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The southwest ARM group has been meeting for almost a year.

We took a long time to come together for various reasons, but when three of us met unknowingly on our home ground at the ARM retreat in Street, Somerset in September 2005 we finally decided we needed to acknowledge our presence and give birth to ourselves…. for discussion, support and maybe to become a force to effect change in the climate of increasingly medicalised and litigious birth…

As a group, we decided that we would only accept paid up ARM members to our meetings. We don’t want to get too dissipated or have to continuously explain or justify our being to people who may not understand where we are coming from.

We currently cover quite a large area of Somerset and Devon and our members are from a variety of settings. There is one independent midwife practising mainly in Devon. There are several midwives from Torbay which has a very high home birth rate and they work as integrated midwives covering community and hospital. There are a few community midwives from Somerset with one who has been in the community for 18 years and has just moved back to the hospital. So far we have only managed to entice one student to our meetings (now qualified!), we hope to attract more.

Everywhere there is a huge amount of change, so there is real variation in our working practices, experience, training…. And of course we have wonderful food at our meetings – which is sometimes all the temptation needed to come! We don’t organise ourselves over food, so we have had one meeting when everyone bought puddings!

We have put together this issue of Midwifery Matters to bring the group together, to support and share our experiences with others, and create discussion. Enjoy!

Jane Tucker
I wanted to write this article because so much is hidden away when we are not feeling on top of the world. There are times when we cannot be the strong, supportive, empathetic, caring midwife. We need time out.

And that should be OK. In a profession like ours people should be encouraged to have six-month sabbaticals every 10 or so years. Working so intensely for so long is unhealthy, and it seems time off sick for burn-out is becoming more commonplace.

I want to share my time of weakness, which has enabled me to grow and become much stronger as a person and as a midwife.

We all know as midwives that Growth/Birth can only come through pain.

My story

I trained as a direct entrant midwife in my late twenties in 1979; I am a feminist, a childless woman with no dependants. I threw myself into the world of midwifery with a passion. I was shocked at how women were treated and at the abusive practices in the maternity system. I had joined ARM before I started my training and the support was invaluable in seeing me through.

I took no breaks, I was aware that if I did I would find it difficult to go back. For 26 years I worked in the NHS, for the last 18 working autonomously as a community midwife – my dream, giving my life up for the women and their families, trying to chip away at and improve the system from within by increasing women’s choice and autonomy in their care. I prided myself on the care I gave women. I felt that midwifery provided the seed from which pro-active community health could grow.

My identity was strongly bound up with being a midwife. It was not a job but a vocation. (Almost verging on an addiction!)

Initially I loved the responsibility of being the sole carer, being a caseload community midwife in a rural area. At first I was working in a unit that was very pro women’s choice, but later I moved to a different area with a much more conventional set-up.

I was working days and nights on call, home births, dominos, being the advocate for women to support their choices, particularly when they went against local guidelines, and finally I had the added exciting responsibility of setting up the local Sure Start midwifery team, networking along with other community organisations to create a supportive network for new families in this rurally impoverished area.

However, on top of this, there was more and more pressure from above reducing midwives’ autonomy: increasingly medicalised care; prescriptive NICE guidelines; risk management strategies designed to fend off litigation; accountability; computerisation. All these management issues were being dumped on midwives and, when coupled with financial cutbacks, the net result was less time to give adequate midwifery care to women. Instead of supporting midwives, management was becoming more and more constrictive. It all took its toll.

I was asking for help but no one had time to listen. I received minimal support.

In retrospect, after fighting the system for 26 years, I’m surprised I didn’t burn out faster.

It was a dear friend who challenged me about my state of health and questioned whether I was fit to be working. I responded in terms such as, “I’m just holding it together,” or, “I’m feeling just about to crack,” and these words said it all. My mind was continually racing and I couldn’t sleep.

I thought I could battle on, as I had been doing for so long. I agreed to go off sick during my annual leave so I wouldn’t let anyone down! A few days off and I would be back, I thought. I had a monumental feeling of guilt for letting my colleagues and clients down by being off sick.

Eventually my body took over in a hard-hitting way – emotional breakdown.

Physical or emotional breakdown can happen to any or all of us if we are not paying attention to our needs. I was finally forced to face up to what my needs were.

When we are depressed, burnt out, broken, we often become isolated or isolate ourselves. I was embarrassed by the broken tearful state I was in. People do not rally round in the same way they do when you have a physical ailment. My vulnerability even made it impossible to attend ARM meetings, where I would have received support.

In my isolation I continually questioned how much the fault lay with me. All my supporters and counsellors at home were clear that this was not the case, however I was made to feel by my managers that I had a mental health problem. Such was their lack of empathy, support and emotional illiteracy.

I have seen too many midwives, of all ages and capabilities, just ‘disappear’. Is this the reason why? Where is the support framework within the system?

Luckily for me, I have come through it with a lot of support from my partner, friends, a sympathetic GP, shiatsu, therapy and wonderful occupational health counsellors. As
so many others have told me before, the RCM was of little support. (I have since joined Unison and am already an active workplace contact).

I was off work eight months, back for six months, then off for another three months. I had hardly ever been off sick at all before. In retrospect I needed that time — and thank goodness that you can have six months off on full pay. But it shouldn’t have to come to that.

Everyone’s story is different. It is never just to do with work — home stuff and childhood all contribute — but working as a midwife giving care to others all the time with the intensity of emotional and physical pain of birth and death takes its toll.

I still find it unbelievable that working in the health service there is so little caring for the staff within.

Despite the incapacitating emotional distress and torturous anger I went through, for various reasons I am still working in the NHS maternity service.

It has taken me two years to rebuild my trust, confidence and skills as a midwife. I now work on my terms, in a mainstream maternity hospital, giving care to the women and families I am in contact with when I am there. When I finish work, I am off, having handed care over to others. It is a huge change but I am happy. I feel much more respected and appreciated for my skills by other members of staff and students, as well as by women. It feels such a relief not to be the sole midwife taking responsibility for a caseload, being on call, working days and nights… at the beck and call of so many people.

I do not feel guilty about not propping up the midwife shortage, and doing extra shifts.

I have put my time in; if the support had been there when I needed it, I would still be doing caseload midwifery. But now it is time to move on and let others, hopefully, more enthusiastic, midwives take on the role.

Having had time off to reflect and heal has been incredibly important to who I am and how I work. I know I am a good experienced midwife. I now work on my terms.

I am glad to be still working in midwifery where I have a huge amount to share. I now live my life alongside being a midwife.

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Teaching Old Dogs New Tricks
Karen Frost

I thought I would just share my story with you to demonstrate that given the right environment and attitude anyone can change their practice.

I first qualified as a nurse in 1986 and then as a midwife in 1991. Gradually, I worked up the pecking order and gained many friends and much respect along the way. I was a highly regarded midwife who was frequently given the most challenging women to look after. In fact, one night I ‘delivered’ a baby of 28 weeks gestation and then went on to ‘deliver’ twins. That was a normal shift. I went on the high risk study days and could respond quickly and calmly in an emergency. Fantastic, it was such an adrenaline rush!

However, I was aware that something was missing. I wasn’t quite sure what it was but I am aware that I became burnt out. I could no longer work out what ‘normal’ was in labour and I queried each and every event when caring for women.

Then, because of my husband’s job, we moved to Devon. I got a job at Torbay Maternity Unit and saw a side of midwifery that I had only glimpsed before. Women not only gave birth, but they did it on the floor, on stools, even standing if they wished. These were totally new experiences for me. At my previous hospital we used aromatherapy, but couldn’t understand any midwife or woman who wanted to do things a little bit differently, but here women were being encouraged to have an active birth. This was exciting; I had some wonderful experiences.

However, even this was eclipsed when I became a community/integrated midwife. I then found what I had been missing during the previous 12 years. Women are actively encouraged to give birth at home, I had never previously been to a home birth, let alone been the midwife supporting a woman in her own home. My first experience was with a primigravida and during her labour I realised that babies are born not delivered — she was fantastic! I felt fantastic — it gave me a such pleasure. It sounds corny but I felt like a newly qualified midwife with the renaissance of excitement. Integrated midwifery isn’t perfect, it is often hard and tiring and sometimes quite daunting. And the system can sometimes let you down but because I have experienced another form of midwifery I know which I prefer. I still keep myself updated on emergency drills but at the same time I am keen to find different ways to help a woman get through labour. I also have great support and encouragement from my new friends and colleagues. In fact, my former colleagues wouldn’t recognise me now, scrabbling around on the floor, sitting patiently waiting for the baby to be born. However, this is all within an existing system and I can fully understand how midwives get swept along within the organisation they are working within and find it difficult to break out. Hopefully my brief story will inspire and demonstrate that it is possible to ‘teach old dogs new tricks’ and that I am now practising real midwifery being ‘with woman’.

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I finished my midwifery training last autumn; started my motherhood training last year and am currently retaking my pregnancy training. I have always been slightly sceptical of the sweeping dietary ‘advice’ given to pregnant women, particularly that concerning ‘foods which should be avoided’. As a passionate scrambled-egg eater and someone who has only ever (knowingly) had food poisoning abroad I have always felt that I need more information about the true risks of a home-made chocolate mousse before I abstain altogether.

This article will look specifically at the advice given to women about avoiding salmonella and listeria infections whilst pregnant.

The concept of ‘informed choice’ is now ingrained in the maternity services, in sentiment if not reality. With regard to a pregnant woman’s diet however, the ‘choice menu’ has fewer options than McDonalds. Women ‘SHOULD NOT’ eat this or that or the other. Even the otherwise balanced Informed Choice leaflets (MIDIRS, 2005) and recent articles in the RCM Journal (Williamson, 2006) and the Practising Midwife (Ford, 2004) convey the same poorly referenced messages. The professional version of the Informed Choice leaflet on Diet and Nutrition during Pregnancy has no references at all for any of the items on the foods to avoid list.

The consultant midwife at one of the hospitals where I trained called such dietary dogma: ‘social control of women’, a view which may seem extreme until you realise that the list of research into these infections in pregnancy is as short as the list of foods to avoid is long. You too may find it ridiculous that many women will avoid a grape and brie sandwich (or worse, eat one and feel guilty) at the start of their pregnancy and then will have a couple of shots of what is essentially heroin at the end of it (in labour)!

Merely providing women with a list of ‘foods to avoid’ also leaves many questions unanswered:

? Is there a greater risk at certain times in the pregnancy?

? Is an infection from these bugs dose related? i.e. can you have a spoonful (or two or three or four…..) of raw cake mixture and not worry?

? Does it matter if you are used to eating the foods which could be problematic? Anecdotally, French women don’t usually bother to avoid soft cheeses in pregnancy because they are so accustomed to eating them (though they are also tested for listeria as part of routine antenatal care).

? (And one for those amongst you prone to guilt…) Is it possible to have had an infection and not realize it? i.e. could you harm your baby as a result of the consumption of several pieces of feta cheese without knowing you’d been ill? One of the tutors on my course told me that this was possible and I genuinely worried throughout my first pregnancy that I may have caused the fetus some brain damage due to a hastily chosen Greek salad (ahh, the responsibility of being pregnant).

Let’s start with Salmonella (as they might say in a dodgy foreign café…)

Salmonella is the name of a large (and anti-social) family of bacteria which can be found in poultry, eggs, unprocessed milk, meat and water (so that’s just about everywhere then). It causes the sort of illness typical of food poisoning: diarrhoea (or constipation), nausea and vomiting, stomach cramps, etc. Pregnant women are given advice on general food hygiene and, more specifically, are advised to avoid raw or undercooked eggs. This is said to reduce the risk of becoming ill with a salmonella infection.

How likely am I to have a garnish of salmonella with my runny omelette?

Nowadays more than 80% of eggs sold in the UK come from chickens which have been immunized against salmonella (specifically salmonella enteriditis). This includes all supermarket eggs and also eggs from other commercial egg farms in the UK. (The situation with foreign eggs, especially those from Spain, is different – but these are mostly only used in catering).

In 2003 the Food Standards Agency (FSA, 2004) tested a total of 28,500 eggs to discover the occurrence of salmonella. Guess how many eggs were contaminated? Several thousand? Several hundred? 50? 10? No, it was NONE! Not a single egg had salmonella inside. However for those of you who are fantastically cautious they did find some salmonella bacteria on nine of the shells. In other words, it is more important to wash your hands after cooking with eggs than it is to make sure you cook them properly. Even so, nine eggs out of 28,500 means about 1 in 3,000 chance of finding a bug in your blackcurrant sorbet. Now, I like my eggs an awful lot but even I would be hard pushed to eat 3,000 of them in a single pregnancy (about 11 per day…).
So…if I forget to wash my hands could I still be risking harm to my baby?

This is the curious part. The clear cut advice to avoid raw and undercooked eggs makes it seems very likely that contracting salmonella will seriously harm your baby. However a web trawl reveals this belief to be misplaced. ‘Salmonella isn’t likely to have a direct adverse effect on the baby, but it is best avoided’ (Hicks, 2005, from the BBC Health website). ‘Although unlikely to harm your baby salmonella should be treated with caution (!)’ according to The NHS Direct website (2006) (my exclamation mark). I wonder exactly how one should treat invisible bacteria – which probably aren’t there anyway – cautiously. There is very little research or evidence on the harm that potentially could be caused to your baby by a serious infection. One piece of research (Benshushan et al, 2002) states that salmonella infection can cause stillbirth – but the research piece is about listeria and the statement is un referenced.

Let’s have Listeria next…

Listeria is a different petri-dish of bacteria altogether. An infection with the bacteria listeria (most commonly listeria monocytogenes) causes ‘listeriosis’ which can be more serious than salmonella. You are likely to suffer from an assortment of the following: fever, chills, muscle aches and diarrhoea. According to the BBC website (Hicks, 2005) the infection can cause miscarriage, stillbirth or severe illness in the newborn baby. Listeria bacteria lives in soil and water and can be found in unpastuerised milk and cheeses, raw meat and processed meals and salads. The general advice such as that given in the NHS’s free ‘Pregnancy book’ is to avoid all mould-ripened soft cheeses such as Camembert, Brie, Stilton and Danish Blue. What is unclear is whether these cheeses are acceptable if pasteurised (as are many English bries) or whether the method of production still puts them at risk of contamination. The American ‘Centers for Disease Control and Prevention’(2005) state that cheeses are ‘permitted’ if they are pasteurised. This isn’t made clear in any British advice. A blanket approval of hard cheeses is normally given, though fresh Parmesan is nearly always made from unpastuerised milk, so is it a goody or a baddy? Listeria bacteria are also killed by cooking, which is why the advice on how to avoid them concerns avoiding poorly cooked meat (beware of barbecues!), and badly reheated chilled foods. Women are also advised to avoid pâté and packaged salads such as coleslaw. Listeria bacteria certainly seem more powerful than weedy salmonella. On a hospital scale of power, listeria is the consultant whilst salmonella seems to work as the maternity assistant…

How common is listeriosis?

The NHS Direct website (2006) admits that listeriosis is rare in this country. So rare in fact that there is very little research on the subject of listeriosis in pregnancy. The 41 articles written in the last 15 years listed by the MIDIRS search engine include many case histories (a sure sign that there aren’t enough subjects to do any quantitative research) and mostly neonatal case reports. There are no pieces of controlled research listed on the Cochrane Database using ‘pregnancy and listeria’ as search terms and only 17 (out of just under 500,000) pieces which contain the word listeria and none of these concern pregnancy.

The Patient Plus website (Tidy, 2005) states that listeria affects 6-15 pregnant women per 100,000 (though it omits a research reference for the statistic). One study looked at 65,000 women over a 10-year period and found 11 cases of listeriosis (Benshushan et al, 2002). This resulted in: 2 late abortions, 4 caesarean sections for fetal distress, 4 premature labours and 1 neonatal death at term. This research is quoted as showing that 20% of women who become infected with listeria will suffer from late abortions (or stillbirths) which is a frightening statistic until you realize it only means two women out of 65,000. However this research took place in Israel, which may well have a different listeria risk to the UK. Calculator to the rescue, I found that these statistics equate to one case of listeriosis in between 6,000 and 17,000 pregnancies. If we consider that there is approximately a one in 10,000 chance of dying in childbirth, it makes soft cheese look a lot less frightening.

There has been a suggestion that the reduction in cell-mediated immunity during pregnancy makes women more susceptible to infections such as listeriosis. The American Centers for Disease Control and Prevention state that pregnant women are 20 times more likely to contract listeria than other members of the population. But guess what? This statement is un referenced (but often quoted) so we can’t be sure of its accuracy.

Of course, one could argue the fact that listeriosis is still very uncommon obviously means that the advice is working! However that ignores the thousands of women who are pregnant without realising it (which let’s face it is everyone for a while…); the women who inadvertently eat something that they didn’t realise was on the forbidden list; and those who carry on as usual because they can’t believe something they’ve eaten every week for that last 20 years with never so much of a burp of indigestion is suddenly going to result in a nasty illness.

The even better news!

If you are pregnant and suddenly come down with a flu-like illness with a high temperature and you or your doctor is clever enough to guess that it might be listeriosis (several articles have stressed the importance of considering a listeria infection if the woman presents with such symptoms) then you can be treated with antibiotics and this is often successful. Apparently the fetus can even be given antibiotics in utero (Silver, 1998).

In answer to the four questions near the start of the article:

A The risks do not appear to vary throughout pregnancy, though the result of a bad infection with either group of bacteria will obviously vary according to the stage of
pregnancy, i.e. a woman infected preterm could experience premature labour whereas a woman infected at term may need a caesarean section for fetal distress.

There appears to be some evidence of a dose-related risk of catching salmonella though obviously not from eating raw cake mixture! (So long as the eggs are from a reputable UK source…). Due to the shortage of research into listeriosis I can’t find any evidence of a dose-related risk though intuitively there would be one.

It seems highly unlikely that an infection by either salmonella or listeria would pass unnoticed (see also below).

So, could the advice be changed?

I would like to hear fewer ‘shoulds’ in the course of offering what is dubiously called ‘advice’ about diet. When it comes to home birth we seem unable to say: ‘home birth is safer than hospital birth’ and we hedge our bets with the woolly phrase: ‘there is no evidence to suggest that hospitals are a safer place to give birth’. Equally, we seem unable to say: ‘raw eggs are now safe to eat in pregnancy’. But really, how many tests on how many eggs need to be done? The Food Standards Agency found no salmonella bacteria inside nearly 29,000 eggs in 2003. There used to be a problem and the egg-producers have overcome it with poultry vaccination programmes. If you need a caveat it could be that the eggs need to come from the UK.

With regard to listeriosis, this is a very rare illness in this country. If a woman is particularly anxious, then the advice may be appropriate for her, as for other women, they might like to carry on as before and be reassured that the risks are very low. If they are still worried they can be reassured that cooking kills bacteria so they can have their stilton as a meal ingredient (properly) cooked.

In my opinion the most important point for women is reassured that cooking kills bacteria so they can have their stilton as a meal ingredient (properly) cooked.

In opinion the most important point for women is that they need not worry if they have eaten anything that they later discover was one of the ‘forbidden’ foods. If they have not been ill then they have not been infected with either group of bacteria. These do not seem to be illnesses that can be caught without realizing it. You can reassure women that if they have enjoyed an extra large piece of ripe stilton on a digestive biscuit on Christmas Day (as I intend to) and were fine afterwards then their baby will not be born with two heads as a result.

Pregnancy can often be a period of anxiety – Arghh, will my body ever be the same again? – Crikey, is the baby okay? – Help, how on earth is it going to come out of me? – so much so that minimizing a woman’s worries must be one of a midwife’s priorities. If they can do this by being a little less frightening about the danger of certain foodstuffs this would be a start.

All this writing has made me hungry – can I get anyone some home-made (and guilt-free) cheesecake?

Tessa Dean qualified as a direct-entry midwife in September 2006. Thanks to the reduction of vacancies at the local hospital and the expansion of her abdomen due to baby no.2 (another homebirth in February, hopefully), she hasn’t yet worked as a midwife…

REFERENCES
Cochrane Database available from: www.thecochranelibrary.com
Unilateral Breastfeeding
Terri Bate

TORBAY is often praised for its high home birth rate and woman-centred care, but one thing we lack is a designated lactation consultant, or breastfeeding coordinator – someone with the time and energy (and remuneration!) to help us through the Baby Friendly Initiative hurdles. Failing this, we struggle on to provide breastfeeding training for all the staff and to follow the WHO/UNICEF ‘Ten Steps to Successful Breastfeeding’. Most midwives attending our breastfeeding training acknowledge that coverage of breastfeeding in our basic training was scant, and health visitors have had even less. When confronted with breast feeding problems outside the normal range we have no expert to turn to for advice, so we rely on text books and reference materials like the comprehensive La Leche League Breastfeeding Answer Book (Mohrbacher and Stock 1997) – and we even resort to posting a query to the ukmidwifery mailing list. We also learn from reflecting on practice and experience and, of course, from the mothers themselves.

Not long after I qualified, I cared for a woman who had numerous problems with breastfeeding her first two children. She had sustained an injury to one breast as a child, and this breast developed mastitis and abscesses which continued to cause trouble for months after each birth. Breastfeeding was traumatic and painful because of this and the woman ended up requiring several courses of antibiotics. Eventually, through trial and error, she learnt to leave the afflicted breast well alone and feed her last two children unilaterally and successfully with no problems. And this was how I discovered that unilateral breastfeeding was possible.

More recently, a midwife colleague related her own breastfeeding story to me. Her first child had shown a preference for one breast over the other – gradually, perhaps because it was easier, especially at night, and because the milk supply in the rejected breast slowly dried up, this mother progressed to feeding unilaterally – and has gone on to successfully feed all her three children on just the one breast. She does not know why her children preferred just the one, and she looked a little lopsided until the children were weaned, but breastfeeding unilaterally was successful.

Reflecting on these two examples led me to explore the phenomenon of unilateral feeding further. I was surprised to discover that women from the fishing villages around Hong Kong, by custom, breastfeed their children from the right breast only.

If breastfeeding helps protect against breast cancer, how would this affect the woman who breastfeeds unilaterally? Interestingly, one study showed that the unsuckled breast is more likely to develop a carcinoma if it has never been suckled, but that there is no statistical difference in the laterality of breast cancer where women have for convenience primarily fed more off one side than the other (Ing et al 1977).

Likely causes for unilateral preference.

It is thought unlikely that any baby would choose to nurse from one breast on a whim. Likely causes for unilateral breast preference might include an underlying medical condition that makes the baby uncomfortable lying on one side. Examples include congestion in the nose, an ear infection, a hernia or a birth injury such as a fractured clavicle or misaligned neck vertebrae. Depending on how the baby was lying in utero, neck muscles may have to loosen up before he can freely move his head, which may lead to a positional preference.

On the mother’s part, she may have flat, inverted or anatomically larger or smaller nipples on one side which may influence a baby’s preference. Again the milk may let down at different rates on each side and a baby may prefer the side where milk is available at a quicker or slower rate.

Breastfeeding can be problematic after any surgery or injury to the breast. After mastectomy unilateral breastfeeding should work well and provide sufficient milk to feed one baby, however, a breast that has been treated with radiotherapy is unlikely to produce enough milk.

If the mother has undergone surgery or an injury, check where the scar tissue lies – if milk ducts and/or major nerves are not cut or damaged, milk supply may not be affected. If the incisions are located exclusively in the fold under the breasts then the outlook for breastfeeding is good. If the incisions are found near the armpit and the surgeon took good care to avoid the major nerves then breastfeeding will probably not be affected. If the incisions or scar is around the areola there will almost always be some cut milk ducts and possibly nerve damage too.

Nerve damage can be indicated by loss of sensation in one or both breasts which in turn has a detrimental effect on the let-down reflex and milk ejection. A lack of sensation can prevent nerve signals being passed from the nipple to the pituitary gland. Adequate stimulation is required to stimulate the let-down reflex and the release of prolactin and ultimately to maintain milk production.

If a woman’s nipples are injured, for example, following a burn, then her ability to breastfeed will depend on how well milk passes through them. The only way to find out is to try, and some women may find this painful.

The ability to express colostrum during pregnancy is NOT a good indicator (unless of course it works) as many women who can’t express colostrum go on to breastfeed well.

Any woman who has undergone surgery or sustained injury to a breast may well have confidence issues when it comes to breastfeeding her child; she may blame her breast injury for other unrelated setbacks in the
breastfeeding process, hindering resolution of the current problem.

Beware: if a baby has been breastfeeding well off both breasts for some weeks and suddenly and inexplicably refuses one breast, that breast should be checked out by a doctor. Goldsmith (1974) documented several cases where the breast refused was discovered to have a tumour present, several months later.

A less alarming cause for a sudden preference for one breast could be the heavy use of a spray deodorant under one arm, or perfume. It is certainly more easily resolved – wash the breast carefully and perhaps switch to a roll-on or stick deodorant.

**Other possible solutions**

It is desirable to have the baby feeding from both breasts – cosmetically, the mother is less likely to develop one larger breast. Also there is less likely to be soreness if both breasts are used. It may, however, take much perseverance and patience to encourage a baby that has an expressed breast preference, but eventually most babies should learn to accept both sides.

Where there is scar tissue, the mother may have engorged areas in a breast that do not soften after nursing. It is likely, in this case, that one or more ducts have been cut or blocked and the milk cannot get through. Even if the mother continues to breastfeed, within a few days, these areas should return to normal as milk production in the affected areas dries up and the milk is reabsorbed by the body. Cold packs can help reduce the swelling until this happens, and mothers should be offered analgesia compatible with breast feeding. There have been cases of duct ‘recanalising’ or growing back, according to *The Breastfeeding Answer Book*.

Mastitis can make the baby refuse the breast, perhaps because it is harder to remove the milk, or the areola is ‘tight’ – but also possibly because the taste is ‘salty’. Saline and chloride are higher in breasts where mastitis has occurred (Thullen 1988). If this is the problem, the taste will return to normal within a week of the mastitis being cured – if the baby refuses that breast in the meantime – express milk from the breast as often as the baby would have nursed.

‘Slide over’ technique

Persuading the baby to nurse on the less preferred side takes patience. Use the ‘slide over’ technique – where you start on the preferred side and after let down occurs and the milk is flowing, slide the baby across to finish feeding on the other breast. So if the baby is in cradle hold, the baby will be slid into rugby ball position, tucked under mum’s arm on the other breast.

If the ‘let down’ is bothering the baby – then get the milk flowing first. If the milk flow is too slow, starting the baby on the preferred side, as above, should solve this. If the ‘let down’ is too vigorous, then start the milk flowing first, by hand expressing, so the first milk is let down into a towel or similar and will have slowed before the baby latches on.

Try different positions besides the cradle: rugby ball, lying down, even upright with the baby astride mum’s thigh. Try latching the baby on when he’s sleepy or drowsy, or when he’s being rocked, moved around, or in a darkened room. All these are distractions which just might take the baby’s mind off the fact that he is feeding off the less preferred breast.

Regular expressing will help maintain milk supply if the baby refuses, until latching on is successful.

If the nipple is flat or inverted, there are treatments to draw out the nipple that can be followed – some women may do better to begin these during pregnancy.

If, at the end of the day, you don’t manage to find a successful tactic, reassure the mother that it is possible to feed unilaterally. She may be a little lop-sided while breast-feeding but this will return to normal once her baby is weaned. She may find the baby feeds more often off the one breast to begin with. If milk supply is a concern: check that the baby has at least 6-8 wet nappies a day (4-5 disposables) and 2-5 bowel motions (fewer bowel motions are normal in a baby older than six weeks). Frequent nursing combined with expressing after each feed is the best way to boost production. If, after the milk comes in, there are fewer wet and dirty nappies than this despite effective suckling and frequent feeds, then the baby may need supplementary feeds.

The main point of this musing has been to confirm that women can and do breastfeed unilaterally quite successfully, for whatever reason, and I hope it has been of interest, even to those who knew this anyway.

**Terri Bate** is a midwife with the Moorland Midwifery Group Practice, Devon

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Jennifer's Arrival
Tessa Dean

I had always wanted to give birth at home. I was born at home myself and it seemed like a sensible option. My hospital experiences during my recently completed midwifery training confirmed my belief. When nervy and misinformed types would say, "Ooh, you’re brave to have a home birth", I could confidently correct them: in my opinion the bravery awards belong to the women who choose hospital for their birth experiences.

On reflection, achieving a homebirth is the culmination of a nine-month long obstacle course. First of all there's the booking with the medical and obstetric history hurdle (over which I flew). Next, one has to maintain acceptable blood pressure readings, satisfactory urine results and the haemoglobin hoop needs to be jumped through at regular intervals.

I passed the pregnancy section of the course with flying colours (though I felt the opposite of aerodynamic by the end, I can tell you…) but it was still unclear whether the final section of labour and birth would be achievable. Of particular concern was the ‘water jump’ (i.e. would there be meconium stained liquor?). In order to be fully informed I posted a question on ARM’s ukmidwifery list on the web and received several helpful replies. Mary Cronk has given me permission to quote her entry (as clear and concise as usual) here:

Dear Tessa, meconium stained liquor is only to be regarded as sinister in the preterm fetus and in my opinion is not a reason to advise transfer in the term or post-term labour. It is a reason for increased vigilance and if there is any concern about the fetal heart then perhaps transfer should be considered. It would depend on other factors like the stage and progress of the labour. See the chapter on ‘Meconium’ in Lesley Page’s book, The New Midwifery.

Regards
Mary

I felt ready for whatever final challenges I might encounter in the labour portion of my obstacle course….

Here's what happened:

It was a Thursday evening in February and I knew 'things' were starting. At term plus two, this was welcome. I began having regular contractions in the afternoon and a trip to the supermarket in the evening (stocking up on biscuits and nice things for the midwives which I never remembered to offer – though at 6 am they might not have been that gratefully received, anyway) was enlivened by the frequent need to stop and bend over as I experienced stomach cramps and shooting leg pains as well.

Anything to improve the usual supermarket experience was welcome, particularly the likely imminent arrival of the large stowaway in my hold.

A large supper was followed by a show (The Sound of Mucus perhaps!!) and I excitedly phoned some friends from my course to let them know the news (and allow them to organise their sweepstake for the possible time of birth). I also phoned another student-midwife friend, Christine, who was going to be with me during the birth to warn her she might get a call in the night. As an Antipodean, who is capable of asserting herself in a particularly non-English way, she was to be on hand to manage any 'differences of opinion' which might have arisen between myself and the midwives. I also let my Mum (who was joining us too) know of my progress. (Contracting uncomfortably every 15 minutes or so.)

You might well imagine that we lived in a large house with plenty of room for the extensive audience I had invited (I even invited our elderly neighbour because she expressed a wistful longing to witness a birth – but she happened to be on holiday at the time), but in fact our rental house was tiny and was already four-fifths filled with a cattle drinking trough of truly bovine proportions. This had been borrowed from a friend of a friend who had given birth to the last four of her six girls in it. Her ingenious husband had fixed up a detachable heater and it made a large, solid birthing pool.

A usual bedtime routine was attempted and Neil, my other half, managed to get 40 minutes of sleep but only after I had stopped leaping out of bed every quarter of an hour to pace around and had gone downstairs to start filling the pool. During a discussion with my midwife about the possibility of meconium-stained liquor she had mentioned that the blackness of the pool would probably mean that the colour of the fluid couldn’t be ascertained anyway. This, it has to be said made me extra keen to get into the pool as soon as possible. Only, you understand, to avoid any potential disagreement between me and the midwives with regard to ‘the need to transfer’.

Using large quantities of hosepipe and small amounts of ingenuity the pool was filled via the bath upstairs.

At about one in the morning we decided to watch an episode of Sex and the City, this had been a nightly routine (though usually a lot earlier) for some time and we had been through the whole series again, ironically having only the final episode of the final series left to watch again. This seemed appropriate, the end of Sex and the City for both the four girls in New York and the two of us in Taunton (don’t worry, it was only temporary, I’m pregnant again now…).  

…more contractions (2 in 10) …By about 04.00 I’d wallowed for some time and was now finding it necessary to run around the room and hang off the banisters during the peak of the pain. A sick bowl was called for desperately but remained unused. Neil started to wonder if I
might want to call the midwife soon... I phoned Christine first (she was making the trip down from London), then my Mum and then eventually called the hospital at about 05.00. A quirk of fate meant that the midwife who answered the labour ward phone was the only midwife I knew who worked in the hospital. She used to work on a community and had taken my booking, where we discovered that she had trained at the same college as me in London and had also chosen to move west. 'What's it like being in labour?' she asked (she was pregnant herself at the time). "Well, I'm making all the same noises that the women do," was all I could reply.

...more contractions (3-4 in 10) ...more wallowing... A midwife whom I hadn't met before arrived at about 06.00. My birth plan was vague and attempted to look 'reasonable' in order to not be considered awkward. Nearly all my requests were worded similarly: 'I would not like to be examined vaginally unless I feel that labour is taking longer than I expected; I would like a physiological third stage unless... etc...'. The midwife read it and said that because I didn't want any VEs I would need to let her know exactly what I was feeling in order to call the second midwife. I said I thought I was probably somewhere between 5 and 10 cm dilated. This was recorded in my notes as: ...feels she is between 5 and 10 cm dilated! Accurate, yes, but what was with the exclamation mark? Did it mean, 'Don't be ridiculous you're probably still in early labour'? Or was it, 'Thanks very much but that is such a wide spread of dilatation (so to speak) that it doesn't help me at all...' 

...more contractions (3 in 10) ...more wallowing... more spacing out... more back-rubbing... By 9.30 I was starting to make bearing down noises during contractions. The midwives felt that the contractions were slowing down and I should get out of the pool and start 'mobilising' (walking around to you and me). The wallowing was over, the pacing had begun. I paced up and down the stairs and around and around and around the sitting room (a small room, remember), at times I paced on the spot (as requested by the midwives), during which time I bore a strong resemblance to a circus elephant according to my mum. [My mum used to tell me that giving birth was no worse than having a headache. I reminded her of this whilst I was pacing and how I had to say that I disagreed quite strongly. But it was over a lot quicker.]

...more contractions (5 in 10) ...more pacing...more stairs...more back-rubbing...more bearing down... At 10.30 the midwives asked if they could do a VE as they wanted to make sure I was fully dilated. I was. Ten minutes making lots of noise by 'ohhing' throughout every contraction. Sometimes in the spirit of amusement (I felt that I may would have approved) I would say 'o' is for orange or 'o' is for opening which I thought highly appropriate.

Once the labour was over I decided that the whole experience was in many ways like a large, drunken night out. Everything seems as clear as crystal at the time and then as blurry as the view through the bottom of a pint glass the next day. Conversation which seems witty and clever in the warmth of the night seems dull and silly in the cold light of day. You feel fully in control, but then realise you weren't. There are some differences however: when you're out on the town (and single...) it's all about pulling but when you're in labour it's all about pushing! And on a night out you might get champagne, in labour you get real pain...
later some vertex was visible. If I was on the stairs and a contraction came I would sprint (like I said, one’s memory isn’t always the best) up into the bathroom to sit on the loo where I could then procrastinate as long as possible using the need to wipe my bottom as the excuse to stay where I was. (A tip here for anyone who has their mother in attendance during labour – under no circumstances let them wipe your bottom, you will regret it was one of the most memorably painful parts of the labour). This desperate need to sit on the toilet led to a weak imitation of some slapstick comedy which occurred twice: I would run (okay, amble determinedly) into the bathroom and Neil’s shirt which someone thought I needed to wear because I was cold (apparently), would get caught on the door handle; like a drug addict, my need to get to the toilet was so great that I would have to throw off the shirt in a panic in order to be satisfactorily seated in my preferred pushing position for the peak of the pain.

...more contractions (3 in 10)... more pacing... more stairs... more back-rubbing... more bearing down... more pushing... By 11.30am I was really pushing hard downstairs. I found the Muslim prayer position the most helpful and would throw myself down onto the floor, push my head into the rug and pull determinedly on my hair with both hands. It was obviously instinctive. Other pushing episodes were spent standing and leaning over the back of a chair. The next day my thighs clearly thought they had run a marathon and hadn’t enjoyed the experience. I was making a lot of noise by this stage, something modelled on Eastern European weight lifters I think. Neil asked afterwards if I had intended my grunting and groaning to attract wildebeest to the garden as large hoof prints were later found on the lawn...

...more pushing... more pushing... more pushing... The worst bit was when one of the midwives ran her fingers around the introitus as the head was emerging. I would leap several feet in the air, cry ‘what are you doing?’ and as Christine pointed out to the midwife I would then suck the baby back up inside me. It happened several times. Note to all midwives: please don’t do this, it’s agony.

11.50 am Birth of a baby girl. Thank goodness!! I had done it, now could I lie down and sleep for a couple of months please? Oh, first I’d better have a lovely cuddle with my sweet new baby (with her very pointy head from all the pushing). A ‘physiological’ third stage followed though it was written up in the notes as ‘placenta delivered by controlled cord traction with Tessa pushing’ which I understand is neither physiological nor safe... And then I was ready to lie on the floor. Which I did for some time. The GP arrived to do the baby check and was ushered away by one of the midwives who didn’t recognise her. The other one had to run out and drag her back, the GP then had to step over Christine in the hallway making placenta prints, which probably surprised her a little... When the last midwife wanted to leave I was still lying on the floor and still unable to stand up so I was lifted onto the sofa and immediately felt much better. Christine cooked us a delicious and most welcome lunch and then headed away.

I’d done it!! I felt so proud. I texted and phoned everyone. Neil and I spent the rest of the day on the sofa cuddling our new baby (who was still nameless at that point). The experience was just what I wanted though the labour I considered deeply unpleasant. Nonetheless, I
never, ever felt the need for any pain relief in addition to Neil, Christine, my Mum and the two midwives, their excitement, their back-rubs, their warm words and their confidence.

One of the midwives said to me later, ‘you would have been ‘a forceps’ if you’d been in hospital, you know.’ In my mind this was the reinforcing icing on the home-birth conviction cake. And exactly why I hope to be able to stay at home again for this birth…

This time though I’m going to get a pool which hasn’t quenched the thirst of any cows in its previous life and I’m going to attempt to stay in it until the end…

Many thanks to all the midwives who looked after me when pregnant and afterwards, especially Lou Dalrymple, June Grant and Jill Edwards.

See page 7 for Tessa’s biog.

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**Edible placentas**

Adapted from the poem ‘To say that worms were edible’ [author not known on Google, happy to acknowledge if identified, Ed]

To say that placentas were edible
Might seem to you incredible
Yet women eat them everyday
They birth their placentas and shout ‘Hurray’
They gobble them with joy and pride
But do they get upset insides?
The moral here is plain to see
What pleases others may not please me
What pleases me to them is hateful
And for this fact we should be grateful!

*poems by Jo White*

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**A busy night’s work**

It was a cold and frosty winter’s night
Even Father Christmas was out of sight
All was quiet and nothing stirred
Except for the midwife whose pager was heard
Off she drove into the cold
And was welcomed into the warm family fold
The midwife rubbed her hands with glee
For this woman was a quick para three
A home waterbirth to the midwife’s delight
Except when the presenting part came into sight
A breech with testes all swollen and tender
Was born at home in the family bender
So into the world comes another life
Thanks to the skills of the caring midwife
MCAD and the neonate
Jo White, Midwife, Torbay Hospital

What is MCAD?
Medium chain acyl-CoA Dehydrogenase (MCAD) deficiency is described by Carpenter et al (2001) as “a fatty acid oxidation disorder with significant mortality in undiagnosed patients.” As mitochondria fatty acid oxidation is an essential source of energy, patients with MCAD will present with symptoms similar to hypoglycaemia. They may also show signs of hepatic encephalopathy. MCAD is the commonest disorder of mitochondrial fatty acid oxidation.

Symptoms and Diagnosis
MCAD is often detected between 3 months and 6 years of age; however, 13% present with symptoms in the neonatal period. Symptoms include fatigue, reduced exercise tolerance, muscle pain and increased weight gain. Some patients remain asymptomatic. 21% developed disability after diagnosis; this may be as a result of episodic hypoketotic hypoglycaemia.

The overall mortality rate is between 22-25%. In one case study the 3 day old neonate had remained asymptomatic, breastfeeding well with changing stools. The baby collapsed in hospital and could not be resuscitated. On post-mortem the blood sugar levels were untraceable as they were so low, hepatic changes were present.

The incidence of MCAD is 1:40 000. It is more common in northern Europe. It is an autosomal recessive inherited disorder.
MCAD is diagnosed through DNA analysis and urine organic acids. Diagnosis significantly reduces morbidity and mortality.

Management of MCAD
The initial treatment for MCAD is to correct the hypoglycaemia. MCAD can only be managed by avoiding periods of starvation and minimising risks of hypoglycaemia. High risk situations such as diarrhoea and vomiting would necessitate early admission to hospital for IV fluid replacement. Parents of children need to ensure they keep a good supply of fluids and food at all times i.e. on long journeys, day trips out etc.

Impact of MCAD on the family
Once a diagnosis is made on one child the rest of the family will usually be offered screening.
As MCAD is a recessive inherited disorder a couple with one person carrying the MCAD gene will be offered screening to the partner prior to conception and if both are carriers they will be offered genetic counselling. Ensuring potential parents are aware of their status prior to giving birth can give them the option of diagnosis prior to the birth by invasive diagnostics such as CVS or amniocentesis. Alternatively the diagnosis can be made through cord samples taken at birth; however, this will take several days. Whilst results are awaited for MCAD the child is usually kept in hospital having regular blood sugar level monitoring and/or on IV fluids.

Neonatal Screening for MCAD
In the UK it is planned to screen for MCAD as part of the neonatal screening program (NSP), although as yet a date has not been fixed. In a study undertaken in Sydney, Australia with 275,000 neonates, 12 out of a possible 13 were diagnosed with MCAD following the routine screening Carpenter (2006). In fact the test detected cases where there were lower risks of becoming clinically symptomatic, thereby offering a diagnosis in children who would not necessarily be identified. Pandor (2006) undertook a cost effectiveness analysis of including MCAD screening as part of the NSP and concluded that it would be economically viable.

Discussion
MCAD is thought to be under-diagnosed because many patients will remain asymptomatic. MCAD carriers may be unaware of their status. By introducing routine neonatal screening a greater proportion of the population will become aware of their MCAD positive status. As MCAD is an inherited disorder this will have a knock-on effect with genetic counselling and antenatal diagnostic screening. Professionals need to be aware that MCAD can be diagnosed through CVS and amniocentesis.

Summary
MCAD is a fatty acid oxidation disorder which presents with symptoms similar to hypoglycaemia. It is treated by correcting the hypoglycaemia; however, it is best managed by preventing these episodes. MCAD is an autosomal recessive inherited disorder which can be detected through diagnostic screening in the antenatal period. Due to the significant morbidity and mortality of MCAD, inclusion in the neonatal screening programme is strongly recommended. Studies have shown that screening is good at detecting MCAD, and screening is cost effective.

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Denial: As midwives can we accept the truth?
Caroline J Hollins Martin

Ask yourself the following questions. Have I ever avoided offering the option of ‘home birth’ simply to avoid the bureaucratic hassles that may be involved? Have I ever ruptured a woman’s membranes when I knew it was completely unnecessary to do so? Have I ever commenced syntocinon when I knew that given time the woman’s labour would progress normally? Have I ever persuaded a woman to have cardiotocography in order to sidestep the consequences of breaking with protocol?

THIS PAPER IS ABOUT DENIAL of our own obedience. Denial is a feature that reduces the psychological stress incurred when a midwife takes an action or inaction that results in consequences that he/she does not like. Refusing to accept responsibility for one’s behaviour removes the uneasiness experienced when carrying out an instruction that is considered by that person to be inappropriate.

In contrast, dissent refers to a verbalised disagreement with the course of action prescribed, with such dissent running the risk of possibly rupturing hierarchical bonds between that person and the senior member of staff. Like other institutions, maternity units have chains of command with incumbent expectations. Within such hierarchies, dissent from complying with senior people is likely to be labelled as disobedient behaviour. What is more, insubordination may be branded a disciplinary offence. In the main, subordinates respect a senior person’s right to overrule their opinion. If a subordinate decides to articulate a differing opinion, this does not mean that they intend to be disobedient. In many ways, voicing an objection and then proceeding to undertake the task anyway reduces any strain that may be experienced by the subordinate. In fact, voicing a contradictory opinion may provide psychological consolation for the moral conflict that may be experienced. For instance, a midwife may publicly declare herself opposed to refusing a ‘home birth’, conducting an amniotomy, commencing syntocinon or undertaking cardiotocography. This public declaration of disapproval enables the midwife to establish a desirable self-image whilst maintaining a submissive relationship with the senior person. For example:

She won’t benefit from that (cardiotocography). It’s pointless. Why does he want it (midwife)?

He wants it to be done (senior midwife).

Well, I would have to agree then! (midwife).

Midwives may experience disobedience as an extreme and radical response, which means they are more likely to obey and deal with the psychological strain involved instead of disrupting the social etiquette. Once strain starts, a number of psychological mechanisms may be implemented to reduce the severity. For example: denial, dissent, avoidance, circumvention, minimal compliance, blaming and projecting responsibility on to others. The intellectual lightness of the human mind and its capacity to dissipate strain allows processes such as denial to come into play. It works through the intellectual mechanism of rejecting apparent evidence in order to arrive at a more consoling interpretation of events. Observers of the Nazi epoch (see Bettleheim, 1960; Blass, 1993; Churchill, 1997) point out how persuasive denial was among both victims and persecutors. Jews who faced imminent death could not accept the clear and obvious evidence of what was going on and even today, some people deny (illegally) that innocent people were annihilated on a massive scale by their government.

Denying accountability and projecting responsibility for a decision on to the senior person permits the individual to impersonalise the event. Unfortunately there is nothing more obstructive to ‘woman-centred care’ than disinterested authority combined with the midwife’s buffering effects of denying responsibility. There is a distinction between what is logical and what is psychological. On a purely quantitative basis, it could be perceived as worse to deny all women a ‘home birth’, than it is to deny one woman the experience. Yet the latter is psychologically the more difficult act. In relation to numbers, diffusion of responsibility and the physical barrier of protocols and patterns of care neutralise the moral sense. There is virtually no personal psychological culpability involved in a remote refusal based on instruction from authority.

Disobedience is not an act that is seen as available to most midwives. They are tightly bound to the institution and a rigid hierarchy makes non-compliance very difficult. When points of disagreement arise, midwives often acquiesce with what has been suggested in order to avoid retribution that might result from their resistance. Acquiescence of this kind could be interpreted as necessary agreement, which was a finding of Brehm and Cohen (1962), Festinger (1954, 1957) and Wickland and Brehm (1976), who found that public compliance without private acceptance can be forced when there is a threat of punishment for non-compliance.

Results of these observations have important implications for events that happen in hospitals. Within midwifery, values are not just dissimilar to those held by the German regime when the Holocaust occurred; they are in fact diametrically opposite. Nevertheless, people use the same psychological processes to deal with the stress resulting from carrying out a task that otherwise they would prefer not to. Unfortunately, obedience sometimes causes midwives to obstruct choice and deny the anguish caused to the childbearing woman. Most frequently among the obedient, we find not a denial of events but a denial of responsibility for them (Krackow and Blass, 1995).
In a recent study, I found a large disparity between midwives’ private responses to work related decisions, when compared with answers they gave when influenced to respond in a particular way by a senior midwife. What these midwives perceived was an obligation to obey the senior midwife when the postal results clearly showed that many disagreed with her point of view. A full report of these studies has been reported by Hollins Martin and Bull (2004, 2005, 2006 in press) and Hollins Martin, Bull and Martin (2004).

Many of these midwives recognised that their focus shifted from giving preferential consideration to the choice of the childbearing woman, to instead fulfilling a perceived obligation to follow the direction given by the senior midwife, for example, carrying out an unnecessary cardiotocography just because the senior midwife has asked you to do so (obedience to authority). Some of the midwives in the Hollins Martin and Bull study overtly denied responsibility for decisions that they made, for example, instead they attributed responsibility to the senior midwife for not permitting the woman to have a water birth (denial of responsibility). Other midwives presented excuses for why they would not accommodate a homebirth, for example, it was the doctor who said that the homebirth was not a good idea.

Results of the Hollins Martin and Bull study showed that midwives’ levels of obedience are similar to most other social groups, such as college students (Meeus and Raaijmakers, 1995), ordinary men (Milgram, 1963, 1965, 1974) and soldiers (Shalala, 1974). Stanley Milgram showed that 65% of ordinary people provide maximum levels of obedience, even when the request made is morally wrong. He designed an experiment with the pretext that he was studying the effects of punishment on memory. The participant was told to play the role of ‘teacher’ who measured a confederate ‘learner’s’ ability to remember a list of word pairs. The ‘learner’ was strapped into a chair and attached to electrical connections. The subject ‘teacher’ was shown into a separate room where a shock generator was placed on a table. They were told that each time the ‘learner’ made a mistake in recall of the list of word pairs, they were to administer a shock by pressing one of the thirty switches on the shock generator. The first switch was labelled ‘15 volts-mild shock’ the next ‘30 volts’ and so on up to ‘450 volts’ and the ‘teacher’ was told to press the 15 volt switch first and then move one switch up the scale each time the ‘learner’ made a mistake. Milgram wanted to know how far up the scale of shocks participants would go when told to continue by the experimenter. This was despite the sound of cries and pounding on the wall from the ‘learner’ asking the participant to stop giving the shocks and, later, the ‘learner’s’ complete silence. The results were unexpected and dramatic, with 65% of people proceeding up to the 450 volt level. No shocks were in fact delivered to the ‘learner’.

Milgram (1974, p 100) describes how Elinor Rosenblum denied responsibility for shocking the confederate learner and deferred responsibility to the experimenter: MRS ROSENBLUM: ‘I kept saying, “For what reason am I hurting this poor man?”’

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<tr>
<th>Question number</th>
<th>Agreement yielded in a private postal questionnaire n = 60</th>
<th>Agreement yielded when under the influence of a senior midwife during an interview n = 60</th>
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Mean 7.5 40
A disparity was evident between what these midwives said they would do in a private postal questionnaire and what they said they would do when socially influenced by a senior midwife during an interview (see Table 1).

Milgram (1974, p 45) discussed disparities between how people expect to behave and what actually happens when they are placed in the countenance of a senior person. In a survey regarding the aforementioned Milgram (1974) study, 110 respondents reported that they would have disobeyed the experimenter at some point in the shock series. According to Milgram's findings, approximately 65% (72) of these participants would have proceeded in the shock series to the 450 volt level. The survey respondents saw their refusal as flowing from empathy, compassion, and a sense of justice. The following excerpt illustrates this:

I can't stand to see people suffer. If a learner wanted to get out, I would free him so as not to make him suffer pain. I couldn't deliberately hurt a perfect stranger” (Milgram, 1974, p 45)

These people,”enunciated a conception of what is desirable and assumed that action follows accordingly” (Milgram, 1974, p 47). They showed little insight into the web of forces that operate in real social situations. Several assumptions underlie these respondents’ predictions. First, that people are by and large decent and do not readily want to hurt innocent people; second that, unless coerced by a physical force or threat, individuals are pre-eminently the source of their own behaviour.

The Hollins Martin and Bull (2005) postal questionnaires also revealed that most midwives begin with presuppositions when asked to think about their own responses to the given questions. Many believed they would argue with the consultant who refused a healthy childbearing woman’s request for a home birth. Others believed they would refuse to carry out an unnecessary amniotomy. On answering the questions, these midwives focused on their own thoughts and denied the constraints of the actual situation, e.g., protocols, rules, punishments and the attendant hierarchy.

As midwives, it is important to gain insight into what is deemed normal human behaviour. If we can acknowledge our own human limitations, we are then in a position to understand and design a system that optimises choice provision for childbearing women. Denial of obedient propensities extends to all people. I sent a paper from the Hollins Martin and Bull study to a professional journal and received the following review: I remain unconvinced of the extrapolations. My view is a midwife lecturer is a peer, not a senior. This reviewer denied the findings of the experiment, instead preferring to believe that those who are higher in the hierarchy are disempowered to influence decisions.

As midwives it is important that we are made aware of characteristics that affect our perception of direction given. It is helpful to understand the results of obedience experiments since they inform us about how people perceive and react to authority. It is important that we are taught to view our communication, not just from the standpoint of sender or receiver, but to step outside the communication process and examine it within its broader context. We may then notice that perception of various elements of the communication process differ between individuals. How a senior midwife perceives herself and how she thinks her subordinates see her, may in fact differ.

This is important, since consequences have profound effects on our midwifery practice. Understanding the psychology of obedience and its denial may help us address the difficulties that we (midwives) have with supporting choices of childbearing women.

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Dear Midwifery Matters

As a wanna-be midwife, this journal is extremely inspiring. It continues to give me motivation to move towards my goal of being a ‘with woman’ independent midwife. Since having a home birth with my son (and only child) nearly two and a half years ago, with family friend Nadine Edwards as my doula, the complexities and beauty of birth have been shown to me.

Since then I have moved to the West Highlands and joined the NHS Highland Maternity Services Liaison Committee (MSLC) and NHS Women’s Health Network (WHN). Again complexities have become apparent, but this time of the structures and hierarchy within the NHS. I plan on doing a direct entry midwifery degree, starting in around three years once my son has started school. As time goes on and my awareness of the maternity services widens I have doubts whether it is truly possible to be a ‘with woman’ midwife within the NHS and whether or not I could financially support my family as an independent midwife. Money is not really much of a concern, but we all need to eat! I am concerned more of feeding my soul and if I will have the choice as a midwife to be ‘with woman’.

As an alternative I am considering becoming a doula. However, if nothing else, my involvement with the MSLC and WHN has highlighted the need for change toward a more woman-centred model of care and surely the best place to do this is from within the midwifery profession?

I also do not understand if the NHS truly wants to reduce intervention rates (and thus their expenditure and debt) why is it not possible to introduce a OMOM caseload model of care? I have heard of this being an extremely beneficial and effective model of care. Meanwhile I will continue to try and improve the maternity services available to women in the Highlands through the MSLC.

I would welcome anyone’s thoughts or opinions on the points I have made and if anyone is interested in joining the Highland MSLC please feel free to contact me.

Finally I would like to say a great big THANK YOU to ARM for keeping me inspired and motivated.

Yours

Laurie Fuller
(laurie@tightrope.org.uk)


Having heard only good about this book I was delighted to have the chance to review it. Like all the ‘Oxford Handbook’ series it really is pocket sized and presents the information in clear concise sections. The introduction has definitions, the role of the midwife and summaries of the NMC rules on record keeping, drug administration and supervision. The rest of the book follows through in a logical order from pre-conception through antenatal, intrapartum, postnatal and newborn care. It is very thorough with each section having first a normal midwifery section which is then followed by pathological or high risk midwifery. There is a section with coloured pages which contain information on emergencies in the childbearing period.

All the information is set out in an easy to read layout. It is all evidence based with references at the end of every section. There are also suggestions for further reading on the topics.

On a personal level I have found it invaluable to dip into to look things up and have carried on reading past the information I originally looked for! I can recommend this book as a good investment. It contains almost as much information, if not more than the standard midwifery textbooks in a more compact and more palatable package. If you are going to get a midwifery reference book, this is the one to get.

Andrea Simpson

Letters for publication are always welcome.
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Winter National Meeting Report
YMCA, Guildford

About 40 midwives and students came from far and wide to attend the national meeting in Guildford.

ARM Business

ARM Yurt. Sarah gave a brief background to the ARM presence at festivals, we started in 2004 with a gazebo, graduated to hiring a yurt in 2005 and bought our own yurt for 2006 which we took to five festivals; 20 ARM members were involved. It has been a great success; the visitors book shows that women have a huge thirst to talk about birth. Plans for 2007 include a presence at Glastonbury, Sunrise, Buddhalife, Womad, the Big Chill and Solfest. We are trying to get more sponsorship for 2007. We also need to find a better way of transporting the yurt, the long poles mean that we need a vehicle that will take an 8’ load. We need people to volunteer to ‘woman’ the yurt in 2007, this a quite a commitment and should not be seen as a way to get into festivals for free! Serious applicants only please to Sarah.

Local Groups. Wendy has revamped the guidelines for local groups and local contacts. She is still hoping to get more group news into the magazine.

Sales and stalls. Income from stalls was less than expenses this year and steering group felt that the membership should have the chance to comment on our presence at events such as the RCM conference where we always make a loss because of the high cost of stalls. The meeting affirmed that it was important for ARM to be seen at this event. At other events, such as the student midwives conference, new subscriptions make up for the shortfall on goods sold. We thought of extending the range of ARM products to include lanyards and knee pads with the ARM logo.

ARM knowledge.

The idea of collating a body of midwifery knowledge has come up again. Rather than putting together a textbook, Aida has suggested starting an on-line resource along the lines of wikipedia but based on midwifery knowledge – ‘midipaedia’. ARM has a history of sharing midwifery knowledge, first through gleanings in the magazine, then in founding MIDIRS, and lastly with the dawn of the internet, through the ukmidwifery list. Midipaedia would be a natural progression in the pooling of midwifery knowledge. There was much interest and a list went round the circle.

We discussed the nuts and bolts of the project and decided that if midipaedia were to become a respected source of midwifery wisdom contributions would need to be vetted by a team of committed midwives.

Following on from this discussion we talked more about the dream of an ARM school of midwifery which would be a ‘more human’ way into midwifery than is available in the UK at present. We have many members with educational expertise who could design and run online modules. One member present, M-J, was involved in setting up such a scheme in the United States. Students started with a six week residential course and then did 3-4 years of distance learning while working with a local midwife and ended the course with hands-on experience in local clinics.

We need to set up a group to work on an ARM school of midwifery.

Name change debate

There were only three responses to the questionnaire in the last issue of Midwifery Matters regarding a possible name change for ARM; two did not want a name change and one was in favour of a change. Steering Group had also discussed this extensively and the consensus is that the ‘radical’ part of our name is an important part of what we are.

However, we did decide that this might be a good time to relaunch ARM and rebrand ourselves and to this end Linda Wylie has had a go at designing a new leaflet telling people who we are and what we are about. Lynne said that we should advertise ourselves more to non midwives; many midwife ARM members were members even before they’d had started their training and some members remain lay members for life.

Ishbel added that at the moment many midwives are battening down the hatches against the NHS storm, there are isolated pockets of brilliant midwives who we are and what we are about. Lynne said that we should advertise ourselves more to non midwives; many midwife ARM members were members even before they’d had started their training and some members remain lay members for life.

We could also be more pro-active in our public
relations, using professionals, many of whom go to independent midwives for their care and who are pro midwifery. We could promote ourselves more at conferences; if an ARM member is speaking at a conference then wear the badge and push ARM in the introduction to the talk. We should present ARM at university fresher’s weeks (perhaps all universities should have an ARM midwifery society?)

**Political issues**

The current most pressing issue is that of Professional Indemnity Insurance for midwives. At present the NMC recommends that all midwives have PII but does not make this a condition of practising as a midwife. The reason for this is that none is available globally. The Independent Midwives Association has been trying to source insurance ever since the Royal College of Midwives withdrew insurance from independent midwives in 1996; all other professional organisations provide insurance for their members as part of membership if required but RCM insurance is not useable for midwifery practice. Midwifery is not the only profession affected; the Government is anxious that all health care professionals should carry insurance, but by its very nature birth has the potential to lead to huge claims. Even the NHSLA has trouble with funding birth accident claims. IMA has been having meetings with Chris Beasley and Caroline Simpson of the Department of Health but at the time of the meeting no route out of the problem had been identified.

One possible route through the maze may be to push for the implementation of the NHS Community Midwifery Model whereby independent midwives can take a caseload of women and legal indemnity will be funded by the NHS above the level of local PCTs. Some members present were of the opinion that there will be no alternative to practising midwifery without insurance and independents will have to risk prosecution. The situation is very worrying for women because there are women who, if they cannot have an independent midwife, will choose to labour alone. We had hoped that no fault compensation could have been brought in just for birth as was mentioned in the Government’s report *Making Amends* but apparently this is just not viable financially. ARM should help to ensure that there is a co-ordinated response to this threat to midwifery. It may seem as if only independent midwifery is under threat but midwifery needs a strong independent sector to safeguard birth for all.

**Student Midwifery Conference**

Following the expensive and disappointing student midwifery conference hosted by the RCM, ARM has decided to hold its own conference. Details were firm up after the national meeting and it has been decided to hold it in Oxford on November 7th. There will be places for 150-200 students costing about £25, and there will be speakers on ‘Being and becoming a ‘with woman’ midwife in the NHS’. Email: armconference@btinternet.com or contact Dot Parry on 0161 795 2425.

Margaret also wanted ARM’s support to help organise a conference on birth complaints. She explained that although things will not change unless women complain, in fact women find many obstacles to complaining and often end up more traumatised after attempting to make a complaint than they were before. Instead of validating the reality of a woman’s birth experience the very process of complaining becomes a trauma in itself; not only did people not listen to her while she was having her baby but also they continue to not listen her complaint, giving defensive answers which continue to undermine her confidence. The meeting gave its support in principle although concern was expressed that the sort of women who complain often have pre-existing mental health issues (this was later clarified to a certain proportion of women). Margaret agreed but felt that this neither excused poor treatment nor precluded dealing with complaints sensitively.

After the meeting Steering Group has discussed having an issue of the magazine devoted to this subject and steps are being taken to put together such an issue. The Steering Group issue of the magazine will be brought forward to the summer and the complaints issue will be the Autumn issue. All are welcome to contribute, from whatever place they wish to come from.

**NHS Community Midwifery Model**

Brenda van de Kooy came to the meeting to bring us up to date with what is happening with this scheme. She introduced us to the model by talking about what it is to supplement, i.e. the 20th century industrial model of childbirth designed to process 600,000 women a year in a process designed around the institution rather than the individual. No one designed such a system, it just evolved that way and people are damaged by the stress of that system. The community midwifery model went back to basics and asked how we could change women’s expectations in favour of midwifery care instead of institutional care; the NHS CMM proposes that the woman is linked to a midwife instead of to an institution. This new model of care requires a change of funding structure and a change of organisation. The Government has accepted the proposal in principle in that it would bring the maternity services into line with other public health issues, putting them into the community instead of the acute sector. Liam Byrne, the then parliamentary undersecretary for health, suggested getting funding from the Social Enterprise Group, a Government agency with a remit to help implement new initiatives for new services. The biggest hurdle to face is to design an acceptable contract that will work countrywide. South London Midwives in Croydon are working with Debbie Gould, a consultant midwife in Croydon, towards this end, developing an administrative structure which could then be rolled out across the country. (This is not a pilot scheme, pilot schemes are set up to fail as we saw after *Changing Childbirth*.) There are various problems, the model is having to be set up under
an acute Trust in order to get professional liability cover through CNST. The scheme is less revolutionary than it first appears; there are already mechanisms in the community for separate funding, for example for pharmacists, opticians and GPs, these models have just never been applied to midwifery before. The aim is to set the scheme up once, well, in a fair way, so that it is accessible to women, and in a sustainable way. Once it has been set up, a political decision must be taken for it to be implemented nationally. The advantages to midwives would be that they could work as independents, having as many women on their books as they wanted to fit in with their family life. The model should go a long way to solving the problem of recruitment and retention of midwives, particularly in London where the birth rate is going up. It would also force a way through to solving the insurance problem since it could not be implemented without taking account of professional liability concerns.

We do need a concerted campaign to implement this model. The New Zealand experience has shown that if the conditions and remuneration is right midwives do like to work this way, the midwives will come. At the same time there will always be a need for core staff at maternity units; not every woman will want to have her care delivered through the NHS CMM and many will want to bring their midwife into maternity units. The scheme is less revolutionary than it first appears; there are already mechanisms in the community for separate funding, for example for pharmacists, opticians and GPs, these models have just never been applied to midwifery before. The aim is to set the scheme up once, well, in a fair way, so that it is accessible to women, and in a sustainable way. Once it has been set up, a political decision must be taken for it to be implemented nationally. The advantages to midwives would be that they could work as independents, having as many women on their books as they wanted to fit in with their family life. The model should go a long way to solving the problem of recruitment and retention of midwives, particularly in London where the birth rate is going up. It would also force a way through to solving the insurance problem since it could not be implemented without taking account of professional liability concerns.

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Home from Home, Guildford

Caroline, a midwife with the Home from Home Unit in the Royal Surrey County Hospital came to talk about her work there. The Dr Foster Good Birth Guide shows the hospital as having a high epidural rate, a very high number of Ventouse births and a caesarean rate of about 30% but normal birth does take place in the home from home unit. It consists of two large rooms, a converted bay on a postnatal ward, there is no obvious equipment, a sofa and a homely atmosphere. They do have beds just in case there is shoulder dystocia – and it is a battle to keep women off the beds! 80% of women use the pool.

The unit is staffed 24/7 by six mainly full-time midwives; because of the numbers this means that staff rota consist of 50% night duty and not many midwives want a job on the unit. Shifts are 12.5 hours long to allow adequate continuity of care and handover which is very important when supporting primigravidae who are labouring without epidurals – it is all too easy to wreck a labour at the time of shift change.

In their own time the midwives also provide a 6-week long active birth course which is very popular – in their own time – though they do fill in time owing forms. Teaching optimal fetal positioning takes pride of place in this class, with the doll and pelvis with a moveable coccyx playing a starring role. The meeting talked about antenatal classes for a bit, deploiring the fact that ‘pain classes’ are taught by anaesthetists who ‘push’ epidurals; when this attitude is challenged by midwives it is claimed they are acting ‘unprofessionally’. Anaesthetists see themselves as saviours of women. In Guildford the active birth classes are oversubscribed – women attend who are planning consultant care and the midwives wondering whether to restrict the classes to women choosing the HFH unit who have a commitment to active birth.

The HFH midwives are confident with water birth but it is not popular with other midwives in the hospital, who do not feel comfortable working without the CTG. The senior sisters on the main unit tend to instruct students to, “Just admit and pop on the CTG.” This style of care leads to more women requesting epidurals, and more persisting OP babies unable to rotate against the pelvic floor with a lowered tone. This is the sort of unit whose philosophy is diametrically opposed to what students are now taught at university. On the other hand, Caroline wondered whether the high OP rate in Guildford was due to women having a sedentary lifestyle, carrying on working until 38 weeks in office jobs. It does seem to account for some of the higher intervention rates.

On the other hand, the obstetricians have had a stranglehold on the services for years, for example, there are no VBACs unless they take place at home – the service has even been described by students as having a culture of terror. Some midwives are passionate about getting ‘our’ women normal births but there are not enough midwives for one-to-one care so this is difficult. There is the tendency to hurry long labours in a situation of shortage of midwives and OP labours are long. How much does the culture depend upon the OP presenting babies and how much do low staff numbers contribute?

There followed a general discussion about the relative merits of epidurals and Pethidine – epidurals muck up labour more. There was talk of ‘senior midwives want...’ and Mary Cronk chipped in her inimitable style with “What is a senior midwife?” Someone replied, “An SHO in midwives’ clothing, a doctor waiting for something to happen!”

There was also talk about NICE guidelines for birth centres – proximity to delivery suite does seem to be a problem in some places although the Guildford HFH has only a 10% transfer rate.

There was, however, universal agreement about the need to get over the terrible fear of pain in childbirth – the present culture of childbirth is immersed in fear from start to finish – doctors’ fears, midwives’ fears, women’s fears. We need a cultural shift in the philosophy of childbirth to try and move on.

Afternoon

Aida and her family provided us with the usual wonderful ARM lunch and we had workshops in the afternoon followed by getting back together for feedback and the usual ‘hugs and home’.
Insurance Threat to Independent Midwifery

Introduction

Independent midwifery may have less than a year to live. All independent midwives have been sent a letter by the Chief Nurse, with the information that the Government is intending to pass legislation to make professional indemnity insurance (PII) a prerequisite for registration. In parallel moves, the European Parliament is also considering similar legislation. Although the initial impetus for this legislation arose because of uninsured members of other professions, it will have a far bigger impact on midwives, because there is no PII available to independent midwives. This legislation will therefore impose a condition on their practice which it will be impossible to fulfil. Independent midwives will no longer be able to register as midwives and they will be committing a criminal offence if they continue to offer care to pregnant and birthing mothers.

Background

Independent midwives practise outside the NHS, usually not because of a desire to have private clients but because it has become increasingly difficult within the NHS to provide the standard of woman-centred, autonomous midwifery practice they wish to give. They are specialists in normal birth and use midwifery skills unfettered by Trust policy and protocols, which are often obstetric-led and therefore focus on the abnormal. Independent midwives are however subject to the same requirements to practise within the NMC Rules and Code of Conduct and they fulfil the same requirements of professional updating and supervisory reviews. They are free to practise within any geographical boundaries and to choose their own case-load. They give one-to-one care, working intensively to give parents information so that they can make informed choices throughout the antenatal, intrapartum and postnatal periods. The number of independent midwives fluctuates but is currently around 200; most now care principally for women planning home births. The concerns surrounding indemnity insurance and liability have already resulted in a restriction of choice for women as the provision of honorary contracts to allow independent midwives to care for their clients within NHS hospitals has by now all but disappeared.

Up until 1994, all midwives were covered by the RCM’s indemnity scheme, regardless of their area of work. Midwives within the NHS were also covered by their employer’s vicarious liability. However, in 1994 the RCM withdrew insurance cover from independent midwives amidst much controversy, and although there were one or two insurers willing to offer cover at first, the premiums rose to £15,000 per midwife per year and the number of providers fell over the next few years until 5 years ago, the last provider withdrew from this market and since then there has been no insurance available to independent midwives in the UK. The Independent Midwives Association (IMA) has campaigned publicly and negotiated privately with innumerable insurance providers over the years, all to no avail. Four years ago, the NMC proposed to make insurance a ‘requirement’ for registration; a campaign then resulted in it becoming a ‘recommendation’ and every midwife practising without insurance therefore has an obligation to make the implications of the situation clear to every client she or he books.

The IMA has also thrown much passion and energy into drafting the NHS Community Midwifery Model, a case-loading model which provides for one-to-one midwifery care for NHS clients and would provide an ideal framework within which the NHS indemnity scheme could be extended to independent midwives. However, proposals to explore the development of the scheme, work out model contracts and create service level agreements within the Social Enterprise Unit’s Pathfinder scheme have been rejected.

What Could Happen

If the Government’s current proposal becomes a reality, the death of independent midwifery will not only have an impact on those midwives who will lose their livelihood. It will reverberate throughout the profession, as independent midwifery is seen as a vanguard and a beacon to all midwives. It will at a stroke remove from practice a group who fulfil many of the Government’s declared objectives for maternity care – the Maternity Services module of the National Service Framework calls for ‘real choice’ and ‘flexible individualised services’. The care offered by independent midwives has the best possible outcomes for mother and baby, both short and long term, and is held up as the gold standard of maternity care. It results in more normal births, reduced caesarean section rates, improved mother-baby bonding and more breastfeeding, all of which has a major impact on the health of women and babies across the country. Independent midwives also consistently provide high rates of normal births even to women usually classified as ‘high-risk’. It will impact on women, whose choices will become the poorer. Women who want one-to-one care with a known midwife will find it much harder to obtain it. Women who want to give birth naturally to their breech babies, their twins, their HBACS, will be less likely to find support (unless they are lucky enough to live in the one of the few NHS areas that offer these things, but they are rare) as independent midwives are one of the last repositories of these valuable midwifery skills and keep them alive through research and skill-sharing. If independent midwifery care is no longer available, a small but growing proportion of women will choose to give birth alone, which is the most dangerous option of all. Reliance on insurance cover is by no means synonymous with good practice, as has been seen in other countries, and frequently leads to defensive procedures, driven by policies deemed acceptable by insurance and legal officials, rather than by evidence based and client-centred care.
The Campaign
The IMA is therefore launching a campaign with the support of other stakeholders in maternity care such as AIMS, ARM, NCT, to fight for the survival of independent midwifery. We will be lobbying for the Government either to ensure that affordable indemnity insurance is made available to all midwives, regardless of their area of work, as has been done in other countries, or to exempt independent midwives from the requirement to have PII. We will be seeking to bring the situation to the attention of all midwives, as this will have an impact on every midwife, not just those who currently practise independently. We will be working with the support of mothers and families, whose choices in childbirth will be seriously restricted by the Government's proposals. We will be fighting not only for our own survival but for the survival of choice and control in birth for women and midwives.

AIMS Confirms Press Reports of Babies Being ‘Snatched’ for Adoption

Following claims from a group of MPs that babies are being taken into care ‘to meet targets for adoption’, (as reported in The Times, 27 January 2007) the Association for Improvements in the Maternity Services issued the following press release:

“The Government is denying that social workers are targeting babies for adoption. Listening to desperate calls from pregnant women or mothers of new babies and toddlers on our help-line would quickly show their denials are not true.

Health visitors are often instructed to give all parents a “risk rating”, if possible while the child is still in the womb, or soon after the birth – this is done without parents’ knowledge or consent. The questionnaire used is highly inaccurate as a predictive tool, and has a very high rate of false positives. Pregnant teenagers, the unemployed, anyone with a history of mental illness, and so on, are on the watch list – supposedly so that they can get extra support, but it is often simply extra surveillance. Midwives are instructed to report risk factors, and are losing the trust of the women they care for.

When social workers investigate mothers as a potential risk to their children we see incredibly high stress levels in women who fear losing their babies (even if the fear may not be justified). Research has shown this high level of stress hormones in the mother’s blood can reduce the baby’s growth as well as causing behavioural problems in childhood. We also suspect that it is affecting the process of birth in a number of our clients. For example, delaying birth beyond term.

Expectant mothers who were themselves brought up in care have an increased risk of social workers taking their babies, without even giving them a chance to show that they can be good parents, and providing them support and help. The State is, in effect, saying as your corporate parent we gave you such damaging care that you are unfit ever to be a parent yourself.

Mothers with a previous history of mental illness (perhaps caused by bereavement or a damaging relationship), or mothers with postnatal depression (very common) or psychosis also risk losing their children. The extreme shortage of mother-and-baby psychiatric units where they can safely be together is a scandal; Primary Care Trusts are seldom willing to pay for such care outside their area. The grapevine in many communities is accurately circulating the risks, so mothers who may need medical care tell us they are concealing mental illness, for fear of their children being taken. Two academic studies have shown that questionnaires to identify postnatal depression no longer work, because mothers lie. This is dangerous, since we now know that suicide is the major cause of death associated with childbirth.

Women also tell us they are concealing the fact that their pregnancy resulted from rape, or that they suffer domestic violence, for the same reason. One man, after beating up his wife, hands her the phone and says “Now call the police – and the social workers will come and take your kids.” So she stays silent. Others tell us that social work intervention has resulted in aborting a baby they would have wanted.

Not all attempts to have children adopted succeed, and mothers may have them returned after weeks, or months. The intense bond fostered by the high levels of oxytocin the mother has from giving birth and breastfeeding has been damaged. The baby has lost the breast milk which gives life-long health advantages, and contact visits are never frequent enough to breast feed.

We are a pressure group with 40 years’ experience in supporting parents with complaints about maternity care. But since the unprecedented growth in calls about child protection proceedings in the last 9 years or so, we have accompanied clients to meetings and observed social workers’ home visits. We have been horrified at what we have seen, and equally appalled by the lack of accuracy and bias in many of their reports, and the selectivity of evidence they give to the courts.

Questions should be asked of the Commission for Social Care Inspection. In their annual inspections up and down the country they criticise local authorities whose adoption figures are not high enough. It is the rise in the adoption total that wins Brownie points, not a reduction in older children lingering in long term “care” with an unsettled future. Hence the social work snatching of new born – prime adoption material, which also met the needs of settled, wealthier, older infertile couples. As one client told us, “What they are doing is redistributive eugenics.” Perhaps it is time we started measuring and recording the damage caused by ‘child protection’ interventions and doing the kind of cost-benefit analysis which is now required for drugs, surgery and other health interventions?

Beverley Lawrence Beech, Chair AIMS
tel: 020 8390 9534

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Recast EU Directive on Infant Formula and Follow-on Formula

“Anyone hear how the EU are getting on with the tough decision about whether our babies should still be put at risk through advertising?”

I took this as a question aimed directly at me from a nettalk piece in the last issue as I am your representative on the Baby Feeding Law Group (BFLG).

EU Member States voted on 19th July 2006 to accept the revised Directive on Infant Formula & Follow-on Formula Milks. The new Directive sets out procedures concerning health claims and obtaining approval on products from the European Food Safety Authority (EFSA).

Follow-on milk

The EU Commission says that Member States cannot ban the promotion of follow-on milk even though these have been deemed unnecessary by the WHO as long ago as 1986. They have no nutritional advantage over standard formula but most parents and health professionals now believe they are an essential progression in baby feeding.

Ideally, adverts should tell mothers that their breast milk is superior to formula and is nutritionally adequate as long as breastfeeding continues.

We are all aware of the survey carried out in 2005 when 60% of mothers questioned thought they had seen adverts for formula milk in the previous weeks. Of course, what they had seen were adverts for follow-on milks which are allowed by UK law.

Follow-on milks are packaged similarly to infant formula. In the adverts the tin is identifiable with the brand and the writing can be blurred, tiny and indecipherable. If pictures of babies are shown they usually appear less than 6 months old.

The follow-on milk market is an area of keen interest to manufacturers and there is increased development in this.

The BFLG considers it is of the utmost importance that a ban on follow-on milk promotion is essential if an increase in the duration of breastfeeding is desired.

Denmark and Luxembourg have included follow-on milks in a general ban on formula advertising – so it is not impossible.

Nutritional Claims

The recast Directive allows manufacturers to continue to use nutritional claims for formula and the door is open to allow many more. Nutritional claims are now seen as equivalent to health claims and are misleading, as they suggest that products have some health advantages over breastfeeding and that they will make children cleverer and healthier.

The Commission is of the view that a prohibition on claims may impede innovation by the industry. Manufacturers will continue to be able to work on additives such as pro-biotics, pre-biotics and omega fatty acids as they are classed as nutritional ingredients.

All current adverts for infant formula say something like: ‘nutritionally the same as breast milk,’ and it could be argued that, nutritionally, formula is the same as breastmilk. Both contain protein, fats, carbohydrates, vitamins, minerals and water. But how many parents, or health professionals, know from where these ingredients are sourced? Some parents think that formula is derived from breast milk. It’s quite a shock to them to find out that the protein is from the cow and the fat from whichever vegetable oil is cheapest on the global market at the time. Even the water can be contaminated when reconstituting milk powder, while the water in breastmilk has been filtered through the mother’s body.

Hypoallergenic and pre-biotic claims are health claims not specified in the Directive so should not be used.

Another disturbing thing is that, despite many members’ objections, the Directive allows manufacturers to add new ingredients before their safety has been investigated by the EFSA, although they will have to provide evidence that supports the inclusion if asked. So, formula continues to be a great big experiment on babies.

Baby Food Market

The overall baby food market was worth £329 million in the UK last year and £6 million was spent on marketing. Manufacturers are concerned that the baby food market in Europe will stagnate due to the falling birth rate and because more mothers are choosing to breastfeed. This is leading them to produce ever more innovative and aggressive marketing techniques for their products.

What Next?

Where this goes from here is up to individual member States. The Baby Feeding Law Group will continue to lobby the Government to opt for the strongest possible interpretation of the recast Directive.

Penelope Samuel
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

Scared cervix

A client of mine is five days overdue and went in for a sweep to be told that she has an unusual cervix due to a colposcopy she had many years ago. She was told that the centre of her cervix is rock hard and fibrous - like a polo mint whilst the rest of her cervix is very thin and ready. She has been told that she will need to have her cervix snipped after which she is likely to go into labour straight away.

She was told she will have to have the procedure under epidural. She is really keen to have a natural birth and would like to use hypnosis rather than the epidural so at least she can have her body kick in with the hormones. She was told that if she does not have the procedure her cervix is likely to rupture and cause major problems.

Can any one shed any light on this? Is it really necessary? What would happen if she waited? She is due to go in tomorrow for the procedure so any response will be truly welcome.

Maggie

Archives

Dear Maggie,

Have a look at our list archives on the cervix:

www.radmid.demon.co.uk/cervix.htm.

There are several posts on there about scar tissue on the cervix, and I think one about a midwifery technique to break the scar tissue, basically like a long stretch and sweep. This would allow the scar tissue to break at its natural weakest point, rather than a place arbitrarily being chosen for a cut.

I'd be worried about having it 'snipped' because this might be more likely to extend to a true cervical tear which can lead to high blood loss. I'm not a professional and it may be that in this case it is necessary - but what's wrong with waiting and seeing how she goes?

The progress of her labour might surprise everybody, and if she's only five days past her EDD she's not even technically 'overdue' by anybody's book. Is this her first baby? If so she's not even at the average gestation for a first baby in the UK yet! How about leaving it until EDD +10, say, and see how she feels then? She's not too late to postpone the procedure tomorrow.

If it's any consolation... I've had laser surgery too and the middle of my cervix often feels very different to the rest - has often felt like a hard ring. It hasn't been a problem, as four spontaneous, trouble-free homebirths have proven. One anecdote is of course nothing to suggest that she too will have no problems, but over the years we have had many women here and on Homebirth UK who've had cervical surgery, and rarely has it ever been a problem, except for causing a lot of worry before the birth. One member even had a very extensive cone biopsy to remove cervical cancer (true cancer, not precancerous cells) and went on to have a homebirth afterwards - see http://www.homebirth.org.uk/jennilyn.htm

Angela Horn

Mum and owner of www.homebirth.org.uk

Leave well alone

Dear Maggie,

I practise as a midwife in California and see many, many women having had colposcopy or LOOP to their cervix. What I see from taking care of these women during labor is very clear; that if left alone, they will actually have a pretty good labor. What I see happening for many of them is the cervix becomes paper thin before ever dilating. They will usually have a prolonged latent phase, irregular contractions over many hours and in that time the cervix becomes really, really thin, at which time I gently examine the cervix, ease maybe one finger in and then two and before I know it, the cervix literally melts under my fingers to allow dilatation to take place.

The active phase thereafter is quite rapid because the cervix is so thin. I agree with Angela, 'snipping' does not sound good practice at all and I think is coming from someone with not much experience. I would go for a second opinion!

I usually warn the women beforehand what to expect and although it doesn’t occur in all of them, it does happen for many. Hope that helps.

Liz, CNM

Let it be

I agree with Lin. Let it be. Expect long latent phase then roller coaster to fully dilated. Have read in Anne Frye’s book about the use of Evening Primrose oil to soften an unripe cervix (not really applicable here). What do others think?

Liz, midwife and mother

Rupture or cut?

Maggie, this has really been preying on my mind overnight. It sounds like a prime case of using scary language to get consent. What exactly is the difference between scar tissue on the cervix “rupturing”, and being cut?

“Rupture” is an emotive word - carries associations of a traumatic burst or of it tearing open dangerously but how exactly could a ‘snip’ prevent a subsequent tear? We know from research on episiotomies how much ‘better’ a “controlled snip” is than a natural tear (rolls eyes!) – a fantastic improvement if you want to create slower healing, more pain, and more extensive tears, and go for the ‘gold standard’ of a third-degree tear... I suppose one could always talk about the perineum ‘rupturing’ in labour to scare women into episiotomies!

Also I should think she b****y well would want to have an epidural in place if they do this, as a) it could be incredibly painful, and b) I suppose they want to have quick access to emergency CS or repair if she bleeds very badly afterwards...

Would you be able to let us know how she gets on? It sounds like you are quite worried about this woman – I know you don’t post here often...

Angela
How much Preparation is needed for Birth?

Hi everyone, I wanted to share something that’s been going round in my head for a while, and was exemplified today by a client who has been scarred witless by her NCT classes. She feels she has been entered for an exam, and that she has to ‘swot up’ before going into labour. She feels that the choices on offer to her are so many and so varied, and her knowledge base so small that she doesn’t have a cat-in-hell’s chance of being able to decide on anything enough to write a birth plan.

My question for midwives is — where do you stand? In your experience, who copes better in labour: women who have researched all angles, prepared themselves and made ‘informed choices’ about how they’d like their labours handled; or women who go in ‘blind’, assuming that everything will be OK, and you’ll look after them if it isn’t?

Some part of me wonders whether ‘a little knowledge is a dangerous thing’, especially if it makes it hard for a woman to ‘switch off’ in labour and let the hormones do their thing. But where does that leave your profession’s laudable aim to educate women to try and make informed choice?

Maddie
Birth and Postnatal Doula

Interesting question

Dear Maddie,

Some of the most straightforward labours I have attended are of teenagers who haven’t much of an idea of what is happening to them. They react instinctively and go with it. Some of the best informed women have to ‘get out of their heads’ to ‘allow’ their labours to ‘do their thing’. It is interesting.

There is sometimes no rhyme or reason, although there is nothing like a busy labour ward to get everyone going beautifully in labour! Some well informed women do very well, some not. Your client may just benefit from discussing what she wants to with you alone. I remember a 17 year old labouring really well asking me how the baby was going to actually come out. Her face when she realised was a picture, and frightening, but she did really well and the baby was born relatively easily, although she did say she was never going to have another one!

I also remember my cousin aged 12 asking her mother questions about sex. She only wanted the answer to her question. If her mother tried to expand she would put her hands over her ears and say she only wanted the simple question answered, not a discussion, or a lecture. It takes all sorts doesn’t it?

Your client’s wish may be to ‘have a baby with as little fuss as possible’. She may want an epidural. That’s her plan. That may be all her plan. Someone else may have a dissertation with references!

Debs
Ind MW, Dorset

Ignorance is Bliss?

I had the easiest labour when I was 17 and I put a lot of it down to ignorance. Although saying that, I wasn’t completely ignorant, I was fascinated by the whole process (hence training to be a midwife a few years later). But I remember dutifully going to the antenatal classes and switching off at the Caesarean bit because that didn’t apply to me. There was no reason for me to have a section and therefore it wasn’t going to happen. Perhaps I was naïve (Is that such a bad thing?)

When it came to labour, I don’t remember being scared – I knew it was going to hurt, but I don’t think I wanted to think about it. It all seemed very natural to me at the time. I remember a midwife examining me in ANC and telling me that if I can relax like that in labour, I’ll do fine. I
was 4 cms and hadn’t felt a thing. An hour later I was beginning to feel it, three and a half hours later I wanted an epidural and four hours later my 9 lb 2 oz son was in my arms. I just don’t think it occurred to me to be fearful (therefore not even starting the fear, tension, pain cycle). It was just a natural process that was going to hurt a bit but then it would be over.

Sarah

How much on complications?
This is a difficult question as it depends on the woman concerned. At the classes I run, we gloss over complications but most of the women want more information on them. I would suggest that, for most women, knowing the complications and problems that might occur is not helpful before the event. If, for instance, a mum comes in and her waters have broken and there is thick, particulate meconium then definitely she needs to be aware of the implications for this to enable an informed choice re: monitoring and so on.

Anna

Mother Led
I agree with Anna, it definitely has to be ‘mother-led’. I for one definitely had better second and third births because I was well-read. For my first birth, I was ignorant about the ins and outs, and ignorant as to the level of pain. It was a long and hard labour with some medical intervention. My second and third births, I was definitely the one in control. I’m a doula too, Maddie, so sometimes mums do want to know what happens if! but other mums just want to have their ‘ideal’ birth plan and deal with other things they happen.

I always say to mums that their birth plans aren’t set in stone, as I’m sure you do, and that they need to remain flexible. As long as they remain the decision makers throughout the birth, they will feel empowered and have a positive birth experience, however they give birth.

Every midwife I’ve met so far has been fantastic at making sure the mum understands exactly what’s happening, pros and cons, and always asked permission before any ‘medical assistance’ is provided.

Jude
Mum of Three

Giving Support Empowers
Sometimes giving people the support they ask for, even when it is not in the way we would normally do so, is empowering them. This lady has placed her trust in you enough to tell you that she is afraid and confused by too much information. Perhaps she feels that, for her, choosing to allow others to ‘get on with it’ is the right choice for her – we all know that there is a certain surrendering to the physiological process of labour – perhaps she’s not planning to try and control the unknown – and is starting this process now rather than in labour. Ask her to stop thinking about choices at this time, encourage and support her confidence in herself and her body, rather than in making the right or wrong choice of options.

In my experience conscious anxiety about anything is one of the biggest barriers to normal labour. From what you have told us I would interpret this as the woman is saying she has been overloaded with information and needs a break.

As the others have already said some people need to know everything and every possibility and feel stronger with more information, others just need to do it with the support of someone they trust and that is their strength. It sounds as though she has found her person to trust in you.

Cassey
Independent Midwife

Women make their own choices
I have been working independently for almost four years now and during that time I have had women making all kinds of different choices, including elective section. The whole point of working this way is that women are making their own choices, not mine, and will come to their own conclusions about things. This is the essence of individualised care. I may not always agree with their choices but I believe it is important they are making their own.

Rosie

BRAIN Power
I’m answering here as an NCT teacher, although, as we come in lots of flavours, I suppose I’m answering with my own thoughts. Any assertiveness work I do with my groups (i.e. BRAIN – Benefits, Risks, Alternatives, Instincts and Nothing), at least as far as labour is concerned, is always aimed at the men. I tell the women that labour is not an intellectual exercise but an animal one, and I reinforce that if they listen to their bodies, labour will work much better. I also tell the men that they should not talk to their partners during contractions.

As I often find that women cope perfectly well at home, then go into hospital, where their labour deviates slightly from the normal in some way, and there are immediately doctors asking the women questions, getting them to make decisions (engaging their brains) or sometimes just dishing out interventions without any discussion. Having audited this year’s birth outcomes, nearly 40% of women were given syntocinon at some point in labour. This is despite us talking specifically about syntocinon, the benefits, risks and alternatives (like nipple tweaking!).

I still struggle with how much intellectual stuff to teach them and how much I should just reinforce labour as a natural process. Whatever I do, I’m not going to get it right for every couple.

Sam
AN teacher

Thanks for your responses. I have to agree that women must be given freedom of choice whatever the personal feelings of the midwife or doula. Personally I’ve seen women benefit hugely from very good preparation (e.g. planning a VBAC) when knowledge can be power. Conversely, I’ve also seen women labour very well without much idea of what’s going to happen to them at all.

I think my client needs it all narrowing down for her – she feels as though she can’t work out what’s important for her, so saying that it’s her choice, her baby, her birth, doesn’t help much. I think she wants to put herself in my hands, and the midwife’s, and let us get on with it, which goes against my normal aim to empower women!

Maddie
Birth and Postnatal doula

Nipple Piercing

Does anybody have any experience with breastfeeding where the woman has a pierced nipple? At the moment the woman in question is only 22 weeks pregnant and I’ve suggested she remove the ‘offending object’ but perhaps I’m wrong, anyone any ideas?

Joanna
Midwife


From my own experience, the mums I’ve seen with well healed nipple piercings done prior to pregnancy had no trouble, and they chose to use the flexible nylon ball and shank piercing. It’s easily sterilized in Milton, and the mums just took it out to feed and stuck it in the Milton, and then put it back in afterwards.

I have heard of women feeding with the piercing in situ, not sure about the effect on latch or nipple trauma, or the risk to the baby of ingestion, but that article in the MIDIRS does go into some of that.

Tania
Speaking from experience ...

I had mine pierced a few years before having my children and it didn’t cause any problems at all. With my son I had the normal bar in throughout pregnancy, and took it out for feeds afterwards. It did get a little sore at times, but I would wipe milk round it after a feed and it would be fine. I actually found it easier on that side as I have flat nipples and the piercing had made this one slightly bigger, so it was easier to latch on to.

Kim

Leave it in

I have spoken to a piercing artist in the past about this and was told that it’s fine to keep the piercing in while feeding, unless you feel it’s in the way or having a negative affect on latching etc. There should be no need to take it out.

Contact a reputable piercing studio and ask them for information.
Sarah, Mum

Take it out

The piercer I used to go to would advise women to pop them out during feeding due to the potential risk of the balls in the piercing coming loose during feeding. That would be no different to taking a pair of earrings out and putting them back in later so there’s no reason to remove the piercing now or permanently once the baby comes.

I used to have nipple piercings, but took them out after 14 months because they would not fully heal/settle down. They can be a little troublesome for some people and, compared to other piercings, have a long healing time so I think this question would also depend a lot on the woman’s personal circumstances.

I also got mastitis and wasn’t pregnant/nursing or anything else like that. I asked two different doctors and a nurse whether my piercings were to blame and they all said it was unlikely, but it seems logical/probably it was the pregnancy/that the pressures involved in breastfeeding could cause the piercing to migrate. As the pregnancy is still in progress then the woman could taper up now if her piercing and jewellery is smaller than that.

The flexible barbells are made of PTFE; if you are worrying about ends being lost then this can be fused. With other jewellery – moving to a titanium banana bar with internally threaded bars will help a lot with regard to the potential for loss (and will mean if one does go down that there is nothing to catch inside baby and that the ball will pass through as well as anything could without/with minimal reaction potential.

Another form of jewellery is the banana bell with a bulbous end. This is an all-in-one piece of jewellery and may require visiting a piercer to insert as basically you taper up the piercing to insert the end, but the main body of the jewellery is the same size as the existing piercing. Once in it won’t go anywhere :-) I can’t find anywhere in the UK selling these at the moment, but getting one custom made wouldn’t be difficult.

Helen

Special kit ...

I think you can get those flexible plastic barbells that you can use easily for breastfeeding. It shouldn’t really be a problem although I have to admit from personal experience that they can get a bit sore during times when you have hormonal surges.

Aida

Feeding comes first

What is the priority here? I say breastfeed. Replace the jewellery later, repierce if desired.
Linda
Mom(x3) breastfed after major biopsy took one-sixth of the left breast’s tissue next to the nipple. Retired midwife

Best of both worlds

I wasn’t suggesting foregoing breastfeeding but I’d hate to see the jewellery going into the mouth, or stomach etc. of a babe. If piercing a nipple is wanted, exciting, whatever, than second time around it will again be so. Nurse the babe, let the hole heal up if it will, repierce if desired.

Aida

Feed then repierce

I didn’t think you were recommending foregoing bestfeeding but I’d hate to see the jewellery could be replaced by one made out a substance that is pliable, therefore more conducive to breastfeeding!

Linda

Getting technical

What might be worth considering is the gauge the piercing is at – smaller than a 16 – 1.6 mm – then there is a chance that the pressures involved in breastfeeding could cause the piercing to migrate. As the pregnancy is still in progress then the woman could taper up now if her piercing and jewellery is smaller than that.

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Helen

Expertise?

I personally would not feel a piercing artist would have much knowledge of breastfeeding. Does anyone know otherwise?
Kate, midwife

Ah, but ...

Well they might if they were female and had breastfed themselves... :o)
Sophie

... more than you might think

IME many of them have lots of knowledge, and will seek the info they need if they aren’t sure etc. :-) I’m not working as a piercer but I’m involved with some who do. For starters piercers are quite an alternative lot and the women tend to have breastfed if they’ve had children :- and a lot of them are dads as well.

It isn’t uncommon for a piercer to have a request for a nipple piercing (which actually sits quite some way back from what is thought of as the ‘nipple’) from someone seeking to release an inverted nipple. There are increasing numbers who seek AAP certification and to get this you need to demonstrate a level of training and knowledge, including a lot of physiology etc. (cos if you get the placement wrong on some piercings you can really maim or kill someone).

But I am of course talking about reputable and trained piercers, not those who insist on using guns, don’t have decent autoclaves, or assume they can pierce because they also tattoo....

Helen

Difficulties

In my experience, the difficulties are risk of swallowing part of the jewellery, difficulty with attachment, possible damage to nipple as sucking alters nipple anatomy and thin bars could cut into the nipple, and damage to the baby’s tongue and gums.

Most mums I know have taken them out allowed the piercing to heal (or not – depends on the mum) and had it repierced later if wanted.

Ang RM

Angela’s Archives

Here are some articles on breastfeeding with nipple piercings which might help:

I’ll start off with one from Medical News Today, which has entertainment value, if only for the preposterous first sentence:

Until recently, the option to breastfeed after birth was not offered to women with nipple piercings. ...While nurses are now encouraged to offer breastfeeding as an option, there are still reservations regarding the results.


When you’ve picked your jaw off the floor... here are some which might be more useful... La Leche League (probably know just a teensy, weensy bit more about breastfeeding than Medical News Today...)

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no reason to suppose a prior piercing should be a problem but breastfeeding with jewellery in could be, apart from the obvious choking hazard, some babies can gag or not want to latch on, and there is also the possibility of sensitisation/allergic response with some jewellery.


Interesting article about deciding whether to have a nipple piercing, with a section on ‘will it affect breastfeeding later on?’ from about.com:

The decision is ultimately yours. You have to decide whether you want the piercing enough now, even if you may lose it later. Once you have a child, you will also have to decide if you are going to keep the jewellery in or remove it. Whatever decisions you make, it should be in the best interest of any future or present child. Nurturing your child through breastfeeding one of the most important things you can do during the beginning of their life. Making sure that everything that enters their mouths and bodies during that time is clean and safe is also your responsibility.

http://tattoo.about.com/cs/piercefaq/a/l10603a_2.htm

Some more sensible considerations from pregnancy.org, e.g. discussing night nursing and nursing in public can be found on:


Angela Horn

Unusual complication

I’ve read some pros and cons here, but the situation I came across doesn’t seem to have been mentioned, so I’ll add to the debate.

The lady had one pierced nipple and from about 28 weeks it leaked copious amounts of colostrum from the holes. I believe she eventually took out the bar because the leakage was so inconvenient. This made no difference at all and it continued to leak.

After the birth the baby was totally unable to get his mouth sufficiently on to the breast to get past the holes and the milk leaked all over the place and he got really frustrated and gave up even trying, it looked like he couldn’t keep enough suction to stay attached.

I know she gave up feeding on that side and I think she shortly after gave up feeding on the other because the milk continued to leak from the piercing site.

I expect this is a really rare occurrence as no one else has mentioned it? Still, it may be worth knowing as a possible complication.

Meg

The Middle Wife

By an anonymous second grade teacher

I’ve been teaching now for about fifteen years. I have two kids myself, but the best birth story I know is the one I saw in my own second-grade classroom.

When I was a kid, I loved show-and-tell. So I always have a few sessions with my students. It helps them get over shyness and usually, show-and-tell is pretty tame. Kids bring in pet turtles, model airplanes, pictures of fish they catch, stuff like that. And I never, ever place any boundaries or limitations on them. If they want to lug it in to school and talk about it, they’re welcome.

Well, one day this little girl, Erica, a very bright, very outgoing kid, takes her turn and waddles up to the front of the class with a pillow stuffed under her sweater. She holds up a snapshot of an infant.

“This is Luke, my baby brother, and I’m going to tell you about his birthday. First, Mom and Dad made him as a symbol of their love, and then Dad put a seed in my Mom’s stomach, and Luke grew in there. He ate for nine months through an umbrella cord.”

[She’s standing there with her hands on the pillow, and I’m trying not to laugh and wishing I had my camcorder with me. The kids are watching her in amazement.]

“Then, about two Saturdays ago, my Mom starts saying and going, ‘Oh, oh, oh, oh!’”

[Erica puts a hand behind her back and groans.] “She walked around the house for, like an hour; ‘Oh, oh, oh!’

[Now this kid is doing a hysterical duck walk and groaning.] “My Dad called the middle wife. She delivers babies, but she doesn’t have a sign on the car like the Domino’s man. They got my Mom to lie down in bed like this.”

[Then Erica lies down with her back against the wall.]

“And then, pop! My Mom had this bag of water she kept in there in case he got thirsty, and it just blew up and spilled all over the bed, like psshhheew!”

[This kid has her legs spread and with her little hands are miming water flowing away. It was too much!]”

“Then the middle wife starts saying ‘push, push,’ and ‘breathe, breathe.’ They started counting, but never even got past ten. Then, all of a sudden, out comes my brother. He was covered in yucky stuff, they all said it was from Mom’s play-center, so there must be a lot of stuff inside there.”

[Then Erica stood up, took a big theatrical bow and returned to her seat. I’m sure I applauded the loudest. Ever since then, if it’s show-and-tell day, I bring my camcorder, just in case another Erica comes along.
Making it Better: For Mother and Baby
Maternity Network Model

Had you heard of the Maternity Tsar, Sheila Shribman a month ago? No, I thought not, me neither, but my guess is that she will become as famous in UK birth circles as Baroness Cumberlege. I hope so. Her real title is National Clinical Director for Children, Young People and Maternity Services, which corresponds with the Children’s National Service Framework.

Making it Better is rather confusing; it starts by talking about moving consultant maternity services from Hudersfield Royal Infirmary to Calderdale Royal Hospital, making it look as though this was about a local issue but later on there is talk of the midwife-led services in Southampton. This is meant to be a national report, I think. Perhaps it was rushed out in haste?

Her report talks a lot of sense. It was released by the Department of Health on February 7th. The report presents the clinical case for changing the maternity services, Making it Better: For Mother and Baby with the expressed intention: “Providing the best services is the major driving force behind service changes.” No doubt there will be groans all round, more change, but this time, perhaps the change will be for the better? If we can get the system and the people in the system to change, that is.

My first impression was that this report was an apologia for closing smaller ‘uneconomic’ maternity units, but no, “in some cases it will mean more investment, not less”. The Conservative Party had produced its own document just a month before (Choice in Childbirth: A Conservative Party Consultation) claiming that of the 43 maternity units under threat of closure most were deemed uneconomic because they had under 3,000 births per annum or they were run by Trusts in serious deficit. A consultant maternity unit needs to employ eight consultant obstetricians to cover the 168 hours in a week – but in terms of births per consultant per year the numbers just do not add up. There are simply not enough consultants to provide this sort of cover, hence the long list of closures. And, of course, there is a shortage of obstetricians as we all know. Who wants to make a career out of being sued?

The cynic in me says that Making it Better is a public relations exercise – the public will just have to get used to the idea of travelling further for consultant care but the optimist in me replies, “So what? It’s very pro-midwife, it wants every woman to have a named midwife. It looks as though it is an attempt to sell midwifery care to women. Of course it’s a shame that the obstetricians did such a good job of selling hospital birth to women 40 years ago that such an exercise should be necessary, but there it is.

The report is very ARMish in its language – it speaks of a vision of giving women the choice of a home birth supported by a midwife; birth in a local facility or birth supported by a local maternity care team that includes a consultant obstetrician. To allay fears about the health of new born babies, there is talk of: “a safety net of fully agreed networks to ensure they have access to the whole range of specialist services.”

It is to be welcomed that the report says explicitly that: “there is no optimum number of births to make a unit sustainable.” This should provide birth centres currently under threat with some high level ammunition to fight closures. There is also a call for change to be developed in consultation with local people. Local people are often very supportive of their birth centres and this has helped some such as Stroud remain open in the past, though whether this has come in time to save the maternity unit at Hope Hospital, Salford (featured in Midwifery Matters, a year ago) is yet to be seen. There is also a call for: “approachable and supportive antenatal and postnatal services in convenient and accessible settings”. This is a little worrying, it rather looks as if postnatal visits are to become a thing of the past and I think there should be a campaign to save postnatal visits – particularly when new mothers are discharged from hospital so soon after birth.

I am also puzzled by the following statement: “By reorganising services, the NHS can ensure families have the best possible antenatal and postnatal care and other facilities such as Jobcentre Plus” – my italics, just why do new mothers need a jobcentre so close to their postnatal services? They’ve just taken on the most demanding and most important job of all – bringing up the next generation. Is mothering really so little valued?

However, a guiding principle for maternity services in the future is that: “all women will need a midwife but some will need a doctor too.” (their italics, this time) This is very much a step in the right direction, as is the statement: “with the increased emphasis on care being provided in community based settings such as children’s centres, midwives will have a more visible local presence.” I’m just wondering whether I can glimpse the ground being prepared for the NHS Community Midwifery Model, where women will be able to choose their midwife? If so, this is most welcome. I do appreciate that the days of seeing the local midwife biking around the neighbourhood in her blue uniform visiting new mums are long gone, but it would be lovely if the public could once again see midwifery as a community profession rather than think that midwives are some sort of specialist hospital nurse!

Margaret Jowitt

(This piece represents my own first impressions and views and should not be taken as any sort of official response from ARM. The report came out after the magazine should have been at the printers and in the middle of moving house!)
Overheard at a surgery

Oh, hi, have you just been to see the midwife?
Yes, she's lovely, she's a bit weird though, she suggested a home birth.
What even though it's your first baby?
"Yes, mad isn't she? Never mind, I'd rather have a mad midwife than a horrible one!"
Anne
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
Aspull, Wigan WN2 1XB
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.3shiresmidwifew.co.uk

**Midstone 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!

**South Wales**
Meeting first Weds of every month All welcome. Please phone or email for details
Annie Burdin
07814 082184
anne-marie.burbin@virgin.net

**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.

**what’s on elsewhere**

Saturday, March 10
University of Salford
Advanced practice in obstetrics and gynaecology ultrasound
contact: Faculty of Health and Social Care, CPD unit, tel: 0161 295 7012 cpdunit-fhs@salford.ac.uk
Fee: £80

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-child-birth-trust.co.uk

Wednesday, March 21st, Birmingham
Natal Hypnotherapy
Introductory study day
Impact of fear on birth; how to break the fear-tension-pain cycle; power of language; effective language in the birthing room; relaxation and visualisation techniques. Fees: birth professionals £70; students £40. contact: Natal Hypnotherapy 01428 712615; www.natalhypnotherapy.co.uk

Wednesday 25th April
Wexham Park Hospital, Slough
Moxibustion
Denise Tiran, midwife, university lecturer, complementary practitioner and author of numerous professional text books will be holding a study day on Moxibustion for turning the breech baby. Fees: £45 midwives; £25 students.
If anyone would like to attend please email Sarah.Coxon@hwph-tr.nhs.uk or telephone 01753 633709, Please leave a message if I am not working and I will return your call asap.

The ARM Student Midwives Conference:

**Being and Becoming a ‘With Woman’ Midwife**

An inspirational study day for student midwives

**Wednesday 7th November 2007, Oxford**

Speakers and workshops to be confirmed

Cost: £25

for further information email: armconference@btinternet.com or contact Dot Parry, 4 Hermitage Road, Crumpsall, M8 5SP 0161 795 2425 (home number you can leave messages here)

**ARM Group in London?**

It seems, as most Londoners are very busy people, that for some time no-one has had a chance to organise a local group for residents of the capital. Well that is soon to change. Midwives! Doulas! Birth-Educators! Students! Women! Men! do contact me if you’d be interested in attending or would like to be involved in leading the groups. Watch this space for details of our next London meeting. Roma@allaboutthemusic.co.uk
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>
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<tr>
<td>Beechwood Pinard stethoscope (continental 13&quot;)</td>
<td>10.00</td>
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<tr>
<td>ARM Badge (Pinard logo, blue/gold enamel, safety fastening)</td>
<td>3.50</td>
<td>A</td>
<td></td>
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<tr>
<td>Calico carrier bag (Pinard logo)</td>
<td>1.50</td>
<td>A</td>
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<tr>
<td>Baby T-shirt (‘Born into the ARMs of a midwife’)</td>
<td>7.50</td>
<td>B</td>
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<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” x 4”, 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>
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<tr>
<td>Car sticker (Logo: Owl on Pinard, ‘Pregnant? Be wise, choose a Midwife’)</td>
<td>0.60</td>
<td>A</td>
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</tr>
<tr>
<td>Mouse mat (Logo: Owl on Pinard, ‘Be wise, read Midwifery Matters’)</td>
<td>3.50</td>
<td>B</td>
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</tr>
<tr>
<td>Silver Miniature Pinard (2 cm) earrings (per pair)</td>
<td>15.00</td>
<td>A</td>
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<tr>
<td>Silver Miniature Pinard (2 cm) pendant on silver chain</td>
<td>15.00</td>
<td>A</td>
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<tr>
<td>ARM CD ROM of the first 100 issues of the magazine</td>
<td>25.00</td>
<td>C</td>
<td></td>
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<tr>
<td>Childbirth Unmasked (stress hormones in labour) Margaret Jowitt</td>
<td>5.00</td>
<td>D</td>
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</tr>
<tr>
<td>Midwifery Matters (single back-copies)</td>
<td>2.00</td>
<td>B</td>
<td></td>
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<tr>
<td>“ Choices in Childbirth” (free leaflet)</td>
<td>see below for postage costs</td>
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<tr>
<td>“What is a Midwife?” (free leaflet)</td>
<td>see below for postage costs</td>
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</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:___________

CD-ROM

Orders to ARM Sales, Sarah Montagu, 16 Wytham St, Oxford OX1 4SU 01865 248159
Spring National Meeting
Saturday, March 10th
9 am - 4.30 pm
Cundall

Cundall Village Hall, Cundall, North Yorkshire

Programme
Morning: The Childbirth Continuum
'Childbirth is more than the act of giving birth. For a women, it is a continuous process from conception, through pregnancy, labour, birth and beyond' (NMC 2004)
Long or Normal – Stages of labour and re-defining them.
• What does it mean to have a long pregnancy, labour or birth?
• Who do the guidelines work for and how can we push the boundaries?
• How to define when medical intervention is truly needed.
Afternoon:
Talk and DVD - Newborn behaviour - Do Epidurals Sabotage Breastfeeding?
Workshops:
• Slings and real nappies • IUD and supporting women’s choices • Home monitoring for long pregnancy
• Caring and sharing time
fees: £15 members, £20 non-members, £7.50 students
Payment on the door; lunch included
Further information: contact Chris Warren: 01423 360460
IMPORTANT If you need overnight accommodation please phone Chris as she has only limited room. Accommodation may be available locally at £10 per night.

Directions:
Northbound on A1 come off at J48.
1st roundabout – right,
2nd roundabout – left on to A168
Continue straight over two roundabouts
Pass under bridge and turn right, signed Norton-Le-Clay and Dishforth
T-junction turn left
T-junction turn right, then immediately left
Follow road, through Norton-Le-Clay and arrive Cundall crossroads.
Turn right
Village Hall 100 yds on right
Turn into side car park round the back

Steering Group March 9th
venue: Chris’ house, Eagle Farm House, 8 pm,
All ARM members are welcome to attend but if a vote is required only SG members may vote.
Agenda items: contact Sarah Montagu on 01865 248159 or 07946 392728 (text) to have an item added to the agenda
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

P.S. So far the extra income from Gift Aid is over £6,000. Thank you to all who have completed the Gift Aid form. Keep up the good work.

Message from Ishbel
In June 2006 I sent out a reminder to the remaining 605 members whose standing order subs were still at the old rate of £25. This brought in a sizeable response, for which I’m grateful. However, there are still around 200 members who haven’t responded.

I’m proposing to send out a FINAL reminder to these members. The problem is that although they haven’t upgraded to £30, their £25 payments are still being transferred into our account. I propose to extend the original deadline to receipt of the Spring 2007 issue of Midwifery Matters, after which payments at the old rate will be treated as donations to ARM funds, and no further issues of the journal to be sent until upgrade and balance due is received.

I know it sounds rather harsh, but the last time we increased the subs it took several reminders over three years to bring everyone into line! Most national journals just cut people off the mailing list without notice, so we’re being very generous!

Many thanks
Ishbel Kargar

So...
If you’ve had a letter from Ishbel please respond and increase your standing order to £30. Do nothing if you no longer wish to receive the magazine but wish to carry on supporting ARM financially! Many thanks.
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):____________________________________________________
________________________________________________
________________________________________________
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