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Welcome and Merry Christmas from Scotland! I am not sure how I landed with the job of coordinating this Scottish edition. I think I was in the wrong place at the wrong time. But fellow Scotland ARM members have done me proud. No nagging, the articles just arrived on their due date! Apart from mine but I expect that is always the way. There is a bit of a slant towards educational issues incorporated in this edition because the west of Scotland local group meets at the University of Paisley where I am a lecturer and as a result a fellow colleague finally joined as she had always intended on doing – and promptly was persuaded to write about a module that we are all proud of. Promoting Normality. Next year it is intended that one edition will be put together by the student members of ARM. I look forward to hearing their views on their education and on the maternity services in the UK.

Within Scotland to my knowledge there are two ‘local’ groups. One covers the West Coast, a huge geographical area and meets every other month. The other is based in Edinburgh and also meets bi-monthly staggered with the west. Some members make the journey across the central belt to attend both meetings. I have been a member of the ARM for many years but have only just got actively involved by starting up the west coast group.

There is a definite move within the west of Scotland for midwives to take the lead in caring for low risk women and the time is thus ripe for interested midwives to come together to share experiences and support each other during this process. Certainly I have seen huge changes in the care that is offered to women since I moved up to Scotland in the early 80’s. None more so than in my local maternity unit where waterbirths have been available to low risk women for over ten years. With the confidence that comes with familiarity, waterbirth is seen as just another one of the options midwives offer for pain relief and birth with few restrictions and an absence of ‘protocols’. But there is no room for complacency and there is a need to maintain the momentum of change to reduce the numbers of caesarean sections and managed births. And I believe this to be no different from many other areas of the UK.

Being once again in the wrong place at the wrong time, my next project is to arrange next year’s retreat to be held here in Scotland. Scotland is a beautiful country so book your holidays now to join us and experience this yourself next September.

Linda Wylie
Mechanical Midwifery – Autonomous or Automaton?

Allison Ewing
Independent Midwife, Reiki Practitioner, Breathwork Practitioner

I HAVE HAD THIS TITLE floating around in my consciousness for several years. It has been an elephant (whale?) gestation and I am still not sure whether I will be able to convey what I have been thinking/feeling, but I am going to give it a shot.

I deliberated about which journal to try to place it; whether to make it a fully referenced research piece; whether it had been said before; whether I would be preaching to the converted by placing it in Midwifery Matters. Then Linda told us earlier this year that the Winter 2006 issue of Midwifery Matters was going to be the first Scottish issue and the decision was made. This is written by a Scottish midwife, living in Scotland, trained in England and has relevance for the whole UK.

So here you have an opinion piece in the journal which kept me sane through student midwife training and some years out of full time midwifery when I moved back to a Scotland which, at that time (1997), still did not have the hand held records I had been used to working with for a decade!

Are we a profession? Simple question really. Through my midwifery career I have swung back and forward between two poles of thought on this. At first I welcomed the move into higher education. Midwifery would finally get the recognition it deserved, financially, academically and professionally. I now know that that was incredibly naive. I thought that the class action taken by female graduate occupational therapists in the early nineties could be a template to be used for equal pay action comparing the remuneration of the mostly male medical profession with the mostly female midwifery profession. Well, we all know by now that we are even further from that possibility.

With the announcement of Agenda for Change and its promise of a single pay spine for all NHS employees I thought, hallelujah, we will all be treated the same. But! Wait a minute! Separate pay spine for medics, and the officers and other ranks pattern is perpetuated. Some are more equal than others. Why on earth did I ever think that it would be different from the “Cynical Degrading” (my terminology) of 1988?

What has this to do with being a mechanical midwife, I hear you ask? Fully professional autonomous midwives should be able to make clinical decisions with the full backing of their clinical experience and evidence based guidelines. Most of the universities are striving to produce these educated, questioning professional midwives. Unfortunately, this type of midwife is the complete antithesis of the ‘flexible’, ‘reproductive health workers’ which the NHS desires to have and many of the most able of the midwives might be passed over in favour of those who will ‘fit in’.

Now, the next bit is anecdotal and I will probably be pilloried, but I can only comment on what I have heard and observed. In some places in Scotland (and probably in other parts of the UK) there is a pattern which goes like this: apply for a job on ‘bank’ as there are few adverts for jobs; if you are able and liked you might then be invited to apply for a temporary job; then, if your face really fits, you might be able to apply for a permanent post. This pattern will ensure that the status quo will remain. As an aside, the cynic in me would like also to point out that when direct entry midwifery was introduced in Scotland, some Trusts took the opportunity to employ the new graduates on D! (remember that in Scotland there was never a minimum F and there is “no shortage of midwives” – yet!)

What the NHS seems to desire is the automaton who will follow ‘one size fits all’ clinical care pathways and algorithms, locally based protocols and the local clinical opinions of another profession. This automaton will then sit easily on the Agenda for Change pay spines.

The other alternative to employing ‘expensive’ midwives will be the introduction of maternity care assistants. As a midwife who wants to be with woman I feel that some of that role will be eroded further than it has been. The ‘with woman’ role has already been undermined whether willingly or not.

Another anecdote

As an advocate, I accompanied a woman for a planned hospital birth last year and in the 16 hours I was with her, she saw 6 midwives, 2 SHOs, 2 registrars, 1 consultant, 1 anaesthetist, 2 paediatric SHOs and uncle Tom Cobbley and all. The midwife who admitted her to the delivery suite from the pre-labour assessment unit was so busy being ‘with notes’, ‘with CTG monitor’ and ‘with computer monitor’ (also centrally monitored at the ‘nurses station’) that I was the only constant in my client’s spiritual, emotional, physical and mental care. I had been employed to provide continuity of carer in all the stages of pregnancy and birth.

It was only after that experience that I finally understood part of what Stockton was saying in her article in MIDIRS in 2003 (13.3 pp 347-350). She accused midwives of being complicit in the move towards obstetric nursing and that doulas would be the: ‘future guardians of normal birth’.

I remember feeling indignant on reading it as I tend towards a ‘Mary Cronk’ view of doulaing. On rereading the article I can see her point but, while acting in a ‘doula’ capacity, I still felt helpless on many levels to help my client avoid some interventions. I was very conscious that, had I
managed to be there as her midwife, I would have had to follow the hospital protocols and might have ended up being with monitor’ like the other midwife. However, as her midwife I would also have been in a better position to question and challenge things. Had I not been a qualified midwife and was simply acting as a doula, I don’t think I would have experienced these conflicting feelings and I have to admit that only to have to be ‘doing’ the ‘touchy feely’ part of midwifery could be appealing. I feel that the use of doulas, while a cheaper option for the woman than an independent midwife, is not the long term solution to the problem. Even if it is harder, I wish to remain an autonomous midwife rather than act as an adjunct to the system. I feel that were I to abandon my role as a midwife and practise as a doula instead, I would simply be shoring up the system and perpetuating it.

But then again what do women themselves want? Maybe they just want somebody kind and competent to deliver them? The manager of the unit in which my client gave birth told me that most of the complaints she receives are from women who feel they didn’t get their epidurals in time! I am told that women don’t care who is with them for the birth and “that the women in [insert town of choice] are different”!

Most of the midwives my client met were kind and caring and competently looked after her. Out of the six, only one was ‘prickly’ at my presence and she was the one who had admitted her to delivery suite. Of course, my clients are self selecting but, when I first met her, I asked her if she had considered having a doula instead. She had decided against that as, although she wanted at least one familiar face at the birth, she also wanted the midwifery care in the antenatal and postnatal period too.

What do the midwives want? With the tightening of the belts in the NHS Trusts in England and Wales and the job losses, midwives who have got jobs will not rock the boat if they have mortgages to pay and mouths to feed.

What does the NHS want? As mentioned above, mechanical midwifery is what it wants. To be fair, it is not just our profession. Medical colleagues in other disciplines are complaining that they are no longer able to exercise much of their clinical decision making skills to prioritise patients for surgery. An oral surgeon of my acquaintance tells me that it is the place of the patient on the waiting list and not the individual Trusts that determines when they will be seen.

I began to see the bigger picture when I was taking a “Health and Public Policy” module as part of a top up midwifery degree three years ago. The lecturer pointed out that many Government health policies had been “written on the back of a fag packet” and usually as a knee jerk response to some high profile health catastrophe: Alder Hey, Beverley Allitt, Harold Shipman etc.

These have all, understandably, provoked wider efforts to control all the health care professions, completely ignoring the fact that midwifery has had Supervision for decades and that, because of this mechanism, far fewer midwives, proportionately, have been reported to their regulatory body. The NMC and the supervisory mechanism are quite capable of chasing and chastising their own “radical midwives and mavericks” (quote from a senior midwife).

So where does this leave us? Does midwifery have to sink to a nadir before it can be reborn again?

The DoH in England and Wales and the Scottish Executive wish to have tighter and tighter regulation with more adherence to CNST or CNORIS insurance requirements. This will leave less and less wiggle room for independent practitioners as in the next two years it is possible that there will be further calls for the requirement to have compulsory indemnity insurance to be a registered practitioner.

If the NHS Community Midwifery Model is adopted this will solve that problem. However, the different way in which health is funded in Scotland will need a modified approach unless Scotland adopts the DoH model. For example, the Trusts in the Greater Glasgow Health Board went back to being divisions of the Health Board in 2004 and employees went back to being employed by the Board and not the individual Trusts! It has gone full circle. This may make it more difficult to get the local funding for an OMOM style caseloading practice to be set up.

Call me a pessimist, realist or pragmatist, but I think it will have to get worse before it gets better. It is amazing that the process which is experienced by the majority of 50% of the planet’s population is not given more real recognition. Many more erudite writers than me have recognised that the gender issue is so strong and one knows deep down that if it was men who had to experience childbirth that priorities would be vastly different. The maternity services will probably have to be squeezed even harder before many women will notice and complain. Perhaps it is already happening. When I started as an IM six years ago, I was averaging 2-4 clients a year. Last year I attended 14 births.

I am repeatedly told up here that the women have to want it and the request for change has to come from them. Meanwhile, we will have Advanced Midwifery Practitioners (aka mini doctors) performing forceps and ventouse to lighten the load of the obstetricians, while the midwives who wish to be with women and practise the art of ‘watchful inactivity’ will be sidelined. In Agenda for Change, there is precious little recognition of the skills needed to facilitate a safe, peaceful home water birth. In Glasgow, as in many places I imagine, previous G Grade Community Midwives are given Band 6, while Labour Ward Gs are given Band 7.

I have jokingly told colleagues that we should have a Campaign for Real Midwifery Practice (CAMP or CRAMP!) along the lines of the Campaign for Real Ale (CAMRA). Perhaps the ARM could be the Association for Real Midwifery? If the NHSCMCM is not universally adopted (incidentally, I can’t square the circle of the call for fewer post code lotteries in care provision while stating that local areas should develop local health policies. Does not compute, Captain!) and Independent Midwifery is more or less outlawed with changes in the requirement for Indemnity Insurance, will Real Midwifery be forced underground?
The Story of a Healing Birth

MOYA WAS BORN on a sunny autumn morning. To be specific: she was born in a birthing pool set up in the bay window of our terraced cottage in Lanarkshire. However, the story of her wonderful, healing birth begins many months earlier, not long after she was conceived.

Prologue

Until we became parents we had no idea how profound an effect the actual births of our children would have on us and, we believe, on them, both physically and psychologically. Naively, we had assumed birth simply to be a physical process at the end of the pregnancy, which involved going to hospital. It would be very painful but would soon be over and we would settle down as doting parents to enjoy our newborn.

Privately, I even went so far as to think that women who chose to give birth at home were somewhat selfish and irresponsible. Could they not put aside their ‘alternative’ lifestyles for just a few hours in the interests of their babies’ safety and go to hospital to deliver? I feel ashamed now at my ignorance five years ago.

Well, how this worm has turned! I still believe hospital is the safest bet for some women, given their medical circumstances, but I am now proud to be pro-choice!

Setting the Scene:
The Previous Births and Group B Strep

On discovering we were expecting Moya, our third child, we were elated! However, it was not long before our initial joy became tarnished with concerns about what lay ahead. Having previously encountered trauma and distress surrounding the births of our previous two children (Eva, 4 and Conal, 2) I was dreading what this pregnancy might hold in store.

In an ideal world we wished to have this baby in the familiar and comfortable surroundings of our home, choosing our birth attendants and minimising separation from the rest of our family. However, we thought this was not possible as I had previously been told by a consultant that I was one of the one-in-three women who carry the common Group B Streptococcal bacterium (GBS) and my babies required pre-emptive treatment with intravenous antibiotics immediately after birth in the extremely rare event they may have become infected with the bacterium during birth.

This was our local hospital’s policy and I was even told by a consultant, that should I refuse this procedure, my baby could be made a ward of court! (This was later revealed to be complete fabrication). It was distressing as it meant I could only have a hospital birth. Not only that but our son was removed following his birth to the special care unit to have the antibiotics administered. However, we found him nearly three hours later, alone and abandoned in a plastic trolley still awaiting antibiotic treatment, when he should have been cuddled and breastfed in the warm arms of his parents: a cruel blow.

I then discovered that correct procedure had not been followed during the birth of my daughter whose shoulders became slightly trapped behind my pelvis (shoulder dystocia) as she was being born. (This was possibly a ‘bed dystocia’ resulting from lying on my back for 12 hours with an epidural). Due to this I suffered terrible tears, internal and external, a consequent GBS infection (hence my being identified as a carrier) and endured a nine-day hospital stay and a month of having dressings applied to heal the ghastly wound I was left with.

Poor Eva was also injured, suffering temporary paralysis (Erbs palsy) and bruising of one arm, from which she recovered after several weeks. To think the outcome may have been different is disturbing.

During my son’s birth, an anaesthetist was called to set up an epidural because the midwives were concerned that I was starting to push at 8 ½ cm dilated (which might have caused the cervix to swell rather than thin). John was sent from the room and consequently almost missed the birth when, minutes later I had to shout to the anaesthetist to stop as I felt my son descending.

The anaesthetist kept calling me ‘that woman’ and was furious. She angrily ripped the line and tapes from my back, giving the midwives a mouthful before marching from the room. So much for caring support and happy faces encouraging women through the final stages of labour! With hindsight, I believe that with some guidance I might have managed to control the strong urge to push without needing an epidural to numb sensation. However, the midwives in attendance kept leaving the room. Fortunately, our son, the ‘no-push’ baby, was actually born early and I required only two stitches.

During this last pregnancy, we expressed some of our concerns to a consultant, particularly regarding the unnecessary separation from our son after his birth. He told us the best we could expect was to be allowed to accompany this new baby to ICU after birth to wait for a paediatrician to become available to insert the IV line. However, this compromise we found deeply troubling.

The Turning Point

Around this time a close friend lent me some copies of The Mother magazine. This controversial publication promotes womanhood: the beauty, innate power and ancient wisdom of ‘wombyn’. I was intrigued by the birth stories I read: of women embracing their labours and births with all their senses and without the cloak of fear that had shrouded my previous hospital experiences.

I was beginning to realise that birth could be a life-enriching, even positive experience! It did not have to be...
frightening, degrading and powerless at the mercy of hospital policies where women's choices and their emotional well-being are often overlooked. Was it still possible that we could have the care and birth of our choice?

We began doing some digging on the internet, and what a lot we uncovered! In particular, information regarding GBS, which was the key factor preventing us from pursuing a home birth. Imagine our delight when we discovered it was not unknown for GBS carrying women to give birth at home!

We researched the green-top guidelines on GBS issued by the Royal College of Obstetricians and Gynaecologists and uncovered the six main risk factors where antibiotic intervention is recommended for babies born to GBS mums (see www.rcog.org.uk “Prevention of Early Onset Neonatal Group B Streptococcal Disease Nov, 2003). It was clear that neither of our first two children fell into this category and it became apparent that different hospitals have different policies regarding GBS: some do not pre-emptively treat babies born outside the high risk category.

We found this staggering! Despite voicing our concerns before our son's birth and during this last pregnancy, at no point did any of the medical professionals (consultants or community midwives) we'd dealt with give us factual information, nor reveal that indeed there was a choice.

Exercising Our Right To Choose: Enter Allison

Armed with this new found information we felt empowered while, at the same time, our trust in the hospital and community midwifery care on offer had been eroded. Our options were now whittled down to one: seeking an independent midwife who would agree to take us on.

Enter Allison.

After looking up the Independent Midwives Association (www.ima.com) we discovered Allison Ewing, our nearest independent midwife, based in Glasgow (www.scotbirth.com) who incidentally had already delivered one or two known GBS carrying women each year.

My heart sang! Our precious growing baby had a chance of being born naturally, in our home.

Allison came to meet us at home one May evening and the three of us chatted for a few hours, getting to know each other in addition to discussing the previous pregnancies, births and just how our antenatal care and home birth might proceed. It was billed as a two-way interview enabling us to ask Allison questions and for her assess whether she was happy to take us on as clients.

Despite the considerable expense involved in employing an independent midwife, we were prepared to see this as one of the most valuable investments in our family that we’d ever make.

Consequently, Allison took over my antenatal care. It was such a different experience. During this time we built up a close and trusting relationship with Allison. Her visits were so much more than blood pressure/urine tests and baby-checking! We would talk (a lot), share stories, a laugh. Sometimes she’d stay for lunch, help me feed the kids, or make us both a cup of tea.

A Sigh of Relief!

Instinctively, we knew we'd made the right decision in taking Allison on. She blew away the cobwebs and was down-to-earth: a reasonable, decent human being, driven by the desire to assist women in the birth and care of their choice.

Allison saw me as a whole being, within a family and not just a 'vessel' carrying a 'foetus'. She provided the positive force and reassurance we'd been lacking until then and was supportive of our choice for a home waterbirth, and happy to fulfil our quest for information.

We repeatedly re-examined with her the issue of GBS: the risk factors, and how they might alter our plans in the interests of our baby's safety. We knew that should the medical need arise and we had to go to hospital Allison would accompany us (though she would not be permitted to deliver the baby) and support us there. This was of great comfort to us.

By the time October rolled up, we felt we knew Allison well and were absolutely comfortable and confident in her coming to deliver our baby. Touching my bump one day on leaving the house, she said she had a feeling this was going to be a good birth. Her prediction was correct and now we’d like to share the story of Moya’s birth with you.

Birth Story

Labour – First Stage

My labour started just before 3 am one October night. I’d had a disturbed night with our two older children; both were up during the night and my mind was churning over other worries. You could say I was restless! Yet despite a false alarm just two days before, bizarrely, I did not feel, ‘Tonight’s the night’!

After settling the kids, I hopped back into the day-bed in the living room and suddenly had a contraction followed by a warm trickle of fluid down my leg. This was it! I rolled out of bed and waddled across the floor to phone a groggy
Allison, to give her plenty of time to get ready and to drive the 55 minutes from Glasgow.

I then alerted John that our baby was on its way. I remember he was particularly tired that night but got going with his two big jobs of the evening (in addition to being my side-kick for the labour and birth, of course!). He got the kids out of bed and drove them over to a friend’s house nearby. On his return he began the technical task of filling by hose the rather huge birth pool, grandly assembled in the living room bay window (where it had been the talk of the village for the past week!).

I took a shower and concentrated on gently breathing out my contractions, which at this stage were frequent, around 5-7 minutes apart but varying in intensity, different from my previous two labours (lasting 17 hours and 4 ½ hours, respectively). I busied myself with lighting a few candles and laying down sheets and towels around the pool, between contractions.

Convinced this labour might proceed very fast, I was relieved when Allison arrived at 4:30 am, with a big hug and a shared excitement and anticipation of our baby’s imminent birth. John fetched her a cuppa and Allison checked me over and listened to the baby’s heart rate — all fine. I was 3-4 cm dilated with my cervix thinning evenly. She also took a vaginal swab to be tested for GBS.

I felt remarkably stress-free and relatively comfortable at that stage. I was simply thrilled to be at home in my favourite room, softly lit and calm. As the labour progressed, Allison checked the baby’s heart rate every 30 minutes, able to do so whatever position I was in. The contractions were growing stronger and the birth pool ever fuller and more inviting. However, I was determined to remain out of the water as long as possible to have a pain relief option for when labour hit the high notes!

During contractions at this stage I held on to a table for support whilst standing upright with eyes closed, knees bent and rocking throughout and breathing heavily. Labour was progressing well and Allison rang her colleague Nessa McHugh who was travelling from Kinross to be present at the birth.

The pool was now ready (after two hours) and at the right temperature, so after another couple of very strong contractions on dry land I decided the time had come. I asked Allison if she wanted to examine me pre-plunge and to my amazement she replied, no, that I would know what stage my body was at and when I’d be ready to push. Such a surge of confidence swept through me! This blossoming trust I had in my body was being endorsed. Control of the birth was in my hands.

At around 6 am I climbed into the pool, had a strong contraction as I did so, and then sank blissfully into the 37°C water, which was surprisingly warm. The sensation of enveloping comfort and buoyancy was fantastic, and I enjoyed the feeling of warm air rising past my face and being able to roll over and float on my front or back.

As the next contractions ensued, I found most comfort kneeling at the edge of the pool, facing out and resting my chin on the rim, eyes closed. I was moaning now as the layer of each contraction built up, up to a peak and then down, down, fading away. Surprisingly, between these fierce assaults, I found myself very nearly asleep, completely relaxed and in a world of my own. I remember thinking, at one point, how absurd it was to be in full blown labour and yet feeling so serene and at peace between these great shuddering bands of pain.

Both Allison and John read the situation perfectly. I was beginning to slip into another realm and at no time did I want to feel petted, touched or even talked to. I only occasionally glimpsed them through half-open eyes. They were part of the world outside the one inhabited by me and our baby whilst on our shared journey to the moment of birth.

Looking back it surprises me but I see now the power that this detachment afforded me. By closing down part of my consciousness, deep within I became completely a mother, concentratong and participating with my whole being in delivering our baby.

**Second Stage – The Final Descent…**

At around 7 am Nessa arrived and I was shaken from this other world briefly, struggling to look up and greet her before succumbing to the onslaught of the next huge contractions. Allison took Nessa through to the kitchen to fill her in on the labour’s progress. John was sitting on the couch opposite the pool, hands clasped on his lap and head back, snoozing (!). I was beginning to feel the pain was unbearable, agony. I didn’t know how I could possibly cope any longer!

And then, suddenly, the next contraction brought a squeeze of head, beginning its final descent, and pressing against my back passage! My eyes flew open, “John!” I cried out. I wanted my birth attendants and I wanted them now! Even as John was calling for Allison and Nessa, like the wise women they are, they appeared in the living room. “We heard that little grunt at the end of the last contraction, and we knew!” Allison beamed.

I was nearly there, thank God! I could cope, I was going to make it! The arrival of our long awaited, much desired baby was only minutes away. Was it a girl or a boy?

The next few contractions brought our baby further down and I let go as my body pushed, easing the head a little lower each time, and panting in between. I was very aware of this descent and remember thinking it was quite sore, despite this being baby number three! Nessa and Allison calmly viewed underwater proceedings with a mirror and a torch.

After a few more minutes, the baby’s head was crowning and I concentrated on Allison’s guiding words as she faced me outside the pool. I panted, allowing my perineum to stretch. Then, pop! Baby’s head was out. I could feel ears against my thighs as it squirmed from side to side, as impatient as I was for the next contraction to deliver the shoulders and propel itself into my arms.

Allison’s soothing words washed over me and then, some 4 ½ hours after labour began, plop! A baby girl was born! In one movement I scooped her up into my arms, kissing her wet head, overwhelmed by a multitude of emotions! She was finally here — John and I were utterly...
delighted! He kissed us both with tears in his eyes. Smiles, joy and congratulations all round!

She was so slippery and covered in waxy vernix, beneath which her skin was still a dark greyish colour, and she had a head of fine dark hair. The umbilical cord still linked us, pulsating away as she gurgled and spluttered a little cry. She was so plump and healthy! Womb life had been good to her!

Allison and Nessa discussed her breathing and after a few minutes decided she sounded a bit ‘mucousy’ and was taking a little while to pink up. The umbilical cord was then clamped and cut, and Moya lifted onto a towel where her mouth and nose were wiped clean. She was absolutely fine and, eyes open, was passed to John for the first of many cuddles. She stuck her thumb in her mouth and began sucking. “Guess what she’s been doing for the last couple of months!” Allison and Nessa laughed.

Third Stage: Delivery of the Placenta

Meantime I remained in the pool, a little shocked by the colour the water had turned with the blood from my end of the umbilical cord. The contractions continued strongly, though more bearable than before, and I got out of the pool onto the daybed to deliver the placenta. Moya came to the breast – and remarkably, she latched on immediately, sucking voraciously. We were all tickled pink!

After a while I felt the urge to stand up and with the following contraction, out shot the placenta, bouncing clean out of a bowl and on to the floor! Allison then examined me for tears, (there were none) and then she carefully examined the placenta which was intact and healthy.

Keeping the placenta was something we’d never considered before this pregnancy. However, this time John washed it clean and placed it in the freezer (in a bread-bag!) where it awaits a spring burial. We plan to have a little ceremony as a family to celebrate the arrival of our wonderful three children, to acknowledge the sorrow of a miscarriage and to close the chapter on our previous traumatic birth experiences and their aftermath.

Getting to Know You

Moya was then weighed; a hearty 9lb 4oz, a very similar weight to her brother (9lb 6oz) and sister (9lb 8oz), and checked over to ensure she was in good health, following which Allison accompanied me as I had a bath. She was smiling and bubbly, praising me for the labour and birth and producing this beautiful, healthy baby girl. She’d really enjoyed the experience. I was soaring! What an achievement; I couldn’t quite believe Moya was here, born at home and it was all over!

Nessa and Allison then plied John and me with tea, toast and biscuits, and with big, hearty hugs they took their leave. John and I cuddled up on the bed, getting to know our baby girl in the candlelit room. It was after 8am and the village outside was stirring into life on a beautiful sunny autumn morning, unaware that just yards away a baby girl was beginning her own life journey in the warm arms of her loving parents.

Thank you Allison and Nessa for attending Moya’s special birth.

And thank you Allison for accompanying us on the voyage to bring Moya safely and happily into the world. The birth of Moya has replaced the heartache of the past with heartsong – third time lucky! You will remain a special friend and will no doubt feature for several family generations in the wonderful story of Moya’s birth.

Male Perspective: a note from John

Cautious by nature, it took a wee while to allay the fears of going for a home birth. It bucked convention and was definitely outwith my comfort zone initially. That said, Allison’s safe-pair-of-hands approach helped enormously. She was great! The peace of mind of having Allison on hand throughout the pregnancy and birth was priceless. Although not a ‘touchy-feely’ person, the fact that I felt compelled to give her a big grateful hug after the birth says a lot for how far we’d come.
The biggest difference of this birth as opposed to the other two, was my own sense of involvement. In hospital you get to keep a powerless watching brief, pushed to one side as it all goes off around you. And then suddenly baby arrives and you know your life has changed for the better. You then do your best to bond in that stark, impersonal environment.

How different a home birth can be! I couldn’t have felt more involved: assembling the birth pool, purchasing the necessary gear; it was like my little homage to the baby and Isla.

During the birth, it was all hands to the pumps, literally! It was good to feel useful. The effect the home environment had on Isla was really cool. She seemed really comfortable, relaxed in her own surroundings. This was very important to me.

The birth was a mixture of pure excitement and joy. Peacefully, baby arrived safely – what a baby and what a mum! Afterwards I couldn’t believe the serenity we felt having mum and baby not stressed. It was a very special time.

Our homebirth was a wonderful experience and I look back and say “Je ne regrette rien”!

Epilogue: a few minor hiccups……

First 24 hours. Moya spent first 24 hours mostly sleeping and quietly feeding. She was very calm and settled, (quite different from her colicky, screaming sister and fretful brother after birth). All the family was reunited in the afternoon with Eva and Conal meeting their baby sister for the first time and expressing curiosity at the mechanics of breast-feeding! The afterpains after baby number three were eye-watering – pass the painkillers – and the pool took poor John 1½ hours to empty by bucket down the loo!

36 hours old. Moya had a blotchy rash which coincided with the return of my GBS vaginal swab from the lab which had tested positive, meaning that I had a GBS colony present during birth. On the doctor’s advice we had the rash checked out at hospital in case it indicated anything sinister but happily it was unrelated, being diagnosed as erythema toxicum, a common rash of newborns as their bodies adjust to life outside the womb.

4 days after birth. I felt unwell, ‘fluey’ and shivery. In the absence of any other symptoms, the doctor prescribed antibiotics in light of the possibility of a GBS infection of the womb. I felt much better 24 hours later.

6 days after birth. Moya had lingering jaundice since two days old, causing a little concern. However, a blood test confirmed she was below treatment threshold and it cleared up completely over following days. After dropping below her birth weight in the first few days it took Moya a couple of weeks to regain it as the milk supply increased, and since then she has put on a steady ½ lb per week.

Several Months Later……. Moya is now a healthy, plump and utterly delightful baby! She smiles readily, chuckles at her siblings and feeds voraciously at the breast, though is now taking a little pureed fruit to try and stem that appetite!

Since birth she has been more placid and tranquil than her brother and sister, (though let’s be honest, not all the time!), and we are sure this is in no small way owing to her calm, serene entry into the world with her low intervention birth and aftercare.

We have absolutely no regrets about our pregnancy and birth decisions which proved the right choices for us. We believe in parents’ choice and fully support the existing campaign to bring in one-to-one midwifery care under the NHS.
A Beginning and an End

Cassy McNamara

An End

Life can always catch you by surprise, even with the inevitable. In late June of this year my father was admitted to hospital after a large mass was discovered in his bladder. As a family of nurses and midwives, my mother, sisters and I knew that it was cancer – and, while waiting for the confirmation of it, my father knew it too. He made his wishes for his treatment clear; there was to be ‘no tinkering about and tubes’. He would have the other tests, the bone scan, the CAT scan – to ‘keep your mother happy’, but told me as we sat together outside the hospital that none of them would make a difference in the end.

A week later his GP prescribed morphine as he found it difficult to walk without pain. We tried to remain optimistic – perhaps surgery, perhaps chemotherapy, perhaps a while longer. Hope is always an expression of fear. He lost his appetite, lost weight, but remained cheerful for us. We spoke openly with him and amongst ourselves about what was happening.

Over the next week we watched as he became more ill and knew there was no more time and no treatment to make it better. I saw him accept the process of his life with strength and courage. We sat with him for hours, surrendering to the inevitable end we knew was approaching. One week later he died in the arms of his family. ‘No tinkering, no tubes’.

He died as he had lived, with determination and conviction in his choices, a strong and brave man until the end. As a close family we were devastated. My mother wanted a family only funeral – our mother, their daughters, son, partners and grandchildren, the youngest only eight weeks old. We felt protective of each other in our grief and too bereaved to share it with others. We laid flowers on his coffin in the yard of the farm he loved before he left for the last time. My husband read a poem called, ‘Miss me but let me go’, my brother read a beautiful heartfelt tribute that he had written to my father, we listened to music chosen by our mother, and talked about him with tears and laughter, comforting each other.

A Beginning

Three weeks later my on-call for a homebirth began. I worried that I would not have the physical and emotional strength my client deserved. But as the days passed and my exhaustion from grief eased, if not the grief itself, I began to truly look forward to the labour and birth, feeling the need to be part of life and living more than death and dying.

The day of my client’s EDD arrived with a puddle of liquor. At midnight I set off to her house after her partner called me. When I arrived it was to a quiet darkened house. ‘Anne’ was resting between mild irregular contractions. I went to bed, but didn’t sleep. I lay there in the dark of their spare room, listening to her pad around the flat, hearing the intensity of her concentration build.

In the early morning Anne was finding it difficult to cope, she was afraid. The contractions were building in strength but still irregular. We tried changing the energy and atmosphere. I opened the curtains to a warm still morning; she walked up and down the stairs in the building and had some breakfast. It didn’t help. She wanted pethidine – I didn’t have any, she wanted to go to hospital – I told her that transfer would not take away her pain. Anne told me and her partner to ‘leave her alone’, so we did. She stayed in her room, alone, for the next hour.

When she returned I could see that she had finally found her courage and determination to reach the end. Her contractions were strong and frequent, her movements fluid and instinctive. A cool shower alternated between the warm birth pool. This worked! The deep sounds of second stage arrived quickly. Ten minutes later in the birth pool a perfect baby boy was born into the arms of his parents.

Anne faced her labour and the birth of her child with courage and the conviction that her choices were the right ones for them. At times she was afraid and in pain but with support she reached the inevitable end of her journey. Anne and her partner welcomed their baby, quietly singing to him.

I have thought a lot about life and death in the past few months – trying to make sense of my father’s death. I know that this is a normal part of the cycle of grief, but in doing so I have realized that the words and emotions that are used to describe and cope with birth are the same we use for death: courage, strength, dignity, empathy, knowledge, support, choice, trust, comfort, fear, family, pain, hope, coping and love.

As midwives I think we all know that birth and death are close, but this year has brought them closer for me. Life and death, birth and dying are all hard to bear, but with courage, strength, support and love we can all face them and become a stronger person along the way, grateful that they mattered so much to us.

I recently read a quote by T.S. Eliot:

I had seen birth and death, but had thought them different.

They are not different at all.
Can education programmes ‘Promote Normality in Childbirth’?
Maria Cummings
Midwife Lecturer, University of Paisley

IN 2002 MIDWIVES in Scotland were challenged by the EGAMS report (Expert Group on Acute Maternity Services) (Scottish Executive, 2002) to regain their role in childbirth and provide women with a better birthing experience. It was commissioned by the Scottish Executive to consider how the recommendations from ‘A Framework for Maternity Services in Scotland’ (Scottish Executive, 2001), could be implemented. The University of Paisley was commissioned to develop a module to assist midwives to ‘build on, enhance and refresh skills to deliver care within a different framework’ (Scottish Executive, 2002).

Background
Scotland has particular challenges that needed to be considered when developing a sustainable, safe maternity service that would meet the future needs of childbearing women, such as the demographic issues surrounding remote and rural areas as well as other issues common to the rest of the UK, for instance, the falling birth rate and women choosing to have babies at a later age. Also the added pressures of providing a service for those women with specialist needs such as substance misuse and teenage pregnancy, as well as improvements in technology for women with complex medical and obstetric problems which has led to an increase in maternal-fetal cases requiring specialist care. Workforce issues were also a priority in the redesign. Recruitment and retention of medical staff was a particular concern for some rural and remote areas. Bearing all this in mind, the group was given the task of defining who was the most appropriate lead professional and where was the most appropriate place for women to give birth.

EGAMS
“This set out a vision and philosophy for maternity services that would provide women with a family centred, locally accessible, essentially midwife managed, comprehensive and clinically effective model of safe care, before, during and after childbirth, which reflects a multi-disciplinary integrated approach…”
(Scottish Executive, 2002, p 4)

A system was developed that categorised levels of intrapartum care by locations and childbirth (normal to high risk), level Ia, being ‘home birth’ to level Id, ‘high risk’. This identified the location of birth, the lead carer, clinical situation, care need and delivery. Midwives were identified as the lead carer in level Ia, which was split into four categories (Ia to Id) from home birth to community maternity unit (CMU) adjacent to a maternity unit (see table 1 below).

The Expert Group conducted a wide literature review and identified CMUs as being a: ‘..cost effective, safe and satisfying alternative for women who are experiencing normal pregnancy and childbirth (Rosser et al 2001), and offer an opportunity for the midwife to utilise her skills and fulfil her role.’
(Scottish Executive, 2002, p 41)

and regarding home birth stated: ‘there is sufficient UK data to support the argument that a planned home birth is a safe option for mother and baby…”
(Scottish Executive, 2002, p 43)

Table 1: Levels of intrapartum care by location and childbirth
Adapted from EGAM’s Report (Scottish Executive, 2002, p 5)

<table>
<thead>
<tr>
<th>Level</th>
<th>Location of delivery</th>
<th>Lead carer</th>
<th>Clinical situation</th>
<th>Care need and delivery</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ia</td>
<td>Home (planned)</td>
<td>Midwife (GP)</td>
<td>Normal pregnancy &amp; labour</td>
<td>Suitable home facility with back-up from the Scottish Ambulance Service (paramedics) and supporting advice from a linked maternity unit</td>
</tr>
<tr>
<td>Ib</td>
<td>Stand-alone community maternity unit</td>
<td>Midwife (GP)</td>
<td>Normal pregnancy &amp; labour</td>
<td>Appropriately equipped midwifery unit for normal care and agreed transfer guidelines to a linked maternity unit</td>
</tr>
<tr>
<td>Ic</td>
<td>Community maternity unit adjacent to non-obstetric hospital</td>
<td>Midwife (GP)</td>
<td>Normal pregnancy &amp; labour</td>
<td>As Ib above. Medical staff (surgeon/GP) appropriately trained to perform emergency caesarean section</td>
</tr>
<tr>
<td>Id</td>
<td>Community unit adjacent to maternity unit</td>
<td>Midwife (GP)</td>
<td>Normal pregnancy &amp; labour</td>
<td>As Ib above</td>
</tr>
</tbody>
</table>
This publication was quickly followed by actual reorganisation of the services in one of the Health Boards which is used for practice placements for the university, leaving many midwives confused and uncertain of their future. Some lacked confidence in their midwifery skills to deliver care in a different framework, particularly those from units that no longer had on-site obstetric and paediatric back-up, such as levels TB and TC.

Concern about this paradigm shift from a medical model of care to a social model of care for ‘low risk’ women was acknowledged in the Report and it was noted that the ‘medicalisation’ of childbirth had resulted in many midwives either not developing or losing midwifery skills. Core competencies that were considered essential in providing midwife-led care that would promote normality in childbirth were therefore identified. These were that midwives should be:

- Confident to provide intrapartum care in a low technology setting.
- Comfortable to use embodied knowledge and skills to assess a woman and her baby as opposed to using technology.
- Able to let labour ‘be’ and not interfere unnecessarily.
- Confident to avert or manage problems that might arise.
- Willing to employ other options to manage pain without access to epidurals.
- Responsible for outcomes without access to on-site specialist assistance.
- Confident to trust the process of labour and be flexible with respect to time. (Scottish Executive, 2002, p 59-60)

In the spring of 2003 the Scottish Office requested that the University of Paisley develop a module based on these competencies that could be delivered, as a priority, for midwives in the West of Scotland who were immediately involved in the change from obstetric-led units to midwife-led units (CMUs), both stand-alone and those attached to an obstetric unit.

**Promoting Normality in Childbirth – the Module**

The module is delivered at level 9 (SCQF) at 15 credits, running over one semester. It aims to build upon existing knowledge, experience and competence in dealing with normality to facilitate the further development and implementation of evidence-based practice within a low technology setting. The underlying philosophy of the module is to provide a supportive teaching and learning strategy and an environment sensitive to the individual needs of midwives. A key theme underpinning the module’s content and delivery is therefore awareness of both one’s abilities and one’s limitations and the need for self-directed learning. The module aims to provide up-to-date evidence-based knowledge/theory to inform safe, effective and appropriate practice and re-appraisal of core skill competencies.

To meet the educational demands of the midwives, the teaching and learning strategy includes a variety of methods including key lectures, guided discussion, guided study, practical sessions, group-work, tutorials and on-line participation. The module aims to foster increasing professional and personal development in the belief that education for practice should continue throughout the professional life of the practitioner and that midwifery practice should be evidence based, effective and appropriate.

Several experts in their field contribute; there are sessions such as aromatherapy, risk management in rural and remote settings, independent midwifery and waterbirth.

Initially there was some hostility from some midwives who had been seconded to participate in the module. It was clear that this was due to the loss of control some midwives felt during this change. There was a distinct lack of ownership of the changes that were taking place and attending the module was another thing they felt ‘pushed’ into. Also added to this, the module challenged practice and some took this very personally, as if it was a personal attack on them and how they provided care for women. However, as the module progressed this was alleviated and out of over 130 midwives only one said she had not learned anything that she could take back to practice.

The module has evolved continuously and it has now been integrated into the pre-registration programme. The classes are combined with third year pre-registration and post-registration students, which has brought a totally new and exciting dynamic to the module. The assessment has also evolved from initially being 50:50 written assignment: simulation, as requested by the Scottish Executive, which was not received well by the experienced midwives, to 50:50 written assignment: focused discussion and is currently 60:40 written assignment: online discussions. The latter is proving successful as it assists in bridging the theory/practice gap and enables students to develop their skills of reasoned debate. Networking and sharing ideas is also an important component for all the students.

Not only did the midwives complete this module but they also participated in an intensive two or three years of educational update, both in-service and external, often in their own time. Combined, this has led to great changes in practice and the promotion of normality in childbirth, particularly within the CMUs, as they have developed their decision making skills and increased in confidence. They have demonstrated the ability to develop new leaders and engage in reasoned debate with the multi-disciplinary team to regain their role in childbirth, provide many women and their families with a better birthing experience and promote a culture that values the art of midwifery and physiological nature of childbirth.

**REFERENCES**


maria.cummings@paisley.ac.uk
My colleague Maria has detailed in the previous article a module offered to midwives and to third year student midwives intended to promote normal birth. One issue surrounding the development of this module was how to assess it meaningfully. Many universities tend to use some form of case study or topic for an essay after a period of clinical practice. The problem with this is that the students forget all about the module and the assessment until a couple of weeks before the essay is due in. Therefore for this module we decided to use a different form of assessment to try and encourage the students to continue debating the issues we had raised, whilst out in practice. We decided to use assessed on-line focused discussions.

Within the University we have a Virtual Learning Environment (VLE) called ‘Blackboard’. The students can log in from any computer and download lecture notes, links, placements, exam results and so on. There is also an area where the students can discuss topics of their choice. We decided to offer them five topics running over a two-week period intermittently during placement.

This proved amazingly popular and for a recent conference presentation we ran a brief survey, also on ‘Blackboard’, to find out their views on this form of assessment. It evaluated very well. We allocated 20% of the total marks for the module to this assessment component and the students all passed with flying colours. Their enthusiasm and the quality and quantity of their contributions to the discussions have recently led us to increase the proportion of marks to 40%.

For the lecturers the whole process was very rewarding. We were delighted to read that the students had learned from the module and were applying these principles to their clinical practice – as far as they were able as students. And they qualify soon after completing the module so we are confident that this will influence their practice as midwives.

The topics I offered for discussion included:

- Do you feel that midwives educate women antenatally for a physiological birth?
- Should low risk women with a breech presentation be given the choice of giving birth in a stand alone midwifery unit?
- Michel Odent (1999) asks the question ‘Is participation of the father at the birth dangerous?’ Your thoughts?
- How can a midwife encourage a normal birth after Caesarean Section?

I want to share with you some of the discussion that resulted from my final question.

‘Grantly Dick-Read (1944) states that woman is physically, physiologically and psychologically adapted primarily for the perfection of womanhood which is, according to the law of nature, reproduction.

All that is most beautiful in her life is associated with the emotions leading up to the ultimate function, being in love, marriage, motherhood.

Yet many then remember only the pain, anger and terror of childbirth.

Is woman expected to arrive at her perfection by the exhibition of beauty on one hand and suffering on the other?’

All went very quiet on the discussion board for a few days. I was not too surprised. Then the debate began and I found myself logging on daily to see what the students had to offer. I cannot repeat it all verbatim here – the postings were often lengthy and there were many more than the number required by my guidance notes. I have selected just a few threads.

One interesting point raised by these debates was that often the students with the most to say were those who never spoke up in class!

The Debate

The question resulted in much reading around the subject....

‘When I read this question I can honestly say that I didn’t know who Grantly Dick-Read was. I did a literature search and found out all about his beliefs and mainly his fear-tension-pain theory – which I agree with.’

‘I found an article on the BBC news website. Stress sparks ‘male fetus death’. ‘Mother’s stress responses damage their unborn babies’. An interesting article but it demonstrates that we as a culture are allowing women to be frightened on the one day of their life that is supposed to be the happiest.’

‘I have been troubled all week re. this Dr and his views on pain in childbirth.’

And careful consideration …

‘I have been troubled all week re. this Dr and his views on pain in childbirth.’

The origin of pain in childbirth was explored...

‘I feel I have to apologize for this quote especially to
those who aren’t religious ... but I have been thinking where the original concept of pain in childbirth and the inferrior sex thing comes from.

Genesis 3:16-21 To the woman He said ‘I will greatly multiply your pain in childbirth. In pain you will bring forth children. Yet your desire will be for your husband, and he will rule over you’.

‘Interesting quote. As I don’t know about the Bible and the creation of man, I too apologise for the following: It is just typical of a man to think of himself i.e. women will suffer to populate the world and man will lie back and reap the rewards.’

‘I found an interesting translation of your quote on www.birthnaturally.net/christian. ‘I will have authority over your labour and fertility. With (toil) work you will have children’

Some worrying statements…

‘I don’t agree. Pain is inevitable. Women now know that there’s no pain no gain when it comes to childbirth. The majority know that they have to leave their dignity at the door even though a midwife should strive to maintain a woman’s dignity at all times.’

I was looking after a 17yr old girl the other day who was 6cms dilated and coping well. On arrival in the labour ward the sister made no eye contact with the girl and looked at me and said ‘What’s she having for pain relief? Epidural I take it?’ (She also went on to refuse her two birth supporters and say that they would need to ‘take turns’)

A touch of philosophy…

‘It is interesting that the discussion so far has primarily focused on the ‘suffering’ of childbirth. Thinking it over it occurred to me that pain and suffering can also occur in love and marriage and what may be being exhibited as being beautiful, may not be perfect ( I realised this after a bit of a domestic at T time!!)’

Humour…

‘To say that every woman wants to be married and have children and that this is her only function in life is appalling, I don’t know if this guy is still alive but come on. Has he never heard of girl power? Or watched Sex in the City?”

And some stories…

I looked after a lady the other day who progressed very quickly. She was rushed down the corridor to the delivery suite. As the head was crowning she turned to me and said, ‘But I haven’t had any pain relief yet!”

A little bit of politics….

‘What is the solution to this problem? Tony Blair won the 1997 election by saying ‘Education, education, education.’ Now is the time that we do the same and in doing so give power back to the women’

And a whole load of further reading…

‘The Birththing Naturally website www.birththingnaturally.com explains how to break the cycle with education, relaxation and medication if required.

‘A study in Sheffield said the emergency caesarean section was not associated with fear of childbirth or anxiety. www.rcog.org.uk/index.asp?PageID=871’

‘This website suggests that the same parts of your brain are affected by love and pain reinforcing the suggestion that to have beauty in your life you will also have to endure suffering!!!? http://msnbc.msn.com/id/4313263’

‘This article is a very interesting read because it brings together all that has been discussed about pain being associated with fear and the conditioning of women into believing that childbirth will be painful. www.unhinderedliving.com/chronicle.html

Some experimentation...

‘Trying to think of a way to test Grantly Dick-Read’s theory!!!!

Try putting a finger in each corner of your mouth and pull backwards towards your ears so your mouth is stretched – how far can you pull without being in pain?

Now try it relaxed with a more salutogenic approach – bring your shoulders down and your knees go floppy……Concentrate on a nice happy thought and breathe your way through it. Get a friend/relative to stroke your arm and say positive things to you and try it again.

Did it make a difference? Was there less pain?”

‘I tried it and my Mum thought I was mad but I told her it was your experiment….. I think I got an extra centimetre before it got sore.’

And finally some solutions…

Sheila Kitzinger (2002) states, ‘When you relax and focus on positive sensory images of birth you open up possibilities for a richer and deeper experience’. These are the thoughts on labour we should be giving women.

‘It’s obvious that times have changed (Thank goodness – equal rights etc) yet many parts of Dick-Read’s research/writing is central to women today and there is a need to take an holistic approach to providing care to women.’

‘With regards to the idea of pain as opposed to ‘beauty’. I feel we are conditioned as a society to expect pain in childbirth. Attitudes need to be changed by positive midwives encouraging women to trust their bodies and their labour. I must stress though I am still a promoter of informed choice and if women say they are sore and in pain – then we have a duty of care to meet her needs in overcoming this.’

‘I think as the midwifery units are becoming more popular with women, they are more interested in the natural birthing processes. Maybe we as midwives need to learn to help these women through the pain and teach them methods of coping with a natural birth which may even include introducing them to Dick-Read’s fear-tension-pain cycle!!’

Many thanks to the student midwives who contributed to this discussion.

REFERENCE

ARM Annual General Meeting Report

September 17, 2006, Maesycrugiau Manor, Wales

There were 38 members present at the meeting

Steering Group elections
There were five vacancies; Donna and Katherine are eligible and willing to stand again; Andi Simpson, Anna Reeve, Liz Parker, Lesley Price/Wendy Blackwood (job share) are all happy to stand and are duly elected.

The Steering Group list is now therefore as follows:

Tania Berlow, Wendy Blackwood (job share with Lesley Price), Deb Byrne (job share with Angela Horler), Lisa Clayden, Penny Davidson, Donna Grayson, Katherine Hales, Angela Horler (job share with Deb Byrne), Rosie Kacary, Liz Parker, Dot Parry, Lesley Price (job share with Wendy Blackwood) Anna Reeve, Lynn Walcott.

Thanks were expressed to Nessa, Andrya and Aida who have stood down from their steering group roles.

Media Liaison and Helpline role
Sarah can’t do helpline role any longer as she is currently suspended from practice; Lynn Walcott can’t do media liaison at present. People are happy for Sarah to do media liaison; people are thinking about the helpline; a straight swap was also suggested between Lynn and Sarah.

National Meeting rota
There was a discussion about reverting to a pattern of alternate Saturdays and Sundays for the National Meetings and it was decided to try it again for 2007. There will therefore be two meetings with Steering Group meetings on Friday night and the National Meeting on Saturday, as at present, and two with Steering Group meetings on Saturday night and National Meetings on Sunday.

There was also a proposal to have the December meeting the first weekend of December; it is already the second weekend, rather than the third weekend as the other meetings are, due to its proximity to a certain festivity, but even the second weekend is often difficult, especially for people with families. The rota was arranged with an astonishing lack of arm-twisting and we even have an advance booking for 2008!

Meeting Place Contact Date
Spring Cundall Chris Warren Mar 17-18
Summer Nottingham Kerri-Anne Gifford June 15-16
Autumn Scotland Linda Wylie Sept 15-16
Winter Southampton Liz Parker 30th Nov/1st Dec
Spring 2008 Sheffield Jane Munro tbc at 2007 AGM

Midwifery Matters rota
Edition Group Contact Copy Date
Spring Somerset Clare Sibley Jan 1st
Summer London Christine Apr 1st
Autumn Steering Group Christine Jul 1st
Winter Students Deb Byrne Oct 1st

Report back on yurt
The yurt was taken to five different festivals, Sunrise in Somerset in June, Buddhafields in Somerset in July, and in August to The Big Chill in Herefordshire, The Green Man in Brecon and Solfest in Cumbria. Each festival was very different but the yurt was well received at each and we reached a lot of people who might never have heard of ARM in any other way.

The yurt itself was a lovely space, but the yurt group are going to have some discussions about the practicalities of it, in terms of storage and transport. Some of the things in the yurt went with it permanently and some were brought by individual crew members. Some of the latter might be worth discussing the option of ARM purchasing to keep permanently with the yurt, e.g. the jelly baby fetal models which were very popular and drew a lot of people to the tent – I’ve looked on the RCOG website and the set is £183. The group will also be discussing which festivals to attend next year – Glastonbury, for instance, is on next year.

We obtained £1750 in sponsorship money; we made £189.80 at the various festivals, i.e. £1939.80 credit; we spent £2500 on the yurt, £500 for The Big Chill (who have said we shouldn’t have to pay next year), £102.67 on fuel expenses, £370 for van hire to get the yurt from A to B, £38.94 on plaster of Paris for belly-casting (though there is quite a lot left for next year), £73 for Natasha’s expenses in doing all the bookings etc, i.e. £3584.63 debit. That’s a net loss of £1644.83, although if we discount the cost of the yurt, as that is a non-recurring expense and will (hopefully) last us a good few years yet, it is a profit of £855. If we also don’t have to pay The Big Chill again, can attract similar sponsorship and can get similar takings at each festival, we can pay off the cost of the yurt to ARM within two or three years. Again, the group will be discussing sponsorship and other ways of fund-raising to keep the yurt project going.

Treasurer’s Report
Linda Wylie’s report had been previously circulated in the magazine. As it was her first year in the post, it has been a steep learning curve for her. The only comment on accounts was that sales income has been outweighed by
outgoings on costs of stalls; the consensus is that it's still worth while being present and visible. However, disquiet was expressed at the rising cost of conferences, both for exhibitors and for delegates, in particular the RCM student conference which has doubled its price for delegates, despite the parlous state of student finances.

The motion to accept the Treasurer's Report and the accounts was proposed by Jane Munro, seconded by Deb Byrne and passed by the meeting.

A presentation was then made to Hilary Rosser – she had served for many years as ARM Treasurer and at the point when she resigned at the last AGM, we didn't make a presentation to her as she would have been in the invidious position of having to sign the cheque to pay for her own present! Hilary carried out the Treasurer's job from September 1999 until 2005, and did it diligently and efficiently throughout, in her usual calm, quiet and unassuming manner. The present was a calligraphed version of the well-known quote from the Tao Te Ching ("You are a midwife, you are attending someone else's birth...") and was chosen for Hilary partly because it seemed so apt for her ("Do good without show or fuss", 'if you must lead, lead so that the woman is still free and in charge').

Secretary's and Membership Secretary's Reports
Sarah's and Ishbel's reports had been previously circulated in the magazine and there were no questions.

ICM (International Confederation of Midwives)
Pam Dorling reported back. The Central European group met in January. They have been charged with three areas that they are working on until next congress: use of research evidence and data to raise awareness of midwifery care with governments and the public (they were apparently very interested in our work in festivals); promoting midwifery education programmes preparing midwives for autonomous practice, which is especially relevant in areas where midwifery education is not at degree level (for instance in Slovakia, nurses are educated to degree level but midwives are not) and strengthening the profession through effective legislation and regulation.

One way of working was by twinning from older more established midwifery organisations with countries with newer organisations. There was discussion about how ARM could perhaps twin with an organisation somewhere and if so, from where. Elizabeth Parker put in a special plea for twinning with places like Romania, where midwives are not at all horrified by, although she was horrified by the state of the labour wards.

Pam still needs someone to be an ICM delegate with her: Katherine Hales, Jane Evans and Elizabeth Parker are all interested; one can be the rep with Pam and the other can be the observer. The next meeting is in Belfast in November. We also need to plan ahead for the ICM conference in Glasgow in 2008 and how ARM is going to be involved at the conference and also in hosting midwives from other countries.

There is a proposal for a new UN Agency for women, similar kind of set up to Unicef; the document is available at www.icn.ch/UNwomen_agency_position_paper.pdf We need to look into it to let Pam know whether we as ARM are willing to support it. Pam says the document is readable, plausible and sounds very positive, see page 26.

EMA (European Midwives Association)
Jane Munro has been representing ARM on this; it started in response to the EU expansion and the expectations of pan-European directives. There are a lot of educationalists within the group and there is therefore often a focus on education. As with the ICM twinning idea, there is an interest in supporting midwifery organisations the new European countries, but there is also a possibility of duplication.

Saving The Maternity Services
There was a lively discussion on this which unfortunately had to be cut short due to time constraints, on revitalising OMOM (the One Mother One Midwife campaign) and on pushing through NHSCMM (the NHS Community Midwifery Model) and on the dire state of midwifery in many areas. We need to enlist support of consumers and we need demanding and pissed off consumers to fight for what they want otherwise we will lose midwifery.

Fears around Birth
Alex Smith, an NCT tutor, led a really interesting session which lasted the whole afternoon. Tocophobia is the fancy new feme for fear of childbirth, but it is not only women who fear birth, and technology has done little to alleviate those fears. Alex's presentation was full of images. She highlighted the difference between natural birth and technological birth, by showing us two pictures - one of an eagle soaring in the sky against a background of mountains and one of a jumbo jet in a similar location - and asked which was more likely to crash. She created flowers whose petals represented people with women in labour, 200 years ago a woman would be surrounded by other women, but now many others are present in body or in spirit - midwife, father, student, obstetrician, paediatrician, managers, CNST (we had to explain this to Alex), lawyers, and so on. Then she divided us up into groups and allocated one of these modern roles to each group and we had to draw the person and represent their fears pictorially. Alex found two more pictures, Edward Munch's Screamin and a picture of the Buddha and these were placed at opposite ends of the room. She described various scenarios (for example one of your clients is asking for a HBAC) and we had to take up physical positions in the room according to our own psychological positions. We ended by making affirmations to counteract our own fears.
After a long drive and a few wrong turns, I drove down the driveway to Maesycrugian Manor. I had visions of the gates creaking shut behind me and a loud voice booming, “Now begins your radical midwives initiation test!” I was quite nervous, as I knew absolutely no-one, and had never even been to a radical midwives meeting before. I saw the retreat advertised in Midwifery Matters, which I have picked up on numerous occasions during my two years midwifery training when I needed inspiration, and it has never failed to offer some. Not surprising, then, that going to radical midwives retreat in Wales turned out to be a good decision too.

The house was huge with massive gardens, a pond, a dining room with a dead deer on the wall, no less than three sitting rooms and too many bedrooms to count, many with four poster beds in them. Being a pikey student, I opted for the cheap breakfast and floor space in a spooky room option and paid £5 a night for dinner, with a tower in it. Inside the tower was an old wooden staircase leading up to the roof of the house with amazing rainy views of Wales. Sarah said if I went up there it was at my own risk! It was fairytale stuff.

Within moments of arriving (no gates closed behind me) I was made to feel completely welcome. I wanted to talk to everyone for longer; there were so many lovely people, all from different places and backgrounds. I immediately found some other students, who were there for the whole week. There were newly qualified midwives, independent midwives, hospital midwives, community midwives, doulas, soon to be student midwives, kids, babies and plenty of wise women. There were people from all over the country and different countries even. For me it made everything seem possible. I had never even met an independent midwife before, and there were newly qualified midwives setting up as independent, something I didn’t even think was possible. I felt, and I think the other students felt this too, that it was amazing to be in such an accepting environment with no hierarchy, to be able to say what you felt, do what you wanted and be who you wanted to be. There were workshops, if you wanted, but it was a holiday too; I went for walks, did yoga, read, helped cook but also just chatted and relaxed.

What I really took away from the workshops, as well as learning lots of things I didn’t know before, was a confidence in women and a confidence in normal birth. Mary’s workshop “Unusual Births” was a real eye-opener. I saw photos of twins and breeches delivered vaginally at home, with no fuss and no intervention – amazing! It made me think, “I don’t even know what a normal birth is!” In my two years training I have only seen one home birth and never a physiological third stage. Here I was surrounded by people who had confidence in birth, and thought it was an amazing phenomenal thing. I suddenly realised, especially after my high risk module, how full of fear I had become. I had forgotten that birth is incredible, I’d started to lose all the idealism with which I decided to become a midwife almost three years ago and perhaps all the reason too. In Lizzie’s workshop we explored ways of looking after ourselves, what we need to be OK, and be good midwives and how we felt about birth. This was a really healing and special experience that I will remember for a long time. I think it’s so important to remember to look after yourself, and I realised how much I needed to express the emotional and spiritual side of what I do in a safe space with good people around me. I don’t think I’ve ever had the chance to do that before.

Every evening we ate together and shared different things. One evening everyone shared something about death. I thought this was good, because it is also part of being a midwife, and a person. Being alive is also about acknowledging death and pain. Afterwards everyone went outside to look at the stars. I think maybe there are more stars in Wales, or there were that night anyway. There was silliness too; I was there for the 30th birthday of ARM, and there was cake and booze and dancing, and pass the parcel which included an underpant-clad superhero, and a re-enactment of a twin breech delivery (thank god Mary was there), with a stubborn placenta and a very angry PPH!

I left on Wednesday feeling completely inspired and alive and ready to finish my last year at college with renewed enthusiasm. It gave me back confidence in women and myself as a woman and a midwife. It made me remember that birth is incredible and my job is a privilege and honour, in fact I think I learnt more in those four days than I have in a long time (definitely more than I would have done that week at college). Most of all though, it makes me feel so supported to know that those lovely people are out there being lovely midwives. I think about that when I feel rubbish. It’s like having a new secret.

Zoe
We were incredibly fortunate in that the Retreat fell during the last week of our summer break, and so with the kind co-operation of our families we were able to come for the whole week. Like Zoe, we had never attended an ARM meeting and the only people we knew were each other. Also like Zoe, we approached the entrance to the manor (finally, after several unintentional detours and directions from a passing farmer!) with a certain degree of trepidation. And also like Zoe, we were overwhelmed by the friendliness and welcome which was extended to us by everyone there, from the minute of our arrival.

The workshops we attended were all interesting, the ones mentioned by Zoe and also the workshop on fear after the AGM, and Jas’ bodywork workshop on Wednesday. We were also very much looking forward to the natal hypnotherapy workshop scheduled for Thursday, and were disappointed when it was cancelled as Maggie Howell had hurt her back – but we have since all booked a place on her workshop when she comes up our way in January instead. In place of her workshop, Kerri-Anne and Liz Nightingale talked to us about some of the practicalities surrounding becoming an independent midwife, the whole idea now seems a lot more feasible should we choose to go down that route.

The rest of the end of the week was filled with chatting, cooking, visiting the seaside and generally pottering about, as well as the inevitable cleaning up! We scared ourselves to death with ghost stories when there was no-one else in the very big spooky house with us, had a go at fire poi with Christine (a personal ambition fulfilled!) and drank even more wine. It could hardly have been more idyllic.

The retreat was far, far better than we could have hoped. We learned so much from the amazing women there, mostly by listening to their collections of stories. We were inspired to hold our heads up as radical midwives, and hopefully amid the chaos of our third year studies, find time to set up a local group. It was lovely to meet other students from around the country as well, to compare our experiences. We came home with our love of midwifery reinvigorated and full of enthusiasm – exactly what we needed.

Frances, Kelly and Tal
3rd year student midwives, Hull.

Greetings,
I gained much happiness from attending the ARM annual retreat. Thank you to those who tolerated my desire to have the Japanese bed to myself for most of the time. Mind you it turned out that my first week-end’s bed companion was a keen BBC world service listener as well! BTW Did anyone want the recipe for the coconut pumpkin Thai curry and also for the Greek spinach pie?

The retreat has helped me deal with the shock of the murder of a seventeen year old lad. I knew him from my NHS midwifery patch. It happened just near the cob shop where we all go to for local neighbourhood banter. Here it feels like a parallel universe to the idyllic setting of the Victorian mock castle in Wales.

The workshops and massages and singing were treats. But mostly I enjoyed the presence of the marvellous midwives, mothers (and a dad or two) midwives-to-be and the spontaneous 30th birthday celebrations with the great Pinard cake (and all that fizz). We had the longer term members with the newer midwifery students blowing out the candles. I reflected on how significant ARM has been for my capacity to keep going and trying to be a loving, skilled midwife. We had some great after-dinner gatherings and touched on subjects from sex, birth and through to death. ARM members can do this in an atmosphere of respect and trust. I also believe we laugh heartily at and learn from our foibles and flaws. We are a healthier organisation because of all of this.

Thank you forever to Sara McAleese and everyone else who helped organise it and make the week what it was.

Kerri-Anne
So What's a Radical Midwife then?

If I had had any doubt about our name (and it's one of those topics we return to every now and again – see p. 33!), it was dispelled over the summer festival season. Virtually every conversation I had in the yurt started off along the lines of, 'so what's a radical midwife then?' and seeing the name 'Radical' on our banners caught people's attention, even those who clearly had barely heard of midwives before, leave alone radical ones.

Only a few years ago, the ARM festival tent was a gazebo at Glastonbury. Last year, ARM hired a yurt and went to two festivals. This year, as avid readers of National Meetings minutes will have noted, we had our own yurt and went to five festivals, the Sunrise Celebration, Buddhafields, The Big Chill, The Green Man and Solfest.

All the ground work had been done by Natasha Bangay, who'd invested a huge amount of effort in preparing packs for potential sponsors and festival organisers, outlining what ARM was able to offer as services for the festival-goers, so that all the bookings were already sorted. However, as her plans for the summer had changed, she wasn't able to attend any of the festivals, and someone needed to make sure the yurt got from one festival to another. Luckily, this coincided with a lull in my independent midwifery practice; although I haven't been to a festival for about 25 years! I've had a grand time, re-visiting my inner hippy; more to the point, ARM has been able to reach out to all sorts of people in all sorts of different areas of the UK.

We had over 20 people who've been involved in the yurt in one way or another, either by helping beforehand in the preparation, by crewing at one or more festivals, or by helping with the logistics of getting the yurt and its contents around the country, and the yurt wouldn't have happened without all their different contributions. People brought bean-bags, sheepskins, saris and wall hangings to make the yurt into a beautiful space, and people brought their talents and abilities to run workshops and offer therapies. We met a huge variety of people; some who had had babies already and wanted to talk about their experiences, some who were pregnant and attended workshops on pregnancy yoga, on everything you wanted to know about labour, on breastfeeding, or who wanted a belly cast…you name it, it happened. Some weren't pregnant at all but wanted to be and I gave out details of Toni Weschler's book so often that I wished I had shares in the publisher.

At each festival, we set up the yurt, set out books in a library corner, hung up wall charts and created spaces to sit and relax as well as a corner with toys and children's books. We put out ARM leaflets, mugs and baby T-shirts on tables outside and banners in front of the yurt, to catch peoples’ eyes. We had a stove so we could make tea; at one festival we had bunches of herbs hanging up to make our own, at another Lola made chai. Women came to chat, to seek refuge and shade when the sun was beating down or to get in out of the wet when it was pouring with rain. Children came to play with the fetal models or to have their nappies changed. We had samples of Floradix from Salus UK, our main sponsors, which we handed out to everybody who came by, as well as samples from Weleda who also contributed to our sponsorship.

Every festival has its own atmosphere; some more music and some more family oriented, but at each there were plenty of women eager to have more midwifery input and time. We had the full gamut of British summer weather, from blazing sun to thunderstorms (though luckily not the mud-baths of Glastonbury from the year before), and the wind sometimes got the better of all our cunning devices for attaching leaflets to tables. However, at each festival, the reaction to the yurt was unanimous; quite a few women said the main reason they'd come to the festival was because they'd seen there was to be a midwifery space. Others had come across the yurt by chance and said how pleased they were to have found us. It certainly made me realise what a thirst there is out there for the kind of information we were able to provide, as well as for...
Dear ARM

This is just a note of heartfelt support for the idea of an ARM school of midwifery as mentioned in the National Meeting Report (Midwifery Matters no. 109).

I am hoping to study midwifery and, like many other prospective students, am having to brace myself for the harsh realities of the existing training; training that for the most part bears little relation to the kind of practice I hope to engage in as a midwife, and which will ill prepare me for such practice. Without ARM, I don't think I could even consider undertaking the training — and I know some incredible women who simply refuse to put themselves through the distressing, gruelling and draining system, the loss being the system's loss of potentially brilliant midwives.

An ARM school of midwifery would capture these fantastic women (and men) and encourage and develop their skills in appropriate ways. However, I feel I must mention that whilst researching different institutions I got the strong impression that the universities themselves are open to, and frequently supportive of, the kind of practices that ARM members advocate — the major problem lies in the failure of such theory being translated into hospital practice. The result is a contradictory situation whereby the experience of students on placement often contradicts the theory students learn at university.

I would therefore advocate that the first step towards the establishment of an ARM school of midwifery should be the development of alternative or additional placements for students enrolled on existing courses — even a simple shadowing or mentoring placement service linking students with independent / "enlightened" midwives would make an enormous difference to the training of student midwives and could radically improve the student experience. Other training elements could subsequently be developed.

Wishing you all the best with the school — do let me know when I can enrol!

Julie Dawid
Glasgow

Dear Midwifery Matters

As my computer knowledge is nonexistent I followed a recent discussion in the Autumn 2006 issue no 110 on page 30 (‘Undiagnosed breech, birth and aftermath’). Lovely responses — did Jo get her job brilliantly done!

I just wonder, did she actually get an answer to her questions regarding her actual management? I do hope so.

Thanks for her standing up against pressure.
A Mum

Eternally grateful to the midwife actively assisting our breech birth when it became necessary.

Jo replies: I did not really get any answers to my questions in the e-mails on the group but Mary Cronk contacted me privately and we spoke on the phone, that was a BRILLIANT help! She was so nice to me and helped me de-brief fully.

Letters for publication are always welcome.
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(normal UK postage)
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book reviews


The book contains one very long chapter of 203 pages, broken down into diary dates spanning nearly two years of this family’s life. At first glance it appeared an onerous task of ploughing through one book of diary dates. But having no chapters, no titles trying to depict the content of a multitude of varying entries; entries based on an emotional rollercoaster, the text flows better and Dr Hogan manages to keep the momentum in the passion of her diary entries to engross me as a reader.

The author is very frank, open and honest about these two years of her life that has been monopolised by the need to conceive a third baby. Whilst it is about conception and pregnancy, she touches on many subjects that are perhaps in all our lives at some time and to varying degrees. The author discusses hot topics between the anti-motherhood and pro-motherhood lobbyists, ageism, political issues, childbirth from her own experience and talks about it as an issue from her own viewpoint, and in relation to newspaper articles.

I threw myself into this book but by page 74 was becoming drained with being ‘with her’ in a repetitive onslaught of her need to get pregnant. I wanted to shout ‘we know that, tell us something else’. However, I actually put the book down until another day. Well, after my near outburst and starting on page 75, I have found the book to be funny, sad, and would perhaps, for the faint hearted, be a bit awkward in places when some of the text becomes saucy. Though her insights into the couple’s sexual activity did make me giggle! Sorry, Dr. Hogan, in my defence I would be hitting a particularly dry bit and then POW! the next diary entry lightened the whole mood. Please give my thanks to your very brave husband. Some of her descriptions are full on. The text also contains a limited amount of swear words – you’ve been warned.

It has taken me along her journey and has made me reflect upon my own journey from childless professional woman to where I am now as an older mother, professional and unemployed. As a midwife I have also found that it meets me on a professional level as well. I would also agree with her list of ‘interested readers’ as listed on the back cover. She openly shares many taboo subjects that have occurred within their family environment; subjects which we may relate to having been through and felt.

Overall, a most enjoyable read, but you need to stick with it and remain open minded about the intimate entries, which pop up quite unexpectedly. In addition to juggling the many aspects of her life, Dr Hogan has managed to pull it all together in a book that most of us can relate to on one level or another; the realities of employment versus motherhood for her can also apply to most of us. I would recommend this book, with the caveat that it may not be your cup of tea.

Wendy Blackwood

alternative midwifery

Thought my experience of a brow presentation labour might amuse...

Some slow progress and high pain levels but just when we were planning to transfer a swarm of wasps invaded the bedroom (it was a hot summer’s dawn so windows wide open). We all leapt up and ran out of the room and down the stairs where mum promptly squatted and pushed the baby out – vertex presentation!

Perhaps not to be recommended but an effective way of shifting the head position and better than a caesarean! Baby had a wonderful circular bruise on his forehead which resolved quickly. Wasps obviously didn’t like the room and left of their own accord.

What fun we have as midwives.

Jane Evans
Here are some threads 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 2006) has now topped 2,400. 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

screaming for an epidural

I cannot be the only midwife who in NHS practice looking after women I don’t know who ARE SCREAMING FOR AN EPIDURAL ‘in case’ who go along with their wishes.

I hate the things with a vengeance but sometimes I see them as a necessary evil, for example, when I am looking after a poor primip who has the misfortune to be being induced/accelerated on syntocinon with an unfavourable cervix. I often find I struggle to support women in the right way to help them attain a delivery without an epidural, but I am getting better.

With a para I recently I knew she was progressing rapidly and she was insisting that she felt she couldn’t cope without one. I felt she would deliver in 30 minutes and that if it didn’t happen we would review the situation. 28 minutes later I was holding her daughter up in the air for her to see.

Sarah

Reducing the rate

We have dramatically reduced the epidural rate among our low risk women by various means:
• We have a dedicated low dependency unit which has nice furnishings, partner stays with the woman (and baby).
• We have info evenings where we explain the risks and benefits of all means of pain relief including epidural but state that epidurals are reserved for women who have very long difficult labours or where they or their baby have a problem
• We have a dedicated core staff on the unit that are familiar with and encourage other ways of managing pain but other staff rotate through the unit to gain experience in this area.

I love working in the unit and only very occasionally need to transfer for an epidural and usually this is due to long OP labours which require help.

Anna

Women’s choice!

Should you not respect the wishes of the women too? There seem to be around four categories of women:
(a) absolutely will not have an epidural
(b) would really like to avoid epidural (c) will have an epidural if they decide they need it
(d) have made a decision prior to labour to have an epidural as soon as possible

In (b) and (c) then support, do whatever you can to get them through without it, but if someone is a (d), then isn’t that their choice, just like choosing third stage management, or any of the numerous other decisions you make?

Anne

Informed Choice

It is only a real choice if:

i) The woman knows what she is choosing.

She is fully aware of the implications of the procedure in terms of its effect on the process of labour and birth – and the increased likelihood of other interventions. And she is fully aware of possible short and long-term risks.

ii) She has an equal chance of availing herself of other methods of support. This will inevitably have involved antenatal preparation (physical, emotional, philosophical and practical). It will have included her making decisions (and being supported in those decisions) that provide her with one-to-one care from a truly supportive midwife or alternative birth attendant. She will need a range of alternative resources like access to water. And she will need to be sure that this support will be there for her at the time.

Only then will her choice to have an epidural be a real one – otherwise it is a choice by default. That is, no choice at all.

Alex (NCT)

Living and learning

I made a decision prior to labour to have an epidural as soon as possible. I realise now that they can actually cause more problems than they solve but I have lived and learnt.

I wasn’t told or prepared for the fact that I might have to wait a long time for an epidural. I was a first time mum in active labour, left alone with no explanation and longing for an epidural to help me manage the pain. At that point if a midwife or anybody else had told me I could manage without an epidural I would have Screamed.... I was deeply traumatised by this experience and that was before the avoidable EMCS under GA.

Michelle

Obligation to treat?

The woman’s wishes should certainly be respected but I don’t feel that respect means one is obliged to go along with her wishes. Someone who is clinically depressed may wish you to give them an overdose of morphine but if in your clinical judgement, that is not in their best interests then you have no obligation to do so.

Obviously a woman in labour is a different situation but I still think a midwife or any other professional must be guided by their clinical judgement. Some women may well need epidurals. I’m not remotely qualified to comment on that, but based on at least one reply to this topic, it would seem many more would benefit from better explanations and other options. You have to ask yourself, on what information did they make the decision before labour that epidural is the only option for them? Was it fear? Was it based on the wonderful way in which media manage to portray the drastic emergency of birth in this day and age? Was it with full knowledge of the complications that can arise from labouring flat on your back?

Anne wrote: if someone is a (d), then isn’t that their choice, just like choosing third stage management, or any of the numerous other decisions you make?

One has to take into account that women are not simply choosing whether they’d like blue or yellow paint on their walls, they are choosing an intervention which could result in the whole cascade of interventions as has already been discussed or could provide pain relief that the woman needs.

In my opinion it’s not about refusing or going along with a woman’s wishes but helping her to come to a decision based on clear and accurate information and evidence.

Abi

Student Doctor
Supporting women in pain

Well said Abi.

Also, if you have a woman who is coping really well and hits transition like a train, and starts really screaming for one, there are other suggestions — if you know that she is in transition! Some student midwives never care for a woman for any length of time who have NOT had an epidural. Supporting a woman in pain is part of our work. And it can be challenging. If you have had several children, and want an epidural, I will get it set up for 37 weeks if you like, but if a client is having a first, or second baby, and has not had an epidural before, and is obviously progressing well, I may question, gently, her request, and do other things, or get her one organised if she really means it.

Depends on many things happening. I may be wrong, but most women I have discussed the care of their labour with afterwards, have thanked me for the support. They may have changed their opinion later of course. Very few had said they wished they’d had one. I have on occasions in the past suggested a woman have one. I have not audited their thoughts some months later though. The questioning has only been a day or so after birth.

I also feel that no one who has not had the responsibility of caring for a woman in pregnancy, labour and afterwards, can appreciate what that means. Doulas included, and I am not trying to cause trouble.

Debs (Independent midwife)

No alternative

I remember when I went in for my induction as a first time mother I had emblazoned on my NHS Birth Plan “I do not want an epidural!”

This got shrieks of laughter from the midwife booking me in and the comment that I was “an NCT-type”. Unfortunately for me, being rather young, naive and ignorant, I didn’t even know what the NCT was. However, I digress!

I was induced, my baby was OP, the whole maternity department was desperately busy. By the time I actually got a room instead of a bed on a postnatal ward, and a bit of attention things were pretty desperate; this was not how I thought it would be!

A few hours later I screamed at the midwife, “I can’t cope any more!” to which she responded, “Are you asking for an epidural?”

Well I wasn’t but as I didn’t know what else anyone could do for me I took her up on it. I had a bar of chocolate and a lovely doze, then woke up in time for the obstetrician to say, “This is a big saga for such a little girl!” and wheel me down to theatre for a caesarean. Lesson learnt!

I feel so frustrated for women and for midwives that the health system is largely not able to give women the one-to-one support they need to get through this intense time. I am sure that poor midwife not have had three other women to look after that night she might have had other ideas for me. I thought she looked very sad when she came across me on postnatal ward.

This was definitely not a ‘choice’ as far as I am concerned!

Sarah (mother)

Birth Planning

Isn’t this really something for prior to labour, that is the responsibility of the named midwife to ensure that has been discussed, OK, so I know that there isn’t time for everything, but if the statement has been made of wanting epidural as early as possible, then is labour really the time to fight that? Perhaps just a brief: “Are you sure that is what you want to do? We can get you in the water or give you gas and air if you want to try that,” etc. but then if she affirms her choice to just get on and order the epidural?

I particularly feel that if a women has chosen a unit because epidurals are available there, then to deny them that could be very distressing, leaving them thinking, “Why on earth did I come here?”.

Anne (mother)

Right to treatment?

I’m not sure that people are always aware they do not have a right to demand treatment. Our rights in the UK are primarily to choose whether to accept or reject treatment which is offered, and government or local policy, and the midwife or doctor’s judgment, determines what treatment is offered. We have an absolute right to decline intervention unless the Trust gets a court order (which would not normally be granted if you were a mentally competent adult).

But insisting that a treatment should be provided depends on a positive right, i.e. one which puts an obligation on others to do something for you. Those other people then have a responsibility to you, and in the case of professionals like midwives and doctors, they have a specific professional responsibility which means that they can be held accountable for any adverse outcome, regardless of whether you demanded the treatment or not. What amazes me, really, is that so many obstetricians, anaesthetists and midwives do take on that responsibility at the patient’s request; agreeing to provide intervention/medication on demand is very different from respecting someone’s right to choose what they themselves do.

I think it is one thing to say “Listen to the mother,” when the mother is relying on 220 million years of mammalian evolution and developed instincts — but quite another thing to expect a mother to be fully aware of all the implications of an intervention which has only been available for the last few decades and which even many professionals are fairly uninformed about!

Like lots of people, I pride myself on being an educated consumer who takes responsibility for my choices, but I do feel strongly that there is a sound basis for this legal position. Either you need to have a totally libertarian solution where everyone takes complete responsibility for their own choices and, for instance, self-medicates with heroin if they feel it necessary, Or you have a system where professionals are held to have a special responsibility to care for you and act as gatekeepers to risky interventions. I don’t think a mixture of the two works — i.e. I make the choice, you take the responsibility.

Angela

Getting past the Gatekeeper

Angela is spot on with us having no right to treatment, but women are given the impression antenatally that they can choose to have an epidural and they may plan to have one, not realising that they still have to get that choice past the gatekeeper midwives in labour.

If midwives are going to refuse epidurals to women who have planned and prepared for them prior to labour then instead of fighting the women who have made that choice, we need to fight the reasons they make that choice, which means doing stuff like volunteering to spend time on the information that goes out to women as standard, like the trust maternity booklet It means writing to newspapers when they have article like the dumb one by Thomas Stuttaford saying women should have epidurals not water births etc. Maybe in the delivery room there is the occasional women whose mind can be changed with the right brief questioning, but the delivery room is not where you are going to change the generalised view and desire for epidurals.

Anne (mother)
Boosting Natural Feeding

NICE, UNICEF BFHI have great, evidence-based ways of improving breastfeeding rates. But they are all multi-faceted, regarding policy, education for HPs, peer support, media etc.

If you could only do one thing, what do you think would be most positive:

a) Increasing breastfeeding initiation?

b) Increasing breastfeeding continuation?

c) Increasing satisfaction of breastfeeding mothers?

Ang

Naturally Nurturing

Stop calling it breastfeeding and refer to naturally nurturing one’s baby as feeding and the alternative as artificially feeding. Cows feeding their calves is not referred to as udder feeding is it?

Mary

Ban Advertising

Ban ALL advertising and marketing of formula and only allow it to be sold by pharmacies – preferably from behind the counter. Research shows that many women learn a huge amount about babies and parenting from pregnancy and baby magazines – and these are stuffed to the gills with formula ads. Couple this with the fact that they generally contain such all information about breastfeeding and you’ve got the ideal tool for persuading women that bottlefeeding is both a normal and essential part of raising a baby and that breastfeeding for more than three weeks is something only weird posh people do.

Wendy

More ‘Visible’ Feeding

Initiation – somehow (chicken and egg) see more ‘natural nurturing’ in public.

Continuation – more education of midwives and other health professionals, to raise our awareness of our attitudes to breastfeeding and hopefully to overcome the negative and unhealthy aspects.

I speak from a bottle feeding area and some health professionals are part of this. However we all need to examine our attitudes.

Alex

No Bottles for Dollies

A ban on baby dolls being sold with bottles and dummies – we need to start young!

Amanda

Education, Education, Education

Initiation – Education and more education starting in primary school. They do lots about healthy eating so why not include breastfeeding as an excellent first start.

Continuation – Support for breastfeeding mums with peer get togethers so they don’t get swallowed up with the artificial feeders. These could be supported by health professionals too but not necessarily in a health centre or hospital setting.

Satisfaction – How about pamper packs for every mum who continues breastfeeding for three months, six months, a year etc. Give them some reward, monetary or otherwise, for saving the Government money in terms of baby admissions to hospital, antibiotics for infections etc.

Just fanciful ideas really!

Anna

Midwife and ex-breastfeeder

Still get the tingle when babies cry!

Dolls Have to Have Bottles at School

Not so fanciful – my daughter, whom I fed until she was 3.5 years, became convinced that babies had to have bottles, because in the home corner in her school nursery class all the ‘babies’ have bottles... she was still being breastfed at the time! It took nearly a year to knock that one on the head, i.e. until she’d seen with her own eyes that her baby sister was exclusively breastfed.

And in the course of the aforementioned ‘healthy eating’ education, the nursery class did some work on babies’ needs:

Teacher: “What do babies need?”

“Food”. Teacher writes ‘food’ on whiteboard, draws saucepan... and a bottle. Lucy (mother)

More Pumping

At home, behind closed doors.

Secretly.

Ang

Lock up the Formula

• All formula on hospital postnatal wards to be kept in locked cupboards.

• Only midwives who have had special training in BF to have key to cupboard.

• Formula to be signed out by named member of staff who takes responsibility for it.

• Intention is not to harass mothers who choose to feed artificially, but to reduce chances of formula being given when mother would really prefer support to breastfeeding. Could also protect Trust against future legal action as mother’s consent to administration of artificial milk is fully documented.

• Consent form for supply of formula milk to be signed by both mother and midwife/qualified BF supporter on first occasion formula given.

Thereafter staff can just sign and date when another bottle supplied. I’m not aware of anywhere which actually uses a system like this, though :-((

Angela

Mum and www.homebirth.org.uk person

Support

I was going to say better support for woman who do want to nurture their babies themselves – the number of friends I have whose health visitor has told them, “Just give them up with a bottle to give yourself a break.” grrr

Stop saying ‘breast is best’. Breastfeeding is the biological norm. Artificial feeding (though necessary in a very small number of cases, possibly due to lack of

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Pessimistic

Honestly – I feel really gloomy about the future of breastfeeding. I think the herculean efforts of midwives and high profile public health campaigns will carry on getting more and more women to initiate breastfeeding but to get the majority continuing for more than a few weeks, and continuing to feed exclusively? Can’t see it happening. Meanwhile the backlash builds….

To me it’s all about our expectations of parenting, particularly in the first few months. Many women now are aghast at the concept of having their babies completely and utterly reliant on them alone, even if it’s only for a few weeks. Like cars have made walking two miles back from the supermarket with a couple of kilos of potatoes unthinkable for many, bottle-feeding has made three weeks of hourly breastfeeding on demand unthinkable for some women! As a society we’re constantly searching for ways to free ourselves from responsibility and from physical effort. I know it is a doddle and much easier than I have made walking two miles back from the supermarket with a couple of kilos of potatoes unthinkable for many, bottle-feeding has made three weeks of hourly breastfeeding on demand unthinkable for some women! As a society we’re constantly searching for ways to free ourselves from responsibility and from physical effort. I know it is a doddle and much easier than even if it’s only for a few weeks. Like cars have made walking two miles back from the supermarket with a couple of kilos of potatoes unthinkable for many, bottle-feeding has made three weeks of hourly breastfeeding on demand unthinkable for some women! As a society we’re constantly searching for ways to free ourselves from responsibility and from physical effort. I know it is a doddle and much easier than even if it’s only for a few weeks. Like cars have made walking two miles back from the supermarket with a couple of kilos of potatoes unthinkable for many, bottle-feeding has made three weeks of hourly breastfeeding on demand unthinkable for some women! As a society we’re constantly searching for ways to free ourselves from responsibility and from physical effort. I know it is a doddle and much easier than

WSam and education) is a sub optimal method of feeding a human baby.

Victoria (mother)

Waters, Wee or … Cervical Weep

When my waters broke with my first baby I was sure that they had broken (and there was old meconium). There are only two holes in which fluid comes out of: (1) the one you wee out of (2) the one from which amniotic fluid comes.

I think that most, if not all of us can tell the difference. Also, we do have control over our bladders and are usually able to stop the flow or at least attempt to. As for amniotic fluid, we are unable to use any sort of muscle to stop this, waters break without maternal knowledge, or effort or ability to stop it.

The point at which the fluids actually exit our body is another give away. We pass urine toward the front of our external genitalia and toward the back for amniotic fluid.

I believe that women consciously know the orifice from which the fluid comes from and I discuss these points with them. Have they experienced SRoM, or have they actually passed urine? I don’t want to put them on the road to IOL or give them 24 hours plus to go into labour with IV antibiotics just because they peed themselves (and no one will own up to the fact it happens).

We are only human, and can make mistakes. So I ask mothers where they think the fluid has come from and explain the difference as I have had both happen to me.

If the women has made a mistake then that is not a problem as we don’t want to the induce her incorrectly because we all think her waters have gone when in fact she has (maybe coughed/laughed/been overfull) and has wee’d herself - or is that just me who does that sort of thing?!!!!!!!

Wendy

HP education – absolutely – BUT the education is not enough – many need debriefing about their own experiences, or they will say the right things, depending on who they are talking to.

• “Formula is bad for babies” – really difficult one. I know mums feel guilty about everything – it comes with the job. But it’s politically OK to point out to mums the harm caused by not having a car seat, or by smoking. Why is it not OK to point out the harm done by formula? Is it because we subconsciously think formula is OK, but smoking over a baby is not? You don’t hear of many HPs telling mums to “Give yourself a break and take your baby to bed with you”. But you do hear of them advising bottle feeding. Is this a message we need to get over to the HPs before the general public?

• As for banning formula adverts – I wish. Anyone hear how the EU are getting on with the tough decision about whether our babies should still be put at risk through advertising? Ang (original poster)

• Why is this not taught to ALL midwives (and obs students)?

• How many women have wrongly been induced because of prolonged or pre-labour rupture of membranes when all that is happening is that their bodies are preparing for spontaneous labour?

The cervical softening occurs at the same time as the uterus feels softer and ‘ripe’ on palpation. This softening is often missed these days as palpation skills appear to be being replaced by tape measures and ultrasound scans. Hands can tell more than machines!

Jane Evans
Midwife

Sceptical line

I take a hard line… if there isn’t fluid to be found on knickers, pad etc then it wasn’t SRoM… Let’s face it, if the membranes do rupture the percentage of women who won’t labour within a few days is tiny… so if it’s SRoM and I’ve missed it then she’ll be back in labour in a little while anyway...

I do find that many women actually can’t differentiate between wee and amniotic fluid… or maybe they think that if they tell me it’s amniotic fluid I’ll induce them… why do so many women want to be induced?

I’m a little more careful if we are well before term, obviously.

Annemarie

Cervical Weep

I felt it really important to post a reply on this subject:

For years I was aware that women often had a watery loss about a week before they went into labour and I just called it a ‘cervical weep’. I was laughed at by several colleagues and GPs who I worked with at the time but I continued to reassure women that this was quite normal and a positive sign for the start of labour.

Some twenty years on through my midwifery career I attended a wonderful study day led by Tricia Anderson and Stephanie Meakin. Part of this day was dedicated to the cervix and the changes it went through during pregnancy.

To my great joy, amusement and chagrin (because I had never got round to researching the subject!) there was all the evidence describing the change in the cervical collagen which allows the cervix to dilate. The ‘old’ collagen is broken down and, in many women, appears as a watery loss from their vagina. The collagen change also requires a high level of glucose so this explains the woman’s need for sugary food for about a week before she goes into labour.

The loss can come in dribs and drabs or may present in a gush, as if the membranes have broken. This raises the questions:

• Why is this not taught to ALL midwives (and obs students)?

• How many women have wrongly been induced because of prolonged or pre-labour rupture of membranes when all that is happening is that their bodies are preparing for spontaneous labour?

The cervical softening occurs at the same time as the uterus feels softer and ‘ripe’ on palpation. This softening is often missed these days as palpation skills appear to be being replaced by tape measures and ultrasound scans. Hands can tell more than machines! 

Jane Evans
Midwife
Gender Equality Now or Never: A New UN Agency for Women

Paula Donovan, senior advisor, Women’s and Children’s Issues, Office of the UN Special Envoy for AIDS in Africa, argues that the UN needs a special agency for women just as UNICEF is a special agency for children

EXECUTIVE SUMMARY

The UN is undergoing reform, and advocates of women’s rights hope that bold changes will end decades of lip service. The international community voices the goal of equality between men and women, but it has not acted on it.

Across the globe and within the UN system itself, women are oppressed, marginalized, under-represented and neglected. They make up a huge majority of the world’s poor, illiterate, exploited and abused, and a tiny minority of decision-makers, power-brokers and influence peddlers. Three of every four HIV-positive African youth are female, while fewer than one in ten ambassadors to the UN are women. Against the goal of a 50/50 staff ratio by 2000, the percentage of senior UN posts filled by women reached a high of 29, and is now moving in reverse.

The UN’s “international machinery” has never been made operational for women. Four entities make up the women’s machinery: UNIFEM, the Division for the Advancement of Women, the Office of the Secretary-General’s Advisor on Gender Issues, and the Institute for Research and Training for the Advancement of Women. All together, they have 101 and the Institute for Research and Training for the Advancement of Women, the Office of the Secretary-General’s Advisor on Gender Issues. They make up the work of experts. UNIFEM received 2.5% of that amount in 2004 to deal with the world’s women. UNIFEM received 2.5% of that amount in 2004 to deal with the world’s women. UNIFEM received 2.5% of that amount in 2004 to deal with the world’s women.

The lack of a fully-fledged agency to empower women renders all UN agencies funds and programmes ineffective. Simple logic applies: second-class citizens — poor, illiterate, oppressed and counter-intuitively responsible for raising the next generations — keeps the world anchored in place unable to develop and progress because only half the global population can contribute and participate fully.

The UN, and the world, need a fully-fledged women’s agency: operational with on-the-ground presence in every country; a guaranteed budget — of $1 billion to start, increasing by 10 per cent annually to $2 billion in five years — and a full complement of expert staff and targeted programmes. A women’s agency is required so that women’s voices can be heard at all levels of society, and in all the decisions that affect their lives. A women’s agency is needed to help governments devise and implement targeted programmes to empower women.

The UN needs a women’s agency to lead — and be accountable for — a ‘deep social revolution’ throughout the system; its technical experts must not only encourage, but assist all UN departments, agencies, funds and programmes to bring a gender perspective to all of their work. Top practitioners — trained, schooled, experienced specialists with particular skills in vital fields — need the infrastructure and resources of a fully-fledged women’s agency, and the UN system needs such an agency to make all its other programmes truly effective.

The resources exist — Official Development Assistance is now said to be $100 billion per year. It requires nothing more than political will to allocate one per cent of that total for half the global population. The pieces exist; they need only be assembled:

The “mission” is stated in the UN Charter:

The legal basis for the mandate is established in CEDAW.

The main purpose and activities are outlined in the Beijing Platform for Action, and priorities have already been set in its “12 critical areas of concern”.

The technical expertise can be found in thousands of civil society organizations.

The governance structures to use as models, with appropriate adaptation, exist within the UN.

The ideal women’s agency envisioned would be a fund or a programme led by an Under Secretary-General. Because its mandate would extend beyond development and into the political realm — implementation of Security Council Resolution 1325...
on women, peace and security, for instance — and because its governance would benefit from the gender balance and expertise found in non-governmental organizations the ideal women's agency executive board would have a formal role for civil society, and would report to the full General Assembly. Its funding for staff would be drawn from assessed contributions, or UN dues, and its funding for programmatic work would be raised from voluntary contributions.

It would have headquarters staffed with technical experts and a budget adequate to support country offices, each with full operational capacity and programme staff field offices in countries with UN Country Teams, led by Representatives and regional offices in Geneva, CEE/CIS, Africa, the Middle East, Asia and the Pacific, Latin America and the Caribbean. It would take the lead in advocacy and communication, collect and analyze data, develop policy, provide technical advice and assistance on gender and women’s empowerment in every specialized field; support and monitor the gender-related work of other UN agencies; and work closely with government partners to plan, implement and oversee programmes at the national level. It would work closely with the CEDAW Committee and the Office of the High Commissioner for Human Rights, which would service the CEDAW treaty body in Geneva. It would establish a formal committee for select joint planning and coordination with key partner agencies including UNFPA and UNICEF. The women’s agency would be allocated the necessary core and other staff required to fulfill its goals and purpose and equivalent in force to UNICEF's, the agency with the most comparable mandate. It would draw in large part — at the outset — from staff seconded from legitimate women’s organizations with appropriate expertise.

The crucial reform question facing the UN is whether it can remain relevant in the 21st century while functioning in a bygone era that had little regard for women's human rights. The crucial question for Member States as they strive for world peace and the Millennium Development Goals is not whether governments can afford to create an agency that empowers women, but whether they can afford not to.

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nettalk  Resisting Induction for shoulder dystocia

A client who was told after a scan that she was having a big baby (11 lbs). Then a few days later she saw a consultant who could only talk about shoulder dystocia and “baby could die in 5 mins”.

I have been a midwife for more than 17 years. I know of no way to predict shoulder dystocia – even if scans are right on predicting size, which they are not. As they say, size isn’t everything. Personal experience of helping women birth over all those years has taught me that intervention causes more problems than it solves. If her cervix isn’t ripe and ready for labour, induction is more difficult and more likely to be problematical. If it is ripe, then why not wait a few days for labour to begin naturally? The evidence for induction for post maturity is unsound and for size is, as far as I am aware, non-existent. Sometimes labour does not start because the baby is not in the most favourable position and pushing labour may not give it a chance to reposition resulting in a more painful posterior labour and intervention for birth.

My friend, whose birth I promised to attend earlier this year, went eventually to 43 weeks and 2 days gestation. She then laboured spontaneously and rapidly at home and birthed her 10.5 lb baby kneeling on her bedroom floor. No shoulder dystocia, no perineal trauma, minimal blood loss, early breast feed etc. Interestingly, the placenta was still large and healthy and the baby did not look as post mature as some 40 week babies I have seen. Gestation had been confirmed by both dates and USS.

No information which includes open threats of babies dying and which does not also include risks of having the intervention, can ever be considered to fulfill the criteria required for informed choice. It is a blatant scare tactic and has no place in childbirth (or anywhere!). Anyone who gives “information” in this way should not be trusted. This lady needs the support of, by now probably more than one, midwives and friends who understand the physiology of labour and birth and who have faith in the woman’s body to get it right. Love, belief, trust, support to birth in a “safe” place – which for many of us is not hospital but home, where we can move freely, where we have power, where we are not watched by eyes that have no faith. I have recently returned from a Midwifery Today conference in Germany and amongst the many things I brought away with me are the words of a most beautiful midwife and teacher, Marina Alzugaray, “The pregnant woman, she is The Queen, nothing about her can be wrong, you have to understand that, then you will (treat) her right.” That’s not quite a direct quote, she speaks fast and it’s hard to keep up! But you get the gist! Treat her with extreme respect, heart as well as mind!

I don’t know if any of that helps. Ultimately, does this woman really believe there is a problem or is she responding to the fear of her “advisors”? Could she sit quietly and talk to her baby and feel whether they are truly in need of “rescuing” or whether the fruit of her body will fall when it is ripe and ready? Remind her she is descended from a long line of women who have birthed their babies safely; modern medical intervention is only a fraction of the time of our survival as a species. If her heart and her gut tell her she needs help, she probably does, but SHE makes the choice and she stays in control.

She keeps her power, never give it away. Give her my love and tell her I believe she will wait a few days for labour to begin, and, if not, you get the gist? Treat her with extreme respect, heart as well as mind!

I don’t know if any of that helps. Ultimately, does this woman really believe there is a problem or is she responding to the fear of her “advisors”? Could she sit quietly and talk to her baby and feel whether they are truly in need of “rescuing” or whether the fruit of her body will fall when it is ripe and ready? Remind her she is descended from a long line of women who have birthed their babies safely; modern medical intervention is only a fraction of the time of our survival as a species. If her heart and her gut tell her she needs help, she probably does, but SHE makes the choice and she stays in control. She keeps her power, never give it away.

I waffle on and could do so, more so. Give her my love and tell her I believe she won’t make a bad choice if she chooses freely.

Meg (mother and midwife)
The Daily Mail is not quite my cup of tea, but the kitchen table has been littered with cuttings given to my mother by Sue who works with her over the road at the surgery. It is currently the newspaper carrying the most — dare I say it? — informed stories with regard to childbirth. I would dismiss them as the Mail scaremongering again — if I hadn’t been brought up in a house where the kitchen table was littered with Midwifery Matters proofs, and midwives dropped in to get to know the family and set the toaster on fire; if I hadn’t seen with my own eyes the birth of my own brother in my own home. Unless I knew otherwise, I’d think, surely this home birth lark must be a risky business; wouldn’t it be safer to be in hospital within reach of lifesaving equipment? I’d dismiss the stories of ‘needless caesareans’ as exceptions, and wonder who said they were ‘needless’. After all, I Googled ‘Guardian’ and ‘midwifery’; top of the page was a story from 2003. Nothing to worry about there, then. The Times said ‘Babies are dying or suffering brain damage at birth through a shortage of midwives and consultants on NHS labour wards, according to a report on maternity care’ – almost a year ago. http://www.timesonline.co.uk/article/0,2087-1938127,00.html The Independent’s links mostly go to education. Yes, we need more midwives. Yes, this means people need to be trained to be midwives. Yes, links to midwifery courses might be helpful. But what about the NHS cuts? The Mail seems to have been running midwifery stories all autumn, most of them plain scary. But for once I think we have a good reason to be scared.

Of course, all the mass media loves drama. Perhaps that’s the trouble: there doesn’t need to be drama around birth.

Someone could let Casualty know this some time, but I doubt they’d take much notice. They need drama, being one. I know this, but getting it across without sounding like a stereotypical manhating feminist or equally stereotypical irresponsible ‘earth mother’ seems to call for linguistic skills that I haven’t yet developed. All I can do is say: look, it doesn’t have to be like Casualty, three days on your back, screaming in agony and with buckets of fake blood. It can be different. Please believe me.

When my time comes, I want a normal birth. Not a Casualty birth, although that passes for normality these days, because it’s what everyone sees. I want people around me that I love and trust, and I want to be confident in my body’s ability to do its job. I want to be in a place — a physical place — where I’m comfortable and relaxed. But how selfish of me. ‘I want, I want, I want.’ It’s not me that matters, is it? It’s the baby. How could I even think of specifying what I want? After all, it doesn’t really matter, as long as the baby’s all right. Does it? Let me be more selfish, then. I want more than that. I want every woman to be able to experience birth the way I want to. I want them to have the choice. I don’t see why anybody should be denied the dignity of giving birth the way they want to, or, for that matter, denied the information to make that choice. I want them to be told the truth. The whole truth. Giving birth the way you want isn’t going to kill your baby. Or, for that matter, you.

I’d like to think that this is a bridge that I won’t have to cross for a good few years yet — I’m only 21, and have no plans involving babies as yet. However, I’ve a nasty suspicion that the bridge isn’t built — or, if it is, it’s in a bad state of repair; and it could only be wise to start thinking about possible detours. J. K. Rowling may be able to afford an independent midwife but I can’t, not yet, and there’s no guarantee that I’ll be able to in the future. Perhaps I should have set aside some of my student loan. It’s a bit late for that now. All the same, I’m lucky. I know what I have the potential to do — but only because I’ve been proofreading Midwifery Matters since I was 11. (Oh yes, she’s going to be biased, being indoctrinated like that. Oh dear me, tut tut.) I know that, when my time comes, given the right people and the right surroundings, I’ll be able to do it. I can’t offer proofs, and I’m telling you things that the medical profession at large will contradict. Birth isn’t medicine. Pregnancy isn’t an illness. I’ve seen it; I know. Trust me. And please, please, just for once, trust the Mail.

[* They didn’t really set the toaster on fire, they just arrived at a critical moment. MJ]
‘Father’ of ultrasound wants patient-centred care

The Times, October 28th, had an interview with Harvey Picker the inventor of ultrasound. He discovered that ultrasonic waves in water behave like micro-waves used by radar in air. “At first the radiologists weren’t interested. Then the obstetricians said they wanted it and that was it; ultrasound was up and running.”

Picker acknowledges the damage that has been done by modern technology; “Until the middle of the twentieth century, if you became ill there were few things we knew how to cure, so patients got very personalised nursing care for almost everything, trying to pull the person through the illness. Then, with penicillin and the introduction of other medical technologies the attitude of healthcare professionals changed from looking at the person to looking at the disease.”

This seems to me to be especially true of obstetrics where three technologies have done much to interfere with personalisation, namely ultrasound which ‘sees through’ the woman as if she wasn’t there, bypasses the need to ensure that the woman secretes and makes the best use of her own hormones, and lastly caesarean section which completely bypasses the physiological mechanism of birth. As well as militating against women-centred care, these technologies have deskilled midwives and obstetricians. Nowhere is personalised care more important than in maternity care; the woman is not just a partner in her care deciding what treatment she is to have, but her body does the actual work of labour.

Picker is credited with inventing the phrase ‘patient-centred care’, setting up Picker Institutes first in the USA then in Europe. On looking at their UK website a yield no results but ‘maternity’ fared a little better – one of their UK researchers is developing a national survey of maternity funds hospital led care, where there is a perverse incentive towards caesarean section. Is there any funding in place earmarked for midwifery care? If there were PCTs would be quick to make the most of it.

Breastfeeding a ‘No Brainer’

Breastfeeding has had mixed press coverage recently, on the one hand a study reported in the BMJ says that breastfeeding confers little extra benefit on development in terms of IQ but on the other hand an Australian study says that it ‘boosts the child’s mental health’.

Previous studies into breastfeeding and intelligence have found significant associations between IQ and length of breastfeeding, however, the BMJ authors claim that these have failed to control for maternal IQ. According to this study, practically all of the supposed benefit of breastfeeding (on IQ) can be explained by the fact that breastfeeding mothers tend to have higher average IQs than most people who artificially feed. There has been a lively response on the BMJ message board with no positive comments and plenty of criticism from every conceivable angle; amongst other things, the study has been criticised for using very old (1979) longitudinal data originating from the US and for conflating ‘breastfed at all’ with ‘exclusive breastfeeding for months’. One wonders why such a non-result is worth publishing at all.

Bridlington is to close to save money – women can give birth at home say the hospital bosses, according to the BBC. Llandries in Ceredigion is threatened; this merry-go-round seems to have been going around for ever and ever. What is needed is clear direction from the Department of Health requiring all PCTs to provide and staff low tech facilities for birth so that all women can have a real alternative to high tech consultant led birth.

One easy way to achieve this would be to implement and fund the NHS Community Midwifery Model. Payment by Results funds hospital led care, where there is a perverse incentive towards caesarean section. Is there any funding in place earmarked for midwifery care? If there were PCTs would be quick to make the most of it.

Birth Centres – Easy Targets

All over the country women and midwives don’t know whether they are coming or going as birth centres are threatened with closure, closed, reopened, until the next time the PCT wants to save some money.

Stroud has been saved, likewise the Grange at Petersfield – for the moment, who were breastfed for at least six months are at lower risk of mental health problems, the benefit persists for at least up to the age of 10 years old, and held even after adjusting for socio-economic situation, education, happiness and ‘family functioning’. Children who were breastfed had particularly lower rates of delinquent, aggressive and anti-social behaviour and overall were less depressed, anxious or withdrawn.

So, lady docs, do your baby a favour, don’t cave in to professional pressure, set a good example to your patients, feed your baby yourself and the whole family will reap the benefits. MJ

Pain and Control

‘Perceived control attenuates pain and pain-directed anxiety, possibly because it changes the emotional appraisal of pain’. So begins the abstract of a paper published in the Journal of Neuroscience that has identified the anterolateral prefrontal cortex as the area of perceived control over pain – and perceived control has an analgesic effect.

Katja Wiech et al used functional (real time) MRI to scan the brain for changes in two experimental conditions, the first where people were told they could control the source of pain (electrical stimulation to the back of the hand) and or the second where they were told it was controlled from outside the room. Self-controlled pain was rated as less intense and produced less anxiety than externally controlled pain and the analgesic effect was linked to the activation of neurons in the prefrontal cortex, an area associated with a feeling of security. Whether this works in the opposite direction is less amenable to experimentation – just how does one induce a sense of security in a room with an MRI scanner in it? But it might well explain the difference between reported pain levels at home and in hospital. Women consistently report less pain at home and many choose home birth precisely for the sense of security it provides.

Another interesting aspect of this work was that the authors referred to their subjects’ outlook on life – those who expect to feel in control of their lives seem to experience uncontrollable pain as worse than those who expect to have little control in the first place. Subjects with expectations of no control were better at activating the prefrontal region of their brain than those with a strong control belief. I can’t help wondering if this accounts for the ‘NCT effect’ – where women going into hospital with a strongly worded birth plan end up with caesareans!
Applications are invited for the post of IMA Database Coordinator.

**Job Purpose**
The purpose of this role is to act as the central point of contact for the IMA Database Project. The work involves updating and maintaining both electronic and manual record-keeping and archiving systems, offering support, advice and guidance to participating IMs as necessary, and providing information to outside bodies as appropriate.

**Support**
The IMA Database Coordinator is given IT support from the IMA Database maintenance officer, whose role is to maintain and develop the IT system as required.

The IMA provides support to the Database Coordinator via a standing Working Group: the IMA Database Working Group.

**Control and Ownership of Database Information**
The IMA controls and owns all information contained in the IMA Database. Information may not be disseminated or publicised without the consideration and permission of the IMA Database Working Group.

**Data Entry**
The IMA pays for data entry of client records. A separate data entry person is engaged to carry out this work.

**Remuneration**
The role of IMA Database Coordinator is an unpaid post. The IMA will offer discounted membership and pays all reasonable expenses.

**Contact details**
For an application form and job description contact Melanie Milan, the current Coordinator, on e-mail mel.milan@btinternet.com.

Please send applications to: Melanie Milan, e-mail mel.milan@btinternet.com

**Closing date**
End of December 2006

**Selection procedure**
Shortlist and interview

**Applications**
Please organise your job application for this role under the following headings:

1. Personal details:
2. Relevant training/qualifications:
3. IT skills and experience:
4. Organising and office experience:
5. Communication skills and experience:
6. Other relevant information:
7. 2 references, one of which specific to office and IT experience
local ARM group meetings

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

Wigan/Bolton/St Helens
Lesley Price
33 Lincoln Drive
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01942 747902

Wigan Homebirth Group
Contact: Jayne Halton 01257 404468
Meetings: Queen’s Methodist church hall, Market St, Wigan, 2nd THURSDAY of every month, 10-11.30am

Herefordshire
Annie Robertson
Cwm Farm, Abbey Dore
Hereford HR2 0AB
01981 240632

Milton Keynes
Valerie Gommon
www.3shiresmidwife.co.uk

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

Norfolk
Any ARM members interested in meeting up on a monthly/two monthly 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

Oxford
From the other Sarah Montagu (!). Meet like-minded midwives and set the world of maternity care to rights.
All welcome. Contact Sarah for date of next meeting 01685 248159

Taunton/Bridgwater area
Clare Sibley, 01823 680763, Regular meetings; phone for dates and times.

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.

West Scotland
Meeting bi-monthly. The first two meetings were both well attended by a mix of hospital midwives, independent midwives and students. All welcome. Please contact Linda Wylie on 01292 316596 for details.
If there’s no group near you why not start one up? Contact Wendy (below) for advice on organising meetings.

It would be good if anyone running a local group could send in details of where and when they meet so that other ARM members can come along to meetings.

We would also welcome any news of what local groups are getting up to. Please send news items to:

Local Group Coordinator, Wendy Blackwood
icwblackwood@hotmail.com
01942 205935

what’s on

University of Salford, Directorate of Midwifery Study Days
Provisional places can be booked now.
Please contact 0161 295 7012 x7014 for an application form and further details.

December
5 Experiences of female asylum seekers and refugees in Britain £45

2007
all to be confirmed
21 February
Alternative Therapies
27 February
‘Don’t Bank On It’: Supervision and Avoiding Risk
15 March
‘A Day in Court’
3 April
‘A Day at the Breech’: Breech Birth – The Issues

Wednesday 28th February, Walsgrave Hospital, Coventry
‘Postnatal Depression in Teenagers’
NHS-ConNeCT, £78.00. Information/bookings tel. 020 8993 3441, fax 0870 770 3237 or e-mail:connect@national-childbirth-trust.co.uk

Thursday 1st March, Low Port Centre, Linlithgow
‘Running Effective Antenatal Classes for Teenagers’
NHS-ConNeCT, £78.00. Information/bookings tel. 020 8993 3441 or e-mail:connect@national-childbirth-trust.co.uk

Thursday 15th March, Bell Green Children’s Centre, Coventry
‘Leading Postnatal Groups’
NHS-ConNeCT, £78.00. Information/bookings tel. 020 8993 3441, fax 0870 770 3237 or e-mail:connect@national-childbirth-trust.co.uk

Following the huge success of and the very positive feedback from the study event ‘Mothers and Midwives Shaping the Future – Power to the Pinard’ held by Wigan ARM on October 7th (there will be a full report on the day in the Spring issue), The Wigan Group has decided to undertake an annual study event. This is being provisionally arranged for October 6th 2007 and Denis Walsh has already agreed to speak again on this day. (I’m sure that all the delegates would agree that his presentation this year was excellent).

Further details of this day will be available in the next issue. Can I take this opportunity to thank all the delegates who attended this year; we have been overwhelmed by your generous evaluations of the day and are taking all of your comments on board. Thank you especially to those who travelled long distances to be with us. I hope I did not pass on my flu to anyone and hope to see you all next year.’

Louise Brown (Chair Wigan ARM)
## Items for Sale

### ORDER FORM

<table>
<thead>
<tr>
<th>Item</th>
<th>Price (£)</th>
<th>P&amp;P code</th>
<th>No. req.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Beechwood Pinard stethoscope (standard 7&quot;)</td>
<td>6.00</td>
<td>C</td>
<td></td>
</tr>
<tr>
<td>Beechwood Pinard stethoscope (continental 13&quot;)</td>
<td>10.00</td>
<td>D</td>
<td></td>
</tr>
<tr>
<td>ARM Badge (Pinard logo, blue/gold enamel, safety fastening)</td>
<td>3.50</td>
<td>A</td>
<td></td>
</tr>
<tr>
<td>Calico carrier bag (Pinard logo)</td>
<td>1.50</td>
<td>A</td>
<td></td>
</tr>
<tr>
<td>Baby T shirt (‘Born into the ARMs of a midwife’)</td>
<td>7.50</td>
<td>B</td>
<td></td>
</tr>
<tr>
<td>Contour pen (rubber grip, retracting, black ink, ‘Midwifery Matters’)</td>
<td>1.00</td>
<td>A</td>
<td></td>
</tr>
<tr>
<td>Jotter pad (6&quot; x 4&quot;, 50 sheets, small owl logo in corner)</td>
<td>0.50</td>
<td>A</td>
<td></td>
</tr>
<tr>
<td>Car sticker (Logo: Pinard, ‘Midwifery Matters’)</td>
<td>0.60</td>
<td>A</td>
<td></td>
</tr>
<tr>
<td>Car sticker (Logo: Owl on Pinard, ‘Pregnant? Be wise, choose a Midwife’)</td>
<td>0.60</td>
<td>A</td>
<td></td>
</tr>
<tr>
<td>Mouse mat (Logo: Owl on Pinard, ‘Be wise, read Midwifery Matters’)</td>
<td>3.50</td>
<td>B</td>
<td></td>
</tr>
<tr>
<td>Silver Miniature Pinard (2 cm) earrings (per pair)</td>
<td>15.00</td>
<td>A</td>
<td></td>
</tr>
<tr>
<td>Silver Miniature Pinard (2 cm) pendant on silver chain</td>
<td>15.00</td>
<td>A</td>
<td></td>
</tr>
<tr>
<td>ARM CD ROM of the first 100 issues of the magazine</td>
<td>25.00</td>
<td>C</td>
<td></td>
</tr>
<tr>
<td><em>Childbirth Unmasked</em> (stress hormones in labour) Margaret Jowitt</td>
<td>5.00</td>
<td>D</td>
<td></td>
</tr>
<tr>
<td><em>Midwifery Matters</em> (single back-copies)</td>
<td>2.00</td>
<td>B</td>
<td></td>
</tr>
<tr>
<td>“Choices in Childbirth” (free leaflet)</td>
<td></td>
<td></td>
<td>see below for postage costs</td>
</tr>
<tr>
<td>“What is a Midwife?” (free leaflet)</td>
<td></td>
<td></td>
<td>see below for postage costs</td>
</tr>
</tbody>
</table>

Post & packing cost codes: A = 50p; B = £1.00; C = £1.50 D = £2 per single item.

**N.B.** For larger orders please contact Sarah Montagu - tel 01865 248159

### INFORMATION LEAFLETS (Single leaflets free of charge)

**Choices in Childbirth.** Comprehensive information leaflet for universal distribution.

**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.

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

- 50 leaflets @ £1.50
- 100 leaflets @ £2.00
- 200 leaflets @ £5.00
- 300 leaflets £5.50

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

Name & address (Please print clearly) ________________________________

_________________________________________________________________

_________________________________________________________________

Post code ________________

Payment enclosed: (Including P&P)_______________ Date:___________

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Orders to ARM Sales, Sarah Montagu, 16 Wytham St, Oxford OX1 4SU 01865 248159
30th Birthday Member Survey

From time to time members question whether we have the right name and whether the ‘radical’ in our name puts people off joining who really belong with us. As you can see from the facsimile below, taken from the very first page of the first issue of what was then the ARM newsletter, this has been talked about for nearly 30 years — it took a year for those pioneers to name themselves at all! We discussed this in the last Steering Group meeting and decided to canvass your opinions. You will see that ARM’s objectives remain virtually identical to those listed inside the front cover of this issue. There’s still a long way to go.

We purposely move the national meetings around the country to give as many midwives as possible the chance to find out about ARM but it seems that few non-members (other than students) do seize the chance to come. Are they scared off by the ‘radical’ word or do they stay away for more mundane reasons? We know that there are many midwives out there who share our hopes and our dreams for keeping midwifery alive in the UK (and the rest of the world) and it would be good to have them on board. It has been said that change happens when there is a critical mass of 17% wanting change and at present only about 2% of UK midwives are ARM members (though many more will share our ideology). How can we encourage more midwives to join the campaign for change?

We do realise that even conducting a survey about our name will horrify some members, but if we are truly radical we should be up to the challenge of renaming our own well loved institution — if it enabled us to achieve our objectives! Please take the time to fill in the short questionnaire below or on our website by the end of this year so that we can report back in the next issue.

1. I attend ARM national meetings: occasionally, sometimes, often

2. Most important factors in deciding to attend a meeting: proximity to home, convenience of travel, advertised programme, special need for support, someone to go with, other

3. I would go to more meetings if: nearer home, easy to get to, combined with formal study day on the day before, childcare arrangements/creche, cost, other

4. Do you think that the ‘radical’ in our name deters midwives from joining?

5. How would you feel if the word ‘radical’ no longer appeared in our name?

6. Can you think of a better name which still reflects our objectives?

Please send responses to: Sarah Montagu, 16 Wytham Street, Oxford OX1 4SU
Winter National Meeting
Saturday, December 9th
YMCA, Midwey House, Wharf Road, Guildford, Surrey

**Registration:** 9.30 for 10 am start
**Main speaker:** Brenda van der Kooy on ‘How the NHS Community Midwifery Model is progressing’ also a speaker on ‘Home from Home Unit, Royal Surrey County Hospital’.
**Workshops:** Angela Horler on parent education; Andrya Prescott on when babies die (IUD)
**Fees:** (including lunch) members £15; students £7.50; non-members £20.

**Directions to YMCA Midwey House, Wharf Road, Guildford, GU1 4RP**
(N.B. beware, take note of the full address, there is another YMCA in the centre of the town)
**From the train station:**
Leaving by the main entrance turn right. At the junction turn left until you get to the main set of traffic lights (big shopping centre ahead of you)
Turn left, You are now on Onslow Street. Keep going. You will walk past several sets of lights and a large(ish) roundabout.
Keep going. You will get to Wharf Road on your left where the cricket pitch is.
Follow Wharf Road to the end and Midwey House is on the left.
**By Car:**
From the M25 Southbound on the A3
You will come in to a 50 mile an hour zone
Take the exit marked Guildford Town centre and A281
At the end of the slip road at traffic lights you turn left (staying in the outside lane)
Then take the right at the next almost immediate set of traffic lights
Get into the left hand lane. You will pass the fire station on left and then get to a major intersection.
Take the left at the intersection into Woodbridge Road A322
You will pass under a bridge and see the cricket ground on your right
Wharf Road is at the end of the Cricket grounds.
**However** you will need to park at the car park indicated just a little further on on the right.
Andrya’s Mobile 07970 473577
Aida’s Mobile 07891 094571
For anyone needing picking up let us know ASAP so we can help arrange it.

**Steering Group**
Friday, December 8th, Angela Horler, 23 Tanglyn Avenue, Shepperton Middx TW17 0AD. 01932 234720
email: ab.horler@btinternet.com

**Directions to Angela’s house**
Shepperton has a main-line station with trains every 30 mins to and from London Waterloo. The station is a short walk from my house. There is also a bus service directly from LHR to Shepperton every hour that stops at the end of the road.
**From M25:**
Leave the M25 at J11, Chertsey and take the exit towards Chertsey/Weybridge/Shepperton.
Take the first exit via the slip road off the dual carriage towards Chertsey. At the 1st set of lights head straight across towards Shepperton. At the next set of lights turn Right towards Shepperton on the B375. You will pass over Cherstey Bridge. At the roundabout head straight across on the B375. After about 1 mile you will see a traffic island – turn left here into Sheep Walk. This will look like it goes nowhere – but keep going and you will pass through some narrow bollards. At the traffic lights turn right (if you are on the right road you will have a pub and a fish and chip shop next to you!) on to Laleham Road. Take the next turning left into Tanglyn Avenue.
**From M3:**
Leave the M3 at Junction 1 Sunbury Cross. Take the exit signposted A308 towards Staines / Shepperton. Pass through the next two sets of lights and move into the left lane (you will have gone past Tesco). At the main crossroads turn left on the A244 towards Shepperton/Upper Halliford.
Keep on this road all way until you come to a roundabout. Take the 2nd exit towards Shepperton. At the next R/B take the 2nd exit onto Green Lane towards Shepperton. Keep on this road, heading straight across at traffic lights on to Laleham Road and over the motorway bridge. Tanglyn Avenue is the first turning on the right after the bridge.
GIFT AID DECLARATION

THE ASSOCIATION OF RADICAL MIDWIVES Registered Charity No. 1060525

I want The Association of Radical Midwives to treat this and future membership fees as Gift Aid Donations, including any qualifying fees paid since 6th April 2000.

Forename: __________________ Surname: __________________
Address: ________________________________________________
__________________________________________________________

Post Code: __________________ Date: __________________ Signature: __________________

Important:
You must pay an amount of Income Tax and/or Capital Gains Tax at least equal to the tax that the charity reclaims on your donations in the appropriate tax year (currently 28p for each £1 you give).

Notes:
1. You can cancel this Declaration at any time by notifying the charity
2. If in the future your circumstances change and you no longer pay tax on your income and capital gains equal to the tax that the charity claims, you can cancel your declaration.
3. If you pay tax at a higher rate you can claim further tax relief in your Self Assessment return.
4. If you are unsure whether your donations qualify for Gift Aid tax relief, ask the charity. Or, refer to help sheet IR65 on the HMRC website (www.hmrc.gov.uk)
5. Please notify the charity if you change your name or address

IMPORTANT REMINDER

In September 2005, membership of ARM was raised to £30 pa. (overseas £35, UK student rate still £12.50).
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 36 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

DID YOU UPGRADE TO THE NEW SUBS RATE?

Many thanks to the many members who upgraded at the beginning of the year, and also to those who responded to the reminder mailings. The response has been encouraging, and I’m hoping the whole membership will be paying the correct membership by the end of this year. Reluctant as I was to make it, the threat to drop laggards off the mailing list has helped, and I’ve had some heartening comments on the renewal forms, e.g.: “Thanks, Ishbel. I couldn't be without my Midwifery Matters”
“Here’s my upgraded standing order, please don’t drop me off the mailing list”
“I’m enclosing a cheque for the balance due this year, and I’ve upgraded my standing order on-line. Can’t bear the idea of being without Midwifery Matters.”
“Thanks for the reminder, sorry I forgot. Just can’t live without MM”.

Ishbel
Membership Secretary
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)

ASSOCIATION OF RADICAL MIDWIVES
STANDING ORDER FORM
To: (Your bank’s mailing address, please use BLOCK CAPS)
________________________________________________________________________
________________________________________________________________________
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 ___________________