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Welcome to Wigan

The Wigan ARM is a large group of midwives and student midwives and women who meet monthly to discuss issues around childbirth. We formed four years ago when three midwives, Lois, Lesley and Heather, felt it would be good to meet and talk. Soon we had a group of talented and enthusiastic mums, doulas, students and midwives in our living rooms. Our members come from Liverpool, Manchester, Bolton, Bury, Southport, Ormskirk and surrounding areas. As midwives we are a blend of retired or on career breaks, hospital midwives, community midwives.

We have had a busy year starting with the ARM Spring National Meeting in Wigan. In June, Brenda van der Kooy gave an excellent talk on the IMA model and then in November Jane Evans and Brenda gave a Study Day 'A Day at the Breech'. All these were well attended and well received. In the meantime we had our regular monthly meetings.

As a group of student midwives, midwives and mothers we invariably find that midwives and mothers want the same thing: continuity of care and carer, and choices to give care. We are looking forward to Liam Byrne, Minister for Health fulfilling his promise of providing midwifery-led care. As a group we are aiming to raise the profile of the midwife as autonomous practitioner and the mother as central to that care. The student midwives in the group are a vital life force and our future and we look forward to supporting and nurturing them in their midwifery journey. We all agree as a group that we cannot expect women to support midwives as experts of the normal in birth, if women are not experiencing normal birth. We are hoping to present a study day later in the year with women, on Birth Issues and Alternative Therapies.

Lesley Price

(on behalf of the Wigan ARM & Home Birth Group)

Robbing Petra to pay Pauline

Having been incensed that Queen Charlotte's has the cheek to charge women £4,000 for continuity of care throughout pregnancy and labour, I started coming round to their way of thinking. Why shouldn't well off women subsidise continuity of care for other women? That's what QC say is happening. It *is* NHS care, *really* it is, they protest. The continuity scheme started in a well off catchment area and was then withdrawn and switched to Sure Start areas. Women in the richer area lobbied for its return and were prepared to pay the price. 75 already have. Result – smiles all round. Queen Charlotte's can now afford 2.5 more midwives. More women will be able to have one-to-one care in labour.

Hang on a minute.

£4,000 x 75 = £300,000; 300K/2.5 = 120,000K – hey, did you know that you cost the NHS £120,000 each folks?

Hello? I don't think so.

I misread *The Guardian* article, the extra 2.5 midwives were 'among other things'. What things? A birth ball or two? The salary of someone to promote the scheme? A bonus for the accountant who realised that continuity of care saved money on caesareans and that getting women to pay for it was a win/win scenario? Happy mother, happy baby, happy midwife, happy accountant. (Sad underemployed lawyers!)

It's a brilliant idea – they could privatise midwifery completely. Why not get women to pay for their caseload midwives if they like them so much. The richer you are the more you pay. Let the NHS pay for the really important things, the scans, the paperwork, the drugs, the technology, the surgeons, the special care cots – after all a caseload midwife doesn't really do anything does she? Why should the NHS pay someone for having a cup of tea with a patient? She's only sitting with the woman, isn't she? I mean, very hands off, really.

If Queen Charlotte's can charge for caseload midwifery, and pretend it's really on the NHS, everywhere can. Aneurin Bevan must be spinning in his grave.

I've got a better idea. We could adopt the IMA's NHS Community Model and have One Mother One Midwife countrywide. The accountants could still be happy enough counting the savings on avoided caesareans and empty special care cots. I'm sure they'd find something else to spend the money on.

The Wigan Home Birth Group

Jayne Halton

I RUN THE WIGAN home birth group. I have three children and my youngest son, who has just turned two, was born at home. I decided to have a home birth because my second child was a very fast delivery. I only just made it to the hospital and the birth was very rushed and panicked and it all came as a bit of a shock. When I had my second child I did not know that there was such thing as a home birth. I was not given any option, but when I fell pregnant with Thomas a friend of mine who had had her baby at home told me what a wonderful experience it had been, so I instantly decided to have him at home. When I went for my booking in appointment nobody mentioned the possibility of home birth and when I brought it up I did not get a great response. I was given all the negatives and told to think clearly about it and they would make a decision when I was 26 weeks pregnant. My doctor also informed me that his practice did not support home births. I came away feeling defeated until I spoke to my friend who had had the home birth and she told me to persevere.

Things did not get any better with each antenatal appointment. I was always given the negative view and discouraged. I understand you have to be told the disadvantages but there are also proven advantages to having a home birth.

I had a perfectly straightforward pregnancy with no complications and eventually was booked for my home birth at about thirty weeks. My baby was born five days early, very healthy, happy and contented, with good Apgar scores. My birth experience was very positive and afterwards I received nothing but positivity from my midwife which was a welcome relief. I just wish I had had this particular midwife during my pregnancy. Even my Mum, who was a bit nervous about me having a home birth at first, found the experience very calm and relaxed and is now an advocate for home birth telling everyone how great it is. Because of this experience, I wanted to help other women in the same situation.

Luckily a lot of midwives are coming round to home births but there are still some problems. The home birth group has helped some women get the positivity and support which is vital for a woman and her family in any birth situation. For a woman a positive pregnancy and birth can make a real difference. Just listening to other peoples' stories can be so empowering and it is lovely to follow women through pregnancy to birth to babies' birthdays, and to make lifelong friends.

I would also like to point out that our group is called the Home Birth Group and not the home confinement group which sounds so restricting.

Beginnings

The Wigan home birth group was originally formed by a lady called Janet Naylor. Janet had been a birth doula to a lady who had delivered her baby at home and had had such a wonderful experience that she wanted to spread the word locally about home birth. She decided to set up a monthly get-together, with the full support of health professionals in a Horwich clinic. This seemed a good set up because, although women led, it also had the backing of midwives and health visitors who popped in from time to time.

The group had been running successfully for several months when Janet realised that many women were travelling from the Wigan area to meet in Horwich. That is why she decided to start our own Wigan group.

Supervisor of midwives Lesley Price and Janet looked for a suitable venue, where women and their families would feel comfortable. Eventually Janet settled on the Queens Hall in Wigan town centre.

The Wigan group started in September 2003 with the support from some midwives and the head of midwifery. They promoted the group wherever they could, on posters, flyers, in clinics and, on several occasions, involved the local press – having our photo taken was a good plug for home birth as well.

Unfortunately Janet had to move away recently and asked me to take over running the group.

The number of people who have attended the group has risen dramatically since the group started, reflecting the increase in home birth.

We started with five or six people and we now have had thirty people attending the group, not just mums and mums-to-be but partners, grandparents, midwives and student midwives. We are hoping to attract many more people in the future.

Aims

The main aims of the group are to provide a venue where women can get information on all aspects of birth – both positive and negative – so they can make a truly informed decision of whether home birth is right for them.

It is also very important for partners and families to come along because if a woman would like a home birth her partner and family may have some concerns, these can usually be allayed by speaking to other women and their partners who have been through similar circumstances and had a good birth experience.

We are currently looking for funding so we can set up a lending library, then we can provide more information on

all aspects of pregnancy and birth not just home birth but breastfeeding, women's rights and any other aspects women would find useful from resource centres like AIMS, NCT and ARM.

Advantages

The main advantage of the group is that women can share their experiences and empower each other, in an informal and friendly atmosphere where anyone can air and share their views and sometimes debrief other birth experiences. Here, myths about home birth can be dispelled. There is a chance to speak to women who have been there and done it, not just to listen to the horror stories and scare tactics that, unfortunately, some women hear from some health professionals. We are all aware of possible risks in any birth situation and we acknowledge things do not always go to plan. Most concerns and anxieties can be allayed by women as well as the expertise of visiting midwives.

The positive nature of this group has also helped to change some attitudes to home birth and the more advertising we do, the more socially acceptable home birth will become.

Disadvantages

The main disadvantages the group has had is the lack of funding. This has meant that we have not had a great deal of resourses at our advantage.

We have had to rely on a voluntary contribution from people attending the group to pay for hall rent and refreshments.

We also need funding towards advertising for posters, flyers and cards, because the more people who know about the group the more we can help and empower other families.

Conclusion

I feel there is a great need in every area for a good support network, which encourages good relations with women, their families and health professionals. As a mother I hope to see the home birth rate increase even faster than it is already doing, empowering women and their families in choosing home birth as a realistic and safe option for delivering their babies. Since having a home birth myself my life has changed dramatically for the better, I feel very privileged to share my story with new people and to help others in their quest for their ideal birth. I have joined many organisations and feel that my voice as a service user can actually make a difference to the way things are done in the future. If I can help just one person then I feel I have achieved so much and as a woman that is very empowering.

If anyone would wish to contact me regarding the group my email address is jayhalton@tiscali.co.uk and my phone no: 01257 404468

Comments from some people who have attended the group

Partner's

I was mortified and frightened when my partner decided she wanted a home birth but, with great reluctance, I went along to the group just to see for myself. My first impression was relief that these women were all alive, their babies were alive and well, and they all had really positive stories to tell. I initially thought that home birth was like economy class and a hospital birth was first class until we experienced the birth for ourselves, within an hour of the birth we were tucked up in bed as a family and had had a wonderful experience. I would defiantly say home birth was the first class and just wish we had had our other two children at home.

Julia's story

When I found I was pregnant with my second child I decided I would like a home birth. During my pregnancy my dates were calculated incorrectly which worried me because I knew just how important it was to get a due date as accurate as possible in order for me not to be considered overdue so I could pursue my home birth plans. This was understandably upsetting so I took my worries to the home birth group to confide my fears. I found the group supported me immensely and without their help I may have given up my plans. I had a wonderful birth experience and can't thank the group enough for helping me achieve my dream birth. I feel as part of the group I can tell my story and possibly help other women in the same situation so they don't feel the way I did.

Helen's Story

Having my daughter Emma born at home was a wonderful experience for me. It was much more enjoyable, relaxed and calmer than when I had my son in hospital. Being in my own environment I felt totally in control the whole time. I had two midwives with me throughout, who were both brilliant, they seemed to enjoy it too, as my husband kept them fed and watered. I had the television on, watching the Hungarian Grand Prix, witch was great pain relief! Within an hour of Emma being born I was sitting in my front room drinking a cup of tea surrounded by all my family.

Student midwife

As a student I want to experience as many aspects of pregnancy and birth as possible and I found the group very interesting. The mums were not hippies with way-out ideas just ordinary people wanting the best for their babies. It was great speaking to women and hearing real opinions and views about what women really want during pregnancy and birth. It was great to see some really empowered women confident in trusting their own bodies for a natural birth experience.

A 12-step guide to setting up a woman led home birth group

Lesley Price, Jayne Halton, Wigan Homebirth Group

1. Find a midwife and a woman who support home birth.
2. Midwife with consent of women interested in home birth passes on names and addresses to each other.
3. Form a group – two is good – three people is even better!
4. Find a venue with a kitchen. Kettle and toilet – cheap rent or even free.
5. Write posters and display in supermarkets, clinics, libraries and dentists etc.
6. Obtain free leaflets from AIMS and ARM.
7. Self-funding – cup of tea 40p?
8. Meet regularly.
9. Invite midwives, student midwives, Supervisors of Midwives, women and men anyone interested in birth issues.
10. Join the local Maternity Services Liaison Committee.
11. Write to Head of Midwifery NHS Trust Maternity units Primary Care Trusts Local newspapers share your views ideas concerns.
12. Share your stories experiences and write them down.

ENJOY!

Waterbirth at Home
Lynn Seddon

My second daughter, Rebekah Rose, was born, at home, in water, on the 2nd September at 6.05pm, following a three hour labour.

The whole experience of this pregnancy and birth has been so positive, so fulfilling and so special. At each ante-natal appointment, as I met the different midwives, I expected to meet resistance to my wish for a homebirth. Nothing could have been further from the truth. I met a team of wonderful midwives (Shelley team) who respected my decision and positively encouraged and supported me in it.

The midwives attending the birth of my daughter, Therese and Vivian, were very special women, who came alongside me and encouraged me to listen to my body and do what I needed to do. As a result, Rebekah was born into our birthing pool, in my dining room, after three pushes, with me needing no pain relief and feeling on top of the world.

What a very special experience, what a wonderful way to continue the bonding that had begun in my pregnancy. I had a fully physiological third stage and declined vitamin K, due to my daughter's gentle entrance into this world.

It was, if there is such a thing, a perfect birth. I couldn't have planned it any better. And to think, when I shared my decision to birth at home with other mums during my pregnancy, they would comment, 'Aren't you brave!' On the contrary, I think the decision to birth in hospital, away from the comfort and familiarity of my home, would be the 'brave' thing to do.

As for my first daughter, who was present at the birth of her sister (in between watching Tweenies) I feel she has been given a real gift. To know that birth is a wonderful, special part of everyday life, something that, as a woman, her body has been perfectly designed to do, not something to be feared. Her expression of joy, as she ran up and down our hallway, shouting, "We have a baby! We have a baby!" quashes the concerns of those who worried about her being present for the birth itself.

So, it is with great satisfaction, that, when people ask, "Oh, did you have your baby at the new maternity unit?" I say,

"No... my baby was born at home!"

Service Improvement Award

At present, services within my Trust consist of a consultant-led obstetric unit, conducting approximately 3,000 deliveries a year. In 2005 there were 41 homebirths (there were19 in 2003). Women and midwives are proud of this increase; not only does it go towards supporting government directives, but it also reflects a philosophy of care in which pregnancy and childbirth are viewed as a normal life event. Indeed, the ninth report of the Health Committee (DOH 2003) claims that maternity services led by acute general hospitals tend to over medicalise birth. They recommend midwifery-led care for all women with uncomplicated pregnancies and increased access to homebirth. Accompanying this is a growing body of evidence detailing the negative impact of medical intervention during labour on women who give birth in hospitals (Laing 2001, Creedy et al 2000, Beech 2000, Hillan 2000).

In January 2005, a focus group of midwives formed to explore ways in which more choice could be offered to women and their needs put firmly at the centre of services, in line with the National Service Framework (2004). We visited other units, reviewed literature, worked in partnership with service users and consulted midwives on their views and ideas for new and improved ways of working. We wanted to advertise the benefits of homebirth to the wider trust, so a midwife colleague and I, in partnership with the women-led homebirth group, decided to enter its 'Service Improvement Awards' presentation. This is an event that is held three times a year and is sponsored by the WRVS. The teams produce a storyboard and then make a presentation to a panel of judges, who question them and judge them against: the impact on the patient's experience; multi-professional teamwork; sharing of good practice; clarity of roles and responsibilities; user and carer involvement and evidence base. Awards are gold, silver and bronze and we were proud to be presented with a silver award which won us £500 to spend as we wished. We have shared this prize with the women-led homebirth group, and we are spending our share to arrange a study day on 'Acupuncture in Midwifery Practice' for any midwife who wishes to attend. We want to thank them for continuing to support us and the rising homebirth rate in our Trust. The group is continuing to look at new ways of working and we have recently presented a proposal for caseload midwifery to managers and the PCT for their consideration (see this issue page15).

Louise Brown

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Jayne Halton, Sue Andews and Lesley Price receiving the Silver Award for Service Improvement from Marie Thompson

Women-led Homebirth Group

The women-led homebirth group was set up in 2003 in order to inform and support women who wished to give birth at home. It is run by service users and has midwife input and support. The homebirth rate increased by 100% in 2004 and a group of midwives started a group in January 2005 to work in liaison with women to take the rising homebirth rate forward. This is a cost effective service that promotes the autonomy of midwifery practice. The NHS Plan states that: "The homebirth rate is a useful indicator of a service's responsiveness to women's choice".

Drivers for change

- Proposed reorganisation of maternity services at a local level.
- National Service Framework for Maternity Services.
- Government directives: 'Promoting Normal Birth'.
- Increasing medicalisation of childbirth.
- Increasing cost to Trust.
- Lack of choice for women/unaware of choices in childbirth.
- Fragmented/poor continuity of care.
- Poor job satisfaction for midwives.
- Negative birth experiences for women and families.
- Public health agenda – to increase breastfeeding rates and reduce incidence of postnatal morbidity.

Aims

- To keep local women as the main focus for change.
- To inform/educate all service users about the provision and benefits of the homebirth service.
- Emphasis on community-based care.
- Promote the autonomy of midwifery practice and the philosophy that childbirth is a normal physiological process.
- The midwife as the lead professional for all 'low risk' women who wish this.
- To develop care options in partnership with service users.
- To increase the homebirth rate.
- To support and value women's choice.

Benefits – to service

- Cost effective – hospital birth costs approximately £850, homebirth £430.
- Reduction of admissions to hospital/care given in home and community.
- Increased job satisfaction for midwives – midwifery skills developed.
- Reduction in complaints.

Benefits – to users

- Research has shown that in low risk women it is as safe to give birth at home.
- Continuity of care.
- One-to-one care and support
- Feel valued by carer and are empowered - involved in decision-making. Less bad birth experience and postnatal depression.
- Are relaxed and more mobile in home environment, therefore labour is shorter.
- Require less analgesia.
- Less likely to have unnecessary intervention.
- Family fully involved and share in experience.

Currently

- Homebirth leaflet, information and support given to women interested in having a homebirth.
- Women-led homebirth group meets in Wigan once a month.
- Homebirth evening led by midwives and women held every three months at Shevington Clinic.

In the future

- Auditing the outcome of all women who request a home birth and researching women's views.
- Informal education of PCT, GPs, medical staff and health workers about homebirths.
- Extending homebirth information evenings to all areas of the trust.
- Women-led homebirth group giving support to service user groups being set up in Leigh and in other trusts. Sharing good practice.
- Development of 'Choices in Childbirth' leaflet to include homebirth information, given to every woman who accesses maternity care.
- Formulation of homebirth guidelines.
- Ideally, caseload practice.
- Study day for midwives and women's group.

Sue Andrews, Lesley Price and Jayne Halton

Lavinia's Story

A POSITIVE PREGNANCY TEST and a scan at the early pregnancy clinic showed that I was 11½ weeks pregnant; quite a surprise given that our daughter was only eight months old. My previous pregnancy had been uncomplicated throughout, however, after sixteen hours in labour and only five centimetres dilated, I was offered a caesarean. I'm sure I speak for many women who agree to a caesarean at this point in their labour, any contraindications or future problems that are discussed during the consent procedure are inconsequential at that point. Needless to say, when I was advised by my midwife that I would need to be referred to a consultant as I was high risk due to the previous section, I was surprised.

During my appointment with the obstetrician, I was advised categorically that I should have a repeat caesarean section. I was told about the likelihood of a ruptured uterus which, if it happened, could lead to the mortality of me, the baby or both. The advice was clear, come into hospital as soon as you feel you are going into labour. At this point, labour would be continuously monitored and if after (an undefined) period of time, labour had not progressed at the required rate, an emergency section would take place. This was the only option offered to me and one I was very unhappy with.

Having undertaken a considerable amount of research into the likelihood of uterine rupture following a caesarean, I felt the risk was small albeit, the consequences were great. I had several conversations with my midwife who was very sympathetic and respected my view. I was not prepared to go ahead with a caesarean until I had tried a natural birth. I planned that at the onset of labour, I would remain at home for as long as possible despite this being against advice of the obstetrician. I felt very strongly that if I went to hospital then medical intervention would follow. It seemed to me that I was not being heard by the medics and the only way to proceed was their way.

During my pregnancy, my mum was critically ill having ovarian cancer with multiple secondaries. Throughout my pregnancy every day I was at the hospital, spending precious time with my mum. Hospital had become a place of extreme uncertainty and not somewhere I was looking forward to going to deliver my baby. On one of my antenatal visits, I was lucky enough to see Lesley Price. Her thorough approach was encouraging and enabled me once more to express my dissatisfaction at having a caesarean. She offered me a home birth straight away and without thinking I said yes. It seemed like the most natural thing in the world. A homebirth would give me the opportunity to feel in control. Lesley informed my obstetrician and all other relevant departments.

Being at high risk, my care package required another visit to the obstetrician. At this meeting, I saw a registrar who told me, "You are the centre of extreme controversy Mrs Wilkinson". Once again, I was told of the uncalculated risk I was taking, the registrar actually said if it were their sister, they would advise her to have a repeat caesarean. There was a total lack of medical support for my decision; moreover, I was left to feel I was being irresponsible.

Sadly, three weeks before my due date, my mum passed away, the pregnancy had long since been the focus of my attention. Now, I had to face a delivery and motherhood without my own mother. The sense of loss and grief were overwhelming. Lesley was tremendously supportive and reassured me about the home birth. I knew I had made the right decision, I could not face going into hospital now.

The birth was truly wonderful. I do not know how any part of it could have been better. The management of my labour was exemplary. I felt relaxed, comfortable and in control. There were no bright lights, clean white backgrounds or the faint humming of hospital equipment; instead there was my husband, pictures of my family, relaxing music, aromatherapy oils, candles and low lighting. Ben was born into beautiful surroundings; he went to sleep that night in his own Moses basket and woke naturally to daylight not to fluorescent lighting in hospital; the voices he heard were ours not the lady in the next bed; the face he saw was his sister who at 17 months old was quite bemused by this moving doll!

When people talk about homebirths, they generally talk about the mess of which there is very little; or the risk despite the fact that most women are not at risk; or the cost but it is cheaper to have a home birth. Based on my experience, I would say it is single handedly the most empowering experience I have ever gone through. It helped me through a time of despair to bring a new born life into the world with no medical intervention required, despite being told that a caesarean was the only option. Ben has been a very placid baby from the start and very content; I am sure this is in part due to the tranquillity of his birthing experience. I cannot thank Lesley enough for suggesting a home birth, an experience which has left me wanting more children despite always saying I only wanted two.

Benedict and Gracie

Lesley's Story

Five reasons why I offered a home birth to a woman with a previous caesarean section

I have decided to write an account of the following events as several midwifery and obstetric colleagues were surprised and concerned that I had offered a home birth to a woman with a previous caesarean section. Some concluded that I was dealing with a difficult woman who did not understand the risks involved and I had somehow been pressurised into offering this option. Nothing of the sort! I was dealing with a very intelligent woman who wanted the safest birth for herself, baby and family, and I was an 'evidence-based' midwife supporting women's choices in pregnancy and birth (NMC 2004).

I work as a team midwife in a consultant led obstetric unit, rotating between delivery suite and the community setting. Working in the community, I work with five team midwives covering three large GP practices. I met Lavinia for the first time at 31weeks gestation at a routine antenatal clinic appointment. We discussed her previous birth (her first pregnancy resulted in an emergency caesarean at 5 cm for failure to progress) and her current pregnancy. The plan was for this birth to be, 'as normal as possible'. Lavinia's notes were marked "high risk, for continuous fetal monitoring in labour". We discussed the birth plan, with options for birth and delivery being hospital birth with intermittent monitoring and mobility or home birth.

Physically Lavinia was well and strong with a healthy lifestyle. She was an academic who had researched VBAC and was well informed of the risk management issues surrounding this. Emotionally she was dealing with the imminent loss of her beautiful mother, friend and confidant, who was terminally ill with cancer, and her time between antenatal appointments was filled by visiting her mother daily in the hospital or hospice. For Lavinia, hospitals with their smells and clinical atmosphere represented loss, separation and grief. She felt that home would be the ideal place to labour and we discussed the advantages and disadvantages. An appointment was made for her to see her consultant and I liaised with my manager, the labour ward manager and my supervisor of midwives.

Following the hospital appointment Lavinia still felt that home was the best way to labour and birth her baby. My team colleagues were supportive and we discussed and researched VBAC. Lavinia's labour was spontaneous and intense with much support from her husband, Mark. Ben was born into his mother's arms, cried gently and remained awake and alert. I was privileged to be present at a true family birth.

Athough I had met Lavinia only at 31weeks, we formed a relationship. An antenatal clinic can become a physical risk surveillance centre where the blood pressure, palpation, urine testing and blood tests become the tasks performed in the allocated time for women. I believe that forming a relationship with the woman is equally important and if we are not forming relationships with woman, then we are missing the pregnancy and birth journey, and midwifery is the biggest loser.

Reason 1

As a research based practitioner the woman and baby are the primary focus of my practice (NMC, 2004). The International Confederation of Midwives (ICM) defines the midwife as *a recognised, responsible and accountable professional who works in partnership with the woman to give the necessary support, care and advice during pregnancy, labour and the post partum period… the care includes preventative measures, the promotion of normal birth …*

Our NHS trust guidelines based on National Institute for Clinical Excellence guidelines, recommend hospital birth after a previous caesarean section. NICE guideline ground rules make it clear that all guidance must be fully reasoned and written in terms that make it clear that it is only guidance. Guidance for clinicians does not override their personal responsibility to make the appropriate decision in the circumstances of the individual patient. Decisions should be made in consultation with the patient and in the light of locally agreed policies (NICE, 2002). Dimond (2004) reiterates that very few of these procedures are law in the sense that they have to be obeyed. Hurwitz (1998) states that guidelines, procedures and protocols will never remove the personal and professional responsibility of the midwife to use her professional discretion in the care of her patients. As a midwife I have a responsibility also to provide and discuss informed choice and consent, supporting personal autonomy and professional accountability, acting in the interests of the mother. Advocacy was maintained with dialogue between the obstetricians and the midwives. It was imperative to provide continuity of care for Lavinia and, with support from my colleagues, I was able to provide on-call cover as much as possible. Continuity of care and carer is associated with high levels of satisfaction for women and midwives and lower levels of intervention in labour (Hodnett 2004, Biro *et al* 2003, Page *et al* 2000, Tinker and Quinney 1998, McCourt *et al* 1998). Brodie (1990) describes how midwives and women develop close relationships. The needs of the woman become paramount. Shiers (2002) also suggests that there is less stress and burnout for the midwife who manages to achieve a relationship with women in the antenatal, intranatal and post natal period.

I discussed with Lavinia the reasons for the last caesarean section which had occurred at 5 cms for 'no progress'. This indication for her previous section gave her a 70-80% chance of a vaginal birth (James, et al, 1999).

For Lavinia the labouring environment was central to her birth outcome. Research has highlighted the centrality of the birth environment to birth outcome. McNabb (1997) and Odent (2002) have both explored the sensitivity of the primary birth hormones oxytocin, adrenaline, noradrenaline and the endorphins in initiating labour and subsequent progress in labour. This biofeedback mechanism triggers appropriate levels of oxytocin release, an activity of the hypothalamus, the most primitive part of the brain, an activity easily disrupted by noise, activity and bright lights. Intense surveillance and conversation will provoke a disturbance in the hormonal equilibrium. As well as being central to human birth physiology, oxytocin has important emotional and social effects. Negative labour and birth experiences for the fetus are now being examined in relation to adult drug behaviour, eating disorders, suicide and autism. Though the design and conclusions of some of these studies have been criticized, they do raise the possibility of adverse consequences of interruption in the physiological birthing process (Downe, Walsh and El-Nemer, 2004).

This is in marked contrast to received opinion in some obstetric units. Simmonds (2002) describes the discourse of obstetrics which now manages pregnancy and birth by institutionalising rigid time standards, carrying out procedures, splitting stages of pregnancy and labour into increasingly more fragmented units, each of which are imbued with the potential for danger. Manders (2005) in the VBAC debate highlights that almost no attention is paid to the effects of the woman's learning and experience, the wealth of knowledge about herself and her body that she acquires from her experience of her labour and birth, and from her experience of caring for herself and her baby. Manders further describes how this insight and self knowledge is able to change the woman and her subsequent childbearing experience, probably helping to make the next labour more effective and the birth outcome more satisfactory.

Supporting Lavinia enhanced my practice and expanded my research on VBAC scar rupture (SOGC, 1997) and I learned the importance of watching for a rising pulse rate; I knew that continuous fetal monitoring was no safe Elastoplast against scar ruptures. Lavinia recorded her own pulse in the antenatal period so we had a baseline to work from when in labour. I liaised with independent midwives who had cared for many VBAC women. (Thank you, Judith Kurutac and Jane Evans). Lavinia's labour and birth reinforced my belief that women do know their own bodies and that women's bodies will work in the right environment. I am grateful to Lavinia for the opportunity to expand and develop my practice and to realise the importance of relationships, which can begin anytime in a pregnancy with a pregnant woman if we make time between the BP, the palpation and the dip stick!

Reason Two

For Lavinia, an optimal birth enviroment was imperative in avoiding a caesarean and subsequent postnatal depression. In the event of any deviation from the normal she had agreed to go to the unit. A study by Green (1990) revealed that women who had experienced a caesarean section had a disproportionally high number of symptoms of postnatal depression. An Australian study also revealed that women delivered by caesarean were more likely to develop PND, experience a sense of failure, loss of control and disappointment (Boyce and Todd 1992). Brown (1994) screened 800 women and found women who had had a caesarean were two and a half times more likely to suffer from depression after the birth. Mutryn (1993) describes how there can be negative and far reaching psychosocial effects of caesarean section and emphasises that birth by caesarean section is not only a medical procedure but is also an emotional experience; even with a good medical outcome it can have negative emotional consequences. The physical risks of infection, haemorrhage, subsequent reduction in fertility and trauma to bladder and bowel are also well documented.

Manders (2004) showed that research into the safety of VBAC has been manipulated by some researchers; for example, Smith *et al* (2002) chose to magnify the number of babies dying as a result of VBAC by classifying any emergency caesarean section (such as a those for abruptio placenta or eclampsia) after 37 weeks gestation as a trial of labour. By using such techniques and tactics medical researchers have presented VBAC as an infinitely more dangerous alternative to elective repeat caesarean. As a result of such biased research, the opportunities for rational decision-making on the part of childbearing women have been seriously curtailed.

Reason Three

Ben would be born when he was ready and not before. Term infants born by elective caesarean section before the onset of labour suffer a considerably greater risk of neonatal respiratory morbidity than those born by any other means (Milner, 1978). Hypertension is also increased. Hook *et al* showed that babies born vaginally after a trial of labour had the best neonatal outcomes. Levine (2001) describes how the physical compression in the birth canal is advantageous for the pulmonary vascular bed of the neonate and that persistent pulmonary hypertension should be discussed. The constant squeezing by the uterine contractions results in pressure on the fetal head This stimulates the fetus to release thyroid hormones and adrenaline that will assist him when he is in the outside world. The pressure on his head will also prevent him from breathing until his head has completely emerged from the birth canal (Nathanielsz, 1994). Compression of the vaginal walls on his chest expels fluid from his lung to accommodate air in his lungs.

Once born, he is passed straight to his mother. His germ free body needs urgent contact with his mother's skin as the baby and mother share the same antibodies (IgG). Therefore, from an antibacterial point of view, the baby urgently needs to be in contact with his mother, skin to skin. An hour later there are a million bacteria covering

his mucous membrane (Odent, 2002). The early consumption of colostrum will establish an ideal gut flora. There is no doubt that, from a bacteriological and midwifery point of view, the hour following birth is a critical period with life-long consequences. Our gut flora can be presented as an aspect of our personality that cannot be easily modified later on in life (Odent, 2002). Natural childbirth generates endorphins in the mother which pass to the baby, reducing the baby's experience of pain without causing respiratory distress at birth. The release of these hormones make the baby alert and his pupils dilate to facilitate eye-to-eye contact with his mother, the most important feature of the mother and baby relationship. Labelling and weighing and measuring disturb this vital process.

Reason Four

For Lavinia a positive birth experience will mean a lower risk of infection, haemorrhage, depression and will contribute to a greater likelihood of successful breastfeeding. These will benefit the rest of Lavinia's family, her husband, Mark, and daughter, Gracie.

Reason Five

Remaining at home for the birth will mean no separation from Gracie and will reduce her stress and maintain her security.

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Risk Obsession on the Labour Ward

Lesley Price
Supervisor of Midwives

CNST is a mutual pooling, pay-as-you-go scheme for NHS Trusts in England designed to enable Trusts to meet the costs of clinical negligence and negligence claims. The emphasis is on prudent risk management, ensuring that quality healthcare is maintained and improved and it is hoped that there will be fewer critical incidents and negligence claims. CNST is about protecting the public – the consumers of the NHS – you and me. The NMC and before that the UKCC have always done this.

For midwives the statutory requirements of supervision have been protecting the public since 1902, long before CNST was born. All health care professionals support systems that improve practice and enhance the quality of care and especially the introduction of CNST. However, another acronym – to my mind more appropriate due to the focus on abnormality and pathology – could well be Controlling Normality and Supporting Technology. The RCOG was a leading light in the formation of maternity standards and thus the obstetric viewpoint has been dominant in the risk management of pregnant and labouring women. Criterion 8.22 (p120) states: "continuous 1-2-1 care of a labouring woman with an epidural *in situ* is imperative". Should this not also have read: "Continuous 1-2-1 care of a women in induced or spontaneous labour is imperative"?

Risk Management – Enabling or Disabling?

CNST can be read as controlling normality and supporting technology due to its emphasis on the pathology and abnormality; the emphasis being on obstetric care and not midwifery care. Focusing on the abnormal can be disabling, we would prefer risk management that enables midwives to do a better job – skill drills to promote normal birth, enhanced record keeping and, moreover, risk management that involves the consumer – and there is no shortage of research telling us what women want. Skill drills are vital in saving lives and the Midwives *Code of Conduct* and *Rules* highlight the need for competence, however, although we seem to have drills for high risk such as massive PPH, where are the drills for physiological third stage with its ensuing benefits for mother and baby? CTG management is vital in detecting and acting on deviations from the normal, but how expert are we at using our Pinard's to detect variability, accelerations and decelerations?

We seem to be entering an age where we have certificates for high risk scenarios and mandatory attendance at study sessions to reduce risk and error but where is the corresponding ongoing education in continuity of care, or building relationships with women so that they see a familiar face when birthing their baby? What better risk management could there be but these?

As well as certificates, should we not also be giving all women 1-2-1 care – then they themselves will be able to comment on our practice and vouch for our standards and the support we give. It would certainly be more representative than a set of case notes.

Midwives have always been risk managers. Our *Code of Practice* compels us to respond to deviations from the normal. As a Supervisor of Midwives I know of no midwife who has gone on duty *wanting* to jeopardise her practice or *wanting* to give suboptimal care. Perhaps it is the system that we work in that needs rather more inspection and scrutiny instead of the midwife and her mandatory training needs. Whilst applauding CNST for supporting good practice and identifying substandard care we should remember that supervison has *always* done that. Risk management is enabling the midwife in skill drills and record keeping but can be disabling by its focus on the abnormal.

Guidelines – Positive or Negative?

Guidelines are there to guide practice – they do not tell you what to do but they act as a basis from which you can give individulised care. The negative side of guidelines are time restraints in labour and the difference in some units of vaginal examination some three hourly, some four hourly – it's almost a postcode lottery. Should we expect any cervix to dilate within the constraints of a guideline? This is when the midwife uses the guideline to support her practice and woman's choices; she uses the guideline as a lever to good practice and not as a prescription for care. For high risk women guidelines are vital. *Why Mothers Die* and CEMACH and CESDI have previously highlighted suboptimal care and multidisplinary working is vital to support good practice. Every midwife should be devising her own individual guideline for each unique and individual woman based on best practice and midwifery research. Intrapartum care can be seen either as risk surveillance or as supporting a physiological process. As midwives and as supervisors, are we controlling or are we supporting the labouring women? Are we watching, waiting and listening while we sit and knit in the room with her, or are we controlled by the clock, managing and intervening? We can't make the abnormal, normal, but are we becoming too expert at making the normal, abnormal? How can we expect women to support midwives in promoting normal birth when women are not experiencing normal birth?

Tina Lavendar states that a healthy mother and baby is the minimum standard of care we should be aiming to achieve. By giving fragmented care we are missing the chance to go on the journey with the woman and not only is the woman the loser but so are we, individual midwives and the profession of midwifery as a whole. You cannot miss what you have never had; most women never experience continuity of care and it is sad that continuity of care

is not a mandatory component of training for most student midwives. Some students do experience giving continuity of care during their training; should we be finding out whether it makes a difference to their practice once they have qualified? As midwives we are missing out on the job satisfaction that comes from forming relationships with women and, as research continually reminds us, women and midwives both want the same thing: continuity of care – to *know* each other – one-to-one care in labour. Do we want midwifery care to become just risk surveillience: measuring the BP – testing the urine – palpating the baby? Do we want one midwife to 'service' clinics of 12-14 women? Or do we want sessions of forming relationships? Discussing family births, grandmothers' births and birth plans are not optional extras but are as vital as BP and palpation. If we haven't time to sit and talk, or laugh and cry with our women, then we haven't time to be midwives.

As midwives do we support or control women in labour and are we controlled or supported in our practice as midwives? Could we start to see risk management as an opportunity to repossess midwifery? Could we learn the value of placing as much emphasis on our Pinnard as we do on a CTG moniter?

Should we not be taking our women with us to our yearly annual one-to-one interviews with our supervisors? We currently take casenotes and discuss our practice. How much better would it be if we took some women we had cared for to speak about our practice!

Soo Downe (2004) wants us to focus on positive outcomes, she thinks positive, not negative, outcomes should drive audit – normal birth rates rather than caesarean rates; the number of intact perinea rather than episiotomies done; a measure of well babies instead of neonatal admissions; best practice reviews instead of just looking at near misses – and a review of compliments given instead of the 'management' of complaints. We should shift the prevalent focus and ethos from risk avoidance to the expectation of benefit.

Supervisors could do such things alongside critical incident meetings. They could promote courses on skills to enhance normal labour as well as courses to refresh emergency management drills. This would certainly help put the normal and natural back into birth, celebrating midwifery skills and autonomy.

I really must finish by saying that I do *work with some* brilliant *midwives in busy obstetric units that can create a positive birth experience amidst monitors and IVACs and clocks!*

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My Home Birth

Sharon Greenough

Planning to have a baby for the third time was a very exciting time, though I also felt anxious at the prospect of having the baby in hospital. I wanted as full and active part in the planning of the birth as possible and wanted a home birth to help ensure this. I felt that being pregnant was a wonderful and exciting time and not to be looked upon as an illness, therefore I did not feel the need to go into hospital. My husband, though, was very anxious at the prospect of me having our baby at home and it was only after speaking to our very supportive midwives that he felt more at ease and understood the benefits of a home birth.

When the day arrived I awoke at 5 am with contractions and did not wake anyone else. I ran the bath, added lavender oil and lay there for three hours, until the contractions became more intense. I then woke my husband and phoned the midwives who arrived at 9 am. She examined me and we sat and chatted in between contractions. My waters broke at 10 am. Though they were stained with meconium, the birth was imminent and Alex was born a healthy 8lb 8 oz at 10.20 Alex and I were tucked up in bed with the rest of my family going about their normal routine.

The most natural process in the world had just taken place the way I wanted it to and I felt wonderful. My baby was feeding with no hustle and bustle of the hospital, just Home Sweet Home, me and my family.

Cervical Reversal/Regression

Lois Bowman

The importance of delivering evidence based midwifery care is now a pretty well understood and established norm. However, from time to time midwives have to deal with occurrences that have never been reported in literature, or researched. Cervical reversal falls into this category. The term cervical reversal is relatively new, first coined, I think, by American midwives. This happens when one midwife's vaginal examination, for example 8 cms, turns out to be *5* cms when done by another midwife or doctor, usually hours later! It happens quite frequently. The frustration is that it is a phenomenon that does not appear in any midwifery or obstetric text book. No research exists to explain it. In practice it is blamed on poor vaginal assessment skills because: "cervices do not get smaller".

A few months ago I was prompted to explore this further following an incident at work. A community midwife had handed over the care of a woman at a stage of 8 to 9 cms, with a persistent anterior lip and strong urges to push. Hours later the woman had an emergency LSCS for lack of progress. The doctor had assessed her cervix to be only 5 cms. This was communicated to the midwife with the suggestion that she needed to be on delivery suite full time to update on her vaginal assessment skills!

Gathering information was difficult, relying mostly on an internet search of world wide midwifery archives. I found the first article on the website www.gentlebirth.org. This is the American equivalent of ARM's midwifery archives. Listed among the topics was cervical reversal. The site is hosted by a homebirth midwife called Ronnie Falcao. Homebirth midwives write in to discuss their birth experiences and many other childbirth issues. The site directed my attention to the Midwives Alliance of North America (MANA).

MANA is an organisation of independent midwives in North America. They are a very proactive group and are involved in varied childbirth research. Interestingly, they have been collecting statistics on cervical reversal since the 1990s. The process started when one of their midwives transferred a woman from home to hospital, at 9 cms. However the obstetrician found the woman to be only 5 cms. Not believing this the midwife examined the woman again while doctor was out of the room; yes you guessed it, 5 cms. Soon other midwives were reporting similar experiences. MANA added cervical reversal to their data collection form.

MANA's first report was on 9,000 births (MANA, 1998). Cervical reversal was reported by 107 midwives and occurred in 234 women (2.6%). Midwives found that the most common factors associated with reversal were: home to hospital transfers; a swelling anterior lip; an ill fitting presenting part; following membrane rupture; anxiety; lack of continuity of carer; and contractions stopping. We are all aware that all the above may affect a woman's progress in labour, but we do not seem to accept that they can be associated with a cervix closing down.

Vaginal examinations are subjective. It is deemed unprofessional to question another person's clinical judgment about something so subjective. The 'holier than thou' attitude has no place in midwifery care. Midwives need to feel confident and supported in their practice. Encourage a life long learning, and be proactive in questioning certain accepted beliefs.

We are conditioned to accept obstetric assumptions that define labour and delivery by the so called 3Ps. The Passenger (baby), the Passages (pelvis and vagina) and the Powers (strength of uterine contractions). Ina May Gaskin (2003) challenges the law of the 3Ps and discusses an alternative, which she calls Sphincter Law. Sphincter law explains optimal psychological conditions for labouring women, which in turn will enable the 3Ps to function well, and suboptimal conditions which can cause the cervix to close down, or labour to stop (to be enlightened on the subject buy or borrow Ina May's book). Sphincter Law manifests itself in the following ways:

- Sphincter muscles of both anus and vagina do not respond on command.
- Sphincter muscles open more easily in a comfortable intimate atmosphere where a woman feels safe.
- The muscles are more likely to open if the woman feels positive about herself; where she feels inspired and enjoys the birth process.
- Sphincter muscles may suddenly close even if they have already dilated, if the woman feels threatened in any way.

I set out to learn about cervical reversal. In the UK midwifery databases I found nothing. Maybe there is, and I have not yet found it. If someone is looking into it, or has produced some work, I would love to hear from them. In the mean time I have started a yahoo group to be a discussion forum for Cervical Reversal. This is to generate interest and collect information for statistics or/and hopefully research. I have a dream!
The group home page location is:
http://uk.groups.yahoo.com/cervicalreversalUK
The group emailaddress:
cervicalreversal/uk@yahoogroups.co.uk

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Caseload Midwifery: A Review

Sue Andrews, Louise Brown, Lois Bowman, Lesley Price and Ruth Taylor

Introduction

CHANGING CHILDBIRTH, the report of the Expert Committee on Maternity Care (DoH, 1993) heralded the beginning of Government policy reform for the maternity services that aimed to make maternity care more responsive to women's needs and improve their ability to make informed choices about their care. Indeed, all registered midwives now have a statutory duty to ensure that the needs of the woman or baby are the primary focus of their practice (NMC, 2004).

Integral to the success of this woman-centred approach is the concept of continuity of carer. The Report set the standard that 75% of women should know the midwife who cares for them in labour as an indicator of success in achieving woman-centred care, yet, despite the plethora of schemes intended to improve continuity of care, most providers have failed to reach this particular standard (Audit Commission, 1997).

In several position papers, the Royal College of Midwives (2001) points out that while these policies still stand, they have been overtaken by new health policy agenda – such as the *NHS Plan* (DoH, 2000a), *NHS Implementation Plan* (2000b), *Keeping the NHS Local* (DoH 2003b) and National Service Frameworks (DoH 2004) – in a drive to modernise and improve services. This is placing increasing demands on managers and midwives to develop more effective means of delivering care within the financial constraints of the NHS.

The model of midwifery care currently practised in this Trust is that of team midwifery, whereby small teams of community-based midwives aim to provide antenatal, intrapartum and postnatal care for women, supported by core staff on the maternity ward, delivery suite and antenatal clinics. This model is based on evidence from trials showing clear advantages for women who receive care from a team of midwives (Homer *et al*, 2002; Homer *et al*, 2001; Waldestrom *et al*, 2000; Biro *et al,* 2000), although these trials are small.

A Cochrane systematic review of two larger trials, (Rowley *et al*, 1995; Flint *et al*, 1989) involving a total of 1,815 women found team midwifery to be associated with reduced antenatal admissions and labour interventions, increased attendance at antenatal education classes, greater satisfaction with care and feeling prepared and supported during labour. No differences in childbirth outcomes, such as caesarean section, induction of labour, instrumental delivery, breastfeeding rates or neonatal outcomes were identified. However, Hodnett (2004) points out that it is unclear whether these benefits are a result of increased continuity of carer, or the fact that care was midwife-led rather than traditional shared care.

While team midwifery benefits women, its effects on midwives are less advantageous. Many midwives in this Trust feel that true team midwifery is unachievable at present with an increasing number of staff having recently left the service, and are frustrated with this. Team midwifery has been associated with high levels of burnout due to low levels of control, fragmented relationships with women and the stressful nature of on-call team midwifery (Sandall, 1999; Barber, 1998; Sandall, 1997).

Caseload midwifery is becoming increasingly common in the UK and Lester (2005) argues that this model of care not only meets the standard of ensuring a known caregiver during labour for most women, but will also improve the quality and cost effectiveness of midwifery care in line with many of the key priorities of the current public health policy agenda. The expected result will be effective, woman-centred services with improved experience of birth and improved health outcomes for all women who access it. As such, caseload midwifery is considered to be the 'gold standard' of midwifery care for women and their families (Lester, 2005). This review intends to examine the implications of caseload midwifery for women and for midwives.

Caseload Midwifery

Caseload midwifery is described as an organisational model of care whereby a midwife is responsible for the planning and execution of midwifery care for an agreed number of women, with that midwife being the primary provider of midwifery care wherever the woman is (Tiran, 1997; National Childbirth Trust, 1995).

In this model midwives' work centres around women, rather than being attached to particular locations (Sandall, 2004), enabling improved continuity of care and communication through building a relationship of trust. The size of a primary caseload for one whole-time-equivalent midwife ranges from 36 (Lester, 2005; Henty, 2004; Hutchings and Henty, 2002) to 40 women per year (Sandall, 2004; Walsh, 1995), with a secondary caseload of similar size – allowing two midwives to work as partners providing on-call cover for each other, ensuring that the vast majority of women are cared for during labour by either their primary or secondary midwife – both of whom they will have got to know during pregnancy.

Caseload midwives manage their own workload but work in group practices which provide mutual support and peer review, working flexibly to accommodate 24 hour cover for their caseload and have 12 weeks annual leave, negotiated within each practice (Lester, 2005; Henty, 2004; Sandall, 2001; McCourt, 1998).

Implications of Caseload Midwifery for Women

The latest annual statistics compiled by BirthChoiceUK (2004) reveal that only 46.4% of births in England last year were normal, with 'normal' categorised here as birth not involving caesarean delivery (22.7%), instrumental delivery (10.4%) or induction of labour (20.2%); epidural anaesthesia is also excluded.

There is a growing body of evidence detailing the negative impact of medical intervention during labour on women who give birth in hospitals (Laing, 2001; Creedy *et al,* 2000; Beech, 2000; Hillan, 2000). The BirthChoiceUK figures provide an average however, and closer scrutiny of the statistics reveal that, while many maternity units are achieving normal birth rates roughly around the national average, wide variation exists; several small, midwifery-led units achieved between 90-100% normal births, while some larger, consultant-led units achieved as few as 32% normal births. (Statistics for our Trust for 2004 are as follows: normal birth 43.9%; caesarean delivery 22.4%; instrumental delivery 11.9%; and induction of labour 24%).

However, even these figures overestimate the normal birth rate, as Downe *et al*, (2001) have demonstrated. The Association for Improvements in the Maternity Services (AIMS) found that many women who accessed their service felt their birth experience had been traumatic, yet was recorded as 'normal' or 'spontaneous' in their health records (Beech, 1997). Beech conducted a study to ascertain how many births within five consultant units were termed 'normal' or 'spontaneous' despite involving one or more of a specific set of interventions defined in the study as constituting an 'obstetric delivery', i.e. induction of labour, acceleration of labour, artificial rupture of the membranes, epidural anaesthesia and episiotomy.

While this set of interventions accounts for medical interventions not mentioned in the BirthChoice UK statistics, it remains limited. Nevertheless, Downe *et al*, (2001), found that 62% of the births recorded as 'normal' or 'spontaneous' in their sample fulfilled their own definition of 'obstetric delivery'. Quite apart from the major public health concern about escalating rates of intervention, Lester (2005) highlights the financial implications – every 1% increase in caesarean section rate costs the maternity services £5,000,000, the equivalent of 167 midwives. Thus, systems of care that reduce intervention rates and increase normal delivery rates are eagerly sought by women, midwives, NHS managers and politicians alike.

Comparing Caseload with Team midwifery

There are no large trials of caseload midwifery available to date, but there is a growing body of evidence from non-randomised trials that caseload midwifery is associated with improved vaginal delivery rates and less intervention during childbirth (Benjamin *et al*, 2001; Page *et al*, 2001; Allen *et al,* 1997; Pankhurst, 1997). Benjamin's study (2001) was of particular interest to us because it compares partnership caseload midwifery with team midwifery care. The trial compared clinical outcomes and labour interventions for 611 women, matched for age, ethnicity, parity, gravida and height.

The trial demonstrated that the 303 women in the caseload partnership group experienced less interventional labour and more normal birth, having significantly higher rates of vaginal birth (74% v 66%), upright birth posture (60% v 14%), intact perineum (40% v 30%) and physiological third stage (37% v 1.5%), alongside significantly lower rates of epidural (21% v 32%) and induction of labour (16% v 23%) compared to the control group of 308 women receiving team midwifery care. The experimental group also had significantly more home births (17% v 1.3%), used the midwife-led birthing suite more often (28% v 12%), were more likely to take early discharge from hospital (25% v 3%) and were attended during labour more often by their primary midwife (67% v 5%) or their primary or secondary midwife (84% v 14%).

A slightly larger, randomised trial by the North Staffordshire Changing Childbirth Research Team (2000) compared clinical outcomes of caseload midwifery (770 women) with traditional 'shared-care' (735 women), finding significantly increased levels of 'known midwife' at delivery (94.7% v 6.7%) alongside a reduced epidural rate (10% v 15%), and decreased augmentation rate (46% v 53%) in those women receiving caseload midwifery care. No difference in the normal birth rate was found, although women in the caseload group experienced labours lasting less than eight hours more frequently than those receiving traditional care.

Although Benjamin's study could be considered less robust owing to the non-randomised design, the results are encouraging and pertinent to our Trust as it compares the current model of care with caseload midwifery. The more robust randomised trial by the North Staffordshire Changing Childbirth Research Team (2000) failed to include any explanation as to what 'shared-care' actually entailed – the wide variations of care from one area of the country to another are well documented (Audit Commission, 1997). Nevertheless, both found a reduction in labour intervention and identified no disadvantages with the caseload midwifery model of care.

Similar findings are cited elsewhere. The Weston Shore Midwifery Group Practice in Southampton works as part of the Sure Start Initiative, aimed at improving health and reducing inequalities related to health and social environment and using the caseload model of care (Henty, 2004; Hutchings and Henty, 2002). When compared to women receiving traditional care in non Sure Start areas of the same NHS Trust, the birth and intervention statistics demonstrate improved outcomes for those women who receive caseload midwifery care in terms of normal birth rate (82% v 69%), intact perineum (62% v 38%), physiological third stage (37% v 1%), alongside a reduced caesarean section rate (6 % v 23%), fewer inductions of labour (12% v 23%), less epidural analgesia (8% v 27%), fewer episiotomies (6% v 14%) and less use of pethidine (5% v 12%). Like those in Benjamin's study, women receiving caseload midwifery care from this practice also had more homebirths (23% v 2%) and attended the midwife-led unit more frequently (30% v 8%).

These figures replicate those of Sandall *et al* (2001) in

their extensive evaluation of the Albany Midwifery Practice (a thorough, 120 page document – available online – which should be read by all professionals involved in maternity care at all levels who are considering implementing caseload midwifery practice). The Albany Practice has been running for several years now and it is unique in that it consists of self-employed midwives working under contract from King's College Hospital NHS Trust, South East London, to provide care for some of the most materially and socially deprived women in that area.

Compared with women who received care from the hospital trust during the same period of time, women who received caseload midwifery from the Albany Practice had a higher normal birth rate (77% v 63%), more home births (42% v 7%), fewer inductions of labour (5% v 11%), fewer caesarean sections (18% v 25%), fewer instrumental deliveries (5% v 10%), less augmentation (0% v 20%), fewer episiotomies (3% v 15%) a lower epidural rate (17% v 35%), used less pethidine (1% v 29%) and were more likely to use no pain relief at all (69% v 16%). In addition to this the Albany Practice boasts a 93% breastfeeding rate at birth, with 70% of women still fully breastfeeding at 28 days postpartum. 98% of these women were attended by their primary or secondary midwife during labour.

The available evidence so far has consistently found advantages in terms of clinical outcomes and labour interventions and no disadvantages have been identified. The implications of such figures on women's health and maternity service budgets are self-evident. However, if services are to be truly woman-centred, then caseload midwifery cannot be considered on clinical outcomes alone. Indeed, the role of the midwife is to provide psychological and social, as well as physical care to women during the entire childbearing period (NMC, 2004).

Satisfaction of women and professionals

To complete their evaluation, Sandall *et al* (2001) not only interviewed all midwives from the Albany Practice and 11 from King's College Hospital Trust, they also interviewed seven medical staff at varying grades, five hospital managers, two GPs who accessed the practice and two health visitors to discover their views and experiences of caseload midwifery in action. More significantly, they consulted women who had received both Albany's services and that of King's College Hospital NHS Trust, surveying 447 women – 299 who had hospital births, 42 who had home births excluding Albany women and 106 women who were cared for by Albany midwives. The overall response rate was 52%, with a 58% response from Albany women compared to 46% from other women in the Trust. Surveyed on multiple aspects of antenatal, intrapartum and postnatal care, the findings are too lengthy to discuss here but it is clear that while most women spoke favourably of their experiences, women who received caseload midwifery thought very highly of the care they received.

This is echoed in McCourt and Pearce's research (2000) in which 20 women from ethnic minority groups took part in a semi–structured interview; ten received caseload midwifery and ten received traditional shared care. Those women who received caseload midwifery were found to hold more positive views, showed greater trust and confidence in the professional they met and in the personal transition of giving birth, whereas those receiving conventional care were disappointed with their care, particularly care given in hospital settings, and did not feel it was focused on them as a person.

This study is very small however and sadly, due to its qualitative nature would not be considered authoritative in the hierarchy of most evidence lists endorsed by the Government (Cluett 2000, Humphris 1999). Yet, as Walsh (2000) points out, human experience cannot be quantified, standardised or rationalised through quantitative methods, and if midwives are to provide care responsive to individual need – as is their statutory obligation (NMC 2004) – then this kind of research is essential in informing practice to enable woman-centred, rather than professionally-controlled care.

Caring for disadvantaged women

What is emerging from the findings already discussed is that caseload midwifery is of particular value when targeted at disadvantaged women, dispelling the myth that such a model is associated with middle-class women, (Sandall *et al*, 2001), and is of particular interest considering the increased morbidity and mortality women from poorer socio-economic backgrounds experience. The *Report on Confidential Enquiries into Maternal Death in the UK* (CEMACH, 2003) found that maternal mortality rates are highest for women who are disadvantaged materially or socially compared with the most advantaged women. Lester (2005) argues that enabling midwives to practise caseload midwifery targeted at such vulnerable groups will enable them to fulfill the public health role that is expected of them (DOH 2000a; 1999). However, there is a danger that this could result in further inequalities if a two-tier system of care develops with some but not all women receiving caseload midwifery care – as is the case at King's College Hospital NHS Trust, (Sandall *et al*, 2001)

All maternity services that increase continuity of carer are associated with high levels of satisfaction for women and lower levels of intervention (Hodnett, 2004; Biro *et al*, 2003; Page *et al,* 2001; Tinkler and Quinney, 1998; McCourt *et al*, 1998). Indeed, Gould (2002) believes that when a midwife knows a woman there is no chance of depersonalising her, especially if she is vulnerable and Brodie (1996) found that where midwives and women were allowed to develop closer relationships, the needs of the women became paramount.

"What is must be best"

Green *et al* (2000) point out that women are strongly disposed to express satisfaction when they have just given birth to a healthy baby with a tendency to show loyalty to what they have experienced. This is what Porter and Macintyre (1984) have termed, 'What is must be best'. In their literature review entitled: 'Continuity of carer – What matters to women'.

Nevertheless, if services are to be truly woman-centred then women's views and experiences must be sought. Walsh (1999) helped to tackle this dilemma of 'What is must be best', by interviewing ten multiparous

women who received team midwifery care with their first pregnancies, but received caseload midwifery care for their second. The women were interviewed individually and at length at eight and 12 weeks postnatally and included women who had hospital and home births, normal and assisted births and caesarean section. Such an approach may be considered to be open to memory bias (Wagstaff, 2000), although Simkin (1992), demonstrated considerable agreement between short and long-term recall of women's first birth experiences, even after 15-20 years. Walsh (2000) found that women's perceptions and experiences were predominantly influenced by the relationships they had with their midwives and that caseload midwifery practice had a significant positive impact on women's experiences of childbirth. His study provides detailed and valuable insight into the experience of maternity care from the perspective of women who have received it.

To summarise, there is a growing body of evidence suggesting that caseload midwifery has no disadvantages for women and their babies compared to other models of care. Caseload midwifery is also associated with less labour intervention and, with the exception of one study, higher rates of normal birth. It appears to be of particular benefit for women from disadvantaged or deprived groups – those who are most at risk of poorer health and even death, but traditionally less likely to access services. Women from all socio-economic backgrounds appear to value caseload midwifery highly, with the relationship between midwife and woman playing an important part in women's overall experiences of pregnancy and childbirth and the transition to motherhood. As such, caseload midwifery is worthy of consideration for implementation as a safe and cost-effective approach that promotes pregnancy and birth as a normal life event and enables midwives to fulfil many key priorities of the current public health agenda through the provision of continuity of carer and woman-centred care.

Implications of caseload midwifery for midwives

Any re-organisation of maternity services must consider the implications of such changes for midwives. New ways of working not only need to be safe, cost-effective and woman-centred, but essentially, they must also be sustainable. As already stated, team midwifery has been associated with high levels of burnout owing to low levels of control, fragmented relationships with women and the stressful nature of on-call team midwifery (Sandall, 1999; Barber, 1998; Sandall, 1997).

According to the Independent Midwives Association (2005) team midwifery and other (often well intentioned) initiatives have contributed to the national shortage of midwives; there has been constant change within the structure of services throughout the last decade, leaving midwives feeling stressed, disillusioned and demoralised. This view is supported by research by Ball *et al* (2002), who found that, while midwives are leaving because of dissatisfaction with midwifery, over two thirds say they would return if the conditions were right.

Lester (2005) argues that caseload midwifery works for midwives because it enables truly autonomous practice, allowing midwives to free themselves from the constraints of 'the system' and to focus on the women in their care. On entry to the NMC register all midwives are deemed capable of autonomous practice, yet Stafford (2001) argues that a range of hierarchical and organisational factors make the concept of truly autonomous practice an illusion.

Sandall (1997) interviewed 48 midwives who worked in either the traditional model of GP attached community midwifery, the team midwifery model, or in a group practice delivering the caseload midwifery model. The interviews were designed to ascertain the impact of different models of care on midwives' work and personal lives. Analysis of the interviews identified three key factors involved in sustainable practice, avoiding burnout and providing woman-centred care. These factors were: occupational autonomy, social support, and developing meaningful relationships with women. All midwives saw a high level of autonomy as vital in managing the balance between work and home life. Those who had most control over their workload – those who practised caseload midwifery – reported significantly lower levels of stress than midwives providing other models of care, particularly team midwifery. Caseload midwives also had more flexibility to respond to women's needs. Sandall's study adds weight to Lester's claim that carrying a caseload is a viable way of working.

Coping with on-calls

Despite the 24-hour, on-call commitment of caseload midwifery, anecdotal evidence from midwives practising this way further supports Lester's argument that caseholding is not as onerous as it seems (Hutchings and Henty, 2002; Sandall *et al*, 2001). Lester (2005) and Davis (2003) point out that although the on-call commitment is constant, it is less stressful because midwives will be called out only for their 'own' women – a view which is confirmed by many midwives who work in this way. Stevens (2002) collected data from 35 caseload midwives over 46 months using a variety of qualitative methods. Contrary to expectation, she found that midwives were disturbed less frequently during unsocial hours once the women on their caseloads had learned when out of hours contact was appropriate.

Steven's published work is a synopsis of a paper she presented to the Triennial Congress of the International Confederation of Midwives, and we cannot assess fully the rigour and reliability of her research method as the necessary information is unavailable. Nevertheless, further evidence is available from McCourt (1998) who conducted a four-week diary analysis of 16 caseload midwives to assess the range of activities involved in their work and the time spent doing this. She demonstrated that midwives were working close (37.9) to their contracted 37.5 hours each week with a balance of activities as follows: 5.1 hours antenatal community; 4.3 hours antenatal hospital; 11.2 hours labour/birth; 3.2 hours postnatal community; 1.6 hours postnatal hospital; 4.1 hours travel; 2.3 hours administration; 1.9 hours meetings; 1.1 hours study; 0.6 hours waiting; 1.4 hours telephone; 1.1 hours other; a total

of 37.9 hours of which 6.5 hours were worked during unsocial hours. It is worth noting, however, that these figures represent average times only and do not demonstrate the fluctuating and unpredictable workload associated with childbirth.

The whole issue of on-call commitment therefore needs to be addressed carefully prior to implementation. (Henty, 2004). Without support, both at home and in the work place, many midwives may feel unable to commit to this way of working. Indeed, in their evaluation of the Albany Midwifery Practice, Sandall *et al* (2001), found that two of the three midwives who left the practice cited 24-hour on-call as the main reason. However, there is a range of ways to organise on-call, for example, caseload partners could work alternately, two weeks on-call then two weeks planned work. Sandall, (2004) argues that the key to success is for managers to devolve the organisation of working patterns to the midwives, thus enabling them to stay in control of their own workload.

Other benefits for midwives

Other advantages of caseloading are that it enables midwives to keep their skills up to date in all areas in ways not achievable while rotating around hospitals, and is associated with high levels of job satisfaction, attributed to forming relationships with women (Lester, 2005; Henty, 2003; Davies, 2003; Stevens, 2002; Sandall *et al*, 2001). Anthropological and psychosocial perspectives suggest that these relationships have reciprocal benefits, reflecting a balance in a relationship and the potential for psychological benefits for both mother and midwife. This may be an important factor in preventing stress and burn-out (Stevens, 2002). Indeed, the *inability* to form meaningful relationships with women has already been associated with stress and burnout (Sandall, 1997), which suggests that midwives value continuity of carer as much as women do.

It seems, therefore, that what is good for women is also good for midwives. Caseload midwifery is associated with improved autonomy and control over working patterns alongside increased job satisfaction derived from forming meaningful relationships and achieving continuity of carer with 'their' women. All this is achieved despite the demanding on-call commitments necessary to ensure continuity of carer for a primary and secondary caseload of women. Formal research and anecdotal evidence both suggest that women tend to call midwives out less than might be expected and that, on average, midwives working this way spend an average of 6.5 hours per week working unsocial hours – and this is only to visit their own women – although this time may vary from week to week owing to the unpredictable nature of childbirth.

In light of this review, the caseload model of midwifery is worthy of careful consideration as a means of being 'with woman' by providing truly woman-centred, safe, cost-effective and sustainable midwifery care.

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Nurse/Midwife v Direct Entry: Is there a difference?

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I WOULD LIKE TO SHARE a 'cameo' of being a direct entry midwife with you and I wonder how many of you will identify with it. Throughout my first year, on entry to any new clinical placement I have inevitably been asked the question:

"Are you long or short course?"

As a more mature woman the consensus of opinion usually came down on the side of my having been a nurse first. When I replied, "The long course," it has been invariably answered with an: "Ah!!!"

So how did this leave me feeling? With the distinct impression that they were not impressed. I had been judged and found wanting before they knew anything about me. Why was this? Perhaps it could be because a nurse-midwifery student will have several years of practical clinical experience under their belt and therefore it is perceived that I will probably need to have the basic practical skills, at best to be reinforced, at worst, to be taught and therefore I am likely to be a burden in my placement area.

I can't say that I felt that I was discriminated against – that would be very unfair – but I certainly felt sometimes that they thought I would be more, pardon the pun, 'labour intensive'. I needed to know how they had arrived at such a perception so I began to look for research to dispel or uphold this opinion. There were several questions that kept coming to me. Was it a fear of the direct entry midwives' academic background? Or was it their anxiety of being found wanting in the academic arena? Maybe they feared having to answer the many questions that I might have, and worried that they may not have the answers ready to hand?

Did I find any appreciable difference in the training of student midwives? Does one type of entrant have a higher status or an advantage over the other?

I have read several pieces of research undertaken over the last ten years designed to highlight any differences between the nurse trained student midwife and the direct entry student midwife.

The evaluation of midwifery training undertaken by Kent *et al* (1994) for England, and by May *et al* (1997) for Scotland, indicated that the higher educational approach to training produced, and I quote: "a knowledgeable doer whose practice was evidence based and their fitness to practise was not in any doubt". Kent *et al* take the profession towards autonomous practice but traditional nurse training was seen by the nurse midwives as important in gaining the clinical and social skills that they perceived to be lacking in direct entry midwives. Lobo (2002) found that the supernumerary status of the direct entry student was blamed for deficiencies seen in individual students along with an inability to conform to the organisation's culture. In other words direct entry midwives had not been indoctrinated into the nurse/doctor, handmaid/master relationship.

It is important at this point to understand that the philosophies of nursing and midwifery are very different (Mahoney, 1997). The former concentrates on curing, the latter, support and facilitation.

Direct entry midwives are not expected to be any different from nurse/midwives upon registration; however, there is a perception that they may need more support and mentoring in the early days after qualification. I perceive this to be mainly within the management of a clinical area, such as postnatal ward or antenatal clinic. These skills would have formed part of a nurse's apprentice/pre registration training. As far as I am aware, it's not part of the academic training direct entry midwives receive but to my mind they are akin to clinical skills and can be attained in time.

In theory, direct entry can be said to be good economic practice as it produces midwives who will stay within midwifery as compared to those with dual qualifications who can move between the two disciplines (Robotham, 1997).

Nurse/midwives and direct entry midwives both aim to empower women on the journey from womanhood to motherhood. Nicky Leap describes this journey as a map that we, as midwives, provide. We facilitate learning, point out hazards, encourage relationships between other women and their significant others, in order to provide social support along the route. Should the terrain become difficult we introduce her to others who have other more specialised/technical knowledge that she can utilise. By empowering the woman, we know that she will manage with the support of those she has chosen to travel with, having gained confidence from the education she has received along the way.

At the end of the journey we celebrate her triumph as she leaves us to begin her next journey, that of parenting.

I concluded that it does not matter from which direction we begin our journey towards midwifery as long as we are for women and with women. Clinical skills can be learnt but being 'with women' comes from the heart and I believe it really doesn't matter from which starting point we embark on the journey so long as we never forget that women are the reason and the goal.

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From Doula to Student Midwife

Janet Naylor

MY JOURNEY has been a long one to where I am today as a second year student midwife. From being a little girl I have always had a 'nurturing' nature, loving my baby dolls, a real 'earth' mother! Maybe this is where it started, the official doula training came much later on. I will take you on my journey which started nearly 24 years ago...

Looking at the tag attached to my baby's cot in hospital, it stated that the mode of delivery was 'normal'. This was despite having been induced for a baby I did not feel was ready to be born, put on a syntocinon drip, pethidine, gas and air, catheter in situ, 'stranded beetle' position and out of control, you know the rest. All this was 'normal'? Apparently so.

I think they meant not forceps, ventouse or caesarean section. Fortunately, I immediately fell in love with my baby and the birth did not affect our bonding, but this experience was the main milestone in my life as regards where I am today, with woman. During my second pregnancy, I had read everything there was to read on active, 'natural' childbirth, influenced mainly by Dr Michel Odent. He seemed to make so much sense – common sense. This was also in the 1980s when, if you had a few ideas of your own in delivery suite, you were frowned upon. Well, I had a non-intervention delivery with a physiological third stage, which was great and probably got me even further interested in women's health and maternity issues. Often I wondered whether I could become a midwife, but dismissed it many times, knowing that I would fight the system. I did not want anyone else to have to suffer the hospital's definition of 'normal delivery' but was helpless. I became a member of the NCT and trained as a breast-feeding counsellor. To me, this was 'doulaing', supporting women, empowering them in their choices regarding pregnancy, childbirth, and parenting. I had read Dana Raphael's book, *The Tender Gift*, so I'd heard of doulas, but not in the way doulas are thought of these days. I was also a member of La Leche League. This kept me familiar with the normal side of birth but distant from wanting to do my training. I met Ishbel at an NCT social evening in the late 1980s.

In 1997 I became pregnant again, there was a large gap after my first two children. We planned a homebirth with an independent midwife, Judith Kurutac – who was my one-to-one midwife and doula (not that she said she was my doula). I wanted every woman to have a 'Judith' baby but sadly home birth was rare and I was still disillusioned with the maternity services within the NHS. In 1999 I attended a doula training course with Michel Odent, spending four full days with him reinforced what I had believed about childbirth. I would like to think that I had been a doula for a long time before my 'official' accreditation, before I knew what a doula was. I don't believe that someone can become a doula after just a four day workshop. I think it is something inbuilt, a certain type of personality is required, perhaps the way in which you relate to women. Of course there are things to be taught, like birth physiology, communication/listening skills, coping strategies, relaxation methods and other things you may or may not already know or be aware of. Doulas do not work in a medical capacity nor do they give advice. To me a doula nurtures, empowers, gives confidence to the woman and her family, thoughout pregnancy, childbirth and early parenting. She helps to make these experiences positive, to enable the family to have good memories, or at least to come to terms with not so good ones.

I worked as a doula for a couple of years within Doula UK. I did birth 'doulaing' and postnatal 'doulaing, some I got paid for, some were expenses only and some for free. I worked really well with midwives across a few different hospitals. I attended homebirths, VBACs and caesareans. I think that some midwives are insecure about their own practice and can feel threatened by doulas. Unfortunately, doulas have had a bad press because some have over-stepped the mark, not knowing their limits and boundaries. This is sad because surely we are all aiming for the same goal – satisfaction for the woman and her family.

Meanwhile, I still wondered if I could become a midwife. In 2000 I became involved in my local MSLC and met Lesley Price. I had trained as a reflexologist, with specific interest in pregnancy and labour, so took my postgraduate certificate in this area. Within a couple of years I became involved in the Wigan homebirth support group and shared Lesley's passion in promoting normality in childbirth and an urge to increase homebirth in Wigan. I also enjoyed attending ARM meetings. I met some lovely midwives locally and renewed my thirst for midwifery. I had been inspired by what I had seen and heard and was impressed; my long held views of the system were changing. Although I was enjoying my doula role, I wanted more. If I could stand the pace and challenge of the training, then why couldn't I be one of those 'good' midwives? I could still be a doula within a midwifery role; surely every midwife should be a doula as well? Though I am aware that one-to-one NHS care is impossible when there are multiple confinements to oversee.

I decided to apply to study midwifery just before we moved South. I was not deluding myself; I knew it would not be like my doula role of one woman at a time to concentrate on, plus all that study!

I started my training in September 2004. So far I have enjoyed it. I particularly love university life. Clinically, like anywhere you see good and not so good practice. I am managing to delete what I don't want to take forward, biting my tongue occasionally and hanging on to the fact that one day it will be *my* registration and *my* practice. I keep focused by being a member of ARM, reading *The Practising Midwife* and I was fortunate enough to meet Ina May Gaskin in Edinburgh in October 2005. I am still a member of Doula UK, who I feel have lots to offer.

So I am still here so far to tell the tale and hope to qualify in 2007, I can't believe that it has taken me so long to make the decision but I feel now that the time is right.

Midwives Should Not Offer Women Choice in Childbirth

Pat Lindsay
Principal Lecturer, Thames Valley University

I AM A MIDWIFE. We'll start with my story. Thirty years ago I became pregnant with my first child. I had antenatal assessments every few weeks; the only screening available was basic blood tests. I enjoyed my pregnancy and looked forward to meeting my baby and discovering whether I had a daughter or a son. I went into labour spontaneously at forty one weeks. I laboured in a GP Unit, with Pethidine for analgesia, and my friends/work colleagues for support. I went to sleep and woke up eight centimetres dilated, reaching full dilatation about an hour later. This suited me fine. I had a lift-out forceps, after two hours of pushing, with the help of a lovely local GP and my manager, who cared for me in labour. My son and I were well, my husband was ecstatic. Most of my friends had broadly similar experiences. Choice was non-existent. Nobody complained. We accepted that childbirth was painful and risky but worth it. We relied on the midwives to use their knowledge and skill to make the process as safe and comfortable for us as they could.

Nowadays dissatisfaction seems common, which is worrying, since women now have more choice than ever before. Research studies have tried to identify the root causes. Positive experiences and increased satisfaction seems to be associated with support, consistency of care, information, good communication, partnership working and shared decision-making (Spurgeon *et al* 2001, Hundley *et al* 1997, Hicks *et al* 2003, Morgan *et al* 1998). What is less clear is the extent to which choice plays a part in satisfaction or dissatisfaction with care.

Women are expected to make birth plans. This is about making choices, based on a personal concept of desired experiences and outcome. The aim is to maximise satisfaction. However the meaning of 'choice' is ambiguous and can be interpreted as total freedom to adopt whatever strategies seem useful or appealing, in other words, starting out with a blank slate and a creative mind.

However, Anderson (2002) suggests that, for most women, choice is confined to the options which the local maternity services provide. This is a necessarily limited menu, dictated by staffing levels, skill mix, local facilities, local protocols and national guidelines. In this case, is it fair to suggest (even tacitly) that women do have choice? When they hear this word what do they understand?

When we talk about choice in childbearing do we make it clear that it is limited choice from a list of options selected by someone else and usually not for negotiation? Even so, the list can be overwhelming and unsettling. Outcomes are unpredictable. How would she know if the choices she is making will really be the best? How do women deal with their feelings if their choice turns out not to have been the best one for them or their baby? We have all cared for women who have had detailed plans for natural birth and have ended up by experiencing most of the interventions on offer, compounded by disappointment.

How did we fail them? What can we do to see that this does not happen to any more women?

I have an idea: we should stop encouraging women to make choices. Western society is based on a democratic structure which fosters unlimited choice. However, there is now a suggestion that more choice is not necessarily better, resulting in stress for clients and placing a further burden on already over-stretched services (Schwartz 2004, Bate and Robert 2005). In fact, excessive choice can be a cause of confusion and unhappiness. The more options we have, the more difficult it is to make a decision and the more regret we are likely to feel if our choices turn out to be wrong ones.

Schwartz (2004) suggests that in some cases, disappointment can result in depression. He proposes four strategies to help inform decision-making:

1. Restrict the options when the outcome is not crucial.
2. Identify the core requirements and stop looking for the elusive 'best'
3. Don't worry about what you're missing
4. Control your expectations

I believe this is crucial to midwifery. We should stop giving choices and start encouraging independence of thought. We should ask women to look at their particular circumstances, identify their core needs or priorities for care and then make their own plan. They should consider fitting in with local service provision only if it truly meets their needs. Women cannot be coerced into obstetrically-approved care and should be taught to recognise the inevitable shroud-waving for precisely what it is: a threat. Midwives cannot be coerced into giving only obstetrically approved care, providing they work within the legal frameworks governing midwifery.

Of course, women should also be prepared to take responsibility for their decisions. This is the action of an autonomous adult human being. We call it empowerment. We talk about it a lot. Why don't we do it? Stop giving women meaningless choices. Start with their core priorities.

I am not saying that all choice is bad. I am not saying that all antenatal screening is bad. What I am saying is that we are in danger of raising expectations that perhaps

cannot be met. This is not helpful. We need to consider women as individuals and help them to identify their own core requirements, as independent midwives do, and then help them to fulfil them. Perhaps listening to their bodies and going with the flow of birth are the most important skills we can teach women. Perhaps creating a safe space and sitting on our hands until they are really needed are the most important things that midwives can do. Who knows, we may find that the women have a greater sense of satisfaction if they do not feel trapped by a plethora of choices. We may find that midwives, too, achieve a greater sense of satisfaction in their work. Obstetric nursing has never stuck me as a particularly rewarding occupation but absolutely nothing is better than being able to use midwifery skills in the service of a woman and her family.

Of course technical and obstetric skills must be available to those who need or truly desire them. Of course reducing mortality and morbidity is vitally important, but are we sure that the care options we are offering are truly instrumental in this process? Can we assist women and their partners more constructively than we currently do?

Incidentally, the boy who was exposed to the horrors of a choice – limited (but lovingly supported) 1970's birth is a happy and very successful professional. The parents were satisfied and both mother and baby did well.

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Reflecting on a Birth

We entered as the morning shift
To find her lying there
Strapped to all the monitors
Not even in a chair.

She had laboured all the night
And the day before as well
She'd now become quite stuck at '8'
And was exhausted I could tell.

But off that bed we got her
No lying down again
We showed her how to bend and sway
So that soon she'd be at '10'

The doctors loitered outside the room
Unnerved by the delay
Let's put up the syntocinon,
That'll have her on her way.

The midwife stood her ground so strong
That hormone we don't need
We can do this with a little time
You wait, she will succeed.

But within these walls of medicine
Of protocols and rules
The pressure to conform is firm
And it takes some strength to stall.

Yet stall them that we did
And time we bought ourselves
We had until the next few hours
Until a half past twelve.

She walked and rocked the time away
Keeping upright when she could.
For gravity is an amazing thing
And it made her feel so good.

Once signs of full dilation showed
The time did start once more
Ticking away the minutes till
They'd again be at the door.

"Only two hours for the second stage,
You've had that and some more"
"Do please leave us all alone,
Please go and shut the door!"

Indeed the minutes were collecting
But the pushing showed advance
It was so very slow however
And I thought she'd lost her chance.

I could quite not believe
The time we'd bought ourselves
But maybe at this point
We needed some more help.

The mentor was relaxed,
She really did not worry.
Everything was going just fine
And the babe was in no hurry.

But the perineum would not give
It really would not go.
I had not experienced this before
Is this why things were slow?

I was sure we'd have to make a cut
To the delicate muscle bands
Yet still my mentor did not move,
She just sat upon her hands.

To and fro the baby went
Still not going to get through.
There was definitely not an inch to give
This experience was new.

Three hours and a half
Had now ticked by – I looked!
Oh well I thought I do still need
Ventouse signed in my book!!

How dare I have such little faith?
And doubt so much right here.
Cos low and behold before my eyes,
The head emerged quite clear.

The body followed quickly
And the little one arrived.
And me the feeling that I had
Was one of great surprise.

Yet my mentor seemed content
With the strength that she had shown
To shoo the doctors all away
And manage the case alone.

And let me tell you this
For I believe it truly right.
The strength that midwife showed that day
Saved that woman from her plight.

Julie Comer, 3rd year student midwife

Michael's Birth Story

Michelle Barnes

I WAS 23 YEARS of age, pregnant with my first child and knew virtually nothing about childbirth but didn't think there was much I needed to know. After all I had chosen to have a hospital birth because both my husband and I believed we would be in safe hands. Unfortunately giving birth turned into an event that shattered my deeply held beliefs about hospitals being safe and benevolent. Like many other pregnant women I was deceived, neglected, insulted, abused and ignored by hospital staff….

I had a normal healthy pregnancy with no problems noted. I was 40+5 on the 10 September 2003 when I was woken at 03:45 by my waters breaking. I knew instantly that I was in labour and was looking forward to meeting my baby boy. I phoned the hospital to arrange to go in and was advised to wait at home for as long as possible. I had a shower and the pain started to increase so much that I cried out and woke the dog. My husband drove to hospital and we arrived in the reception area at 05:45 where we were left waiting with no explanation.

At 06:00 we were taken to a room and I was examined by a midwife. She didn't tell me at the time but I have since discovered that I was 4 cm dilated. My contractions were regular and I was in a lot of pain so I reminded the midwife about my choice to have an epidural which was documented in my notes. I expected to be given this straight away but instead I was put into a queue. The pain was so bad that I had to lie down and I never noticed the midwife attaching me to a Continuous Electronic Fetal Monitor (CEFM). At no point did she suggest I try a bath or try a different position all ideas for easing the pain which I didn't know about at the time. She gave me gas and air which I didn't want and left before showing me how to use it. We were given no explanation or reassurance just left alone for over an hour which gave me enough time to overdose on the gas and air.

I later discovered that the hospital was extremely busy that day and that the anaesthetist and my midwife were both with other patients. At 07:05 the midwife assigned to my care finally arrived but never bothered to introduce herself and gave no explanation or reassurance. I have since discovered that she noted from the CEFM that my baby's heart rate was slightly lower but the overall pattern was reassuring. The anaesthetist arrived and whilst administering the epidural she told me off for continuously using the gas and air. I wish somebody had told me sooner in a more appropriate manner because by that point I was so high I had no idea what was happening.

The epidural was completed by 07:25 and I started to feel in control of the pain. Again no explanation was given about my baby's condition or my progress. I have since discovered that my baby's heart rate was still slightly lower but still reassuring and that I had progressed to 7 cm. The midwife sat in silence and just kept watching the clock then at 08:04 with no prior warning she performed an internal examination. She artificially ruptured the membranes (ARM) with a long thin probe without my informed consent. According to the CEFM my baby's heart rate dropped significantly after this unnecessary intervention. I have since discovered that fetal distress is one of the many risks of ARM we were never told about, also that ARM is a routine procedure in my hospital used on women who choose to have an epidural for pain relief.

I was seen by the consultant and his entourage who I can only assume were students. He thought that an emergency caesarean was indicated from the reading on the CEFM. At no point were any further tests carried out to confirm that the reading on that machine was correct. I signed the consent form because I believed my baby would die if I didn't. My husband wasn't allowed to be present at the birth and was left crying outside theatre. I was told that I would have to have general anaesthetic and I remember my midwife asking the doctor if I could have the operation awake, but he refused and said there was no time. I have since discovered that all they needed to do was to increase the epidural dose. Performing the operation under general anaesthetic intensified the trauma, increased the risks and deeply affected bonding.

My son was born at 08:39 and I only woke briefly to see if he was alright. I was then given diamorphine for the intense pain which left me feeling extremely drowsy for days. I have since discovered that no obvious cause for my son's distress was ever established such as bleeding or problems with the umbilical cord; he didn't need resuscitating at birth and his APGAR scores were 9! This certainly makes me question the reliability of CEFM and the need for a traumatic crash section.

I haemorrhaged (approx 600ml) and was told I needed a blood transfusion but later discovered I could have managed without one. I was unable to lift or hold my baby and felt helpless. I just wanted to be able to look after him and bond with him but I couldn't. I had to rely heavily on the hospital staff and I praise some but not all of them. On one occasion my baby was crying so I called for assistance. A nurse came and told me in an unfriendly manner that I would have to wait because they were just doing a handover for the next shift. Tell that to a hungry baby whose mother couldn't get out of bed to feed him! I couldn't even sit up and had to lie there and listen to my baby crying. I was absolutely devastated and I couldn't even touch him because he had been placed in a plastic crib. When my husband came to visit shortly after that incident we both cried. A few days later some of the nurses on night duty attached a crib to my bed so I could just roll him over to me when needed.

It was almost two days before I was able to get out of

bed and have a much needed wash. At no point before then was I offered a wash and I had to use baby wipes to clean the blood off my hands. How I escaped an infection I will never know… I found it extremely difficult to walk and I was insulted by a member of staff who sarcastically asked me, 'What's wrong have you just had a baby?'

A tag was attached to Michael's ankle and whilst changing him it must have slipped off and was put into a bag with some other washing. My mum left the hospital with that washing and the alarm was raised. At no point did anybody investigate and my mum didn't realise it was anything to do with her and left the building without being checked. Michael was later woken in the middle of the night so the nurse on duty could put another security tag on him. What a waste of time!

After four days of neglect and affliction I desperately wanted to go home and was told I could. My dad took my belongings to the car and I was just about to leave then I was told I couldn't because my blood pressure was high. I was seen by two different doctors and a blood pressure nurse who all told me something different. I was so confused that I initially refused to take any tablets. I was so distressed I made my husband spend the night at the hospital. The following day I was beginning to contemplate escaping through the window when I was told I could go home. While waiting to leave I was at breaking point but determined to hold it together so they would let me go. The blood pressure nurse was very intimidating and determined to argue with me because I hadn't taken my tablets straight away. I even overheard her telling other staff that I had already thrown one tantrum so they must let me go home. I was eventually escorted out of building by the back door like a naughty little girl.

Words cannot describe how relieved I was to see the back of that dreadful hospital and some of those uncaring people that call themselves nurses. But the nightmare didn't end there and I suffered severe stress reactions including the high blood pressure, an inability to sleep or relax, numbed emotions, anxiety, irritability, loss of appetite, poor concentration and as a result I was involved in a road traffic accident… Fortunately nobody was hurt.

Due to a lack of professional support, understanding and empathy the stress reactions continued for many months and evolved into what I believe to be Post Traumatic Stress Disorder (PTSD). It took months for me to accept that my son wasn't going to die and that is when the severe symptoms began to subside. I was so grateful that I just tried to avoid thinking about what happened. But then my husband and I decided we wanted more children and that's when I started to fall apart. I was afraid to conceive because I had an intense fear of the same thing happening again. So I became obsessed with finding out what really happened to try and prevent it from happening again. I started waking up in the early hours trying to make sense of it all. I was extremely angry with the hospital, I felt guilty for not reading and preparing more for my son's birth and I felt sad that I had not bonded with him straight away. It's taken me over two years to discover that my son was never in danger in the first place and that we were simply the victims of an extremely busy and short staffed hospital.

I don't feel guilty any more because I now know you have to be extremely lucky to get a good hospital birth. I think I will always feel a little sad and angry and as yet there still isn't a day goes by when I don't think or want to talk about what happened

I would like to think that what happened to me happened for a reason and so I decided to join the Association for Improvements in the Maternity Services (AIMS) and campaign for change. Through AIMS I have found strength and support from human commonality and hopefully time and a positive birth experience will provide some more healing.

It was at my first AIMS meeting where I discovered the Independent Midwives Association (IMA) has developed a new model of midwifery care that would be responsive to the needs of the parents, babies and the midwives. I was also introduced and joined the net based One Mother One Midwife group campaigning for the implementation of the IMA model of care.

The concept is easy. When a woman gets pregnant, she has direct access to a list of midwives local to her. She meets one or two and chooses the one she feels most comfortable with. That midwife then enters into a contract with the NHS, which pays on a set-fee-per-case basis.

This is the beginning of a relationship between the midwife and the woman which can develop over the months of pregnancy and provide a firm foundation for an equal partnership based on trust. This, as the research shows, makes for good outcomes and positive experiences for everyone involved. And it isn't just about home births – the midwife would have full access to NHS facilities so that her client could choose the place and type of birth that most suits her needs. In the areas where this service already functions they do not have staffing problems. Now under consideration by the Department of Health, the suggestion is that this new model should sit alongside the current provision, and be available to any midwife interested in working in this way and to any woman who would like to have genuine continuity of care.

So if you haven't done so already join the campaign and hopefully effect change.

For further info visit: http://www.onemotheronemidwife.org.uk/

Prolonged Prelabour Rupture of Membranes

Katherine Hales

MIDWIVES will be generally aware that at present most local NHS protocols suggest that labour should be induced within 24-48 hours of rupture of membranes at term, although NICE gives 96 hours (post 37 weeks gestation). The rationale for this is that, once the protective barrier of the amniotic sac is breached, infection may arise, causing illness in the baby and possibly the mother.

Consequences

When I was a student midwife I questioned this practice because I had seen a number of women who, unfortunately, did not prove responsive to induction and who ended up with birth by caeserean section, even when they may have previously laboured and given birth vaginally. This seemed to happen more frequently when the membrane rupture took place at 37-38 weeks, perhaps because the woman was really not ready to labour. As I had seen premature rupture of membranes managed expectantly, I questioned why this was not possible with term ruptures, but was told by obstetricians that as the woman was at term, "We might as well get on with it."

There is also the vexed question of forewater versus hindwater leak. Many women with ruptured membranes on being induced are found to have intact forewaters and one wonders whether this should be considered as a lesser infection risk, (although it is not always possible to diagnose this until labour starts). Also I pondered on the theoretical risk of inducing with syntocinon, as I was always led to believe that inducing labour with intact membranes could lead to amniotic fluid embolism, so what of the woman later to be found with intact forewaters while being strenuously induce by this method?

When a woman presents with prelabour rupture I have a sinking feeling (shared by many of my midwife colleagues) because the woman is on the countdown to medically managed birth if she doesn't labour within the protocol driven time.

A testing case

This leads me to the case of my friend who I shall call Jane. I was not her midwife because it was not logistically possible for me to fulfill that role at that time, but we did have some very lengthy discussions on birth and related subjects and, to the extent that I gave her information and shared my opinions, I felt responsible for my influence!

Jane was a 41year old expecting her first baby, she was very healthy and very interested in avoiding uneccessary interference in the pregnancy or birth. She wanted midwives to care for her throughout and had an especially strong wish not to be attended by a man. She considered home birth, and the local NHS midwives were, to their credit, supportive but because of her partner's fears she felt she would probably go to the local average sized district general hospital. I had hoped that she would prefer the smaller midwife led unit, but an unfortunate impression of a midwife she met there had put her off.

As her pregnancy progressed we had many discussions and I tried to present as balanced a picture as I could, being truthful but without trying to direct her, and I promised to attend labour in a supportive role if I possibly could.

Jane remained healthy throughout pregnancy and her ideas developed too, in a very natural organic way. At 39+2 weeks of gestation she rang at night to say her membranes had ruptured; she gave a very consistent history of clear liquor draining in large and then lesser quantities. I was a little worried by this because she had a strong family history of 42 week pregnancy and I doubted whether she would be ready to labour. We discussed the likely progress of events if she attended hospital: speculum examination; high vaginal swab; CTG; and induction planned for 24-48 hours time.

I explained to her the rationale for the standard management and that infection in a baby could be serious but that there was no real research on the level of risk. Her response was, "Well, I don't think I'll do that then." This was very much in keeping with her character. I had examined Jane abdominally in the week before and knew the baby to be head down and well into the pelvis, left occiputo anterior position, so I had no concerns over cord prolapse. Jane felt that she had a low risk of infection having been thoroughly screened for infection prior to conception, and having been celibate for some years prior to meeting her present partner.

In the next week I visited again and we discussed the ongoing situation. Liquor was still draining in varying amounts, Jane was apyrexial and well, and her abdominal circumference had increased slightly, which seemed to indicate continuing production of liquor. However, there was no sign of contractions. The baby was very active and still in the same position, with good descent into the pelvis.

We also discussed the very difficult question of Jane informing her own midwives of the situation. While we are both inclined to be truthful, I had become aware of a

case where a woman with prolonged prelabour rupture of membranes had been threatened with a care order upon the baby when she refused induction and antibiotics for that baby. We also realised that if a midwife in the NHS was aware of a client in this situation she would be obliged to advise induction and antibiotics and we felt it would put her in a difficult position if Jane refused these.

Evidence for optimum management

After another week had passed, while feeling ever more responsible for my collaboration with Jane's situation, I had been searching for information about the possible length of the prelabour stage and risks of infection. Two independent midwife colleagues kindly gave me the benefit of their experience. The longest prelabour ruptures they had experienced had been 9 and 13 days respectively. Both outcomes were good, though the latter woman had been transferred to hospital for an unrelated reason after labour, at which point she was reprimanded when it became plain that her membranes had ruptured quite some time before labour and she had refused antibiotics. Both midwives confirmed my own findings – there is not really any recent clear evidence of the actual risk of infection to give to women. For the last 30 years at least nearly all women with prelabour rupture of membranes will have been induced or given birth by some means within a short period of time.

My colleague who qualified in the mid seventies tells me that all women in these circumstances were being induced, so it is easy to see the problem of gaining clarity on the subject. (She did tell me an interesting anecdote of a friend of hers who was cared for by a local GP in pregnancy, who routinely used to rupture his clients' membranes at term (when?) and then just send them home to see what happened – it's a pity we couldn't get some more data on that! Obviously this was in those days of GP obstetrics and when clinicians had their own ideas and carried them out without reference to NICE or anyone else.)

Even with expectant management, 94% of women with PROM will have given birth by 95 hours (RCOG, 2001). What happens to the other 6% is unknown; the numbers will be vanishingly small in the current climate.

The Cochrane review on management of prelabour rupture of membranes (plain language summary, 2006) states the following:

"Some evidence in favour of planned management (usually by induction) when women have prelabour rupture of membranes at term.

When women's membranes rupture at or after 37 weeks' gestation without having contractions, they can choose to intervene (usually by immediate induction with oxytocin or prostaglandin) or they can wait for spontaneous labour to occur. The concern that early planned intervention might result in more caesarean and operative births was not supported in this review, which also found that fewer mothers developed infections and that fewer babies were admitted to the neonatal intensive care units than if women waited for spontaneous birth. Similar number of babies developed infections whether intervention was early or whether women waited. In one trial, women clearly preferred early planned intervention.

This review, then does not confirm a higher risk of infection for babies for expectant management, although the risk of maternal infection is higher (one does wonder why).

Jane's case

Jane continued well, her baby was active, a varying amount of clear liquor was draining; perhaps, I thought, it is a hindwater leak. As she approached 42 weeks gestation she agreed to be monitored by CTG and to attend for induction at T+14 (about 20 days after rupture of membranes) and I agreed to attend with her. The strain was becoming very great for all of us, despite our convictions. In the evening of T+12 she rang me questioning whether the contractions she was feeling were Braxton-Hicks. As they were two minutes apart, this seemed unlikely and she went by herself to the midwife led unit, deciding against going to the DGH at the last minute. After four hours she gave birth to an eight and a half pound baby with no problems, she did not need me as supporter/doula as it was too quick!

She had exemplary care from her midwives and when they discovered absent membranes (no forewaters then!) Jane reported a recent rupture before admission. I must confess that neither of us was at all comfortable with our untruthfulness, and I still felt anxious until the baby was seen, plainly fighting fit, but we did not see how we could otherwise proceed without compromising the lovely midwives who cared for her; and possibly even causing Jane to be at risk of threats from the child protection system.

As I type this I am somewhat shocked at this compliance with the system. No doubt I would say from my feminist stance that we were behaving in the manner of oppressed minorities in the face of the dominant group, using subterfuge instead of confrontation as a strategy. I would be grateful for comments on this or any other aspects of our experience and would appreciate any anecdotal evidence of further such cases to inform future practice.

I was very proud of Jane and her clarity about what was best for her and her baby.

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Dare MR, Middleton P, Crowther CA, Flenady VJ, Varatharaju B. Planned early birth versus expectant management (waiting) for prelabour rupture of membranes at term (37 weeks or more). *The Cochrane Database of Systematic Reviews* 2006, Issue 1. Art. No.: CD005302. DOI: 10.1002/14651858.CD005302.pub2.

National Meeting Report

December 10, 2005
Birmingham

We hadn't had a national meeting in Birmingham since ARM's 21st birthday, nine years ago, but many of the well known and well loved faces were there and I didn't notice anyone looking any older. There was at least one new face – Theo, Jo Hindley's son – whose birth was featured in issue number 105 and it was a joy to meet him! And it was good to meet a ARM member from many years ago, Dorothy MacDonald. There were new faces as well. We are always pleased to 'catch' students early; many members who joined as students say they would not have survived the course without the support of ARM.

As usual, we kicked off with ARM business.

Editorial Group

There was good feedback about the last issue of *Midwifery Matters* from Sheffield but a plea for more news items. The Editorial Group asked people to send news cuttings, web links and stories to Margaret so she can compile a page or two of current affairs in midwifery. We also need more illustrations of normal midwifery. Perhaps you could take a camera to work one day and take some shots of normal everyday practice, in hospital, in the community, wherever midwfery happens and email the results to Margaret (margaret.jowitt@tiscali.co.uk). We discussed future issues, it would be good to have one on 'challenging births' but it was felt that it is important to continue to celebrate normal birth.

Finance

Linda Wylie, our new treasurer, reported that the paperwork has now been done for her to take charge of the ARM chequebook! The AIMS/ARM conference made a profit and the meeting hoped that some of this could be spent on producing a booklet of the conference proceedings. It was suggested that the Action Plan for change should be published on the websiste (also Linda's domain).

Reed Elsevier and the Arms Trade

Reed Elsevier, an academic publisher also has a subsidary company, Spearhead Exhibitions, which hosts DSEi, the world's largest arms fair.

In September 2005 *The Lancet,* which is owned by Reed Elsevier, published a letter signed by public healthcare professionals from five continents. The letter highlighted the involvement of *The Lancet*'s publisher in the global arms trade. The Lancet's editorial board issued a scathing condemnation of Reed Elsevier in the same issue and called on the company 'to divest itself of all business interests that threaten human, and especially civilian, health and well-being'. *The Practising Midwife* is published by Reed Elsevier and the company also publishes books by ARM members. The meeting decided that ARM should write to those involved bringing the arms trade connection to their attention.

Politics

The meeting with Liam Byrne, Minister for Health responsible for the maternity services, about commissioning the new NHS Commnity Model has been delayed yet again until January. The link with Steve Walker of CNST forged at the October AIMS/ARM conference is being maintained.

Festival Yurt

For the last two years we have had stands at festivals around the country and Natasha, who organised this year's, has suggested that we buy a yurt of our own. The ARM space has been widely appreciated by festivals and provides a good opportunity to promote normal birth and midwifery to women. There was a lively discussion with Tania Berlow filling us in on the nuts and bolts of what would be involved. People were worried about who would look after it, how it could be transported, who could put it up, where it could be stored and how we can stop it going missing (we have lost a wonderful ARM banner and some display boards – if anyone knows their whereabouts please contact Sarah) The meeting thought that we would need a 'yurt mistress' which would need to be a paid position but could be to some extent self-funding by sponsorship. We need to set up a working party to take this forward. The meeting voted to buy a yurt on the grounds that we could always sell it again if we changed our minds, and we will order a 16' diameter 'pop-up' yurt with medium grade canvas. Three people abstained from the vote.

Website links

ARM has had a policy of not linking our website to commercial sites but linking to sites giving information about, for example, home birth. However, at present there were links to individual independent midwives and to conform to policy these should no longer be allowed but there should instead be a link to the Independent Midwives Association site which lists individual independent midwives.

ICM

Pam Dowling reported on ICM. Kerri-Anne has now stepped down as ARM's representative and spoke of how ICM has changed over the years. When she first became ARM's representative, ten years ago, it was dominated by

mainstream midwifery associations and there was little vocal opposition to the powerful organisations such as RCM and but dissenting voices are now being heard and ICM is becoming more active in supporting normal birth and promoting midwifery. Some ARM members did not like the way that ICM teamed with FIGO (the international federation of obstetrics and gynocology) but this link was useful for midwives in developing countries because it gave them more professional status. Some people at the congress had been worried about ICM's stance on syntocinon and syntometrine and the active management of third stage but it was pointed out that it would be a godsend for midwives in developing countries to be allowed to carry drugs at all and that they can be lifesaving.

Pam emphasised that ARM must make its presence felt at Glasgow (there were calls to pitch the ARM yurt at Glasgow!) ARM has been meeting RCM who are organising the event to make sure that there are affordable spaces for fringe stands. We must make the most of the fact that this congress is taking place on our doorstep. ARM is looking for someone to join Pam as ARM's delegate, if anyone is interested please contact Sarah Montagu.

Birth Pool in a Box

Amy Maclean of The Good Birth Company came to the meeting bringing a pool with her. It was on display in the lobby. She has a mission to increase access to using water for labour and birth by making birth pools more affordable and available whether women labour at home or in hospital. Pools cost around £55 and can be used up to ten times. Each pool comes with a hand pump to inflate it and you can buy or hire extra kit comprising a water emptying pump, a step and other accessories. Pools are available free for hospitals for the price of 10 disposable liners, i.e. £200.

Apollo Study

Bernadette Early came to the meeting to talk about the Apollo study, a study designed to see whether fetal position at the onset of labour affects labour outcomes. Four years ago Jean Sutton had come to speak to the Birmingham Women's Hospital about her theory of Optimal Fetal Positioning. Her ideas took root and soon midwives were holding Birth Ideas workshops to encourage women to get their babies into the best position for labour. In recent years there has been criticism that the theory is not backed by research, as yet there is little formal research linking the occipito-posterior position with dysfunctional labour. The physiological mechanisms behind Jean's theory seem plausible but have not been tested in practice. The research team is recruiting women into a study whereby they will be scanned in early labour to determine fetal position. It is an easy scan to do technically if the head is not too far down, the thalamus points to the occiput, and women like scans, so recruitment is not a problem. It is expected that enough women will be recruited in the next 12-18 months. The outcome variables will be length of labour, analgesia, interventions, type of delivery and fetal condition at birth.

Bernie's enthusiasm was infectious. Although the study is based on a simple premise, she expects that the team will learn a lot about the mechanisms of normal labour. It has taken three years to get the study off the ground, it was originally turned down by R&D, which seems to prefer obstetric research, and by the ethics committee but once funding was obtained the objections melted away. The Apollo team hope that this study will strengthen the midwifery research culture, dispelling the notion, "we are only midwives, what can we do?" If the study establishes that fetal position does have a role in determining the outcome of labour, then the team will go on to research the efficacy of interventions such as those suggested by Jean Sutton to try to change fetal position.

Midwifery Journeys

Jo Hindley and Elsie Gayle gave very moving accounts of their journeys as midwives and as mothers. They both ended up in Balsall Heath, Jo researching women's experience of birth and Elsie becoming midwifery development worker for the St Paul's Community Development Trust, implementing caseload midwifery for women in this deprived part of Birmingham. Both accounts were inspiring about what can be done and if it can be done here why not elsewhere in the country? Members talked about the problem finding midwives wanting to work in this way. People had some depressing comments to make about why this should be, in one university 50 people started the course and 30 finished it with only five describing themselves as interested in normal birth. Another university appears to screen out potential members of ARM! Dorothy MacDonald said she was not surprised, in today's climate the threat of litigation is drummed into students so much that they end up not wanting to lift a finger without someone else taking the responsibility. "We're afraid to live so how can we be born and how can we die?"

Hugs and Home

After lunch there were workshops on independent midwifery, Jo talking about her research, and caseload midwifery. I'll leave you to imagine or remember the usual things that people said at the end of the day and finish, as the day ended, with a quotation from Elsie:

"Whatever you can do, or dream that you can do, do it. Boldness has genius, power and magic in it. Do it now."

book reviews

***The Oxytocin Factor: Tapping the hormone of calm, love and healing*, by Kerstin Uvnas Moberg, Da Capo Press, Cambridge, 2003, ISBN 0-7382-0748-9. £13.99**

I came across this book by accident when searching for information on the 'Hormone of Lurve' as Michel Odent describes oxytocin. This book has been translated from Swedish and is the culmination of 20 years' research into the hormone, mostly by observing animal and human behaviour, as a result of the authors own experiences during childbirth.

This book is inspiring! It discusses the largely neglected physiological mechanism of 'calm and connection' which counters the 'fight or flight' mechanism so commonly described when discussing the increased stress levels we live in today. The author looks at oxytocin not only from its powerful influence on birth and breastfeeding, but in all aspects of our lives.

The book is divided into five parts:

- a description of the environment and the need to balance our stressful lives with periods of calm, in order to maintain a healthy body and mind.
- the underpinning anatomy and physiology of the nervous system in order to understand the hormone and its action
- the effects of oxytocin on every aspect of life including birth and breastfeeding
- the role of oxytocin in developing 'connections' - relationships
- a discussion of some of the ways we seek the effects of oxytocin without being aware of it, massage, alcohol, smoking etc.

I would recommend that everyone should read this book. Not only does it offer good evidence for many of the midwife's activities to encourage women to give birth naturally and breastfeed successfully, but it will also enable the reader to better understand human behaviour.

Linda Wylie

***Not What I Had in Mind*, Nicola Murray, Pegasus, ISBN 1 903490 20 0, 2005, £8.99.**

This might be a good book to read to get an insight into how it feels to have trouble conceiving, to go through fertility treatment, bring premature twins into the world and cope with the problems of a sick baby, a story that could no doubt be replicated by dozens of women. The narrative is enlivened by letters she wrote to her great aunt to whose memory the book is dedicated.

Margaret Jowitt

book received

National Perinatal Epidemiology Unit Annual Report 2004

Annual report of a 'national treasure' (according to a DoH inspection team). Who's doing what, where, who's funding it, who's published what. A few interesting oddities concerning research itself - does increased funding to centres in RTCs increase recruitment to trials; how come women are recruited into RCTs and only neonatal sequalae, not maternal outcomes are looked at? Some gems - a trial of routine admission CTG in low risk women confers no neonatal banefits over intermittent ausculation (National Maternity Hospital, Dublin trial of 8,580 women)

letter

Dear Margaret

Firstly, thanks for printing my article (rant) and for your cards and words of encouragement. It was good to feel able to speak honestly about what the women here have experienced with their birthings. I feel I have shared in their empowerment and am very honoured to have done so. I enjoyed your family news as it gave me an insight into who you are. Did you deliberately choose that paper with those subjects of midwifery research*? I have had hardly any contact with mainstream midwifery writings. I had presumed that Ina May's ideas were all new amongst midwives, I can't believe that midwives have access to the information that was quoted here. If this is the sort of stuff recent research has come up with, what is happening? Why are women still treated in the way they are?

I'm going to subscribe to *Midwifery Matters* as I am interested in what's happening out there. But also we need access to straight basic information. Our local midwives are very nice and they are trying to change, but we have been lied to so much in the past that it's hard to totally believe them. At the moment a woman with a previous c-section wants to give birth at home – what is the actual risk of the scar rupturing? How do we find out? I don't want to take up your personal time but if I write questions to your paper would anyone tell us where to look? I think all most people need is straight forward information to make their decisions. Thanks again for printing my writing, it helped me a lot to write some of my feelings down. Now I've the daunting task of passing it around every one and receiving the criticisms! All the best to you in the New Year.

I am excited to think there are midwives out there trying to change things. Let's hope they can get on with it quickly.

Love

Scilla

(I enclosed a Christmas card printed on recycled paper (old proofs) with Scilla's copy of her article. Please respond to this letter. ARM has been trying for 30 years and it still feels as if we are getting nowhere. MJ)*

maternity politics

Misgivings in the House of Lords over Payment by Results

In the House of Lords, Baroness Cumberlege asked Her Majesty's Government what impact the new financial system of payment by results is having on the National Health Service.

13 Dec 2005 : Column 1114
The Minister of State, Department of Health (Lord Warner): My Lords, in 2005–06, payment by results applies mainly to elective admissions. At this stage, the emphasis is on learning how to operate successfully in the new system. We are doing that in a managed way, introducing the tariff incrementally and limiting the financial impact. We will bring more services within the tariff from next April. By 2008, the tariff will apply to the vast majority of acute services. Early indications are that organisations are paying more attention to productivity, financial management and better information.
Baroness Cumberlege: My Lords, I thank the Minister for that reply, but is not payment by results a misnomer as it is payment by activity, regardless of quality? Hospitals whose reference costs are below the national tariff increase their income by admitting and treating patients. Does the Minister share my deep concern at the 50 per cent rise during the past 10 years in Caesarean section rates? What financial incentives are there to promote natural birth?
Lord Warner: My Lords, I do not share the noble Baroness's concern about payment by results generally. That system will improve productivity and quality of services. International evidence from similar payment schemes shows that the benefits include increased use of day surgery and a reduction in length of stay. On the specialty that she mentioned, I share her concern about the rise in Caesarean operations but, under a tariff scheme, we can adapt the tariff over time to ensure that best clinical practices are pursued through the tariff.

Call for REFORM

A new independent non party political think tank, Reform, has published a report into the maternity services and paints a dismal picture of the maternity services today. Quite short, 35 large print pages, the report gives a useful summary of the current state of the maternity services in the UK, it is a useful source of facts and figures and shows how little has been achieved since *Changing Childbirth*, with consultant numbers 50% up but still not there when they are needed, at night, and more midwives working part time. Most units are staffed below the recommended Birth Rate plus level and some do not even reach their funded establishment.

They bewail the fact that risk assessment is still very rudimentary, with very few units seemingly able to find even 30% low risk mothers for whom a midwife could be the lead professional. They are concerned about low risk women blocking high risk women's access to consultants and screening tests. They were also concerned that a recent survey of 676 women in 2005 revealed that 27% had not received one-to-one care in labour.

Among their main recommendations are that centralisation should stop, no more maternity units should be closed and women should be able to choose from a variety of providers. Funding should 'directly and transparently' follow the mother. Units need more administrative and financial autonomy, responding to local needs, including increased demand. This change would require managers other than clinicians.

Perhaps most significant is that the authors recognise the importance of a friendly environment for labour and see this as more than getting parents to write a birth plan. However, they appear to be against free standing birth centres, wanting instead high and low tech services on the same site, competing with each other. For some reason they also want more screening, scanning and testing in the independent sector, is this to ration NHS facilities to high risk women, I wonder?

The full report is available on www.reform.co.uk. It's worth a look.

OMOM

One Mother One Midwife has come a long way since the campaign started in July 2005. We now have over 230 active campaigners across the UK, some of whom have presented aims and proposals of the IMA Com-

munity Midwifery Model to organisations such as local NCT groups and MSLCs. We also have many campaigners lobbying their local MPs. We have had our press release, with our logo and OMOM photographs reproduced in various journals, namely, *The Practising Midwife*, The Royal College of Midwives Journal, *MIDIRS* and The Association of Improvements into Maternity Services Journal as well as a number of articles written and published.

We have backing far and wide and are grateful to our many 'official' supporters who can be found on our website.

Politically, we have strong interest from all three major political parties and a meeting is being arranged with the Under Secretary of State. We have campaigners in all areas of the UK and there is information for our Scottish campaigners on how to get their politicians involved on our website.

Media interest is variable but we do have a features writer currently writing a feature on OMOM who has interviewed some of our campaigners. OMOM was recently talked about very favourably on Radio 4's Womans Hour by Jean Robinson of AIMS and "One Mother One Midwife" is a buzz phrase which many are now familiar with. We now have interest from some well known women, so it looks as though

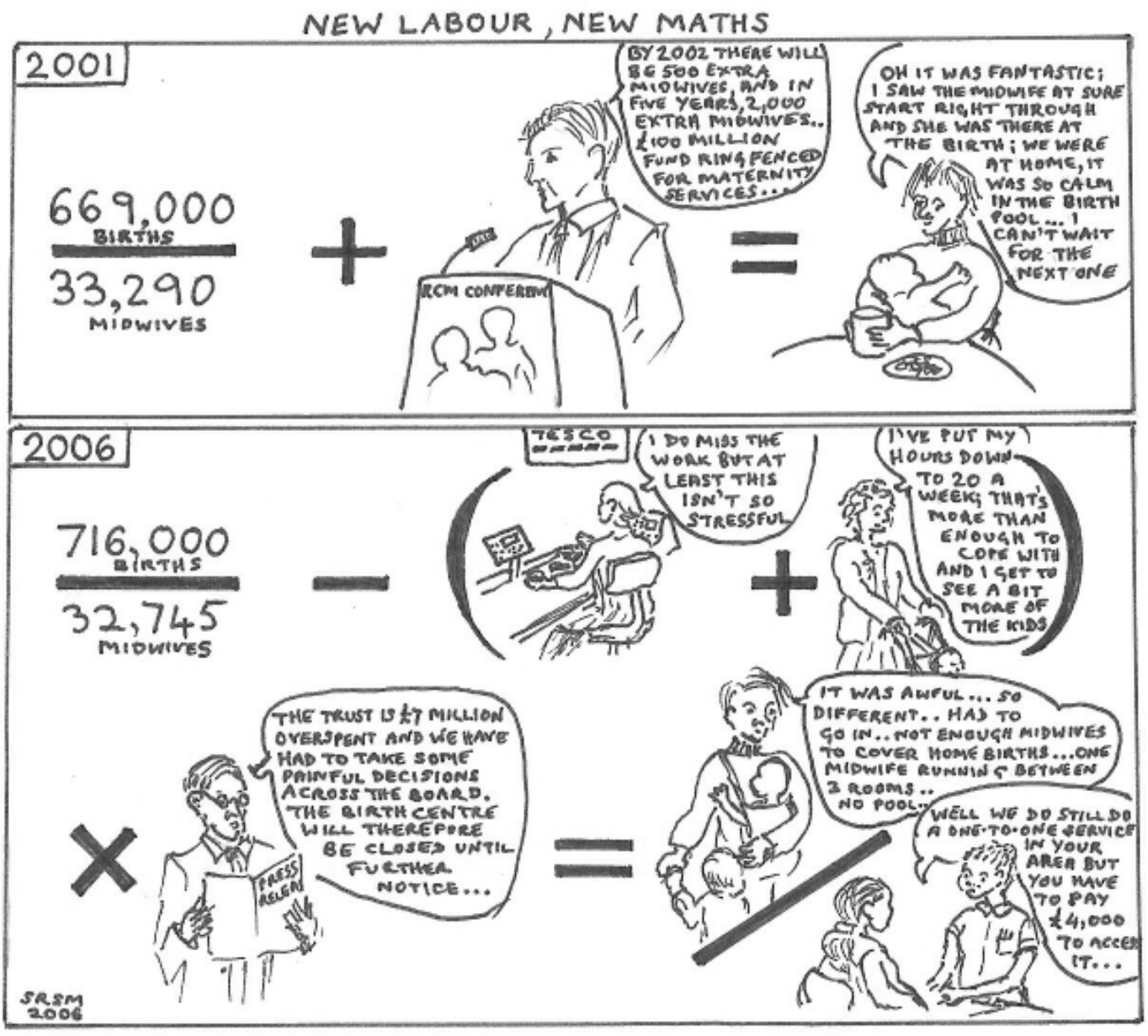
we may have some celebrity backing at some stage which will increase media interest.

Our petition is ongoing and now has over 1400 signatures. Please visit the website and sign if you haven't already done so! We expect more support as our promotional material is distributed around the UK. We do need more donations as we are trying to get a stand together to take to conferences.

If any more postcards are needed, please send a SAE to:
Laura at OMOM, 8 Fairground Way, Clifton, Bedfordshire, SG17 5JN.
Laura Abbott
Independent Midwife
www.homebirths.net
www.onemotheronemidwife.org.uk

IMPORTANT REMINDER

In September 2005, membership of ARM was raised to £30 pa. (overseas £35, UK student rate still £12.50). However, many renewals are still coming in at the old rate of £25, to which I usually respond with a reminder. To avoid excessive admin and postal costs, I now propose to post out individual reminders **once only,** before reluctantly dropping non-upgraded subs from the mailing list.
To make sure you don't miss any issues of *Midwifery Matters*, please note the following:
1. If your renewal is due shortly, please use the form on page 48 as soon as possible.
2. If you have Standing Order with your bank, please upgrade to the new rate at least a month before your renewal is due.
Many thanks to those members who have already upgraded.
Ishbel Kargar
Membership Secretary



NMC Elections

The following ARM members are standing for election to the NMC:

England
Laura Abbott
Paul Lewis

Scotland
Sheila Hunt
Mary McElligot

Wales
Sandra Arthur
Catherine Langley

We wish them well and hope that ARM will be strongly represented on the first elected Council of the NMC.

Lack of Oxytocin Surge in Adopted Children

Even after three years of life in a loving family, children adopted from eastern European orphanages still demonstrate hormonal signs of their origins. An American study has measured oxytocin levels in natural and adopted children (from different families) after sitting on their mothers' knees playing interactive games. The adopted children had lower baseline measurements of vasopressin (involved in recognition of familiar people) and, unlike their peers, lacked an oxytocin surge following this close contact.

The researchers speculate that the lack of a close loving relationship at the very beginning of life may mean that their brains are not wired up for social relationships later in life: "...it seems that social experiences after birth are vital for opening up the pathways and strengthening the connections in the brain for these hormones," says Seth Pollak, a psychologist at the University of Wisconsin. He suggests that since oxytocin acts on the reward centre of the brain associated with addictions, we are designed to seek out close relationships throughout our lives.

Sadly, babies denied the early pleasures of interaction may have less incentive to seek out human interaction, perpetuating their social isolation.

BDF New Life Special Source

124 babies a day are born with a birth defect in the UK. Most parents of such children say they were not given enough information at diagnosis and nearly all felt compelled to do their own independent research on their child's condition, some even attending medical conferences in an attempt to learn more.

BDF Newlife's new online service Special Source uses down-to-earth language to explain what syndromes actually mean, their symptoms and inheritance patterns. 1,300 medical terms are translated, 500 support groups for specific conditions are listed together with details of 750 general service organisations which can offer help. The site will be regularly updated with the help of Michael Patton, Professor of Medical Genetics at St George's Hospital. Even professionals cannot keep up with the constantly evolving knowledge of conditions so the site will be able to help them give parents up to date information.

Special Source can be found at: www.bdfnewlife.co.uk.
There is also a helpline 08700 707020.

The S L O W Caesarean

Nicholas Fisk at Queen Charlotte's Hospital has pioneered what he calls the 'natural' caesarean. There is no reason, he says, for caesareans to be performed at breakneck speed, the baby can be born slowly and given to the mother instead of being placed on a resuscitaire.

The legendary concern with speed was related to the dangers of the operation. We do hope that this new form of operative delivery is being subjected to the necesssary RCTs. We await the published results.

Still, it's lovely to think that there's a consultant somewhere allowing someone a little more t i m e for something!

Vitamin K

Are we too quick to condemn the giving of vitamin K to newborns? A Danish study has shown that it may protect against alcoholism in later life. The authors speculate that brain bleeds could affect neural structures controlling pleasure and reward.

Aceh Midwife Fund

This fund sends holistic midwives and practitioners to the most remote tsunami hit area of Sumatra. ARM member Tania Berlow is going out straight after the next National Meeting. Please donate via the website: www.acehmidwifefund.org.

Anyone interested in volunteering please contact Tania on 01308 861376

Waterbirth Expertise

For 18 years, Dianne Garland, a longstanding member of ARM, has been passionate about using water in pregnancy and the postnatal period. Her work with water has taken her all over the world, speaking at the last six ICM congresses. She is a supervisor of midwives and acts as professional advisor for review panels and the ombudsman. She has been described as a very inspirational speaker and wonderful mentor.

Now she is branching out to offer waterbirth study days geared to local needs. Each day is tailor made for the location, and encompasses practical, physiological and audit issues. A practical session can include 'emergency evacuation' and dealing with 'what if...' scenarios.

To book a study day with Dianne, call her on 07845 192146 or contact her at: www.midwifeexpert.co.uk.

OBITUARY

We lament the passing of Joan Donley who died in December. Joan was a well known New Zealand midwife at the forefront of the fight for autonomy through the 70s and 80s. Without her tireless work New Zealand midwives would not have had the success they had in achieving autonomy and the legislation changes necessary to give us our current system. Joan published many books, the last a compendium of her knowledge acquired over her years of practice.

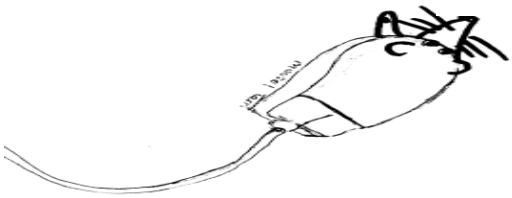
Joan held a special place in the hearts of all New Zealand midwives and I'm sure we all feel much sadness at her passing and send love to her family as they grieve.

Annemarie
ukmidwifery list

nettalk

Here is a thread from our email discussion group (sometimes known as the 'List'). Formed in April 1999, it is now a lively forum for the exchange of ideas, opinions, hints and tips, reports, etc. and a valuable resource for study and research. Current membership (mid 2005) has now topped 2,000. The group is open to midwives, student midwives, mothers and others interested in improving maternity care in the UK.

Non-members of ARM are welcome to join the group. To join, go to http://health.groups.yahoo.com/group/ukmidwifery



ptyalism

I am caring for a woman having her second baby who is now 16 weeks pregnant. She had a very easy pregnancy last time but this time is really struggling with nausea and ptyalism. Ptyalism is an excess of saliva, and women who suffer from it have to spit the saliva out all the time it's not nice to have to carry a little pot round all the time.

Does anybody know of any treatments, therapies or strategies to help?

Dot

I can highly recommend acupuncture for morning sickness (obviously to be given by an appropriately accredited practioner) our local maternity ward offers it. I'm not sure about ptyalism but my sessions relieved all my pregnancy sickness, niggles etc.
Charlie

Those tiny little sherbert pip sweets helped one woman I know of for the excess saliva.
Anna

It's horrible – I had it with DS1, and to a lesser extent with DS2.

To be honest I didn't find that anything helped, but I've since heard from women who found homeopathy worked well.
Deborah

There are several homeopathic remedies that may help.
For sickness:
Nux vomica 6c if nausea is worse in morning and small amounts of food with mucus are brought up.
Ipecac 6c if non-stop nausea and unable to keep even liquids down. **Natrum mur 6c** if there is excessive thirst, craving for salt and aversion to fatty foods and bread.
Sepia 6c if vomit is like milky mucus and the woman is irritable and weepy.
Pulsatilla 6c if nausea is worse in the evening and wears off at night.
Ferrum 6c if nausea occurs a few hours after eating and then sudden vomitting everything.
For ptyalism:
Mercurius 6c if there is a sweet metallic taste in the mouth
Pulsatilla 6c when there is nausea, aversion to food and whilte or yellow coating on tongue
Ipecac 6c if ptyalism, nausea and aversion to food but the tongue is clean
Arsenicum 6c if also weak, chilly, restless and worried
Veratrum 6c if forehead cold and sweaty and there is weaknesss and apathy
Petroleum if nausea, ptyalism, irritable and easily offended
Sanguinaria if aversion to butter, nausea, ptyalism, unquenchable thirst, heartburn and feeling faint

Acupuncture and acupressure can help both nausea and ptyalism, the main point being **Pericardium 6** which is on the wrist so easy to stimulate yourself using acupressure.

Although I am an acupressure practitioner, I actually find acupuncture works better for me and I had terrible morning sickness with Kalonice that wasn't helped at all by acupressure.
Herbally, she could try ginger, black horehound, peppermint or spearmint.
Anne

In TCM they recommend celery for ptyalism. www.hyperemesis.org may also have recommendations for this.
Viv

Extraordinary Breastfeeding

The TV programme Extraordinary Breastfeeding *really got the ukmidwifery list going earlier in the year. Here's a selection of what members had to say:*

Not Helpful

There's no such thing as 'extreme' breastfeeding... maybe breastfeeding while skydiving?

My main issue with the programme was that it didn't help the cause of breastfeeders because the tone of the programme was that breastfeeding was 'odd' and that breastfeeders are a 'minority group' for a reason. The Little Angels group were great and should have been given more airtime but the emphasis seemed to be that breastfeeding equals no life, that you are tied to your child and that you are placing strain on your family and relationships if you EBF, which is in reality, not usually the case. Also, the general public is mostly made up in the UK of people who will not breastfeed (men) or people who have not breastfed (women who artificially fed or women who have not yet had children) and are therefore perhaps less likely to take away a positive message, (though the programme was full of positive messages) because the sensationalist bits are what they will remember.

The public won't remember Little Angels and the health benefits; they will remember an 8 year old breastfeeding, an exhausted mum of twins permanently with her breasts exposed and her other children saying that they never see their mum any more. The good points won't be remembered in the face of that.

On a slightly different note, I have often thought that this country's paternalistic approach to feeding children is centuries old... don't forget that breastfeeding used to be seen as 'common' (women would send their babies to be wet-nursed if they could) and children of rich families were sent to school at an early age – I know people who were boarders at 6, so that puts paid to EBF. And as traditionally the middle classes did what the upper classes did, you can see how BF went out the window! What will be interesting is to see where we are in 50 years time...
Claire

Not the Whole Truth

I waited with bated breath as a child-led weaner for this programme. I belong to The Natural Nurturing Network and have several La Leche friends. The reason it was bated was because of the fear that prime time TV will trash one's view point and make you look ridiculous. Talking it over with friends, our first reaction was 'whew' they seemed OK and it was not too sensationalist, ie:

1. it could have been worse
2. it was pro breastfeeding in slant
3. it is nice to 'noticed' (i.e your way of child raising exists) there was almost a sense of gratitude for being recognised.

However, the experiences of these three women certainly do not reflect the experiences of the many child-led weaners who I have met over the years. Yes, we juggle with other family needs (who does not), yes it can be tiring sometimes (but then so is a screaming toddler who is tired), yes breastfeeding in the big wide world (well the UK) can be daunting, yes those of us with partners have varying degrees of support at different times.

but the programme did not...

1. Cover long term health benefits for the child neither psychologically nor health wise.
2. Show the use of slings which makes it *so* much easier and, if necessary, discreet
3. Show or discuss the huge network of people who raise kids in this way – i.e. support, nourishment and acceptance

Most kids stop around age five so the family with the older child, whilst not unknown, is unusual even in La Leche. They made it seem as though the child was addicted to booby – that psychologically she was 'stuck' and therefore it was 'weird' whilst in reality at that age breastfeeding is not something that is as constant as it is in the younger years – it is a godsend when the child is miserable, insecure, hurt or ill.

The woman with twins was sleeping in a different room from them – no wonder she was knackered. I cannot even begin to imagine being able to manage this. I also wonder on a scale of 1-10 in ten years time, how supportive she considered her partner. There are much gentler ways of supporting kids through the adult's choice of withdrawal – one would have been to have the husband tend the kids for the few days of stopping as the kids had no other way of comfort from their mother at that point.

The adoptive woman, whilst noble, was not shown as understanding that a child who had never seen a breast before (probably) was not going to take to just like that and therefore came across as neurotic and, dare I say it, pushy i.e. not child-led. I would LOVE to know if she succeeded and would be really truly happy to hear that she did.

The women shown all had situations which made them atypical which I guess is what TV does best – that's what made it *extra* ordinary.

I just wish they had shown the easy, relaxed and close relationship between mother and child that I have seen over and over again whilst mixing in these 'extraordinary' circles. I know my critique of the three women and their families may come across as judgmental but this is something very close to my heart and I simply feel that it did not represent me or the others I know.

Tania

Truncated rather than Extended

What a great debate this programme has stirred! I bet the programme maker is pleased! But I do agree with you Tania, and don't think you are being judgmental. I found the programme sensationalist, and to call it extreme breastfeeding was just to get an audience.

I object to the word 'extreme' and I don't even like the word 'extended'! The breastfeeding that is acceptable in our society (if at all) is 'truncated' or 'shortened' – as others have pointed out, there are good reasons to breastfeed until the age of four or beyond.

Nicky

Breastfeeding Toddlers

Having gone through toddlerhood with four children, one of whom breastfed throughout toddlerhood, and three of whom weaned at various times during it, I have to say that *not* breastfeeding a toddler is far more tiring than breastfeeding one. Breastfeeding a toddler is fantastic! It's such a great way to reconnect after the stressful moments, it's an easy way to settle them down for a much-needed and much-fought-off nap (and thus a great way to get a rest yourself!), it's just one of the best tools I know for parenting toddlers!

A friend of mine who had no children visited when one of mine was about 2.5, and he was having a meltdown right before dinner (you all know how that can be - kids are hungry and getting tired, mums are tired and trying to get food sorted... not the best time of day for many of us!) He really needed to eat but was in zero-cooperation mode. I sat down with him and breastfed him for about 45 seconds, after which he got up, said "Thank you," with a smile and went off to sit at the table to eat his meal. My friend looked at us open-mouthed, sat speechless for a minute, then said, "If I ever have children, I'm *definitely* going to breastfeed!"

A good moment, but one that sums it up :-)

Deborah

Mothering tool

I totally agree with this my friend's daughter self weaned at 20 months and she said she has found parenting *so* much harder since. There's no magic get them back to sleep boob or easy way to deal with toddler melt-down.

My daughter often wakes up grotty and grumpy from her afternoon nap. If I don't feed her for whatever reason she's often grumpy until bedtime or at least for a good couple of hours. Boob can bring a smile in minutes!

It's a shame that a lot of these benefits don't really become apparent until after baby is 12 months. 0-6 months can be really hard, 6-12 months too can bring its own sets of issues (teething, nosiness etc.) but after 12 months it's a doddle! For me that's when I really started to enjoy breastfeeding as it was *so* easy. Now for me it's not a feeding method but a mothering tool.

Charlie

At my place of work, there was much talk of this programme. Overwhelmingly (and this includes me) the feeling was that the programme only served to perpetuate the notion that only weirdos breastfeed. I work in an area with its fair share of very young mothers, and breastfeeding is often (almost always?) seen by them as weird/wrong/earth mother (which incidentally is not a positive thing !).

This programme has only helped to make them feel this even more strongly. The overwhelming cry from us labour ward midwives was 'Where were the neonates breastfeeding?'

Advertised as a freak show, it was a freak show I'm afraid.

Flo

Extraordinary Breastfeeding - Channel Four

Veronika Robinson

On February 1st, Channel Four aired *Extraordinary Breastfeeding*. It was a sensitive portrayal of long term breastfeeding and showed the stories of four families. Sophie weaned her two year old twins. Dolores, who was breastfeeding four year old Tristan, adopted a Chinese girl who she hoped to breastfeed. Kirsty runs a breastfeeding support group called Little Angels which has doubled the local breastfeeding rate. Kirsty goes into the local hospital and teaches new mums to breastfeed.

My family's story is simple. We chose to let our daughters wean themselves when they were ready. They both weaned at a similar age. Bethany was seven (despite stating on the documentary that she was five) and Eliza was a couple of months shy of her eighth birthday. Bethany drew huge media attention by the fact she requested to breastfeed for a 9th birthday present. The media played on her statement that breastmilk is better than a million melons. Better than mango, even.

In the media frenzy around the publicity, there were many factual errors. *The Daily Mail*, to whom I gave an interview, *fabricated quotes left, right and centre* and in one particular quote, wrote the exact opposite of what I said. They hounded me for a family photo on the day of my mother in law's funeral. Not only was my story fabricated, but the other two women involved also had their stories altered in favour of how the Daily Mail thinks their stories should be! In Sophie's case, they stated (wrongly) that breastfeeding caused the break-up of her first marriage.

I also gave an exclusive interview to *Now* magazine by email, but they too, sadly, managed to misquote and change the tone of what I said, despite it being written in black and white.

It was an honour to be a guest on the *Richard and Judy* show a few hours before the documentary went to air. They publicly stated that they could find *no* medical or psychology expert to come out against full term breastfeeding. Of course they couldn't! Studies show that it is psychologically beneficial to breastfeed this way.

Extraordinary Breastfeeding had 3.9 million viewers! More than the population of New Zealand.

So, for the record, here is what I really feel about extended breastfeeding. The truth, the whole truth and nothing but the truth!

Firstly, let's get rid of the term extended breastfeeding, for it suggests that we are doing something beyond a normal or natural timescale. The appropriate words for describing a situation where a child is allowed to self-wean is called *full term breastfeeding.* This is regardless of whether a child weans at 2 years of age or later. From my perspective, the age is irrelevant. What is important is that the child is welcomed to the breast and that the relationship is mutually enjoyable for mother and child. Not all children would breastfeed beyond five or six years of age if allowed to self wean.

So why would a woman choose to breastfeed her child for years on end?

When I began breastfeeding I never gave it a thought as to when I would wean my child. I had an infant in my arms who needed my milk. I seriously didn't plan ahead to when she would stop having this milk. When Bethany was a year old, I was dining in a friend's café. The niece of this friend was heavily pregnant. Upon seeing me breastfeeding, she snapped, "I will be weaning my child when it is nine months old!"

It was the first time it occurred to me that I might be doing something a little unusual. Sadly, this woman never did breastfeed her child, but chose to raise it on goat's milk. She was proud that her child would be raised on goat's milk just like her mum had been.

When Bethany was fifteen months old, I became pregnant with my second daughter Eliza. Again, it didn't occur to me that I might be doing something odd because I was breastfeeding while pregnant. I even had one elderly lady suggest my breastmilk would be poisonous to my toddler! I can assure you, breastmilk made during pregnancy is NOT poisonous.

When I gave birth to Eliza, Bethany was 22 months of age. She breastfed during my labour and continued again after the birth in a practice known as *tandem nursing*.

Now, I can tell you, breastfeeding an infant and a toddler is rather a juggling act. In the early days I fed them both at the same time. One on each breast. Bethany stopped eating food altogether. She was in heaven with all this lush new breastmilk gushing forth. As they grew older, I tended to feed them one at a time.

It was about this time that a friend recommended I attend La Leche League (the international support group for breastfeeding families). When I went to the meetings I saw a woman breastfeeding a five year old girl. My eyes nearly fell out of my head! My goodness, I thought, look at that huge child – breastfeeding!! Despite my shock (*not* revulsion), something changed inside me that day. A door opened for which I will always be so grateful. My frame of reference widened. I began to study about breastmilk and breastfeeding. I was stunned by what I learnt, and trained to become a breastfeeding counsellor. It is impossible not to be passionate about breastmilk and breastfeeding when you truly know of its benefits. There is no other product on this Earth capable of nourishing our body, brain and immune system like mother's milk. But there was more! So much more to learn. And this is what led me and my family to the place we came to where we let our daughters self wean.

The human body biologically expects to breastfeed for up to about seven years of age – the universal age for losing the milk teeth. There is so much anthropological and scientific evidence to show that this is what our body needs and expects, regardless of the culture, climate, race or status we are born into.

People often wonder if full term breastfeeding is 'for the mother' as if we're being selfish. My experience couldn't be further from this way of thinking. If I was looking out for me, I'd have no doubt weaned them years ago. I put their needs first by allowing them to self wean. There is nothing selfish about putting your own needs to one side for a few years in order to give your child the best start in life.

However, there *are* huge benefits for women who breastfeed for many months and years. *Studies have shown a significant decrease in ovarian and breastfeeding cancer in mothers who breastfeed long term.* Now that's a reason to be selfish! :-)

I can honestly say though, for me, this reason played no part in my decision.

There is also an assumption that mothers like me are smothering – forcing the child onto our breast. YOU CAN NOT FORCE A CHILD TO BREASTFEED.

Breastfeeding in children is initiated by the child. Because breastfeeding involves the sucking 'reflex' you cannot force it. And it is this same reflex that is responsible for self-weaning. As a child gets older, they are so busy with life, playing, running, and all the other adventurous things they get up to, that they simple aren't breastfeeding that often. It varies from child to child. Some will breastfeed once or twice a day, others may go for days without breastfeeding. Some will go weeks and then have a feeding frenzy. The reflex needs to be regularly used in order to work efficiently in extracting milk from the breast. ALL children will lose this reflex as some point, if allowed to self wean.

The World Health Organisation recommends breastfeeding well into and beyond the second year old life. This is a conservative organisation which is saying two years is the minimum we should breastfeed for, NOT the maximum!

*The American Academy of Family Physicians (*yet another very conservative organisation) states that weaning a child before two years of age *leads to an increase in illness*.

The worldwide average for weaning is 4 years and 2 months of age.

I'm no mathematician, but I can assure you that you don't get an average like that if the majority of people are weaning at 6 months of age.

There are so many benefits to breastfeeding and the consumption of breastmilk. I am all too aware that the average person on the street knows next to nothing about breastmilk, and that is why, in Britain, we have such appalling breastfeeding rates. Many people assume formula is an appropriate alternative to breastmilk, no different perhaps than if they were to choose Pepsi over Coke.

Breast milk is a living food. It is constantly changing as the mother's body scans the environment for dangerous pathogens. Her body adapts and produces milk to build her child's body in the way no other food can. No two mothers have the same breastmilk. No mother produces the same milk twice. It is constantly changing to suit the needs of the child.

Formula milk is static!! Formula is not a living food. It cannot build the brain or the immune system. When babies are fed from a bottle, they are denied their birthright to develop right and left hand/eye coordination; the building up of oro-facial muscles which can only happen when extracting milk from a breast; the warmth of giving and receiving from mother to child. A bottle, a dummy ~ these are no replacements for the love and comfort of a warm, comforting breast. The human needs to suck. But it needs to suck at the human breast to have this need met fully. The consequences of not doing this are many. It may be as simple as sucking a thumb, or could manifest later in the shape of cigarette smoking, food addictions, etc.

Animal milks are made for animal babies. Cow's milk is designed to build a calf's body very quickly. Goat's milk is designed for a kid.

In the past few weeks I've been asked many questions that people clearly want to know. I'll do my best to answer some of them here.

No, my sex life has not suffered because of breastfeeding. Nor has it for my husband. Many people suggest that it is difficult for men to be at the back of the queue when kids come along, and goodness me, how did my poor husband cope with not being first in line? Well, I am blessed with an emotionally and mentally mature husband. He has never felt jealous or needy. He knows I love and adore him. That doesn't change because I'm breastfeeding the two children who were created from our love! It is hardly beneficial to parenting if the partner is acting like a needy child.

NO, my nipples have never hurt. Sore nipples are the result of the baby not latching on properly. If a woman has sore nipples, she needs to get help immediately. Nature intended that breastfeeding be enjoyable. If your health visitor or midwife don't know how to help your baby latch on, then please, contact LLL (La Leche League) or the ABM (Association of Breastfeeding Mothers) or , better still, an experienced breastfeeding mother. Many women give up breastfeeding because of sore nipples. Latching on correctly is very easy to address.

I've been asked over and over if I'm concerned about my breasts changing shape because of breastfeeding. Breastfeeding does not change the change of your breasts, PREGNANCY does! And how could a mother not value her breasts, regardless of their shape, when she has fully nourished her children through them? So what if they aren't a certain size or a certain shape? My kids and husband love them the way they are. Why should I care what the average man on the street thinks of them? I don't!!

Do I care if people think I'm weird for breastfeeding so long?

Nope. To be completely honest, from my perspective, I find it strange that people aren't breastfeeding their children as nature intended.

I was surprise at how many people recognised me on the streets after the documentary was aired. Clearly the British public haven't learnt how to be discreet when they recognise someone from television. The pointing, staring, whispering, laughing….are all indications to me of people who just have NO IDEA what they're doing to their children by not breastfeeding.

I've been inundated by supportive emails and cards. I know that for every person struggling with the concept of full term breastfeeding, there are at least two people cheerleading the cause.

Fake milks are relatively recent in human history. A blip in time in the scheme of our evolution. If we continue raising children on fake milk or milk from another species, we will see not only a rapid decline in humanity's mental, emotional and physical health, but I believe humanity would die out if we were to all stop breastfeeding.

I appreciate this is a radical statement from which most people will immediately define me as a 'crank'. But when the scientists raise their heads above the horizon and start saying the same thing, then, I'm afraid, it may be too late to undo the damage we've done to our children. It may be two or three generations from now when we'll see the shocking problems, but they will happen. If we were meant to drink crap from a can, milk from the udder of a cow, goat, camel or horse, then we'd have been born to those animals rather than a mammalian human.

***A very special and heartfelt thank you to Katie Buchanan, Producer of* Extraordinary Breastfeeding *and a mother who breastfed, for staying true to your goal of a campaigning documentary for the right to breastfeed in public while skilfully grabbing the attention of mainstream Britain.*

by kind permission www.themothermagazine.co.uk

Underwater

(Birth — The Woman)

It is beginning
Be excited with me

Here it is again
Reassure me

Long are the moments when it takes my breath
Talk me through it

Strong is the wave coming again
Hold my hand

And again flow in my back
Rub it just there

The back hurts too much
Remember the hot packs

Relentless are the waves crashing over my body
Help me to ride through them

I don't want to go on
Remember a bath

Warm water caresses parts of me
Think of the pool

Deep water envelopes me, holds me afloat
Let me rest here

The water reaches into my soul
Encourage my efforts

New life is unfolding
Hold me close

Life is emerging from out of myself
Encourage me more

Let's lift him together
Be amazed at our son

Born under water
Celebrate what we have done

Underwater

(Birth — The Midwife)

Excitement. Am I in labour?
Not quite, stay home, enjoy

It's me again I can barely breathe
Concentrate, be calm that's fine, your doing so well

She arrives her contractions are strong
I hold her hand

You can see it in her back
I show him massage

She grips her back
I lay on warm towels

Relentless waves seem overwhelming
Keep going you're doing so well

She wants to give up
What about a bath

She sighs as the water covers her
I'm filling the pool

The relief as she sinks down
I think we'll stay here

She's at one with her body
I stay close and watch

As life unfolds
He holds, I encourage

A baby is emerging
We reach down together

They are amazed at their son
I stand back, still amazed

Each one is a miracle
Land or water

We all celebrate
What they have done

Underwater

Sue Gill, midwife, mum and student

Items for Sale

ORDER FORM

	£	P&P code	No. req.
Beechwood Pinard stethoscope (standard 7")	6.00	B	
Beechwood Pinard stethoscope (continental 13")	10.00	C	
ARM Badge (Pinard logo, blue/gold enamel, safety fastening)	3.50	A	
Calico carrier bag (Pinard logo) please circle: **long**/**short** handle	1.50	A	
Contour pen (rubber grip, retracting, black ink, 'Midwifery Matters' and ARM address)	1.00	A	
Jotter pad (6" x 4", 50 sheets, small owl logo in corner)	0.50	A	
Car sticker (Logo: Pinard, 'Midwifery Matters')	0.60	A	
Car sticker (Logo: Owl on Pinard, 'Pregnant? Be wise, choose a Midwife')	0.60	A	
Mouse mat (Logo: Owl on Pinard, 'Be wise, read Midwifery Matters')	3.50	B	
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Silver Miniature Pinard (2 cm) pendant on silver chain	15.00	A	
ARM CD ROM of the first 100 issues of the magazine	25.00	C	
Vision for Midwifery Education (Report of the ARM Working Party, 1999)	1.50	C	
Childbirth Unmasked (stress hormones in labour) Margaret Jowitt	5.00	C	
Midwifery Matters (single back-copies)	2.00	B	
"Choices in Childbirth" (free leaflet)	see below for postage costs		
"What is a Midwife?" (free leaflet)	see below for postage costs		

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 01865 248159

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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.

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Celebrating Change:

Evidence Led Innovations In Midwifery Practice
3rd International Conference of The Evidence Based Midwifery Network

Saturday, 25th March 2006

Leicester General Hospital

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Jane Sandall on "The evidence for differing models of maternity care"

Ingela Wiklund, on "A Stockholm Experience: Achieving 3.5% Caesarean Section Rate"

Fees: Midwives/Other £50 : Student Midwives £30

For full details and concurrent sessions visit the Network Website http://www.ebmn.org.uk or contact

Ms Sharon Mills
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University of Nottingham
Postgraduate Education Centre
City Hospital, Hucknall Road
Nottingham NG5 1PB
0115 8231927
Sharon.Mills@nottingham.ac.uk

what's on

Doula course
June 16-18,
Kendal
Fee: £230 including refreshments but not lunch.
contact: kate@positivebirthing.org or 01539 741407.

Study Day - 7th October 2006
Mothers and Midwives in Partnership
(Power to the Pinard!)
Study Day - 7th October 2006
Hosted by Wigan Local ARM Group
North-West Speakers and workshop leaders
Jayne Halton (Chair Wigan Home Birth Group and MSLC member) - Wigan home /water births
Lavinia Wilkinson - Home birth after caesarean section
Susan Baines - aquanatal exercises and birth outcomes
Dr I O'Connell (consultant endocronolgist) and Jane McCallister (Diabetic specialist nurse) - The medicalisation of glycosuria in pregnancy
Sandra Smith (SoM) - Maternity support workers in the NHS
Other speakers: Denis Walsh, Soo Downe
Full details, (topics, workshops, venue, registration fee, etc.) in Summer issue of *Midwifery Matters*

Rest & relax in beautiful rural surroundings for the ARM gathering, this year in wildest West Wales.

Maesycrugiau Manor is an elegant estate with long distance views over the Teifi River Valley. The manor has great architectural value and wonderful views over the landscaped grounds and local countryside.

Each room has its own unique name which describes its interior, most rooms including the bedrooms have the most exquisite fire places, some of which are still in use, and there is more than ample public space, with three lounges, one of which has a Playstation and another a grand piano! If you tire of the peace and quiet of these idyllic surroundings, then this makes a good base for visiting the market town of Cardigan, on the Teifi River, which has a good theatre, golf course and golden Poppit Sands just a couple of miles away. Mwnt is well worth a visit to see the dolphins and seals frolicking in the sea, whilst Tregaron has a Welsh red kite and gold centre, and is in the foot hills of the Cambrian Mountains.

As usual, we have the place to ourselves and we do our own shopping and cooking, (taking it in turns!). By common consent the evening meal is vegetarian, but since lunches are BYO or 'eat out', meat eaters need not suffer!

In addition to the AGM on the Saturday, several Workshops will be offered during the week, to be booked separately from the holiday. You may of course prefer to relax all week, and leave the brainwork to others. Apart from the workshops, the congenial company will provide a safe, healing and energising space to talk out problems and ethical dilemmas (especially useful for student midwives!)

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 Gommon
Independent Midwife
www.3shiresmidwife.co.uk

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

Norfolk
Three ARM members are interested in setting up an ARM group for the Norfolk area and have begun to meet informally for coffee and a chat. Any other ARM members interested in meeting up on a monthly/two monthy basis to share good practice and ideas about midwifery in a supportive environment please contact Sarah G Montagu on 01603 614434 or email your details to s.montagu@virgin.net

Taunton/Bridgwater area
First meeting of new local group for ARM members in the Taunton/Bridgwater/ Tiverton area will be on Friday 24 Feb at 7.30. Please contact me direct for further details/directions.

West Sussex
Contact: Aida (01730 812086)
aidastephens@tiscali.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. Broomsticks optional!

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

West Scotland
The first meeting was on 21st February at 7pm at the University of Paisley. See you at teh next? All welcome. Please contact Linda Wylie on 01292 316596 for details.

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

BOOKING FORM
ARM annual holiday/gathering/retreat
Maesycrugiau Manor, Carmarthenshire, Wales, 16th to 23rd September 2006

(PLEASE WRITE CLEARLY IN CAPITALS)
Name:_____Email address:_____

address_____

_____postcode_____Tel._____

£15 per night half board (shared self catering) Discount for full week (7 nights**) £95**

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

Sat 16th Sun 17th Mon 18th Tues 19th Weds 20th Thurs 21st Fri 22nd Full week

I enclose £_____ (please make your cheque payable to A.R.M.)

Signed: _____ Date _____

Please send your completed form and cheque to ARM Holiday Booking, c/o Sara McAleese, 1 Queen Street, Goginan, Aberystwyth SY23 3NU (Tel 01970 880856)
Your booking form and payment will be acknowledged with a receipt, together with a map and travel directions.

Would you like to offer/share a lift?
Lift offered from _____area Lift required from _____area/train station (eg Carmarthen, Aberystwyth)
If your car sharing requirements match with someone else's, I will contact you.
N.B. Since we have to confirm the booking and pay the balance of the booking fee to the proprietors by 1st July 2006, no refunds will be given for cancellations received after this date.
I will contact you by email regarding the study sessions as they are arranged.

Spring National Meeting

Saturday, March 18

Fernleigh Centre, North Street

Chichester PO19 1LX

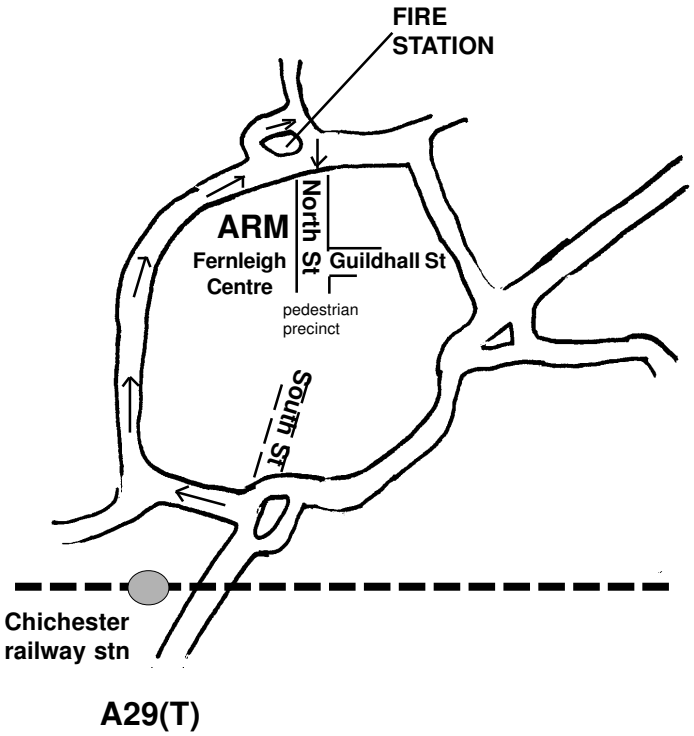
What are We Worth?

We hope to have a lively meeting spending time considering what women are worth, as students, as midwives and as mothers. We will discuss double standards in the maternity services and are planning workshops on clinical issues (with Mary Cronk), intuitive midwifery, maternity service politics, and storytelling. With any luck we'll be treated to a session on belly dancing in pregnancy! What more could you want for an exciting day out?

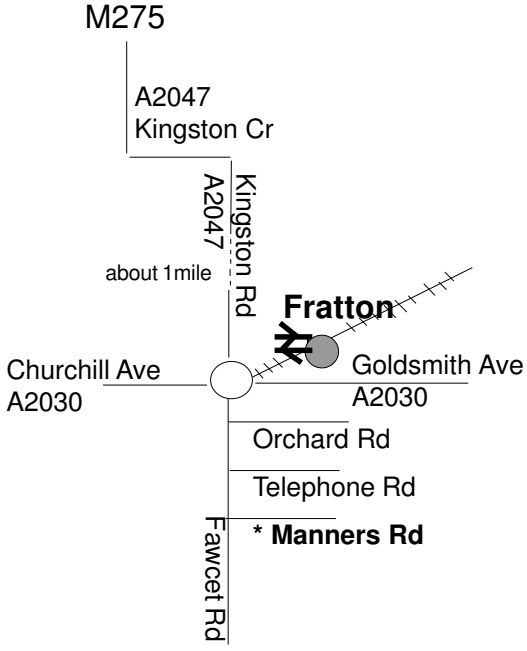
9 for 9.30 start
Morning: ARM business and speakers
Afternoon: workshops
Cost: members £15, students £7.50, non-members £20
Contacts: Aida Stephens tel: 01730 812086
Joy Fowler, 2 Manners Road, Fratton, Portsmouth PO4 0BB 023 926 46805

Please let us know if you plan to attend and if you will need overnight accommodation after the Friday evening (please bring a sleeping bag and an airbed if you can)

National Meeting 18th March Chichester



Steering Group 17th March, Fratton



Steering Group meeting 8 pm, Joy Fowler's house, 2 Manners Road, Fratton, Portsmouth PO4 0BB. An easy walk from the station.

PERSONAL SUBSCRIPTION FORM
(N.B. new rate from 1st September 2005)

(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 when attending the quarterly National Meetings (for details see inside front cover).

NAME: (please use BLOCK CAPS):_____

ADDRESS: _____

_____

POSTCODE: _____ TEL: _____ email _____

MIDWIFE *(Please circle relevant status)*: Community Hospital Team Tutor
Independent Manager Research Not practising Retired

STUDENT MIDWIFE: Course ends: Month ..... Year.....

NON-MIDWIFE: (Occupation) _____

Is this your first subscription to ARM? YES/NO

If 'NO', please give your previous surname and address if these details have changed.

_____

SUBSCRIPTION: UK and Europe.....£30 p.a.
Other countries (airmail).....£35 p.a. (UK£ only please)

Optional concession, UK addresses only (unwaged, grant-aided students etc):..... £12.50 p.a.

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

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ASSOCIATION OF RADICAL MIDWIVES
STANDING ORDER FORM

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_____

_____

_____ Postcode _____

Please pay £_____ on Day ____ Month _____ 200__ and **ANNUALLY** thereafter until further notice to:

THE ASSOCIATION OF RADICAL MIDWIVES

Community Account No. 20776831, (20-35-84)

Barclays Bank PLC, PO Box 14, Halifax HX1 1BG

and debit my account number:_____

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

Signed_____ Date _____

Name and address (please use BLOCK CAPS):_____

_____

_____ postcode _____