried upon and from whom we have received good advice and support; and b) nothing written in this column is directed at any individual no matter how much you may think it sounds like an event you may know about! It is all entirely disguised even the author’s name. However, there is some truth in the fact that I am both a bit mad and fairly increasingly angry about aspects of my experiences of being an NHS midwife for a number of years now. Although instead of the attraction of breaking down I’m breaking out instead (metaphorically speaking via ‘the pen’). I will also declare an author’s prejudice against the existence of Supervisors as I’m sure there is a better way of supporting and improving professional midwifery practice other than the anachronistic method we have in the UK!

This column will be an on-going forum for midwives to outpour their hearts anonymously but publicly and to share their best gems from the following sources e.g. ‘audit letters’ from SoMs, reasons why you have had to write an incident form or had a finger pointed at you scurrilously and irrationally! Not to be entirely negative, you may wish to share a fantastic experience of supervision? But more likely you may want to tell us about a crap day/night at work when people expected you to be super human, when unbelievable scenarios occurred. You may wish a share a scary event whatever the outcome. Your identity will be completely protected it will not be bullied out of me. We need to expose the underbelly stories that we all know get swept under the carpet. If you pick up a bit of emotional language then you’re getting more of the feel about the contents of this column and feel free to share your own emotional perspective by writing to me via the editor. Freedom of speech is not dead in this part of the midwifery world so express yourself as did the author’s prejudice against the existence of Supervisors as I’m sure there is a better way of supporting and improving professional midwifery practice other than the anachronistic method we have in the UK!
One of Connie Ross's photographs was featured on the cover of the last issue. In this issue we show more of her work celebrating the pregnant female form. She writes:

My ‘mothers’ work began in February of 2002. Now, I exclusively photograph pregnant women. I've always admired the human form and been awed by what our bodies can do, especially the shape we take while pregnant. When I was pregnant with my son, I went from being in the best physical shape of my life as a competitive bodybuilder to watching my changing body with amazement. The change was simply incredible. I was accustomed to being photographed with very few clothes because of the bodybuilding, however it was not yet in vogue to be photographed while pregnant. I had someone take a few snap shots of me throughout my pregnancy but always had the desire to be photographed professionally. I think I live my dream through the women I photograph in my desire to capture this truly beautiful time.

My goal is to photograph more coloured women. I have travelled extensively throughout the world and have a strong passion for knowing about cultural diversity. I find even more beauty in humanity when I think of our various belief systems. Our human race is exceptionally lovely! When I have a nice collection of images I will publish my work in a coffee table book.

All of the mothers/families that are pictured have signed a model release for me to use their images.

Connie M. Ross
I have around 3-4 weeks to go and some of you may remember my much earlier VBAC queries. I have now discovered that the nice hospital here plans to monitor me continuously throughout labour but I’ll, “be allowed to sit up on the bed.” When I insisted I didn’t want an elective section they did grudgingly agree that I didn’t have to go in at 36 weeks, “so the consultant can plan how [I’ll] have [my] baby”.

This isn’t my idea of active labour. I was told I couldn’t use the local birthing centre because I score ‘10’ for a previous section eight years ago – for a labour hastened with chemicals and with me lying on my back for a day and a half. Hmm.

I have spoken to the local consultant midwife and everyone else I can think of, and it has now come down to the fact that I can have my baby wherever I want - but they don’t advise it. And that maybe all those interventions aren’t necessary – so I will need to refuse them.

I don’t really want to be put into the position where I turn up somewhere I’m not welcome, or spend however many hours in labour actively refusing monitoring, refusing to have a cannula put in, insisting on being able to move around, begging to use a pool (or even a bath) and refusing heaven only knows what other cocktail of interventions I endured before. At least I have 4-6 hours in which to achieve birth. Lucky me.

Apparently, this is evidence based. So really, birth choice is nothing to do with choice in Wales, as the ideal birth has already been selected. All I have to do is opt out of it at every stage (and/or be devious about length of labour etc). I can’t have a home birth as we’re in the middle of moving house - wow, I can’t wait to go into labour.

“This is just a rant really, but I would appreciate hearing whether others’ understanding of ‘choice’ does actually necessitate refusal?

CW

**Not surprised**

Um, no it doesn’t. Choice means being offered a variety of things and deciding which one you want. They seem to be trying to put all the onus on you – “We’ll tell you what to do and if you refuse it, well that’s your look out,” rather than offering you genuine choice. I’m disappointed for you but not surprised.

FN

**Car Park Delivery?**

I wonder whether the birth centre would turn you away if you turned up in labour? Or insist you deliver in the car park? I really hope you get the birth you want – when I got stroppy everyone fell into step with my wishes and I had a perfect two hour labour and three pushes delivery. The midwives had a lovely time and so did we. The objections all melted away in labour and I felt completely in charge.

K

**Loud talk**

This was the scenario of ‘choice’ I was faced with for my daughter’s birth two years ago – I ended up hiring an IM and planning a home birth, when suddenly, magically, some genuine choices (as opposed to like-it-or-lump-it) from the NHS were offered, e.g. I was now most welcome to birth my baby in the MLU.

I have a clear memory of miserably envisioning my labour as a series of confrontations with, and lectures from, stressful HCPs. This may be unrealistic (and therefore unwelcome) advice, but if I were you, I’d look into finding the money from anywhere and getting my hands on an IM as soon as possible. Talking loudly to the hospital people about a home birth with an independent midwife may get you somewhere new.

AS

**Welcome Attitude for Some**

I have sneaking suspicion that you and your sensible attitude may be very welcome by midwives who are pleased with your attitude and welcome caring for an informed woman. You have already seen how your choice of place of birth was listened to. What has to be remembered is that consultants do not DO normal and therefore have little knowledge of how a normal labour is “managed.” What you are told and what you plan to do may well be two different things.

MC

**Flawed Concept**

You wrote: I would appreciate hearing whether others’ understanding of ‘choice’ does actually necessitate refusal

Well, if I’m honest, in the NHS, that is exactly what it means. Remember, local guidelines have been developed to give the best possible outcome, based on evidence (do I really believe it?) They will try and steer you to what is ‘best for you and your baby’ – so if you would like to do something other than what they have decided is ‘best for you and baby’, then to obtain your choice you will have to ‘refuse’ the said guideline.

Informal choice in the NHS is a flawed concept, as it assumes that everyone will agree what is ‘best’ – and we never do, as women often base choices on personal reasons, not always clinical ones.

LW

**Ammunition**

How frustrating to be put in this position. I suggest you write a polite but firm letter to the Supervisor of Midwives at this hospital to thank her for all her help in trying to achieve the birth you want. After much research, thought and reflection you have made the following informed choices, and you trust she will be able to provide a midwife with sufficient skills to support these choices, wherever you choose to give birth.

*Re. risk of scar rupture:

1. You are aware of current best practice (NICE) guidelines to recommend continuous fetal monitoring in labour, but that you would prefer to have the baby’s heart rate intermittently monitored with a hand held Doppler. (If you opt for a hospital birth, you may find that everyone is more relaxed if you agree to a short burst of continuous monitoring every four hours or so – this is the compromise that our Trust makes when people want to labour in water after a CS. I’m not saying I agree with this, but sometimes you find people are more accommodating if you agree to meet them halfway).

2. You could also say that you would be willing to have your pulse rate measured every half hour as this may detect any uterine rupture more readily than continuous monitoring.

3. You would prefer not to have arbitrary time limits imposed on your labour but to be supported to labour naturally as long as you and the baby are making reasonable progress (ie not 1 cm per hour!)

4. You would prefer to go into labour naturally rather than be induced, and to avoid the use of IV Synthocin as these increase the risk of scar rupture.

*Re. positions in labour and for birth:

1. You would like to remain upright in labour and would welcome support to adopt different positions, perhaps using a
birth ball and/or beanbags and floor mats, and to be able to labour in water.

2. You would prefer not to have an routine IV cannula, in order to restrict your mobility, but would agree to having one sited in the event of a medical emergency

Re. consultant involvement with your birth:

You understand that it is usual practice to have consultant led care with a previous CS, but that as you are hoping to achieve a normal birth you would prefer to have care from midwives who are experts in normal birth. You are happy to receive care from a consultant in the event of a medical emergency.

I don’t see this as refusing care, but just making an informed choice to decline many routine interventions. It is your body! I know you are moving house, but this doesn’t have to preclude a homebirth. You don’t need a lot of space for a homebirth - just a few square feet in one room. Or perhaps a friend of relative would be happy for you to use their house? I recently cared for a woman at her mother in law’s house and it was great. I really echo many on this list who suggest you opt for home. It is much easier to decline intervention at home than in a hospital, and because you are more relaxed you will probably labour more quickly and find the pain easier to cope with. Birth centres may feel safer, but the outcomes for birth centres and home births are the same - why leave the comfort of your own home?

I wish you all the best. JK

Thanks to all of you who took the time to reply. I think what upsets me most is that I can spend several months reading research and notes on evidence-based practice and hear the tiny risks of VBAC, and hear that doing something in labour is better than lying on your back – and then hear back from local midwives that, well, that might be the case, but here are the guidelines written by some obs cons and... you know the rest.

So, it looks like it might be homebirth amidst the removal boxes. I have a meeting with the cons midwife here tomorrow morning – I’ll let you know what the final decision is. CW

Research Evidence not always useful

I think what upsets me most ... is to hear back from local midwives that, well, that might be the case, but here are the guidelines written by some obs cons and...

Yes, this is frustrating. However, to put the situation into perspective, although there is a rhetoric of informed choice in maternity care, NHS culture actually encourages coercion, not choice (Mavis Kirkham and others have written loads about this and it is very sad but compelling reading). Individual midwives must stand up for women but it is so hard, and I speak as an NHS midwife who often gets into trouble for supporting women in making unusual choices. It is actually much easier for the midwife in this situation if the woman firmly and politely states what she intends to do and does not try to negotiate. In this way the midwife is not put under pressure from managers to try to change the woman’s mind, and is not accused of putting unrealistic ideas into women’s heads. Instead she will be supported to provide the sort of care the woman wants, and this will translate into better care for the woman.

Remember to be firm in your meeting with the consultant midwife! No negotiation.

I fully endorse the information you are giving C about her options. However if I am caring for a woman hoping for VBAC I feel her pulse more frequently than you suggest, half hourly OK in early labour but as the labour intensifies I increase the frequency of pulse taking, making a right nuisance of myself by taking it almost every five minutes once the contractions are strong and frequent. I would also suggest that the woman feels her scar and lower abdomen in late pregnancy and then feels it frequently during the labour she will know if there is any change in tenderness or texture and can inform her attendants whom I sincerely hope will pay attention. I would not “try to avoid synto” I would FORBID the use of any oxytocic drug either to induce or augment labour.

MC

VBAC - Feel the Pulse, no Synto

I am going for a group interview tomorrow where the topic of discussion is “How would I feel about a woman having a home birth against medical advice?”

Does anyone have a working opinion on this that I can consider during the discussion? I would like to get on an the ground view of how this situation might pan out. Are there any legal implications should something go wrong as a result of allowing a home birth to continue?

What are the midwives’ responsibilities, to insist at all costs that the welfare of the woman and child are ‘enforced’ or to support her wishes? Any thoughts would be appreciated, and any information about what is actually done in this situation would really help.

KE

Right to Home Birth?

A woman has chosen midwife led birthing unit as most appropriate place for her to labour but is being blocked by a Supervisor of Midwives as she does not fit criteria of the midwife led unit. (due to previous LSCS). I’m trying to sort this out prior to labour, not as a confrontation scenario in labour. Any suggestions from a rights/legal/ practical ideas on how to resolve this.

KA

Woman should inform the head of midwifery in writing of her intentions and plans. Should she get a refusal to meet her wishes and needs, she might choose to inform them that if the door to the unit is barred to her she will have no option but to return to her home and summon a midwife. This usually leads to negotiation on the part of the MLU. The woman may also find taking advice from AIMS helpful.

Informed Decision

In my understanding, a woman does not have the ‘right’ to enter an area for which she doesn’t meet the criteria. Just as a midwife does not have the right to enter a woman’s house if she is not invited in. However, no one who can stop a woman from having a home birth and safety shouldn’t be an issue as the safety of a midwife led unit should be equivalent to that at home. A midwife is obliged to care for a woman in labour at home whether or not this is deemed a ‘safe’ place for her or not, and hopefully the place would be the woman’s informed decision.

M

Feelings

How would I feel about a woman having a home birth against medical advice?

Marvellous question – it is actually, asking about your feelings on the matter, rather than ‘the rights and wrongs’. Some of us have been in this position frequently, and are comfortable provided we are sure the woman is ‘of sound mind’! However, there are many midwives who feel very uncomfortable about it and who can blame them?

There are real risks to consider, usually. It is all about making the situation as safe as possible. As an independent midwife, I regularly attend women in the homebirth environment ‘against medical advice’. I have found these women to be amongst my most informed clients. For me, it is about ‘planning’ and ‘support’. I can feel confident and comfortable when everything is in place.
Saying that, there will always be the ‘emergencies’ like being called to a stranger in labour with a breech at home, a primip – not a common situation – and then that’s when you realise that you are well trained, actually!

**Fetal Rights**

Should women have a right for a homebirth against midwifery and medical advice?

Aha! completely different! Well, what’s the alternative? Do we really want to go down the route of America and ‘fetal rights’ - where does it end? Should we lock up those who smoke during pregnancy? Are we suggesting that we drag women into hospital having got court orders! Utterly ridiculous.

I can’t believe anyone would seriously consider anything else? Anyway, women have the right to refuse medical advice – if we didn’t we would be forcibly ‘treating’ everyone depending on what docs ‘ordered’ – I don’t even believe docs would want this.

I preferred the other question! there’s more to discuss!

**NICE Advice**

Doesn’t it specifically say in the NICE guidelines that a woman cannot be forced to have a caesarean – even if this is in the interests of her own health and that of the unborn child…?

By extrapolation, in order to force someone to receive treatment, surely they would have to be sectioned under the Mental Health Act – which is not easily achieved.

**Sectioning**

This would be completely illegal. Sectioning under the Mental Health Act can only undertaken only in order to treat the mental illness for which the patient is sectioned. As yet, pregnancy has not been classified as a mental illness, so this cannot be done. Not ever.

**Perils of Expert Advice**

Remember all the things that have been advised over the years by medical and midwifery ‘experts’? Routine x-rays, to make sure the pelvis was big enough; routine vaginal douching to clean the dirty birth passage; routine shaving from the nipples to the knees; compulsory enemata; mandatory episiotomy (my personal catharsis); circumcision; formula feeding; separation of mother and baby. It wasn’t really us in our wisdom who stopped these abuses, it was informed parents who threatened us with litigation and who refused to obey doctors orders. Why should we be any more infallible now than we were then?

What really gets to me in this debate about enforcing treatment is the assumption that the opinion of doctors and midwives about what is in a baby’s best interests is taken as being a pronouncement ex cathedra. When will we learn that we are not infallible and that sometimes we can be wrong? I also think it is rather impertinent to assume that a mother is not wanting to act in her baby’s best interests.

**Bits and Pieces**

**Double Uterus**

I currently have a client with a two uterus, each with a cervix. She is pregnant on one side with a single baby. Where could I find out some more information about this and about how she might labour. At the moment, consultant ‘advice’ is swinging between elective section and vaginal birth, so she doesn’t know whether she is coming or going. She is coming up for 30 weeks, her edd being 26/6/05.

Any wise women out there got any ideas that might help her? Also, she is pregnant on the right side, so am I correct in thinking that so long as the baby stays head down, it may well be ROA?

NF (NCT teacher)

It may be ROP, ROL or even LOP, LOA or LOL as it could be on the right or left of that uterus. We had a woman recently who had a unicoronal uterus (or possibly a partial septum) which allowed the baby to be comfy in a breech position and she elected for a caesarean section for breech, so I’m afraid I cannot help with specifics about labour. We did not know she had this anomaly until the caesarean and she was going to have further investigations following this as it was difficult at section to tell exactly what it was!

**A friend of mine had the same thing. She delivered vaginally with no problems at 36 weeks – I seem to remember that was considered likely due to lack of space? JW**

**Birthing Stools and Tearing**

I used a birthing stool to help me squat and deliver my 9lbs 12 oz son three years ago. I was very comfortable in that position, and simply breathed my baby out very quickly. I did however sustain a 2nd degree tear that was left to heal naturally causing me very little discomfort.

Chatting to the student midwife who did my booking in appointment this time around, she seemed to think that I may not have torn at all if I had used a different position… I was on all fours up until crowning, when I had an urge to move to the stool.

Now I’m wondering if I should go ahead and hire a birth stool to use this time around, and risk a tear again or make do without. What experiences do people have here of using birth stools? My midwives attending the birth of my son were very impressed with the stool! I used last time. My DH has said he’s happy to support me in a squat/standing, etc. Any thoughts?

**Sitting Right**

I caught a baby from a lady using a birthing stool, admittedly I was a bit shocked when I realised she was going to deliver there as I had never done such a delivery before! However, she birthed a 8lb something and had an intact perineum.

Since that experience I have had a couple more ladies birth on the stool, again with the odd labial graze but intact perineums. I have heard that you can sustain tears on a birthing stool and this was going through my head at the time of my first birthing stool catch (‘ohmigod, my first third degree’ was something like it anyway!) but I think it has a lot to do with HOW you sit on the stool, i.e don’t sit right back and abnormally stretch the perineum, because that in itself can cause the perineum to button hole, even without the baby.

I think, if you feel that you want to deliver on a stool, go for it. It was interesting that you wrote, “I had an urge to move to the stool!” – go with that urge, that’s your body advising you IMHO.

**L.**

**3rd year student midwife**

Ps you may get away with an intact perineum on all fours, but I have seen some awful labial tears/clitoral tears on all fours when I have gone in as ‘second midwife’. Makes you really want to cross your legs!
Cervical Sweep

I thought list members might be interested to know that a newish consultant in the local unit is asking midwives to do cervical sweeps at 38, 39 & 40 weeks. The first patient was very uncomfortable with SPD, she wanted a sweep so I carried one out. To my surprise, I found a very soft, thin cervix. She went into labour within six hours and had a wonderful birth.

Last week I had the same instructions, a woman with two previous sections hoping for VBAC, same result SVD 12 hours later.

I saw the consultant yesterday and asked whether he had any research to support this intervention, he hadn’t, he just thought it might work.

I have now spoken to my manager and we will be collecting data on outcomes but I wonder if any one else has come across this as a method of early induction. My usual recommendation is for lots of passion, but that’s just to cheer them up!

VH

**Normalised Intervention**

It doesn’t make sense, it’s another intervention that’s being normalised. I’m assuming it’s ‘offered’ as an alternative to chemical induction but wouldn’t it far more physiological to only offer induction at real post term (ie + 42 wks). I speak not only as a midwife but also as one who has birthed babies at 41+ and 42+ wks. Instead of being reassured by my midwives I was made to feel twitched as if I were a ticking time bomb! Babies come when they are ready, not always when we are ready. Crazy world innit?!

JD

**NICE Evidence**

The following is from the NICE guidelines on IOL. The research they looked at was of sweeps from 38 weeks, which may be where they are getting their info from.

6.2.2 Summary
- Membrane sweeping is associated with a reduction in the length of time between treatment and spontaneous labour.
- Sweeping of the membranes reduces the incidence of prolonged pregnancy.
- Sweeping of the membranes reduces the need for the use of formal methods of induction of labour.
- Sweeping of the membranes is associated with an increase in maternal discomfort.
FN (3rd year student midwife).

**Why Induce?**

Why are these women having their labours induced? What is the advantage? I note you give anecdotal evidence of successful outcomes, but one could be putting over the message intervention to encourage labour is good; awaiting one’s body knowing best is bad.

Is this just another example of a medical practitioner being unable to mind his own business and interfering??

MC

**Ethics**

I think it is simply unethical for health professionals to put their fingers in women’s vaginas on the off chance that it might precipitate labour. If women request this and have full information it’s a different matter. This may seem extreme but I think there are a number of issues.

1. the consultant’s motivation and the assumption that, on what is essentially a whim, he can determine other health professionals’ actions.
2. the acceptance that pregnancy should be shortened for no apparent reason.
3. the disregard with which the female genitalia are held.

I’m on one of my hobbyhorses — that any interference with normal physiology needs to be justified in ethical terms.

I’ve read the various abstracts which people have posted. There is an unthinking assumption that a shorter pregnancy is better and according to my reading of the original mail the consultant didn’t justify or rationalise this instruction. And even if it doesn’t cause infection and regardless of the degree of discomfort it seems wrong to me to subject women routinely to this. It seems to suggest that pregnant women’s genitalia should be generally available to any health professional. It is common for women to say after they’ve had a baby that they have lost all modesty — and I don’t think it should be like this. This kind of routine treatment is a way of inducting women into a submissive role.

MT (retired midwife, probably with a rather strange sense of proportions)

Hear, hear!

What a wonderful way you have of putting things! I entirely agree with all you’ve said, I wish you were still practising.

H

**Reducing the IOL rates**

We have one of the worst IOL stats in the country, and are trying to reduce it. Our protocol is IOL after 41+4 according to RCOG green top guidelines I think, and even with informed choice many women will still favour IOL (like they do Vit K and Syntometrine etc.. because it seems to be the norm — and if it’s the norm for others then it’s good enough for me)

Given this (awful) situation, some midwives (and women) might feel that a few sweeps after 40 weeks which may start labour before 41+4 weeks may actually be preferable to some women than a whole hog induction with Prostin etc.

Of course I do discuss this with women, so they are fully informed about the whole process of IOL and their right to decline and await labour. All the women (not that many - about four, those fed up with being pregnant etc) who have had this procedure in my practice went into labour after the first sweep in the space of a week and did not require IOL. But this may have happened anyway.

A colleague had a woman who wished to avoid IOL and c/s she had a fair sized baby and the head had been slow to descend - at 40+ weeks it had come down and the midwife swept her membranes at her request. I was asked to see her in three days time to sweep again - which I did with consent - when I found the cervix to have changed quite a lot. She laboured four days later and went into labour suite fully dilated - the midwife who admitted her could not believe she was fully because she didn’t act at anytime like someone who was at that stage.

She had a lovely birth and breastfed well, and was happy because she had avoided IOL and c/s (things which had been mooted because of the size of the bump and the head not engaging (prim). Of course you and I could argue that it was the negative programming she had received that this babe might not come that could have delayed her going into labour, and eventually could have led to the interventions she dreaded. And yes a VE is best avoided, but for some women it is a whole lot better than three or four VEs for Prostin and ARM plus an IV and Syno and so on.

Ethically it is a difficult situation — a woman might avoid IOL with a sweep or two that she was happy with and end up with a lovely birth, or she could be left to get on with it and at 41+ weeks will be offered IOL, which she consents to although she is informed that pregnancy is 37-42 weeks long normally and therefore actually not indicated. She has IOL, it fails and she requires C/S. Or it’s ok, she has epidural and ends up with a Kiellands/Haigs Forceps or Ventouse and a third degree tear. These are average outcomes where I work. If you have been fully informed which would you choose?

Just putting over the other side of the story - in a perfect world all women would absolutely decline IOL but it does seem to be becoming the norm.

C
Conflict of Responsibilities

I assisted a woman to birth a beautiful baby in the waterbirth pool last night and feel very guilty as I left before she was out of the pool and the placenta arrived. She birthed right on shift changeover and I stayed to help her even though the next midwife and student were in the room. Beating myself up now that I should have waited to ensure she was out of pool and her placenta delivered and perineum ok before leaving. It is really snowy up here though and I had a 30 min drive home to let my husband go to work and then take kids to school. What do other hospital midwives do? Should I have let the other midwife take the lead and just left or what? Or should I have hurried her out of the pool to deliver placenta (she wanted a pool to deliver placenta) and perineum ok before leaving. It is really snowy up here although and I had a 30 min drive home to let my husband go to work and then take kids to school. What do other hospital midwives do? Should I have let the other midwife take the lead and just left or what? Or should I have hurried her out of the pool to deliver placenta (she wanted a managed 3rd stage). I'll see her tonight hopefully and make sure everything was OK, but just woken up and feeling guilty.

A Midwife on delivery suite moving to the postnatal ward next month and not looking forward to it.

That's you and me both beating ourselves up. I'm sure you gave that woman ample reason for leaving, snow, husband and work and kids. Yes, we have a duty to the women in our care but we do have lives outside and sometimes they have to take priority.

I know you care, you know you care, the woman knows you care, this list knows you care. So big HUGS to you from me. Love G

Postnatal care

I'm not sure why you're not looking forward to postnatal ward, but I guess it may be due to lack of staff/ not enough time to spend with individual women.

I have stayed as a mum on postnatal ward three times over seven years. I accepted that I would often have to wait a considerable time for assistance owing to staff shortages. What I couldn't accept was the lack of kindness and sometimes outright cruelty on the part of several midwives.

I remember getting out of bed to fetch my baby after a c-section. I had my crying baby in one arm, my catheter bag in the other hand, and proceeded to 'flood' blood over the floor. I didn't know what to do first, change the baby, feed the baby, change my underwear,... I called the midwife who told me that I needed to be able to cope with things myself and walked away.

I burst into tears and an auxiliary whom I will never forget came to help without asking. She changed and comforted my crying baby (even though she wasn't allowed to) whilst I changed, tucked me up in bed to feed and cleaned the floor for me. I held my baby all night because I didn't want to call the midwife to help me. I will never forget how she made me feel. :(.

But I will also never forget those midwives whose small acts of kindness made such a huge difference. The one who arranged for the midwife in theatre during my GA to come and talk to me and describe my baby's birth. Those who were happy to support breast feeding and co-sleeping. Those who always had a kind word.

And the only midwife in many shifts/stays to offer me some ointment for my piles - bliss!

I'm sure you will have many frustrating times – but you appear to be such a caring midwife and that can mean so much to so many. Good luck, J(mum)

Not Complaining about Poor Care

I've just been speaking with a friend who has a four week old baby about her birth experience. She was admitted to our local maternity hospital for an induction as she was 'very overdue' (41+1) but was told that owing to a lack of free rooms on the labour ward, she would need to wait in another ward until there was space in the labour ward before she could be induced.

So, one VERY LONG wait later, my friend happens to begin a strong, efficient labour before they could induce her. She was pleased, but the midwife on duty on her ward wasn't, as she 'couldn't have her baby there' and there were still no free rooms on the labour ward. This midwife then proceeded to repeatedly, and heavily, pressure my friend into accepting a dose of morphine as it would apparently slow her labour down, giving time to free up a labour-room.

My friend, who hasn't had a problem coping with her contractions, who has had morphine in the past for an op. and was violently sick, and who didn't want the drug in her system for her baby's sake, refused, very definitely, every time the morphine was offered. Her labour was cracking on at a great pace, and apparently there was a great deal of unrelenting pressure on her to have some morphine.

I am just astonished at this! Could this really have happened in this way?

My friend said the midwife was very anxious that a woman was in labour in the Wrong Ward where there was no availability of G&A, and the midwife even went on to offer to arrange an epidural – for a woman who was relaxed and coping well with her labour.

I just needed to rant about this really – my friend was unhappy with her care, but is not someone who feels she has the right to question what happened.

AS

Complain!

Well, I'm afraid that until women complain, nothing will change. I strongly urge your friend to make an official complaint. If she is concerned about Trust discipline, then she should complain to the local Supervisor of Midwives. I'll say it again... until women complain, they will continue to get 'care' like this.

LW

A Duty to Report?

You and your friend might like to consider if you have a duty to report this incident to the Supervisor of Midwives who may be able to address the issues you raise and improve the situation. I also wonder if the 'midwife' was in fact a nurse working on the ward and who was not therefore able to attend the birth? This behaviour is NOT acceptable but if the SOM is not made aware of it it will continue.

MC

Antenatal Midwife

The midwife was definitely a midwife, but apparently usually worked on the antenatal ward, and didn't seem comfortable with the idea of attending a birth.

Unluckily for my friend, owing to the lack of free labour ward rooms and/or staff, a deal was struck between wards whereby a room was found for her but only if the midwife in question accompanied her to assist with the birth!

My poor friend - possibly due in part to the kind of care she received – sustained a fourth degree tear. My friend is never going to complain. And I know that nothing will change until women complain. And sadly, as I think everyone on this list knows too, many women consider that they have no right to complain about bad practice within the health service; it would be like complaining about the law of gravity. :-(

AS

Publish

The other way of getting these experiences into the public domain is to have them published. The AIMS journal, for instance, is always happy to print women's experiences. For some women this is much easier to do as they can just write about what happens without the risk of conflict.

DCD

[Midwifery Matters will also publicise such cases if asked.]

Summer 2005 ISSUE 105 Midwifery Matters 31
gleanings

Achieving Normal Labour

Trusts that have a large proportion of women on the Pathway to Normal Labour at the start are more likely to have a larger proportion of women completing it. Conversely, in Trusts where a small number of women start the Pathway, a larger proportion will then have a deviation from normal that will require them to exit the Pathway.

We should ask what is happening in a particular Trust that has nearly two-thirds of women start the Pathway, while in a similar Trust the number is as low as a third. Is it the culture in a Trust that enables midwives to adapt to changes in practice so readily? Is it leadership that generates commitment or is it simply the passage of time?


VBAC

…the phenomenon whereby the researcher may surreptitiously ‘enhance’ the research findings to suit his agenda has been dubbed ‘massaging the data’. This activity, which has also been entitled ‘spin doctoring’, is clearly unethical as it denies the reader the opportunity to make a sensible judgement on the basis of unambiguous research findings. McMahon’s (1996) manipulation of the data during analysis involved the categorisation of wound infections and haemorrhage (sufficient to need blood transfusion) as ‘minor’ complications. In this way, these researchers were able to suggest that elective repeat caesarean is the safer way of giving birth after caesarean’, giving birth.

Rosemary Mander, ‘Need to know, Vaginal birth after caesarean’, The Practising Midwife, November, p4-5

Psychophysiology of the Sphincter

Sphincters are circular muscles that surround the opening of those organs that are called upon to empty themselves at appropriate times. These openings ordinarily remain closed but have the ability to open as widely as needed when necessary. Their function and character are implicit in their name in the German language, Schliessmuskel, meaning ‘closing muscle’.

Each of the organs I have referred to is able to contract rhythmically as it fills, until it reaches the point of urgency at which the sphincter relaxes enough to allow urination, defecation or birth to take place. The basics of sphincters are worth remembering:

- Sphincters open best in conditions of privacy and intimacy.
- Sphincters don’t respond well to commands, such as ‘Push!’; ‘Poop now!’ or ‘Get ready, get set, pee!’. They are not under our voluntary control.
- Sphincters are shy. Even in the process of opening, they may suddenly close when their owner is frightened or embarrassed. This is because high levels of adrenaline in the bloodstream do not usually favour (sometimes, they actually prevent) the opening of the sphincter.
- Sphincters do respond well to praise, if it comes from a trusted intimate companion or family member accompanying the sphincter’s owner.
- Sphincters open better when their owner’s mouth and jaw are relaxed and somewhat open.
- Sphincters open better when their owner is smiling or laughing

Ina May Gaskin, ‘Smile for your sphincter’, The Practising Midwife, November, p4-5

Beware ginger for nausea

...There is an almost contagious trend for midwives to take as gospel a ‘snippet’ of information relating to the use of complementary and alternative therapies. It is regrettable that midwives may use therapies such as ginger as heartburn, or that it may interact with several drugs such as anti-coagulants, including aspirin, given to women with a history of pre-eclampsia.

Denise Tiran, ‘Complementary medicine in pregnancy and birth’, The Practising Midwife, November, p12-16

Tsunami claimed thousands of midwives

So many midwives died in the tsunami on December 26 that some women in Indonesia have been forced to work in dark tents without even a bar of soap, using shards of bamboo to cut the umbilical cords, according to media reports.

Others have had to walk through miles of jungle for antenatal help, and many women are facing the danger of giving birth alone.

The Indonesian Midwives Association says 1,650 midwives – 30 per cent of its members – on the northern tip of Sumatra island died in the catastrophe. Many who survived are too traumatised to resume work or lack equipment.


Contraception Education in Brazil

In the early 1990s, 1.4 million abortions were performed each year, almost all technically illegal: there was approximately one abortion for every two live births. Although abortion in Brazil is legal only in cases of rape and danger to the mother’s life, the law has never been strictly enforced. Back-street abortions explain the country’s position as having the fifth highest maternal mortality rate in Latin America, estimated at 141 deaths per 1,000 births.


Discontinuing Epidurals (Cochrane Review)

Whether the epidural was stopped, replaced with a placebo solution or continued with a real epidural solution, no difference was found in:

- the number of women giving birth vaginally, unassisted
- the number of women requiring instrumental delivery
- the number or women requiring caesarean section
- the length of second stage
- the number of fetal malpositions
- Apgar scores
- Umbilical arterial pH


Skip to the loo

The often unloved sanitary ware is quite universal, does not have to be hauled around in the back of anybody’s car and transcends location. It is equally available in homes, hospital and birth centres, and sometimes even in the more unusual places in which women occasionally give birth, such as supermarkets and aeroplanes (although admittedly not often in taxis). Toilets, which were described by one midwife as ‘a place of total privacy and where you let yourself go’ have their uses in every stage of labour…

IMPORTANT NOTICE

ARM Membership and Mailing List

New Membership Fee - EFFECTIVE 1ST JANUARY 2006
The annual membership fee has remained the same since 1st January 1999. At the AGM in September 2004, the new rate of £30 (UK), £35 (overseas), was approved. The increase will be effective from 1st January 2006. (Student and unwaged members’ fee will remain at the current level of £12.50). The new rates will be shown on the subs form in the December 2005 issue of Midwifery Matters. Members using Standing Orders will need to give new instructions to their banks, using the new forms (see below for how these work).

I am asking everyone to be as prompt as possible in upgrading their standing orders. After the last change (January 1999) I sent out many reminders, sometimes more than once to the same person, before the upgrades were complete. The whole exercise took more than two years, and journals continued to be mailed out to these people.

This time, to be fair to those members who upgrade promptly, it has been agreed that non-compliance will result in being dropped from the Midwifery Matters mailing list, until the new fee has been received.

Change of Address Notice

After every Midwifery Matters mailing there are always a few journals returned by Royal Mail, marked ‘gone away’. The only thing I can do in these cases is to remove that member from the mailing list until I receive the new address. In their busy lives, members don’t immediately realise that they’ve not had the magazine, and by the time they contact me, there are no back-copies of the journal left. So, if you are moving house, PLEASE LET ME HAVE YOUR NEW ADDRESS BEFORE THE NEXT MM IS DUE!

Do YOU check your monthly Bank Statements?

No, I’m not being nosy! Banks are not infallible. ARM bank statements occasionally show that a member’s bank is paying us monthly, in spite of the word ‘ANNUALLY’ in bold type on the standing order form. I then have to write to the member pointing out the bank’s mistake. Sometimes it takes two or three letters before she finally contacts her bank. When the member has moved house (see above), then there’s nothing I can do. Recently this has been the case with two ex-members, who are claiming refunds of over £200. All this entails a great deal of extra work, and after discussing the problem with Sarah and Hilary, we’ve agreed that the responsibility lies with the member, to check her bank statements and take appropriate action if such errors occur. The bank must then immediately refund the overpayment into the client’s account, and claim reimbursement from ARM. We feel entitled to deduct a suitable charge to cover our extra admin. costs.

The Difference between Standing Orders and Direct Debits

Some members have mistakenly assumed that ARM has deducted a membership fee from their accounts. I’d like to clear up any such misunderstanding, as follows:

Under the Direct Debit system, the account holder authorises a company/organisation to draw an agreed (variable) amount from her account on an agreed day, or at agreed intervals.

Under the Standing Order system, the account holder instructs her bank to pay a fixed amount to a company/organisation on a fixed day at fixed intervals.

The low number of transactions means that ARM’s account does not qualify for the DD system. ARM is therefore unable to draw money from members’ accounts. We use Standing Orders, which once set up, can only be amended or cancelled by the account holder.

Many thanks for your help.

Ishbel Kargar
Membership Secretary
Items for Sale
ORDER FORM

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<td>Car sticker (Logo: Owl on Pinard, ‘Pregnant? Be wise, choose a Midwife’)</td>
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<td>ARM CD ROM of the first 100 issues of the magazine</td>
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<td>Childbirth Unmasked (stress hormones in labour) Margaret Jowitt</td>
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<td>Midwifery Matters (single back-copies)</td>
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<td>“Choices in Childbirth” (free leaflet)</td>
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<td>“What is a Midwife?” (free leaflet)</td>
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Post & packing cost codes: A = 50p; B = £1.00; C = £1.50 per single item ordered.

N.B. For larger orders please contact Sarah Montagu - tel 0121 689 2800

INFORMATION LEAFLETS - (Single leaflets free of charge)

What is a Midwife. Our leaflet was highly recommended by the Government Expert Maternity Group (Changing Childbirth, 1993) as a method of increasing the awareness of the midwife’s role and skills.

Choices in Childbirth. Comprehensive information leaflet for universal distribution. Printing sponsored by the Midwifery Department of Napier University, Edinburgh.

Supplies for local distribution are available for the cost of postage & packing as follows:

50 leaflets @ £1.50; 100 leaflets @ £2.50; 200 leaflets @ £4.00; 300 leaflets £4.50.

Please send your order to ARM Sales, with a cheque made payable to ARM

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We have reproduced all the first 100 issues of ARM magazines on CDROM for you to browse through, offering nostalgia for long-standing members and satisfying curiosity for more recent members!

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PC and Apple Mac compatible versions are available.

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MAGAZINE CO-ORDINATOR AND TYPESETTER

Are you an active member of ARM? Can you attend most national meetings?

Do you have copy editing and typesetting skills? Do you have an eye for a good story, page layout? Could you coax words out of busy midwives?

Could you ‘midwife’ Midwifery Matters through from copy stage to page proof stage?

ARM now funds the post of typesetter and magazine co-ordinator to the tune of one day a week (up from about 0.5 days a week) at mid F grade with the postholder working on a self-employed basis. This post is open to all ARM members. Applications will be welcomed from people willing to share the post.

Enquiries & applications to: Sarah Montagu, 16 Wytham Street Oxford OX1 4SU  
tel: 01865 248159  
mobile: 07946 392728 email: sarahmontagu@postmaster.co.uk

Closing date: June 15th, 2005
Cranio-Sacral Therapy

Complete courses in this exceptionally gentle yet extremely powerful therapy

CCST is the most established college of Cranio-Sacral Therapy in Europe, renowned not only for the high standard of its training, but also for its caring and supportive approach to students.

The course includes an important emphasis on Birth Trauma, treatment of babies and children, treatment of mothers during pregnancy, birth and post-partum, vital relationships between birth and subsequent development, common childhood conditions from colic and ear infections, to learning difficulties, behavioural disorders, epilepsy and cerebral palsy.

1 year course (London) starts July
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Introductory course:
16th-21st July 2005

Introductory Day:
July 2nd 2005

College of Cranio-Sacral Therapy (CCST)
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Tel: 020 7483 0120
e-mail:info@ccst.co.uk Website: www.ccst.co.uk

CALL THE MIDWIFE

by Jennifer Worth

Riveting stories of district midwifery in the slums of London in the 1950s

“I found it utterly fulfilling. Sheer magic”
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The publisher offers readers 25% reduction + FREE p&p. Total £12.99 EACH on mail order, quoting MM2
Have you yet found time to book for the highlight of the midwife’s year – the ARM Retreat? Olga and Ishbel have found wonderful venues in the past and I hope we’ve found somewhere equally enjoyable for this year.

We decided to book a venue further south this year, as there had been a fairly consistent northerly bias to meetings over the last couple of years. The only drawback to the idea was that I volunteered to organise the retreat but live in one of England’s northernmost counties! However with kind assistance from Debs Purdue and Frances Finlay and extensive research we hope we have overcome the problem.

The youth hostel sleeps 25 which I hope will help with the problem of extra demand which has sometimes occurred, we settled for a youth hostel to keep costs as low as they have been in previous years to make the retreat affordable for everyone. It seems holiday houses in the south are much more expensive, and the season lasts longer, making late September summer! The sleeping accommodation will be more communal than before as there are a couple of six bedded rooms but I feel you adaptable people will not find this problem – any bed must be better than the floor. Frances was not able to view the inside of the hostel but the information suggests there is plenty of public space for workshops and socialising. It is near Glastonbury (has factory retail therapy close at hand) and is not too far from Bristol and Wells hopefully making it fairly accessible. I could not find a genuine coastal site but I am told it is in beautiful countryside and that there is plenty of parking space.

Please book as soon as possible. £15 for per night dinner, B&B.

ARM MIDWIVES RETREAT
BOOKING FORM (PLEASE WRITE CLEARLY IN CAPITALS)

NAME: _________________________________________________________

ADDRESS: __________________________________________________________________________

POSTCODE: ___________________________ Tel.________________________________________

I wish to stay the following nights (Please circle your choice)

Fri 23rd   Sat 24th   Sun 25th   Mon 26th   Tues 27th   Weds 28th   Thurs 29th

£15 per night half board. Discount for full week (7 nights) £85

I enclose £______________

(please make your cheque payable to A.R.M. Holiday)

Signed: ___________________________ Date ___________________________

Please send your completed form and cheque to ARM Holiday Booking, Waterside Mills House, Chesters, Hexham NE46 4ET

Your booking form and payment will be acknowledged with a receipt, and a map of the location and travel directions will follow.
local group news
The following people co-ordinate local groups. Please contact them for details of what’s on.

Sheffield  
Mavis Kirkham  
221 Albert Rd, Sheffield S8 9QY  
0114 255 7945

Cambridge  
Pat Lindsay  
8 Moory Croft Close  
Great Staunton, St Neots  
Cambs. PE19 5DY  
Bi-monthly meetings often with invited speakers.  
Paul.g.lindsay@talk21.com

Wigan/Bolton/St Helens  
Lesley Price  
33 Lincoln Drive  
Aspull, Wigan WN2 1XB  
01942 747902

Herefordshire  
Annie Robertson  
Cwn Rarm, Abbey Dore  
Hereford  
HR2 0AB  
01981 240632

Milton Keynes  
Valerie Gormon  
Independent Midwife  
www.3shiresmidwife.co.uk

Maidstone area  
Midwives Muddle  
Joy/Kemp  
29 Woodpecker Rd  
Larkfield, Aylesford  
Kent ME20 6JQ  
joykemp@blueyonder.co.uk

East Sussex  
We meet roughly every 4–6 weeks at someone’s home, sharing tea, homemade cakes and lots of chat. We often have speakers on topics such as aromatherapy. The students find it especially valuable hearing midwives talk about the home births they have attended. We vary the venue between North, South, East & West (of East Sussex) so that we take it in turns to travel further.  
Anyone wanting to come to our next meeting please phone Maia Jones on 01273 487 553.  
maia.j@ntlworld.com

West Sussex  
Next meeting: 3rd March 2005, 7 pm.  
Venue: Steep, Petersfield, West Sussex.  
Please e-mail for full address and directions. It’ll be nice to have an idea how many are planning to come.  
Contact: Aida (01730 812086)  
aida@lotuswithin.co.uk  
Cathy (01730 231024)  
cathy@coomasaru-walton.com  
You do not need to be a mother, or a midwife or a member to attend. Hats and brooms optional!

Wigan Homebirth Group  
contact: Jayne Halton 01257 404468  
Meetings: Queen’s Methodist church hall, Market St, Wigan  
2nd Tuesday of every month  
10-11.30a.m.

Wendy Blackwood is the Local Groups Co-ordinator. Please send updates to her at 11 Hazelhurst Grove, Ashton-in-Makerfield, Lancs  
WN4 8RH tel: 01942 205935

AIMS/ARM Conference - 1st October Birmingham

“Do women want midwives or obstetric nurses: an action plan for change”

Speakers to include:  
Nadine Edwards  
Do women want midwives or obstetric nurses?  
Mavis Kirkham  
Should I stay or should I go?  
Speaker to be confirmed  
Demystifying and understanding the role of CNST in the maternity services  
Mary Cronk  
Why midwives are reported to the professional conduct committee  
Barbara Hewson  
The law supporting women and midwives’ autonomy  
Jean Robinson  
Women’s influence on maternity service politics  
Jane Evans  
Am I redundant as a ‘midwife’ today?  
Lesley Price  
Risk obsession on the labour ward  
Speaker to be confirmed  
A woman’s story  
Brenda Van Der Kooy  
The IMA community midwifery model

Anyone wanting to make a booking please send cheques to:  
Anna Fielder, 25 Lees Hall Road, Sheffield S8 9JH. Tel: 0114 2582221

Price: £30. Reduced rate: £10

Closing date for bookings is Friday 23rd September 2005.
Summer National Meeting
Saturday 18th June 2005
Edinburgh

Registration: 9 am for 9.30 start - 4 pm

am: ARM business followed by presentation of the IMA community model

pm: Workshops and Speakers

‘Midwives in rural areas – What problems do they face?’ Mary McElligott
former chair of RCM UK Board, Scotland and Professional Practice Development Manager for the Western Isles

‘Deaf women’s access to maternity care’, Caroline Thompson
Health Promotion Team, Deaf Connections, Glasgow

Concurrent workshops

‘Practicalities of independent midwifery’, Alison Ewing, independent midwife, Glasgow
‘Therapeutic touch’, Nessa McHugh, independent midwife and midwifery lecturer, Glasgow.

Venue: St Ninian’s church hall, St John’s Road, Corstorphine, Edinburgh. See map.

Steering Group: Friday, June 17th, 7.30 at the Birth Resources Centre, 18 St Peter’s Place, Edinburgh. All ARM members welcome but if majority decisions are required, only members of the Steering Group may vote.

Directions for Steering Group: From Lothian Road, travelling south, take a right where Lothian Road branches off. Follow Home Street-Leven Street until you come to the crossroads/traffic lights and junction with Gilmore Place, turn right here. Follow this road along until you come to the junction with Viewforth/St Peter’s Place. St Peter’s Place is on the right.

Accommodation: Local accommodation may be available in ARM members’ homes. If you want accommodation, or are local and can offer accommodation, please contact Sharon Baillie at 03006275@napier.ac.uk. If you are staying over in a member’s house, please bring sleeping bag and airbed if possible.

Evening entertainment. For those making a weekend of it, we are planning a pubcrawl and evening Ghost tour of Edinburgh. Places MUST be booked, contact Carrie-Anne Gibb at carriedannegibb@hotmail.com to book a place on the tour.

Further information: Please contact Carrie McIntosh, carriemcintosh@hotmail.com
0131 660 9140 or 07831 794658
or Nessa McHugh 01592 840408

St Ninian’s Drive

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St Ninian’s Road

St John’s Road

Kirk Loan

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Glebe Road

Manse Road

Kirk Loan
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, part refund of expenses for travel to National Meetings (for details, see National Meetings inside front cover).

NAME: (please use BLOCK CAPS): ____________________________________________________________
ADDRESS: ____________________________________________________________________________
POSTCODE: __________________________________________________________________________

TEL: __________________ email: __________________

MIDWIFE (Please circle relevant status): Community Hospital Team Tutor
Student (course ends __/___ m/ y) Research Manager
Independent Not practising Retired

NON-MIDWIFE: (Occupation) ____________________________________________________________

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