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cover: hands off the breech!

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contents

articles from Steering Group

Making it Better for Mother and Baby: A strategy or a sop, *Ruth Deery, Deborah Hughes, Mavis Kirkham* 2
Maternity Matters: ARM's response, *Sarah Montagu* 4
Are we Sacrificing Normal Birth? *Angela Cartwright* 5
A Brief History of ARM, *Ishbel Kargar* 6
Keeping the Wolf from the Door, *Elizabeth Parker* 9
A Philosophy of Midwifery, *Jolanda Corbijn* 10
Student Life on the Ward 11
Measure for Measure, *Sarah Montagu* 12
Student Hardship Campaign, *Andrea Simpson* 14
Normal Breech Birth, *Lynn Walcott* 16
Escaping the Clutches of the NHS, *Margaret Jowitt* 19

business

National Meeting report 21

news and views

nettalk: *Panorama* 23

Reviews

Self-Improvement Toolkit for Maternity Units 30

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Making it Better for Mother and Baby: A strategy or a sop?

Dr Ruth Deery, Reader in Midwifery, University of Huddersfield

Deborah Hughes, Researcher, University of Huddersfield, Midwife, Calderdale & Huddersfield NHS Trust

Mavis Kirkham, Professor of Midwifery, Sheffield

Sheila Shribman, National Clinical Director for Children, Young People and Maternity Services, has recently presented the current widespread reconfiguration of maternity services as an opportunity to improve choice for women (Shribman, 2007). Important parts of this strategy are midwife-led units, whether free-standing birth centres or 'alongside' midwife-led units located on the same premises as consultant-led maternity units. Whilst the rational for such units is partially to satisfy the demands of Health Overview and Scrutiny Committees, they also fulfil important roles in terms of effectiveness and efficacy. Sheila Shribman lists these as:

- Safer care
- Improving access and outcomes
- More choice
- Promoting normality
- Local ante- and post-natal services closer to home
- Home-like birth environment

Hodnett *et al* (2005) in a systematic review of births in birth centres, found they were associated with a reduction in interventions in labour. The National Childbirth Trust (2007) identifies a range of benefits including increased breastfeeding rates and client satisfaction with services. Birth centres and midwife-led units are also associated with improved job satisfaction for midwives, and are important in the recruitment and retention of midwives (Kirkham, 2003; Walsh, 2007).

At the present time, there are approximately 112 birth centres and midwife-led units in the UK, 72 of which are free-standing birth centres, 36 are alongside midwife-led units, and four are privately owned and run. 16% of babies born in the UK are born in birth centres and midwife-led units (NCT, 2007).

However, five of the 112 units are currently temporarily closed and a further 16 are under threat of closure. This means that of the 108 NHS birth centres/midwife-led units, 21 are (or 20%) are either currently closed or threatened with closure (and this is probably an underestimate). Sheila Shribman does not mention this worrying fact in her report, despite her advocacy for such units, and the Government's pledge *"to give all women a choice over where and how they have their baby… by 2009"* (DoH, 2007).

We have recently been undertaking a study into one such unit, a free-standing birth centre in England that has experienced considerable problems. We believe that there are important lessons to be learnt from struggling birth centres, and these should inform strategic planning if birth centres and midwife-led units are to be a successful part of British maternity care and not a sop to local communities faced with the loss of maternity services.

There is a recognised political dimension to birth centres and midwife-led units, most of which enjoy considerable local support and are also favoured by influential user groups such as the National Childbirth Trust (NCT) and the Association for Improvements in the Maternity Services (AIMS), as well as professional bodies such as the Royal College of Midwives. However beliefs about birth are also deeply personal. This philosophical and personal dimension can undermine the political and strategic support for birth centres, as in Sheila Shribman's report.

NHS managers, based in hospital at the hub of medical services, may often feel personally ambivalent about the very units they are responsible for. This personal ambivalence is echoed in the often-vocal professional opposition of GPs and obstetricians, who may feel threatened by non-medical care. In a highly medicalised society, midwifery-led care is likely to be seen as deviant, despite the evidence. The midwives working in birth centres and midwife-led units therefore struggle to gain and retain the support necessary to make the units successful and sustainable.

The midwives in the Birth Centre we have studied have reported many instances of deep-rooted lack of support for the unit:

"I think the rot set in even before it opened up. I think the fact it wasn't supported by the consultants, it wasn't supported by the Trust really had a lasting effect on the midwives working in the Birth Centre." (Manager)

"When we went to meetings… the conversation always was "… how can we shut it down, how can we pull out, how can we do it less?" … it was always kind of looking for a way of not doing it the way we'd have loved to do it." (Midwife)

"That's what they do, close it by stealth, because what they do is make it impossible for you to manage…" (Midwife)

Whilst financial considerations are often presented as the primary reason for reducing or closing birth centre services, many supporters and midwives reason that the costs of such units are often over-estimated as 85% of costs are midwifery salaries and this cost has to be met

wherever women give birth (NCT, 2007). Birth centres are undoubtedly an easy picking in the current financial climate and more accurate financial analyses of such units are urgently needed.

Whilst the Birth Centre in our study was opened for all the reasons endorsed by Sheila Shribman, and has enjoyed considerable support from local women and midwives, as well as from some local NHS managers, our findings are that there was a lack of willingness to give the support and make the decisions necessary to make the Birth Centre successful. The midwives were constrained by guidelines and organisational protocols designed for hospital care, a lack of marketing and publicity, an unfavourable grading structure, and an absence of support from medical and senior managerial staff.

"Nobody once turned round and said to any one of us "you have done a good job… we were battered all the time." (Midwife)

No strategic or action plan was ever put into place to address the problems of the Birth Centre. Instead, every opportunity was taken to reduce staffing cover and facilities for women. Whilst the Birth Centre remains open, it is largely run through an on-call system and this has a detrimental effect on the community midwifery service, resulting in frequent closures, particularly at weekends. The midwives describe it as 'dead in the water' and not providing any true choice for women, as women in labour are often told they have to go to the consultant unit 10 miles away because of staff shortages. Disillusioned and demoralised midwives have left to work elsewhere, thereby aggravating staffing problems.

This picture is not uncommon. We have visited other birth centres and found similar stories. Whilst Sheila Shribman and other policy makers at the Department of Health may advocate birth centres and midwife-led units, and there is ample evidence that these units offer a safe and probably cost-effective alternative to larger consultant-led maternity units, the picture on the ground is less rosy. Existing birth centres and midwife-led units need to be better supported within the current NHS structures, and the reasons why so many struggle must be better understood if newly planned units are not to suffer the same difficulties. The midwives who run such units need to be listened to and given the resources and structures to make their units successful. There is no room for managerial ambivalence about birth centres if such units are to realise their potential in tomorrow's maternity services. Without clearer commitment, things will not get better for mother and baby, despite the Department of Health's best intentions.

REFERENCES

Hodnett ED, Downe S, Edwards N, Walsh D (2005). 'Home-like versus conventional institutional settings for birth', *Cochrane Database for Systematic Reviews*, Issue 1.

Kirkham M (ed) (2004). *Birth Centres: A social model for maternity care*. Books For Midwives.

NCT(2007). http://www.nct.org.uk/about/campaigns/birth Accessed 13.2.07.

Shribman S (2007). *Making it Better for Mother and Baby: Clinical case for change,* Department of Health.

Walsh D (2007). *Improving Maternity Services: small is beautiful – lessons from a birth centre*. Radcliffe Publishing Ltd.

Valuing our Worth

If this magazine has arrived on your doorstep later than usual it is because net talk was replaced to take account of ukmidwifery list responses to the *Panorama* programme screened on May 3rd.

When *Maternity Matters* came out in April there were various newspaper articles leading to internet responses on various sites from the public which showed how much of an uphill struggle it is going to be to reassure women and men that birth is safe away from consultant units, and then along came *Panorama* which showed just how much pressure midwives and maternity units are under. Women are now caught between the devil and the deep blue sea. It seems to be a choice between an 'unsafe' birth away from a consultant unit, or cattle market obstetrics in a large understaffed hospital, with staff and beds cut to the bone. As for postnatal care, beds are freed up as soon as possible after birth and, "Could you possibly manage to get to the Children's Centre, because we're so busy, they called me into hospital last night, they were short staffed and... "

I know I am painting a bleak picture, and I know it's not like this everywhere, but I think healthcare managers in this country need to consider whether they place any value at all upon new babies and their mothers – and their midwives. All that seems to be considered is the financial cost of litigation when something goes wrong and this is a profoundly negative way of looking at maternity care. All the health managers seem to think about is how to run maternity units with the smallest number of staff compatible with the least amount of litigation. Labours are speeded up to save staff time, and time is money. There are some things that money cannot buy, a good birth, a happy family, a happy workforce. The maternity services run on the goodwill of those who work in them and when the goodwill runs out what will be left? Dead and damaged mothers and babies and litigation.

If this Government thinks that Maternity Matters then it must realise that midwifery matters too – and there is enough evidence to show that one-to-one midwifery care from a known midwife is the key to improving the maternity services. The Government must be prepared to put its money (no, *our* money as taxpayers) where its mouth is.

Because we're worth it. Or aren't we?

Margaret Jowitt

Maternity Matters
ARM's response

There seems to have been one report after another on the maternity services, and this one follows hard on the heels of Dr Shribman's *Making it Better for Mother and Baby*. It's hard not to feel cynical, as the reports jostle for space in the headlines and seem to move ever further from the realities experienced by mothers and midwives – are the Government really hoping to improve things or do they just hope that if they keep telling what wonderful things they're going to do, we won't actually notice how bad they really are?

In *Maternity Matters,* there's lots of positive sounding stuff – choice for women on the place of birth, midwives as the portal of entry into the maternity services, integration of services into the community, expansion of choices in accessing antenatal and postnatal care and outreach programmes for vulnerable and excluded groups – but there seems to be very little that will ensure that it will become reality. The major difficulty with virtually every Government pronouncement on this topic since *Changing Childbirth* is that not enough concrete targets are set and there is no ring-fenced funding – in other words, there is no incentive for PCTs or acute Trusts to deliver what is set out and no money for them to do it with either. Seeing as we're currently regularly hearing of home birth services being suspended for lack of staff, post-natal care limited to two or at the most three visits, and student midwives qualifying from their courses and finding there are no jobs for them to go to, not to mention midwifery led units under threat of closure, it is hard to see how all of this can be implemented by 2009.

There are also several areas where the promises don't reach far enough, for instance, the document specifies continuity of care for the antenatal and post-natal periods, but refrains from any mention of continuity of intrapartum care, where research has shown that it is likely to make the most difference – it even singles out for particular praise the Southampton Sure Start maternity team, where one of the key factors is that they offer 'continuity of care throughout pregnancy, *birth* and afterwards for up to six weeks' (my italics), but doesn't appear to notice the contradiction. There are also passages that appear to contradict *Making it Better for Mother and Baby* which called for a cut in the number of obstetric units, whereas *Maternity Matters* calls for ensuring that 'all women have access to their midwife in their local community and, should it be required, can have immediate transfer to a fully equipped local hospital with obstetricians, anaesthetists and other specialists..' Other statements that don't quite add up include the hope that commissioners use 'tariffs (to) support the effective commissioning of high quality and innovative services', when major concerns have been expressed that Payment by Results is leading to perverse incentives to intervene more in the birth process. The other massive gap is in staffing levels – the document is calling for increases in home births and midwife led units, choices in location of antenatal and postnatal visits (presumably home visits, antenatal clinics and 'shop-front' midwifery centres), while at the same time acknowledging that the changing profile of women getting pregnant is leading to more women being classified as high risk, so there is still a need for fully staffed obstetric units. Although there is a lovely table showing the number of midwifery training places, there is barely any mention of the huge deficit in midwife hours. Even if there are 900 more WTE equivalents than in 1997, the birth rate then was 609,000 and is projected to be 701,000 this year, so those 900 extra midwives are going to have to work their socks off even to keep up with present demand, never mind providing lots more choice.

Despite the statements in favour of home birth, it's not clear how much they really want the home birth rate to go up – for instance, under 'choice of place of birth', the document states that providers offering 'high quality services' can increase capacity so that they can offer services to women from outside their area. 'High quality services' are therefore being equated with hospital care – there's no suggestion that high quality home birth teams can offer home births to women in neighbouring areas – how about that for an idea, roving home birth teams?!.

This may seem a minor point, but the internal pedant was both appalled and astounded to see an errant apostrophe on page 20 – 'It's focus is on providing antenatal…' – perhaps the Government's prioritisation of 'education, education, education' should start with its own civil servants! Mind you, I wasn't much impressed either with the thought of a glorified employment agency having won the Social Enterprise Unit pathfinder funding, rather than the IMA's NHS Community Midwifery Model, so mere grammar isn't the worst part about that paragraph!

I would really like to be able to welcome this document and the statements it contains. However, the lack of specific targets and the absence of funding unfortunately means that this document will remain a 'soft' selection of aspirations that will probably remain as little implemented as *Changing Childbirth*. If one compares what it advocates and what one daily hears of happening in today's NHS, one has to wonder sadly what planet policy makers are living on.

Sarah Montagu

What the RCOG thinks

Following the publication of *Maternity Matters*, the Royal College of Obstetricians and Gynaecologists issued a statement welcoming it as an opportunity to bring back the spotlight to maternity care in this country.

In particular, it believes that women need to be well informed ... particularly their choice of place of birth. This should include the arrangements for transfer of care where the place of birth is not in a consultant led unit. It continues to believe that hospital births are still the safest option for most women.

The RCOG "particularly welcomes the Department of Health's acknowledgement of the need for more senior cover in maternity care and the need to increase consultant obstetric presence on the delivery suite. This will improve the quality of care and reduce maternal mortality and morbidity."

It welcomes the acknowledgment of the need for a set of national Maternity Standards.

RCOG President, Professor Allan Templeton said, "*Maternity Matters* will help put maternity services back on the NHS agenda. There is the pressing need for us to refocus our attention to ensure that safety at birth is never compromised, but where possible, normal childbirth is encouraged.

"This report will help us implement a safe and satisfying environment for childbirth. If this is to be an even better experience for women and their babies, investment in maternity care will need to increase. Inevitably there will be, in many places, a need to consider the reorganisation of current services.

"If we are to provide mothers with more choice, then this can only happen when our places of birth are fully staffed. We will need more consultants and midwives if both women's expectations and standards of care are to continue to improve."

Are We Sacrificing Normal Birth on the Altar of Perceived Safety?

I do agree we need a greater interest in birth from consultant obstetricians. Complex cases seem to be left to the management of staff grades/registrars, some of whom have very poor practice. I don't know about other units, but paediatric SHOs seem to cover neonates – with staff grades coming reluctantly when the SHO is out of their depth.

They are absolutely right about needing more midwives – but this does not mean all women will want to have their babies in hospital.

Professor Templeton says "There is the pressing need for us to refocus our attention to ensure that safety at birth is never compromised, but where possible, normal childbirth is encouraged."

There was an interesting comment by Diane Weissinger on this at a conference I recently attended (Lactation Consultants of Great Britain conference at the end of March):

Have we sacrificed normal birth for most women for the perception of safe birth for all babies?

As far as I know, the rates of perinatal mortality and morbidity are higher than in other countries, with a soaring surgical delivery rate and increasing emotional trauma to women. And in sacrificing normal labour and birth – what impact have we had on our relationship with our children? In most mammals, abnormal birth often results in the mother abandoning the infant(s) and refusing to nurse.

Various tactics are employed by vets, such as ensuring the calf born by caesarean section suckles – they put the mother in a stall so she cannot walk away or kick the calf. The suckling seems to make the cow accept the calf as hers. If puppies are born by caesarean, the puppies and placentae should be placed at the rear end of the bitch before she comes around from the anaesthetic. This ensures the bitch accepts the puppies.

Di Weissinger mused that it was only social conventions and acceptance which means these primitive instincts in humans are not played out, i.e. the babies rejected. But how many of us have had these feelings, whilst playing out the role of the loving mother?

In the Philippines babies were regularly abandoned at the maternity unit. When the Baby Friendly Initiative was introduced, all babies stayed with their mothers, even ventilated neonates. Most babies stayed in their mother's bed and formula was not provided. The number of babies abandoned dropped considerably.

As the current climate of medicalisation of pregnancy and birth has not resulted in healthier mothers and babies, maybe this needs a rethink. But in the current legal climate, no one would dare to sacrifice the occasional mother and baby for the greater gain of humankind.

Angela Cartwright

A Brief History of the Association of Radical Midwives

Ishbel Kargar

JOINING ARM in January 1981, half-way through my midwifery course, was like opening a door to fresh air after being cooped up in a cupboard.

I'd qualified as a nurse (SRN) in 1950, and in 1951 completed Part 1 SCM (6 months hospital-based midwifery course). The 30 year gap is explained by my life abroad from 1952 until 1975, raising a family with my Iranian husband. In 1980 I started the one-year hospital-based course. Clinical and theoretical teaching was given on the premises by midwifery teachers and, while my group was fortunate in having the best of the four tutors, I was frustrated by the medicalised and routine nature of the maternity care in this large consultant unit. A chance reading of an article by Beverley Beech of AIMS, pointed me in the direction of ARM, which was then 5 years old. The women of the local ARM group impressed me with their political awareness and their determination to tackle the erosion of the midwife's role, threatened by the widespread adoption of routine interventions in maternity care, a 'gift' from the USA.

That Name

It's now 30 years since the group chose its name. Searching for a suitable acronym, A.R.M. was an obvious choice, as Artificial Rupture of Membranes was almost universally practised and these initials were on the case notes of most women having hospital births. The 'A' and 'M' were easy – Association and Midwives. But what about the 'R'? Dictionaries were consulted, and by mutual consent the word 'Radical' was chosen, because: "it expressed in its original sense the essence of our group, i.e. pertaining to roots and origins."

It was realised that the word 'radical' might alienate potential members, and indeed there have been a one or two debates about changing the name, none successful. Membership continued to grow, in spite of (or because of?) the name, and the respect which ARM has earned among professional and political circles is proof that we are appreciated, in spite of our being radical in both senses of the word.

Aims and Objectives

The co-founder, Marianne Scruggs described the birth of ARM in a published article. She tells how she was half-way through her midwifery course in the Midlands in the early spring of 1976, when she met another student who was just starting her course in 'a Northern Hospital'. (Note how she carefully avoided naming the hospitals, which illustrates ARM's avoidance of identifying people and places at that time). She wrote, "for the next three days we shared books, newsletters, information, and more importantly, support. We were afraid that in the present surge of obstetric interference we would never learn how to be true midwives: women who are 'with women' in pregnancy and childbirth, and who are caretakers of normal birth, women who use their hands, eyes and ears as sensitive, diagnostic tools, who are patient, knowledgeable and supportive".

There is no better way to describe the kind of midwife which ARM stands for. Marianne and Judy Rogers talked with other students and midwives, and their ideas spread by word of mouth. The first meeting was held a few months later, attended by "ten student midwives and one staff midwife".

General Management

ARM decided at the outset to avoid hierarchy. Initially there was a 'secretariat' consisting of about half a dozen local members. The group was responsible for decision making for a year, then handing over to another group and so on. This spread the management expertise around the country. At the AGM in 1988 a 12 member elected Steering Group was formed, with a mandate to spearhead ARM's objectives and to respond to national and local issues as they arise. The term of office is three years, with the option to be elected for one further three-year term before standing down for at least two years.

The 'Newsletter'

In 1978, with membership growing, a quarterly newsletter was started. I remember the thrill of receiving my first copy by post, (issue No. 9, cover photo of Nicky and family, newborn Reuben being bathed). I was greatly impressed by the content, which included an article about children watching their siblings being born; a birth report, with the familiar theme of routine intervention and subsequent post-natal difficulties; a report from a Dutch midwife about birth in Holland; the current position following the publication in June 1980 of the 'Social Services Committee Report on Perinatal Mortality' (commonly known as the 'Short Report'); an article about Direct Entry Training (under threat of extinction); a report of the Second

'Research and the Midwife' conference; a selection of gleanings and mini-reviews of new books, films and other journals.

The high quality and breadth of topics has been constantly maintained up to the present day, with the inevitable improvements in production methods as these became available. Initially the newsletter was untitled, the cover carrying the heading 'Association of Radical Midwives', with a photograph or drawing, and the issue number. The Autumn 1982 issue was the first to carry the title 'Newsletter' which was sporadically used until Winter 1986, when the journal became "Association of Radical Midwives Magazine". In 1989 members were asked to suggest a title for the journal, and at the AGM that year the journal became "Midwifery Matters" by popular vote.

Membership role

In 1982 I took over the membership work. In those early days, the mailing of the quarterly journal involved going through the stack of record cards, handwriting the addresses on the magazine wrappers. Then we acquired a second-hand addressograph machine which was kept at Jane Grant's house in London. She had the job of typing new and changed addresses on the metal strips, which were then fed into the machine which stamped the addresses on to the newsletter wrappers. A year or so later Marianne Scruggs bought one of the new home computers and offered to set up a simple membership database. This was before the days of email, so I periodically posted a list of new and amended details to Belinda Ackerman who updated the membership list and produced printed labels.

The big breakthrough came in 1987 with the Amstrad Personal Word Processor, affectionately known as the PCW 8256. I have fond memories of that green screen and the little three inch disk. (Yes, I even learned to spell disk with a 'k', thanks to the American influence on this new technology). At £450 it was a very expensive machine, paid for by instalments, but it did come with a printer and a keyboard, and in addition to the word-processing software (another new word to learn!), it also had a database programme which we embraced with heartfelt thanks. No more lists to London!

Producing the Magazine

Each of the quarterly journals was put together and produced by a different regional group, giving the members the opportunity to write their own articles and reports, with extra content being supplied by the secreraria t and other ARM members elsewhere. This inevitably resulted in a wide variety of styles and quality of typesetting, though the quality of the content remained consistently high. The advantage of this system was that all members were able to contribute, and take an active part in ARM. However, the disadvantages gradually became apparent, in that some groups had less easy access to printing facilities than others. Eventually, it was decided to form a magazine group which would be locally based and which would produce all future issues of the journal. The Manchester local group became the first Magazine Group, producing their first issue in Autumn 1986, using a local printing firm, and the journal began to acquire a standardised format.

After about three years the South Wales group took over, producing their first issue in December 1989, transferring responsibility for the typesetting, layout, and so on to a company in Cardiff. When this group decided it was time to hand over, it was decided to continue with a permanent base for the journal production. At the 1995 AGM Margaret Jowitt's application was accepted and she was duly appointed Magazine Editor. Her input includes editing, typesetting and layout, using a local company (Orphans Press) for the final printing. We have developed an excellent working relationship with this firm, thanks to their consistently high standard of work, working from a CD and they now also mail out our quarterly journals, using emailed address lists which I send.

The main content has remained the responsibility of volunteer regional groups, and the four groups for the following year are decided at each AGM.

Membership

When I joined, ARM was well established, with 16 regional groups and a total UK membership of about 150, roughly divided between students and practising midwives, with a number of non-midwives concerned about maternity care. From the outset, membership was not restricted to midwives and students, indeed ARM is always eager to hear the views of women from other walks of life, as their input to the debate is valued highly.

During the early years the newsletter was available on subscription and for sale at meetings. Actual membership of ARM included the minutes of the National Meetings as well as the newsletter. It's interesting to note that this separation was designed to preserve anonymity of contributors to the discussions at the National meetings. In 1982 the separation was discontinued, newsletter and minutes were combined in one annual subscription of £10 p.a. Current membership is approximately 1300 UK and 70 Overseas, (£30 UK and £35 overseas).

National Meetings

Shortly after its birth, ARM began organising weekend meetings every six weeks, at different venues around the country. As is the case today, overnight accommodation was offered by the hosting group, and the meeting itself was usually held in a member's home. When numbers grew and more regions were represented, meaning longer journeys, it was decided to hold the National Meetings every three months, with the Autumn meeting becoming the AGM. The informality of the meetings has been retained, though they no longer cover the whole weekend; the Steering Group meets during the previous evening, and the National Meeting is a full day event with speakers, workshops and internal issues included.

Local Groups

As ARM grew, the membership gradually spread around the country, and local groups began to form, holding meetings in each others' homes or other venues. Contact addresses for these local groups were published in the journal. Gradually this list grew to include members who offer local information on maternity services to women in their areas. These members were often in isolated places, unable to get a group together. The list continues to include active groups as well as local contacts.

Campaigns

ARM has continually campaigned for improvements in maternity services, sometimes individually on a local issue, and sometimes nationally. There are too many examples of this work to go into much detail in this article, so I'll list the main ones, taken from the pages of the ARM journal.

The Nurses, Midwives & Health Visitors Bill 1978. This was based on the 'Briggs Report' published in 1972, which recommended the abolition of the three bodies regulating nurses, midwifery and health visiting in favour of one central body controlling the education, professional standards and discipline of all three, i.e. United Kingdom Central Council, (now NMC). ARM successfully campaigned for a separate Midwifery Committee when legislation was finally passed several years later.

Project 2000 –1985 (A proposal to set inclusive training for all health professionals, midwifery successfully opted out).

Rubella –1986 (Anti D prophylaxis)

Professional Conduct Machinery –1989

Midwifery Legislation Campaign – 1990 (An attempt to obtain a Midwives Act)

Midwives' Contract –1990 (Provision of services in the new market force NHS)

House of Commons Health Committee Enquiry into Maternity Services – 1991/1992 (The Winterton Report); (ARM member, Caroline Flint, appointed advisor).

Changing Childbirth –1993

ARM Full-day Conferences

June 1981, Sheffield – The Role of the Midwife
May 1982, London – The Practising Midwife
June 1983, Nottingham – Education and the Midwife
May 1984, Oxford – Working for Change
May 1985, Manchester – Active Midwifery
May 1986, London – Alternative Midwifery: Care and Practice
May 1987, Birmingham – The Mother and the Midwife
October 1988, Milton Keynes – Homebirth for Midwives
May 1989, London – The Political Midwife
April 1995, Liverpool – Super-Vision: Supervision in Midwifery
April 1998, Birmingham – Vision for Midwifery Education

MIDIRS (Midwives Information and Resource Service)

No history of ARM would be complete without mention of MIDIRS, which sprang from an ARM working group, (Midwives Information and Resource Group), set up to provide a source of information gleaned from UK and international publications. It soon became apparent that ARM couldn't finance the tremendous amount of work involved, so the group split from ARM and became a registered charity, making it eligible to apply for grants and other funding sources. We are very proud of our part in the foundation of this unique source of research material.

UKMidwifery Email Discussion Group

In April 1999 I set up an email discussion group, open to midwives, students, mothers, and anyone interested in improving maternity services in UK. A lively forum where people exchange ideas, opinions, views, information, etc. Valuable and helpful discussions on midwifery and maternity care take place, some of which find their way on to the pages of 'NetTalk' in Midwifery Matters. It is an extremely successful venture, membership currently over 2,760, including several from overseas, in spite of UK in the name! (To join the group go to http://groups.yahoo.com/group/ukmidwifery/).

Free Information Leaflets

"What is a Midwife?" – a guide to the role and responsibilities of the midwife, with popular myths explored.
"Choices in Childbirth" – describes the maternity care choices available to pregnant women.

I could write lots more about ARM's work, but I've reached my 2000 word limit. All the main articles and reports can be found on the CDROM *Roots from the Past, Routes to the Future*, (the first 100 issues of ARM journals, with word search facility for research purposes as well as PDF copies of all pages).

Back-copies from number 101 onwards are available from Sarah Montagu, (see 'Items for Sale' page **).
Of course the work doesn't stop there – so watch this space!

Keeping the Wolf from the Door
Elizabeth Parker

I've called this article 'Keeping the Wolf from the door' not to reflect the pay we receive compared to the cost of living, but to describe the embodiment of the Senior Midwife on duty and how she may interrupt us as we work with women as they birth their babies.

I am passionate about protecting the process of labour for women having their babies in hospital or birth centres where midwives, as NHS employees, are expected to follow protocols and guidelines. So often I find myself in the 'grey area' that falls between the pure white (Wolf comfort zone) and pure black where no-one wants to be.

Over the years I have employed many strategies for keeping the Wolf at bay.

Home assessment in early labour

This is an all too familiar scenario: a woman phones in early labour. From the sound of her voice you can tell that she's progressing well. Her partner or mother are panicking but the woman and her baby in tune and coping fine. If you are able, offer a home visit then observe, monitor and record. Then invest some time in explaining that all is well, labour is beginning, but not well established yet, and it is best to be here at home with your caring family until things progress further. Leave them after an hour or so. Everyone is very happy. Then wait.....

You've guessed, some hours later she phones and "It's all too much now." Now's the time to invite her to her chosen place of birth and there you find that she is now in good established labour. If you do an internal then you will usually find that she is 6 cm or more dilated. Usually all progresses well. The time taken to do that home visit was time well spent. She didn't come in too early.

Getting rid of Popper-inners

Once in the unit, the Wolf may pop in to check how things are going. You may anticipate this visit and be able to defer it until later because: "Not a lot is happening" or, "They're rather anxious, they only came in for reassurance," or, "They came in to consider pain relief." The Wolf goes away wondering who needed the reassurance, the family or the midwife.

I hear many of you screaming at me:

"BUT **YOU** ARE THE MIDWIFE."

Oh yes, I know that, but it is only with time and experience that as a midwife in the system one learns how to work within the system and still enable women to birth their babies as they want to. To me it does not matter if Senior Midwife X thinks I'm not the real thing, because to her I never will be, we are poles apart in the attitudes we have and in the ways we work.

The Wolf pops her head round the door again.

"How dilated is she? I need to put it on the handover board."

You could reply along these lines:

"I'm sorry, her contractions are not really coordinated yet. I'm not sure... I may even send her home again." The Wolf loses interest and leaves you to it.

The curtain trick......

I have worked in a unit which had curtains to be drawn over the closed door in the labour room to offer more privacy when doing any intimate procedure. Pulling them not long after arrival meant you were left alone, even the doctor's ward round would pass by.

The partogram

It is best to be cautious when to start – once on the partogram the clock starts ticking. It is imperative to keep accurate records but I never overestimate cervical dilatation and always err on the side of caution. "Is labour really established?"

For me *all* the criteria of established labour need to be met: regular painful contractions, effacement and dilatation. If the body language I see from the labouring woman does not indicate established labour and not all the criteria are met, in the absence of risk factors that need to be bourne in mind, then I will delay starting the partogram.

Progress of labour

This too is multifactorial, unlike our obstetric colleagues (Mary's wonderful term) midwives remember that cervical dilatation is NOT the only indicator of progress. It is so important to consider position, descent, degree of flexion and quality of contractions. My team members and I have regularly been able to affect the outcome of a labour positively by looking at the whole picture. That is another factor that we find important when working within a team striving to keep birth normal.

Safety in numbers

We will often call a colleague to be present with us, not for any reason of safety but to act as a buffer between the midwife offering the care and the 'Wolf'. Two wonderful examples involve a vaginal breech birth on labour ward and a twin birth in hospital.

The role of the colleague is to distract the Wolf who will want to implement all the guidelines to the letter. In the case of the breech guideline, the protocol states that, whether or not the woman wants an epidural, the anaesthetist must be called to attend. The woman was then starting to doubt her capabilities and waver but with our

support she stayed focused until after a short while she wanted to push, the second midwife came back and did the record keeping while the lead midwife was able to support the woman and her partner as they birthed their baby. One senior doctor was in the room but she observed from the sidelines and between the two midwives we created such an atmosphere of confidence and safety that she was content not to interfere. The paediatrician was present. He too stood in the background and left immediately our vigorous little girl arrived safely. The birth took place in the 'nest' we had created in the labour room *not* in theatre where the breech birth should have occured according to the protocol.

The twins, unfortunately, were born in the theatre but with our steadfastly dominant presence in the room, the doctor was kept away.

Following the birth of the first twin he demanded that I perform an ARM for the second, the baby wasn't in the pelvis yet! I refused and stood at the foot of the bed, bodily preventing him access to examine her. I waited until the contractions returned and the baby came into the pelvis and the experienced mother had urges to push. By then the doctor was scrubbed and asking that I move so he could examine her prior to performing a caesarean. The fetal heart was fine and soon the urges to push became stronger and the membranes ruptured. I stood aside and our senior student very proudly helped the second twin arrive, safe and sound. The presence of a team colleague again gave not only the opportunity for on-the-spot record keeping but support to the second midwife and student enabling them to aid the woman birth her twins without ARM, syntocinon and a caesarean section.

This is by no means a definitive list of ways to protect women from 'the system' but a few strategies I have used most successfully without causing too much confrontation at a time when women are often vulnerable to the pressure put on them by the establishment.

I would be interested to have others share their experiences on line or at future ARM meetings.

A Philosophy of Midwifery

The place of birth and the way of birthing are things to be guarded by each and every one allowed to be present a the birth of a new baby and a new family with every fibre within us.

This is the place mother and father find the power within them and connect with the ancient wisdom of birthing through the ages to be able to make and take decisions that are best for them.

As birth attendants it's a privilege to be able to educate and be educated time and time again, while attending women giving birth.

We need to stand back and observe and allow the woman to birth the way is best to her and her baby and only intervene when it's really needed, and do it while keeping mum and dad informed as much as possible, because they are the main players, not us. We are there to assist!

Do we need this process to be disturbed by unnecessary official formalities or rigid observance of rules that stiffle the whole process?

I do understand that both the professionals and the birthing families need to think about eventualities but I think it doesn't need protocols, but the essential supporting structures like a framework that can be flexible enough to adjust to different situations and needs, so we can continue to create this sacred and safe place for women to birth the next generation of human beings.

Educating both birthing women and birth professionals in the innate wisdom of birthing, coming alongside, healing bad experiences from the past which are too common for too many women, especially in the Western world, that is the greatest part of the job of birthing profesionals.

Jolanda Corbijn

Student Life on the Ward

I'VE BEEN WORKING on a combined ante- and post-natal ward. The number of students on the ward at any one time varies enormously but is seems we are desperately needed. Numbers vary between none and eight depending on which years are out on practice, how many students a mentor has, and so on.

Here we get to see life how it really is. Quite often the ward has no beds so we have to ask women to go home perhaps before they are ready. We have two or three elective caesareans a day and these women go straight to labour ward. There are two beds for high risk women by the nursing station; the occupants change frequently. Then there are the emergency sections and the difficult deliveries. The women who were lucky enough to have a normal delivery go four-bedded rooms; the beds are quite close together and it is the last place on earth you'd go for a rest.

It is just too busy to be able to give good care. Post-natal women are left to themselves a lot of the time, we seem to do only postnatal checks and discharges. We spend most of our time caring for those who are unwell whether antenatal or postnatal. It is frustrating for the midwives and gives the impression that no one gives a damn about the other women. Most of these women are very understanding – when you explain that you are so busy and you will come when you can. However, there are some who think they are at the centre of the universe!

... but why shouldn't they be? They have just had a baby and they've been told to stay in hospital to establish breast feeding. To be honest they'd be better off at home where the community midwives and midwifery care assistants have more time to give them.

It is quite frantic at times. Frequently we don't get breaks but grab a cuppa as we pass the kitchen. I once made a cup of tea and left it to brew. Two hours later some kind soul had removed the tea bag and I drank it cold, a useful skill developed when I became a parent! Often the midwives do not get a break. Late shift seems to be the worst, as the door bell goes constantly, the phone rings, women buzz asking for help and in the middle of it all you have notes to write up. It's all very well trying to focus on the job in hand, as you have been taught, but which job was that then? You are interrupted several times before it is completed!

Students are supposed to be supernumerary. When I mentioned this to my mentor she asked me to imagine what it's like without any students, with all 30 beds full. She is concerned that it is not safe. On a night shift there are regularly only two midwives. If someone is taken seriously ill there is one left to care for the other 29.

In January Patricia Hewitt was quoted as saying, "Vacancy rates in most parts of the country are low..." She chose her words carefully; there were few vacancies because there were few jobs being advertised. The NHS thinks it cannot afford to employ the number of midwives that are actually needed. Staff cuts are the easiest way to save money and the easiest way to implement staff cuts is to pretend that there is no vacancy to fill when someone leaves or goes on maternity leave.

Nine years ago, when I had my eldest, there were three maternity wards and a delivery suite at the hospital where I am doing my placement. Now there is only one ward for ante- and post-natal women with high risk and low risk women on the same ward. At the same time there are more babies being born each year. Nine years ago I stayed in until day 3 after a normal delivery, now the women are sent home from delivery suite. Women go home on day 3 after a caesarean. Last year they went home on day 4, six years ago it was day 5. How long will it be before they are sent home from the recovery room?

Quite often the ward is full. We tell labour ward that we're full and labour ward asks for how long? When can they send a woman over? Eventually labour ward gets full and it's a toss up between our unit and the other one in the Trust as to which closes first. In this area, quite a lot of the women just turn up without phoning first. Sometimes the labour ward announces that it is closed and no one else is to come – except those who just turn up – and then when they clear because some of the women leap at the chance to go home rather than stay in, they open again, only they forget to tell the postnatal ward – and we *still* have no beds.

Now the early shift handover takes twice as long as it used to and this eats into the time the night shift have to stay to cover before the early shift can start. One night I stayed to write up some notes before I went home because I just hadn't got them done that afternoon. The buzzer went four times, the phone rang three times and even though my shift ended at 21.30 pm I didn't like to leave the desk with no one there just in case something happened that needed me to get help fast, and it was 22:10 before I left. I don't begrudge it at all because I was needed and to be honest it was quiet and I got everything done, but it is not safe to leave the desk area completely unmanned for 30 minutes. You can't hear the bells from the staff room. The midwives were very grateful to me for staying back and said it's not necessary. Perhaps, when I have been qualified for X years, and rushed off my feet for the whole eight hours, I too will be desperate to get away on the stroke of end of shift. As a student I happen to think that the care the women receive is more important, and what was I going to do with those 5 minutes anyway? But all too often those 5 minutes stretch into 30. When will I start putting myself first?

However, as a student midwife if I can help to make even one woman's stay in hospital more bearable or even give them some good memories then that is a job well done. A smile takes no time and costs nothing.

Measure for Measure

Sarah Montagu

EXTERNAL PELVIMETRY is a technique that has almost entirely fallen out of favour in British midwifery. In the past, when many women had pelves deformed by malnutrition, particularly rickets, the information was valued and often routinely gathered – I have a couple of midwifery textbooks from 1915 (Eden; Longridge and Banister) which both go into great detail on the different methods of establishing the exact measurements, not to mention illustrations of a variety of mediaeval looking instruments used to assist in the process. When X-rays were discovered (and before the deleterious effects of X-rays on the mother and the unborn child were realised), X-ray pelvimetry made it possible to assess the pelvis even more readily. However, several research studies have made it clear that this is a poor predictor of outcome in labour (Rozenberg, 2007; Biswas and Johnstone, 1993) and X-ray pelvimetry has almost entirely disappeared.

If you look at a current midwifery textbook such as Myles (Fraser and Cooper, 2003) there is no mention of digital pelvimetry at all. It receives more attention in American textbooks such as Davis (2004) or Frye (1998) and the techniques are gone into in detail, although the process sounds potentially pretty uncomfortable for the clients.

Although most of us had the phrase 'power, passenger and passage' quoted to us at some stage in our midwifery training as the three factors which affect the progress of labour, the focus is almost entirely on the first two elements. Doctors are interested in the first part of the equation, looking at starting contractions ("Term + 7? We'll book you in for an induction tomorrow; get that labour going"), keeping them going ("Let's rupture the membranes and put synto up if she's not 4 cm by 2 o'clock") and making them stronger ("Incoordinate contractions; let's get synto up…). Doctors and midwives look at the passenger; doctors mostly to say "it's too big" (or "it's too small" – you never seem to hear a doctor saying "this baby's growing beautifully, just right") and midwives mostly to recommend optimal fetal positioning. But nobody seems interested in what the passage can tell us.

So can it be useful to know what sort of pelvis a woman has, and how big or small her pelvis is, and if it is, how do you avoid self-fulfilling prophesies? A couple of years ago there was some discussion about this on the List (http://health.groups.yahoo.com/group/ukmidwifery) and Melody Weig, a long-standing ARM member gave a very interesting workshop on non-invasive techniques for measuring women's pelves. Obviously I wouldn't want to advocate the type of pelvimetry that divides women into those who can have a baby vaginally and those who can't, in other words labelling women as 'too small' to birth a baby or creating fear and doubt in her mind about her body's ability to give birth. On the contrary, the purpose of Melody's workshop was to give us tools which can be useful in helping a woman to birth so that you are prepared for what might happen – which can be positive (if your client is a woman with a gynaecoid pelvis with large diameters, you may need to be prepared to drop everything and get to her house as fast as possible to beat the baby to it!) as well as more of a heads-up (if your client has a anthropoid pelvis, you might need to be prepared for a higher likelihood of a posterior position, a long, slow first stage but a relatively fast second stage, and so on).

The classic types of the pelvis were classified in 1933 by Caldwell and Moloy and there seems to have been surprisingly little work since then on the incidence of the different forms of pelvis. The four types usually mentioned are the gynaecoid, the android, the anthropoid and the platypelloid. In each case, there are differences between the shape and dimensions of the inlet and the outlet, the relationships between and the angles of the various planes and in the way each impacts on the mechanisms of birth.

Melody's workshop focused on measuring the external diameters and geometry of the rhombus of Michaelis, as these reflect the type and size of the rest of the pelvis. The rhombus is measured from side to side from one posterior-superior spine of the ilia to the other, and from top to botton from the sacral promontory down to where the gluteal muscles converge. It takes some practice locating the landmarks and it isn't easy to convey in a written description, but Melody is willing to do workshops for anyone interested.

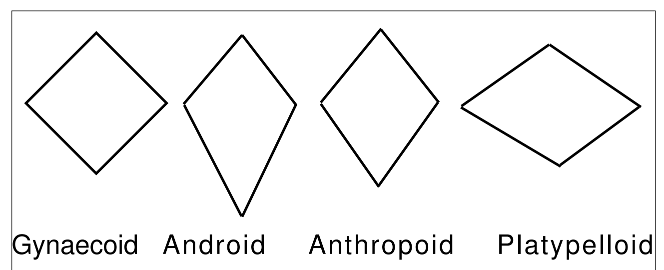


Fig. 1 Types of pelvis (not to scale – just to give a rough idea of the different geometries)

The incidences of the different shapes are different in different sources, varying between 41% of women having gynaecoid pelves (Frye) and 50% (Myles).

Pelvimetry in practice

My main concern about using this technique with all one's clients was that you can't predict what the result will be until you've done the measurement but once you've done the measurement, you can't 'un-know' the results. So how can you avoid presuming that a labour is less likely to go smoothly if you identify small measurements or an awkward shape of pelvis?

It is vital to remember that the static measurements of the pelvis are only one factor in the complex dance of labour, and the flexibility created by the hormones of pregnancy and the potential of the fetal head to mould as it travels through the pelvic cavity adds centimetres to the effective diameters. The positions that the mother takes up during labour are also critical, and here the knowledge of the type of pelvis that the woman has can assist you in the suggestions that you might make – for example, making sure that the woman with an android pelvis maximises the freedom of movement of her pelvis to make best use of the diameters. The absolute measurements will not allow you to predict whether or not this particular woman will be able to give birth vaginally; the only thing to tell you that is the process of birth itself, and one of the things I've always tried to keep in mind is the capacity of birth to surprise you. I have attended labours of some very petite women and seen good size babies emerging from equally petite pelves.

However, should things not go according to plan, one of the other useful skills is knowing when to call it quits, particularly if you're at home and are considering a transfer. Recently, I cared for a woman who had a beautifully positioned LOA baby; she was tall (5'9"), in her first pregnancy and went into labour at 41 weeks. She contracted well throughout, so there were no problems with the 'power' part of the equation. In her case, I hadn't actually measured the rhombus prior to labour for a variety of reasons; however, as the labour went on, it became very clearly visible. I would normally take that as a sign of progress – Kitzinger (1993) states that Jamaican midwives say that the baby won't be born until the mother opens her back – but in this case it wasn't accompanied by the other signs I would have expected of approaching full dilatation and of the descent of the baby. The dimensions of the rhombus were narrower than average from side to side and reflected the narrow pubic arch I had felt on vaginal examination. The baby gradually rotated from LOA to LOT and, if anything, ascended in the pelvis rather than descending any further. I don't routinely do vaginal examinations but in this particular case, the woman had asked me to do one not long after I arrived, about one hour after her contractions had become regular and strong. At this point the cervix was already 5 cm, which would reflect good progress in a primigravida; the problem was that this was as good as it got. We used all the tricks we could think of to encourage the baby to turn back to LOA and I was careful to use as many as possible of the methods that would maximise the free movement of the bones of the pelvis (Simkins and Ancheta's *Labor Progress Handbook* is a great trouble-shooting guide; it is small enough to fit into your pocket or midwifery bag and has all sorts of useful tips for helping overcome slow or stalled progress), but to no avail. There is no research based evidence for artificial time-limits in labour but I wouldn't be happy to stay at home if there was absolutely no progress or, of course, if there were any signs of maternal or fetal compromise. In this case there was no problem with the latter, as the mother was well hydrated and nourished and the baby was quite comfortable sitting up above the pelvic brim, but there was absolutely no sign of any shift in its position, no further dilation and no descent. The fact that the baby had definitely been optimally positioned at the onset and for the first part of the labour but had still not been able to find its way down and through the pelvis made me think that we were probably looking at true cephalo-pelvic disproportion and we did eventually transfer in after the woman had decided we really had tried everything, and in the end she had an 8 lb baby by caesarean section Interestingly, her mother had had a three day labour which had ended up as a caesarean section as well. Although we didn't end up with a home birth or even a vaginal birth, I felt that the information about the shape of her pelvis had helped me support her in trying all the techniques that gave her the best chance of overcoming its potential disadvantages and enabled her to keep in control of the process. Would she have had a completely normal birth if I hadn't paid any attention to the size and shape of the rhombus or the angle of the pubic arch? I don't think the outcome would have been any different; knowledge is power, even if power won't always get us what we would like to have.

Melody's website
http://fafu.co.uk/development/birthritesfinal/index.html

REFERENCES

Eden TW (1915). *A Manual of Midwifery* Churchill, London

Longridge CN and Banister JB (1915). *A Manual for Midwives,* Churchill, London.

Rozenberg P (2007). 'Is there a role for X-ray pelvimetry in the 21st century?' *in Gynecol.Obstetr,Fertil*, **35**, 1, 6-12.

Biswas A and Johnstone MJ (1993). 'Term breech delivery, does X-ray pelvimetry help?' *Aust NZ Journal of Obsetrics and Gynaecology*, **33**, 2, 150-153.

Fraser D and Cooper M (eds) (2003). *Myles' Textbook for Midwives* (14th edn) Churchill Livingstone, London.

Davis E (2004). *Heart & Hands; A midwife's guide to Pregnancy and Birth* (4th edn) Celestial Arts, Berkeley.

Frye A (1998). *Holistic Midwifery Volume 1 Care during Pregnancy* ,Labrys Press, Portland.

Caldwell WE, Moloy HC. (1933). 'Anatomical variations in the female pelvis and their effect in labor with a suggested classification', *Am J Obstet Gynecol* 1933, **26**, 479–505.

Kitzinger S (1993), *Ourselves as Mothers,* Bantam, London.

Simkin P and Ancheta R (2005). *The Labor Progress Handbook* (2nd edn) Blackwell Publishing, Oxford.

Student Hardship Campaign

Andrea Simpson

RECENTLY I was invited to speak at the 2007 Royal College of Nursing Congress in Harrogate, on the theme of Changemakers. I spoke about the campaign, how it started, and how far we have gone with it.

The Student Hardship Campaign happened by accident. My friend started her midwifery degree in September 2005. She is very organised and she prepared for the course by filling in the bursary application form well in advance – in May. She duly sent it by registered delivery and had a receipt for the day it arrived at the Student Grants Unit (SGU). After three months she had still heard nothing and contacted the SGU. It took several attempts to get through to them and more than once she was disconnected while she was in a very long queue. When she did get through (because a colleague was already on the phone to them and gave her the phone instead of hanging up) she was told that her form had been lost. So she filled it out again and sent it by registered post again only for it to arrive in the mass influx of applications, and by this time the applications were being dealt with in order that the forms arrived.

My friend has children and needs to pay for childcare and this made things very tight financially. The midwifery course started and there was no sign of the bursary payment. October came and went and she only managed to get through to the SGU when a colleague who was speaking to one of the workers gave her the phone before the worker hung up. She was not surprised to find that her application was still not being processed. By this time they were paying for food with credit cards, borrowing money from relatives for childcare and had already sold their car to pay the mortgage. At this point she told me just how bad the situation was and that they were going to have to move house too.

I emailed our MP and explained the situation to him. A few days later I got a phone call from his aide and within 24 hours my friend had her first bursary payment. Feeling very chuffed at this success, I posted on the Student Midwives Sanctuary forum and was then inundated with requests for help. I passed on the tactic I had taken – phone/email your local MP.

I vaguely remembered some information about the RCM campaigning for a £10,000 bursary for midwifery students. Another friend was starting her nursing training at the same time as I started my midwifery training and she too was preparing for having no funds available. I started phoning around, asking people about student finances and the RCM campaign. I phoned the RCM and they put me through to the student advisor, who gave me some more information. I was also put through to their political officer who was trying to get politicians to sign an early day motion (EDM). At this point I was on the phone to my MP's aide frequently and he told me about things that could be done, for example getting signatures on the EDM, and how they were viewed in parliament. At a student conference I spoke to magazine/journal editors about what was fast becoming a campaign and they asked me to write articles for them. I spoke to the *Nursing Standard* and the campaign started to take off. I organised an on-line petition and paper petitions which could be posted back to me. By February 2006 I had 3,000 signatures and my MP was keen to submit them in Parliament. I have carried on collecting those signatures since then and Stuart Bonar of the RCM has managed to get enough MPs to sign the EDM to trigger a debate on the issue in the House of Commons.

There has been much debate about maternity services in Parliament. Quite rightly, the main focus has been the lack of jobs for midwives (and nurses and all NHS workers in fact) and the lack of midwives where they are needed because the Government wants NHS trusts to balance the books within the year. So with this massive problem I decided to take a back seat. I have already written to Patricia Hewitt, in Parliament, at the Department of Health and at her local constituency office. She took a while to get back to me but the message was, sorry we have no money. Quite obviously, she doesn't have to survive on the equivalent of £2.50 per hour. The minimum wage is now £5.35 per hour for over 21s. Even school leavers of 16 are guaranteed over £3 per hour.

I recently spoke to a midwifery student and asked her opinion on the bursary and she said "The bursary is c***. When I qualify I will be working for the first year to pay of the debt I have accumulated – if I can find a job."

Other people are not so lucky. Many midwifery students have had to leave because, despite the measures they took to prepare themselves for a low income before they started, it is impossible to survive. They have had no choice but to defer the course or leave altogether – not an easy decision to make when you have studied hard for a year or two to earn your place on the course only to find something as simple as money is standing in your way to your dream.

The following story was written recently by a student

who has made this hard decision…..

I am very sad to say that I have decided to give up the course. I have wanted to be a midwife for so long and I finally started in September and it was everything I hoped it would be. Okay it was tough going – I didn't qualify for a bursary so I've been completely skint.

As a result of the skintness just before Christmas we sold our house and moved to a cheaper area in order to reduce our outgoings, but things haven't really got any better.

We have really been struggling with childcare. The childminder I had when I started got pregnant and decided she didn't want to do it any more and I couldn't find anyone else to have my little boy before school that wasn't going to charge me a fortune. My family are pretty shit I'm afraid to say so the only alternative I had was to dump my son in the school yard in the mornings on his own! Not good! Especially not when you are on placement!

To make matters worse my hubby has just changed his job. He will be working away a lot and working really long hours. He isn't much help around the house as a result of this so all the stress of family life, the course, childcare, housework, has been dumped on my shoulders and I just couldn't cope with it. Neither could my kids. It's just so unfair on them to have two parents with really stressful jobs. The reason we had kids is because we thought they would enrich our lives, not so we could dump them in front of the telly while we worked. I was at a northern university and it's a four year course – that's a long time and my kids and sanity had to come first.

I know in my heart that I have made the right decision but its been the hardest one that I've ever had to make. The worse part was ringing my mentor to tell her – I really felt like I had let her down.

There are many stories like this. We need to put an end to them. Money should not be the reason people are not able to complete the course. In the summer the government did look at the bursary and decided to revamp it. However, they have only manipulated the same pot a little. Now single parents quite rightly are eligible for more money but this is at the expense of married people with children needing childcare if their spouse is earning a half decent wage. There is an annual increase in the bursary which is supposed to keep up with inflation but it doesn't really. Now the RCN and the Association of Radical Midwives (ARM) are behind the campaign we need to make a push for the Government to listen to us. If the students are not able to survive on the bursary then many will end up leaving before they qualify. If this is the case, and we are already 10,000 midwives short in practice then the Government will have even fewer to employ and the deficit will continue for many, many years regardless of whether the jobs are there to fill.

Should you have problems with the bursary, then these are the basic guidelines to follow:

1. Do try ringing the SGU on their helpline you may get through!
2. If you don't then ring: 01253 774774. This gets you through to the pensions agency switchboard. Ask to speak to an SGU Manager. Don't tell them you are a student. Ask for the name of the person you speak to and then next time you phone them ask for them again. They will sort you out to stop you phoning THEM all the time!
3. If you get no joy with your phone call, contact your local MP. You can find their name on www.writetothem.com and put your postcode in. You can also email them from here. However it will give you their name and then you can look in your local yellow pages and find their constituency office number. Alternatively you can phone Parliament in London. The switchboard number is 020 7219 2000. Ask to speak to your MP and they will put you through to their office. Their researcher may answer and these people are fabulous and know everything! More importantly they will ask the MP to contact you to sort out the problem. MPs have a direct line to the SGU and will sort any problem. However if you don't tell them then they won't understand the scale of it. The quicker they realise how bad the problem is the sooner something will be done.
4. Write to MPs. Write to Patricia Hewitt. She can be reached by these addresses:

Mrs Patricia Hewitt MP
Secretary of State for Health
Department of Health
Richmond House
79 Whitehall
London SW1A 2NS
Or Parliament:
Mrs P Hewitt MP
Secretary of State for Health
House of Commons
Palace of Westminster
London SW1A 0AA

I am still collecting signatures on the petitions too. You can sign an online one at:
http://www.petitionthem.com/?sect=detail&pet=2348
and print out the paper one here and send it to me
http://www.pintofale.f2s.com/PETITION.doc
Together we will be listened to.

A Normal Breech Birth

Lynn G Walcott

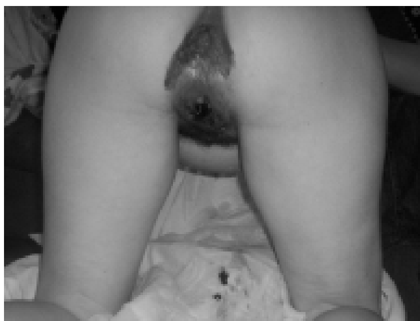
Meg and James were already 'independent' clients with this their second baby, having had their first with me, when we discovered Meg was having a breech. No big deal? Meg had choices – *her* midwife will support breech birth. But, just to cover all bases, Meg decided to meet with an obstetrician and midwife at the hospital to discuss ECV – "But he won't turn, you know," Meg confidently asserted, "He's happy this way".

So, a failed ECV later, Meg contentedly looked forward to a breech birth at home, with wonderful support from James and Meg's family.

Meg's first baby had been comparatively quick – so for this baby there were plenty of midwives on call (5) and, with the first baby, Elsie coming at 36 weeks, we were all very ready when by 37 weeks, Meg still had not laboured.

We were also ready at 38 weeks – and 39 weeks – and 40 weeks – and 41 weeks! Finally at term plus 11 (what would the NHS have made of this?) Meg called in the evening – but Rosie and I had to wait until after 09:30 in the morning to witness the lovely birth below.

1. Meg finds a comfy spot to birth



2. PP visible – is it a boy or a girl?

3. Pretty sure – but not telling Meg or James

4. Nice and gentle – here 'she' comes

5. Mmmmmm! Meg choosing something a little unorthodox with her left leg (I wonder why?)

6. Meg knows best, so midwife happy

7. It is rather slow for a second baby – keep a close eye on the clock

8. It is slow – prepared to act if necessary – but still advancing with every contraction

9. Feet at last

10. Oh look! Flexing of legs, just like Mary taught me I'd see (point it out to Rosie)

11. Still slow, but advancing – colour ok – 'Hands off the breech'

12. Come on — where are those arms?

13. Phew! Well here's one

14. This is starting to be hard work for Meg – getting prepared – I may need to intervene?

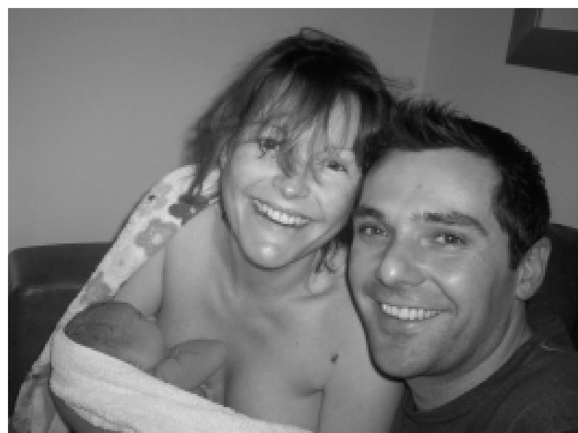
15. Right – one more contraction –
and I think I'm going to help

16. Yep! time's up – I'm going in –
Rosie's getting resuscitation equipment ready

17. One little flick of the second arm and here she is

18. Let Meg have a cuddle – HR is good, but we're going to give her a hand – colour not improving, no attempts to breathe

19. There! That only took a few minutes – lovely and pink now!



20. 'We did it!'

Afterthoughts

The descent was slow, Meg adjusted her positioning spontaneously to help. Baby Delphine was clutching her head all the way! Second arm when swept away brought head out at same time! Hindsight is a wonderful thing. Delphine just needed some inflation breaths to get going – but I think that to have acted with first arm would have been the best option – it was a posterior arm first, not the more common anterior arm. Faced with this again, I would act one contraction sooner, and sweep both arms down.

I am thankful, once again for the courage of a strong couple to teach me a little bit more about birth – and particularly breech.

Thank you Meg and James.

Reflections on Escaping the Clutches of the NHS

IT'S USEFUL to see life from the other side occasionally. While I am now too old to make use of the maternity services myself, like anyone else I have the occasional health emergency. Thus it was that I was taken into hospital at the end of January after having breathing problems at home during a bout of what I would call flu. The NHS does emergencies fairly well; modern medicine has saved my life twice now and I am grateful.

I was in the middle of typesetting the Spring issue of *Midwifery Matters* at the time and was anxious to get home to finish it and sign it off to the printers. But I made the best of my time in hospital by taking the opportunity to observe people's behaviour and reflect on the patient experience. Once a psychologist, always a psychologist!

My first reflection is this: hospital is the place to be when you are so ill that your children are worrying about you. This seems to have something to do with responsibility and kicks in when you don't want your nearest and dearest to have to take responsibility for you. Many years ago, my father and I spent Christmas with my great aunt because she was too ill to look after herself; we walked over on Christmas Eve, picking up basic bits and pieces on the way. On Boxing Day she was asking for the doctor to call and after a lot of persuasion and sweet talk he was able to get her a bed at the local eye hospital – the only hospital with any spare beds (some things never change!). My great aunt was a single lady who was not used to being looked after and certainly not by a man and a young great niece and as she got more ill she didn't want us to have to take the responsibility so she asked us to call the doctor. Yes, I do remember it being a great responsibility and can still remember the relief when that responsibility passed to someone else.

To return to my own story, I was admitted and they made me well enough for me to want to go home and pick up the reins of family life again. This was when the fun started.

Having been admitted on a Tuesday night, I felt ready to resume full responsibility for my own health on the Thursday. The hospital had already started shunting me around. Clearly I no longer needed much care but the hospital wanted me to be seen by the consultant under whose name I had been admitted before it wanted to let me go. They expected that I would be discharged on Friday. I agreed to stay another night and the next morning I showered and dressed and waited for the ward round. I rang my daughter so she could accompany me home and we arranged for her to come at about midday. I rang the surgery (where I work) and made an appointment to see my GP in case I needed medication for the weekend. I wrote down a list of the medications I was receiving in case I needed a prescription. It did feel rather devious but I wanted to go home that day and knew I still needed some medical support.

Kathleen arrived and we waited and waited and waited. We worked out the bus we needed to take in order to be at home when David arrived home from school at 4.30. The 3.15 would connect with the 3.45 and would do just fine. One of us would have to be on it to meet David anyway, so it might as well be both of us.

At 3 pm I picked up my bag and we went to the nursing station to inform the staff that I would be leaving. (No mention of buses was made – no need to scare them silly!) There was a student nurse at the station and I agreed with her that it would probably be best if I saw a qualified nurse and she went to get one. I was expecting what came next: the "You can't go home, the doctor hasn't seen you" scenario. However, I was not prepared for the strength of the persuasion and the reasons: "We'll have to inform the police," and "You're putting our nursing registration at risk."

I tried to imagine Mary Cronk behind me reminding me that I was an adult woman, perfectly capable of making my own decisions as to whether or not I needed to see a doctor. Anyway, the doctor in question was a gastroenterologist, not a respiratory physician. An orthopaedic surgeon whom I had met was also at the counter and I suggested that he might like to sign the form. Laughing, he declined. No hard feelings. I'm afraid I wasn't brave enough not to sign something but I did cross out the word 'medical' and substitute 'nursing' where it said "against medical advice".

We didn't have time to argue, in fact I was careful to remain very polite and not argue, though I tried to alleviate their fears by informing them that I had an appointment with my GP later that afternoon.

We then made our escape and with the prison just the other side of the road we did feel rather like escaped convicts. Actually it was quite fun and I was so relieved to get back home, admittedly still very breathless, but whatever they had given me had knocked whatever infection I had had on the head. My GP was quite wonderful, solemnly prescribing all the medications I was on and lending me a surgery nebuliser for as long as I needed it.

It was a beautiful weekend, I really enjoyed pottering around slowly and luckily I had booked annual leave for the next week so I was able to recover at my leisure at home (and finish the Spring magazine!)..

I did make a complaint about this, and I have received an apology. The hospital was already in the process of reviewing its discharge policies and perhaps the complaint came at a useful time. I offered to do an audit of patients'

experience of discharge and I still think this might be useful. With all the talk of bed blockers I should have thought they'd be only too pleased to discharge a patient who wants to go home but the cynic in me does wonder whether they like to keep the hospital full of nearly well patients over the weekend to keep the payment by results money coming in with little actual work to do! (No?)

Why put this story in *Midwifery Matters*? Firstly, if I found it so difficult to self discharge, having been well steeped in Mary Cronk's tactics for coping with authoritarian behaviour, how much more difficult it is for a new mother when it is not her own life that is supposed to be at risk but that of her new baby?

In the last issue of *Midwifery Matters* Caroline Hollins-Martin reported midwives' experience of coping with authority and on the ukmidwifery list it is often asked why women are not more forceful in resisting unwanted treatment. My own experience has reinforced Caroline's message: it is *exceedingly* difficult to act against authority figures even when you know that you are in the right, and particularly when you are on their territory. Never underestimate the power of authority figures. Never underestimate the power you have over your clients and don't be tempted to misuse it.

Secondly, the physiological visceral consequences of resisting pressure from authority have to be experienced to be believed. I was very much aware of my heart racing and becoming more breathless. I felt very much more ill after my encounter with authority than before, so much so that they gleefully pointed it out and tried to use it to keep me in.

How much better not to submit women to that sort of pressure in the first place, midwives need to get to know their women so that the women trust them (although I appreciate that this might have a downside). I do wonder whether there are pressures from above for midwives *not* to get to know the women so that they don't have anyone on their side when push comes to shove – or when lack of push comes to cut?

And one final comment. Afterwards, on the phone to Sarah, I wondered aloud whether I had somehow by my behaviour made them act in the way they did. After all, I had been expecting some opposition and thanks to Mary I held the stronger hand in that I had forewarning of what was likely to occur at the desk. Did I invite their response? But isn't this just typical female thinking – blaming oneself for someone else's behaviour? But it is what we women do. We'd better teach ourselves not to!

Spring National Meeting Report
March 17, 2007
Cundall Village Hall, Yorkshire

Despite the wrong date in the magazine for the Spring National meeting, for which many apologies, put it down to a house move and health scare, everyone turned up on the right day, which was also Mothering Sunday and St Patrick's Day. Thank goodness for the internet and the ukmidwifery list! (Chris was around the week before on the wrong day and didn't notice any radical midwives skulking around looking lost.)

This was the fourth time we'd had a national meeting at Cundall village hall but the first time we had snow! Some of us were secretly hoping the snow would continue and settle so that we could stay for longer in the peace and quiet on top of the world (well, on top of England, anyway). We had the usual 40 or so midwives coming from all over the country – radical midwives are hardly usual and the actual faces change at each meeting but there are always old friends to greet and new people to meet. That's the beauty of ARM; whoever is actually present it's like coming home.

We started the meeting by asking ourselves what ARM is for. ARM is us – a group of women who are passionate about birth. ARM can be whatever we need it to be, a safety net, a campaigning support association which is open to midwives, student midwives and mothers. While most independent midwives are ARM members as well, ARM is by no means an organisation for independent midwives, rather for midwives who want to work as true midwives in an obstetric culture.

Steering Group Awayday

Earlier in the month ten members of Steering Group had met together in Oxford to consider the future of ARM. We worked towards making a 5-year plan. Central to that plan is to increase membership among students who are the future of the profession. We need to go in to universities to speak to students. Deb Hughes suggested sending a box of ARM goodies to contacts in universities every September. Others suggested waiting until the second year when students are some way into their course and are more in need of the encouragement and support ARM can provide when students are becoming disillusioned and despondent in an increasingly medicalised environment. Elizabeth Parker went into her local university and put ARM on the map by giving the students coffee and biscuits instead of giving them a dry lecture on the benefits of membership. Actions speaker louder than words!

The new ARM flyer (see below) is now ready for printing and the intention is to circulate it as widely as possible, have it inserted into *The Practising Midwife* and *MIDIRS*. This leaflet emerged out of the recent discussion about whether the word 'radical' in our name was preventing midwives from joining us. We also plan to raise our profile with the launch of 'Midipaedia'. The online encyclopaedia would work like Wikipaedia which allows readers to edit entries except that it would need to be moderated by midwives. This could be the start of a revolution in the spread of midwifery knowledge which could only strengthen the profession and reduce the dominance of obstetric thinking in maternity care.

Steering Group had decided to update and relaunch *The Vision* which is as pertinent today as it was 20 years ago. The essence is the same but because the organisation of the maternity services has changed, for example there is now less input from GPs, it needs revision.

One of ARM's strengths is support for like-minded midwives, we should do more to increase this support and advertise it. We need to strengthen the local group network so that people have support near where they live or work as well as at national meetings. This will help to keep radical midwives in midwifery, and encourage students to stick to their courses. Andi's student bursaries campaign (see page 11) is also seeking to increase financial support for students.

ARM as a Trade Union

Widespread dissatisfaction with the RCM is voiced at ARM national meetings and we have talked on and off for years as to whether ARM could perform a trade union function as well as being a campaigning and support organisation for midwives. Much of the dissatisfaction results from the withdrawal of insurance from independ-

ent midwives but it also relates to the unhealthily cosy relationship which the RCM seems to have with the establishment. An independent midwife was recently told that RCM didn't deal with them – and this was an issue not to do with insurance.

If we were to go down the trade union route, we would probably need to set up a separate body at arm's length from ARM itself, and this would lead to a change in ARM's structure which has always been loose and informal. Also at present we operate on a shoestring budget and adding a trade union function would require us to have salaried employees. On the other hand we want to strengthen our support for individual midwives and having a trade union arm may make it possible to find insurance for all midwives. We decided to set up a working group which would look at structural issues and feasibility and then report back to the AGM in September.

ARM Yurt

Sarah announced that there is now a yahoo email group for ARM members wishing to take join the ARM yurt team at festivals this year. Contact her on sarah.montagu@postmaster.co.uk if you want to join in the fun – and do some hard work – there is no room for free riders! Six venues have been confirmed: Sunrise, Glastonbury and Buddhafields (all in Somerset). the Big Chill in Herefordshire, the Green Man in Wales and Solfest in Cumbria. We are looking for people with skills to offer such as aromatherapy, reflexology, breastfeeding, facilitators for groups, belly casters and also people to be around in this space for women, handing out leaflets, talking about birth and so on. We are still looking for a permanent means of transporting the yurt which is rather awkward because the poles are 8' long.

Other ARM business

The Student Conference group reported back that they are in the process of doing a final draft for 'Being and becoming a "with woman" midwife'.

Debs Purdue, an independent midwife in Dorset is being sued in the civil courts as the result of a breech birth diagnosed in labour where the baby died after hospital mismanagement after the prompt transfer. We agreed that ARM should make a donation towards her legal costs and individuals who wish to help further can contact Debs via deblybug@megadodo.freeserve.co.uk.

At the end of the morning we had a singing session led by a friend of Chris Warren's and managed to sing a 16-part round to the words "Ama-bu-lu-ah-du-we-eh" which felt and sounded so amazing that I think we should try to repeat it at the next meeting!

Insurance

Insurance is still a hot topic following the announcement by the Government that professional indemnity insurance will be a requirement of midwifery registration within the next year or so. The Independent Midwives Association is still pursuing avenues for insurance. Jane Evans addressed the meeting about the implications of the new requirement for Professional Indemnity Insurance which will come in within the next 12-18 months. This applies to all professions allied to medicine, not just to midwives, but midwives are unable to get insurance because the cost of caring for a disabled baby for the rest of its life are astronomical. The Medical Defence Union and the NHS do not have insurance as such, both operate 'mutual funds' money gathered in the first instance from doctors and the second from hospital trusts. Not having insurance will not be punishable by prison but will carry a fine of £5,000 per birth. IMA has used its contacts to get media coverage on this and it has been given space in *Woman's Hour*, *The Times* and *You and Yours*.

Independent midwives are concerned that their practice may be constrained by insurance requirements, should insurance become available, for example Dutch midwives do have insurance but terms and conditions rule out all VBAC births. (Insurance is available and more affordable in the Netherlands because European payouts for birth trauma tends to be lower than damages awarded in the UK.) Independent midwives in the UK want to be able to work to the *Midwives Rules* and *Code of Conduct*. Many women come to them precisely because the NHS has said that it will not allow them vaginal breech birth or VBAC. IMA is worried that some of these women will choose to birth alone.

Visit the saveindependentmidwifery.org website if you want to support the campaign, write to your MP asking them to sign the Early Day Motion calling for a debate in parliament.

Workshops

After lunch (the bread and cake were quite delicious) there were workshops. I went to one led by Susan Stephenson on long labour and another led by Chris Warren on long third stage. Chris started by asking how long people had had to wait for a placenta. Deb Hughes gave the longest time of five hours – but also the shortest – the placenta shot out two minutes before the baby (the computer wouldn't allow this data to be inputted!). Practice seemed to centred around the principle of wait two to three hours then go to theatre when it is convenient. For physiological third stages there are signs of imminent separation which are not well known about – restlessness, trembling legs and the woman looking 'spaced out'. There is little actual science behind the length of third stage, practice is driven by people's fear of the risk of bleeding, the sooner it is out the sooner you can stop worrying. The time may vary depending on the placental site, how 'tired' the uterus is. There may also be a psychological factor – women may hold on to the placenta to remain the centre of attention for just a little longer.

Then it was hugs and home after a great day of listening to midwives talking midwifery!

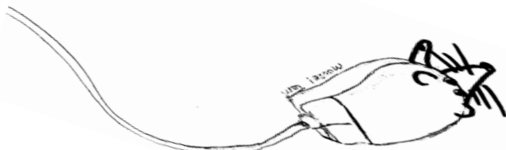
Margaret Jowitt

nettalk

Most of nettalk this issue is devoted to discussion following Panorama on BBC 1 on March 3rd which showed film from a researcher working undercover as a volunteer in UK maternity hsopitals. This was interspersed with interviews with parents and comments from Professor Mavis Kirkham who has been a member of ARM since its beginning.

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 is 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



Panorama

Did anybody see *Panorama* last week? There was an undercover investigation into care at three different hospitals in England. The findings were shocking but, to me, sadly not surprising. Any thoughts anyone?
Alison
Midwife and NCT antenatal teacher

Getting a Life

Yes, I saw it and it was disgraceful. One stressed midwife spoke of a woman labouring in a corridor: "Tell her to get a life." Excuse me, that's just exactly what she was doing. It was the midwife's life that needed serious attention.

I had three of my four babies at home and am not a midwife and on some levels can hardly believe what I hear on this list and at ARM meetings, I can't believe that women can be so horrible to each other. Now I can't believe how there are any midwives who are prepared to work in such conditions. I take my hat off to all of you on this list who are trying to do your bit in humanising these baby factories.

I can also see how midwives can get dehumanised themselves by this system and this is almost worse – the mother can go home at the end of it but the midwives are stuck with facing similar situations day after day and it MUST corrupt and dehumanise them.

I think that the culture must change and every hospital should have an ARM style support group for midwives to debrief – and all midwives should report every single instance of bad care and innundate management with forms until something is done. (Staffing levels mostly I suspect)

And I think it has become women's public duty to complain about their care if it is substandard. This affects the whole of family life and thus the whole of society. And NICE thinks *home* birth is unsafe!
Barbara
Mother

Incident forms

The sad thing is that those midwives were completing incident forms yet they were not acted upon, or at least the midwife who said she was completing them all the time had never once heard anything back .

I agreed with Mavis Kirkham's comments about the third world conditions at those hospitals. The attitudes of the staff were also appalling and some of the things they said left me gob smacked. Is it any wonder that women are suffering from post natal PTSD even when they manage to escape with their babies alive!

Midwives should not have to go on working this way and I hope that this program will go some way to change those conditions for both midwives and women.

UK Civil servants were on strike again last week for the second time this year. I am a civil servant and my job is like a day at the seaside compared to those midwives.(the world has gone mad!).
Caitlin
mum

Cost of Complaining

Leaving my meeting last week about my complaint, this was the one essential message I took with me – women must start complaining in their droves! Very conveniently, the director of medicine (who happens to be an obstetrician) and the director of nursing (who happens to be a midwife) both kept harping on about what I wanted being 'special' and needing prior discussion. The things I wanted were: to be treated with respect, to be told the findings of examinations in full detail, to have my birth partner treated with respect, to have options presented in an unbiased manner, and to have my child's birth treated with the reverance it deserved.

Apparently these 'requests' are special and could have been accommodated if I had had a prior meeting with the consultant! Again and again I pointed out that every woman should be able to expect these things, they are basic. The CEO tells me that women don't want them or aren't bothered because no one complains. I tried to break down for them what complaining has cost me in time and money (sending letters recorded delivery, getting a copy of my notes, photocopying and printing, childcare to attend meetings) as well as the unmeasurable emotional stress. They didn't listen.

All I can say is complain, complain, complain. I don't think midwives want to work the way the system is almost forcing them to work. Women are the client group so we must state what is wrong and take it to the top, instead of grumbling at coffee mornings amongst each other.
Dora
mother

but gets Results!

Well said Dora! Complaining via the Chief Exec and on the MSLC has helped to achieve a better homebirth service and the guarantee of more homebirths for the women of Sheffield. The Head of Midwifery recently announced that by September 2007 the women of Sheffield will have more choice of where they want to give birth. The one-to-one midwife teams are going city wide and there will be a team of eight dedicated midwives available for any woman who chooses to have a homebirth. As I understand it when a woman chooses a homebirth her care will automatically be handed over to this new homebirth team. The woman will then receive one-to-one care from the same midwife throughout pregnancy, birth and the post-natal period.
Elspeth.

Gut Clenching

This programme left me gasping and feeling the familiar clenching in my guts that accompanied every shift worked as a midwife.

I cannot excuse how those midwives

behaved – they were breathtakingly cruel and flippant – but also clearly stressed and demoralised.

I returned to practice in 2005. I left in 2006 because I could no longer be associated with this type of care. In fact it was worse where I was – often only me and a health care assistant on the antenatal / transitional care ward with over 25 labouring / very sick antenatal women / just out of special care babies. I got sick of fighting for good practice and not having the time to be the midwife that I knew I could be. Everyone else was so burned out and hard that I got labelled as a whinger and not being 'real'.

I had transferred into the hospital because I had burned out after just a year in the community – community being a very loose term when you consider the amount of work I did in the hospital propping up their understaffed and dangerous hospital in addition to my own caseload – frequently working a full day and then being called in at night to cover labour ward when I was on call.

After a year in a different job where I am valued, cared for and appreciated, I felt sick as I watched those poor midwives and women. My husband turned to me afterwards and said, "That's just what you described – no wonder you left". I think he thought I had been over-exaggerating.
Fenella
'ex' midwife

Stunned Silence

[in a previous post] Barbara said, "... Panorama *(about which this list seems surprisingly silent, any reason?)*

It is not just on here that it has been silent; none of the women I look after have mentioned it and the media seem to have been very quiet since it was aired.

I wonder if it is because we who work in the NHS can empathise with the situations those midwives found themselves in and are thinking there but for the grace of goddess go I. I suspect that film could have been filmed in almost any maternity ward in Britain and that is what is quite scary. It is not necessarily every day ... but it happens.

And I for one hold my hand up and admit I have said inappropriate things at times, things that I didn't actually mean but born out of frustration and I would be horrified to have them played back like the midwife shown in the programme, I really felt for her. I am not saying what she said was right but none of us is perfect! (and we don't know how it was edited)

There is a kind of black humour now amongst staff on my ward that when things are going pear-shaped or we are yet again hunting for a piece of equipment it is now a *Panorama* moment.
Gertrude
hospital midwife

Not Typical

My CMW, her student, and a colleague came out to attend me on Thursday night as I seemed to be going into labour and we were talking about it. She knew people who'd worked at the Manchester hospital, and they both knew about the conditions at Chase Farm – in fact they were of the opinion that *Panorama* deliberately picked bad hospitals rather than 'typical' ones so as to paint as bad a picture of midwifery care in hospitals as possible.

They were both concerned as to whether I'd seen it (I hadn't, but I'd read the write-up on the BBC News website) and were anxious to reassure me that should I need to transfer into hospital Whipps Cross is nowhere near as bad as Chase Farm.

The two midwives who came out to attend me on Friday night were the same. I got the impression that they are all mortified at the attitudes displayed by the midwives in the programme.

I've seen quite a bit of discussion about the programme over on the HomebirthUK list, where the programme seems to have pretty much reaffirmed everyone's intentions to keep as far away from hospital as they possibly can.
Harriet
Mum

Not so Bad Here

I'm now on postnatal ward and it seemed like there was a mass watch there amongst the women. Most of the midwives had watched it as well. The general consensus of the women I was caring for was, thank goodness it wasn't like that at our hospital.

They were also quizzing me about it and whether they'd just been lucky but I can honestly say that it is not like that at all, although we do struggle for beds and equipment, but not to that extent.

I, like Gertrude have said and heard said things which, if aired on national TV, would be equally cringeworthy. We were discussing it at work and why things like that are said and sometimes it's just to relieve the stress of a situation, and sometimes I also think it aids teambuilding and internal relationships between staff. I have never seen it used in any way against women and is only ever said in private. Makes me sound awful that, doesn't it, but I'm really not.
Ingrid
Midwife

Scaremongering

As a midwife working in a hospital I feel incredibly sad to read some of the comments posted on this website. We are all undoubtedly under pressure but the cases shown on *Panorama* were in my experience extreme and not representative of care generally in the UK. It worries me that women are, as a result of this, wanting to 'stay as far away from hospitals as possible'. Whilst I am a full supporter and advocate of homebirth, where it is appropriate and safe, I would hate to think that women are staying away when circumstances arise that require them to come to hospital because the scaremongers have well and truly worked their spell.
Juliana
hospital midwife

Thrown out of training

I was a student midwife in 1997/8 and I witnessed midwives treating labouring mothers similar to what was shown on this programme – and when I voiced my concerns I was taken off the course!

I would love to have the chance to go back into training and qualify – but no-one will take me on, probably because they know I would voice my concerns again if I ever felt that the midwives were treating the mothers badly.
Kirsty
ex student midwife, mum

Scared of being failed

Isn't that just ironic? You tried to be a midwife and speak out against bad practice and care and you get punished for it!

I wouldn't be surprised if many other students and midwives felt that would happen to them too. It is no wonder that whistle blowing doesn't happen as often as it should. I admit as a student midwife I felt scared that my mentor would fail me at the assessment for standing up for the women's choice. It's bad, but for me that was the reality. It is a fine line between getting your mentor's back up or not.
Letitia
student midwife

Prioritising

The truth is, midwifery in busy times and/or in busy units, can be a very hard job to do. They can't do it all and they have to prioritise.

I wonder whether teachers ever have to go from classroom to classroom, looking after more than one class at a time, the way that midwives have to go between delivery rooms? Just a thought.
Mirabelle
nurse, midwife and health visitor, and mother of three

Not Extreme

I hate to say this, but I don't think the cases shown on Panorama were extreme, in fact I think they were quite restrained. Have a look on the BTA or AIMS website and read some of the wonderful stories written by women.

During my stay in hospital I had several encounters with midwives/nurses who were under pressure. Different actions and words, which taken individually seem minor, when accumulated had a devastating impact.

If anybody on this group has ever tried to make a complaint about maternity care they will know that the complaints system is a joke, a collection of organisations established to ensure that the complaint never goes any further. And when you do find the strength to take it further it can leave you in a worse state than when you first started, as I'm sure others on this list will agree.

I can't imagine that any woman would stay away from hospital if her baby was truly in danger even if going to hospital meant reliving a nightmare. And I don't recall anybody in this group saying that if a baby dies it's always someone's fault.
Nigella
mum

Cascade of Intervention

I hear what you are saying and I agree it must be a damned hard job. What a pity for most midwives in these units they spend their time doing things to women that then cause them to need to do something else to rescue the situation.

It seems to me that we can trivialise the idea of 'not having enough time to do things' but actually one serious upshot of that is that loads of women are being continuously monitored by a machine. Comparing ways of monitoring is not like choosing between tea and coffee, is it? Because many of these CTG monitored women end up with traumatic 'save the baby' surgical births when in actual fact the baby is fine. We know that continuous monitoring increases caesarean section with no improvement in outcomes for baby, and certainly worse outcomes for mother long term.

When we have to prioritise, what is the priority? Do post dates inductions, graph plotting, routine VEs, ARM go out the window? Not in either of the places where I've had children.

I don't know whether this is an accurate analogy, but whilst teachers probably don't have to go from room to room, they do have about 30 kids to teach, all of whom you would want to be treated sensitively and as individuals. We all know this couldn't and doesn't happen most of the time because of pressure on time, resources, marking etc. It is then up to individual parents if they want to take their chances or not by entering into that system. After watching *Panorama* maybe more parents will opt out and have a home birth – no bad thing.
Octavia
mother

Machine Monitoring

I have worked in a big consultant unit, I have used CTG monitors to babysit because I simply cannot be in two places at once. For the record, though, it's not very effective because the CTG monitor itself does not have the ability to call you back like a babysitter can from the restaurant you are eating in. You only find out after the event has happened when it's all there in black and white (and big deep 'u's usually) and there's b**ger all you can do about it.

Now I have escaped and I love my job once more. Even if I hated where we live (which, fortunately, I don't) you wouldn't catch me touching a big unit again with a ten foot barge pole.

There should be no excuses for the behaviour witnessed, but we all know there are good and bad midwives and those who deal with stress (thrive on it?) and those who go to pieces. We all know that, even if it shouldn't, things like that go on all the time.

I feel for those of you still stuck there, chasing your tails and being the brunt of the abuse – I know that I couldn't have managed another five years, let alone the 30 odd until I can retire.
Priscilla
midwife

Long-term Health Impact

In my experience, (which is only limited to the women I know and myself so very much smaller than yours, Juliana) the cases described weren't extreme. Even if they were seldom happening, the effect on those women and their long term mental, physical and emotional health as well as the health of their babies and whole family is huge.

My reading of Marjorie Tew's research was that even high risk women had better outcomes at home. I think in the quite small number of cases where being in hospital would benefit a woman or her baby, this would be obvious to women and they would go there whatever the 'scaremongerers' said. To be honest, I wish more women would know the reality of hospital birth before they crossed the threshold and then make choices that are more likely to lead to a healthy start to parenthood. It isn't about scaring people, but people have a right to know that likely they won't get 1:1 care unless they are at home.

The lack of complaints does not signify happiness. If you have ever tried to complain as a client of the NHS, you will know how emotionally trying it is when they send you some stupid response that insults your intelligence and you will recognise that women who are in difficult circumstances are not even going to begin that process. Women who are complaining need a lot of support from their peers and family and most women are going to struggle to get that and fall at the first hurdle, in a lot of cases maybe just when they tell the birth story to the CMW or HV and get brushed off.
Queenie
mother

Volunteer better than nothing

One of the things I thought was a bit daft about this programme was all the fuss about the untrained volunteer using a foetal heart monitor – all she was doing was holding the transducer on, so that a midwife could (presumably) check it later; she wasn't asked to interpret the trace or give any advice. It was just an admission trace. Presumably having a volunteer there to hold the transducer in place is better than leaving the woman alone and then having to re-do the trace when it was lost. There was no suggestion that this was a dire emergency.

I have to say there wasn't anything in that programme that being a member of this list hadn't led me to expect, especially here in London where maternity units generally are very busy. Midwives are trying to do their jobs but to get to each labouring woman they have to jump over the hurdles of bureaucracy, inadequate support, and in many cases obstacles to using their professional judgement. What a system to have to work in. Only the state could get away with treating its employees and customers like that :-(Oh yeah – and then trying to put independent midwives out of work on the grounds that they are unnecessary because the NHS provides all the maternity care that women need!
Roseanne
Mum

Doing our best

We are a high risk unit and so deal with people who are obviously likely to have problems and yet our caesarean section rate last month was only 17% and

we get thousands of thank you cards and letters from our patients who really appreciate going home with a healthy baby... we are lucky to have some very good consultants who do not wield their scalpels at the drop of a hat, and compared to the units shown on Panorama we are relatively well staffed. I just feel so sad that women are being frightened at such a vulnerable time of their lives. Yes, they deserve to know the truth but the truth is rarely accurately reported!

As a midwife I strive with my every molecule to deliver good care and get very frustrated when we are short of equipment or staff but I do my best. I just feel very sad that we all get tarred with one very large brush.
Sian
hospital midwife

Is There Any Hope?

I watched the programme and felt so very very sad. I am a first year student and although my in my heart I really want to qualify and become an independent midwife the state of play for all midwives, whether in the system or not, is completely diabolical.

The whole story for women and midwives is in a very sorry state, and yes I agree that some units are coping with the staff shortages in the best way they can and it isn't all as sensational as the *Panorama* programme prtrayed.

I just want to cry for those women and their midwives, I also ask what's the point doing my long hard intense not-family friendly training. Perhaps only to end with the prospect of being an illegal independent midwife or in the position of not being able to get a job in one of the better units, in which case, I'll have to re-locate and uproot my settled family of four kids? I'd love to have my head in the sand, but my conscience won't let me!

It's a struggle sometimes being the 'odd ball' at uni, banging on about Nest**s and being the only alternative woman on a course full of very nice but very straight students, and then there are the midwives who don't like my questioning – 'Why' or 'What evidence supports that practice?'

I can only try to be positive and hope that this going situation turns around and puts women and their midwives first, and treats them with the dignity and respect they all deserve. I'd do a protest or whatever to take my views out there.
Tabitha
student midwife

Never say Never

Please Never Give Up. I have been a midwife for a very long time and, believe me, it has never really been easy. As a District Midwife employed by the Local Authorities Health Committee pre 1976 where we were competing for equipment with the Gardens and Parks Committee and the Education Committee to the takeover of District Midwives in 1976 by the NHS it was always a struggle. Then the loss of our Statutary body when the Central Midwives Board was subsumed into the UKCC now the NCM. Now, of course, the very real possibility of our ability to practise outside the NHS. Please do not give up. After 50 years I am still in there fighting and carrying on for women for whose benefit we practise.
In sisterhood,
Ursula
[Oh, OK, some voices are just too recognisable, no prizes, but hope she doesn't mind her pseudonym. MJ]

More Beds

This has been a very interesting discussion, and I am glad that *Panorama* showed a bit of what maternity care is really like nowadays.

There was a lot said about staff shortages, but not so much about the lack of beds. Decisions have been made to close smaller units or close beds in the main units, so Trusts can save money by sending mothers home earlier, (but with less not more community support.)

And now we are finding that labouring women are waiting in reception areas, or worse, turned away from "closed" units. Or they are given beds in other, unsuitable, places. SCBUs are also frequently "closed". This never used to happen. How have we let this happen?

Why is good quality maternity care such a low priority?
Venetia
midwife, health visitor, nurse, mother

Confused

I have watched this programme twice once on my own and once with a retired midwife friend of mine. My reluctance to comment stems from the fact that it has left me quite confused and I think some of the issues are not solely staffing issues.

I left the NHS in 2000 partly because it felt unsafe and partly because I felt that I was unable to provide true 'with woman' care. Someone suggested that some of the statements overheard aided team bonding of the staff on the ward. This is a valid point but to me that also illustrated what I felt and still feel when I take someone into a hospital – the connection between the staff members and the institution is always stronger than the connection with the woman. I am sure there are sociological and psychological studies to show this. Supporting a woman's choice even in a well staffed hospital can invite hostility and it requires great strength to be with woman and against institution or against the colleagues who are disapproving.

A common reaction in my experience is therefore to distance oneself from the woman especially if you know your contact with her is transient.

Supporters of a continuity model and midwives like myself who have experienced it know that this totally transforms the attitude you bring to the woman – she matters so much that this overrides other issues and you certainly wouldn't forget about her or give her the sense she is not important after she lost a twin, has a disabled baby and undergone repeated surgery.

This brings me on to the other point the death of babies. Like everyone involved in childbirth I know that babies sometimes die, even with the best care given. The best care given in my opinion is not necessarily the most invasive one.

The programme seemed to suggest that monitors save babies – they certainly don't! Especially in the way they are often used – I think there should be a rule that any woman attached to a CTG machine has a midwife with her at all times! I think that would change the usage of those things drastically – and please don't introduce these central monitoring stations.

The case of the woman who was in labour with an undiagnosed breech baby also stayed in my mind – she was told the hospital was closed, no other hospital was willing to admit her and when she needed it there was no support – she must have excreted massive amounts of adrenaline – do we know what this does to a baby? We also don't know how she birthed her baby but can safely assume it was a breech extraction.

My heart goes out to midwives who are trying to do an often impossible job but it is the women that have the power to change things. Please complain – as you get told over and over and over – the women are happy they don't complain! *They don't complain because they are too unhappy!*

Call to action

We need to protect our right to receive appropriate postnatal care and this needs home visits for at least the first 10 days – women should not be encouraged to leave the house and seek support in a 'Children's Centre' during this time.

I have attended a session recently with someone who knows about lobbying politicians – apparently they take women of child-bearing age very seriously because they and people over 50 are more likely to vote.

Please therefore let's not despair when we see programmes like this let's act, let's lobby. Stop accepting that there is no money for maternity services, demand the best care at the beginning of life and to support good mothering.

The future is at stake here and the wellbeing of women and their babies is essential!

Wanda
midwife

The Perfect Midwife ...

Oh, to be the perfect midwife!

• To be able to give women the reassurance that they are being cared for by a experienced midwife, despite being newly qualified and to be able to give women the reassurance that they are being cared for by a midwife who has 'been through it' herself, whether or not she's had children.

• To be fully competent and experienced in facilitating breech birth, water birth, vaginal twin birth and physiological third stage, not just having attended endless study days.

• To write totally accurate and contemporaneous notes at all times, that cannot be in anyway misconstrued, misunderstood or perceived as just wrong months, years or decades later (meanwhile continuing to be 'with woman').

• To never EVER say or do anything that could come across as uncaring or disrespectful, whether through feeling misunderstood, overworked, unsupported, whether through frustration, tiredness or behind closed doors.

• To support breastfeeding, but never to do or say anything that could make a woman feel guilty, a failure or that somehow I don't approve of her choices.

• To work to support normal birth but not ever to be seen as forcing 'some Earth Mother concept' upon women.

• To provide IM quality care at all times to women who can't pay and who, quite frankly, wouldn't even if they could.

• To always facilitate choice for women, even those who don't seem to give a monkey's about how their babies come into this world and who don't seem have strong opinions about it.

Now I try really, really hard to provide the best care I can to the women who come to the hospital I work in and in the community and I know that changing the model of care in which I work would go a long way to help me achieve some of these goals, but I know that as my career progresses, there are bound to be women who are unhappy about the care I provide for them for whatever reason, and why? Because I am a human being.

Xantia

(midwife tired after night shift and then not sleeping much today)

..is a human being

Well said Yvette. I too am striving to be all things to all women, partners, babies, my family and friends. Sometimes I succeed, most often I don't.

Yvette
Midwife, single mum of two, soon to be divorcee, student and human being

No Magic Cure

Hear hear Xantia! And I'm sorry but one-to-one care doesn't guarantee happy women. As part of my annual feedback I got two negative comments... In my view completely unfounded (actually both women got excellent care, the complaints being that we asked about a woman's safety at home in a 'judgmental' manner, um... partner in prison for armed aggravated robbery, not judging just concerned, and the other complaint that she didn't get her caesarean quickly enough.... um, progressed to fully over 6 hours, pushed for just on one hour....then taken to theatre by cut happy doc)

But there you go... two unhappy women in my caseload last year. It doesn't matter how you practice, you can't please all the people all the time. I think many women have unrealistic expectations about the level of care that should be provided. And it's hard to provide good care in an atmosphere of criticism and mistrust.

My love goes out to all you UK midwives who are struggling on in the face of this *Panorama* programme, New Zealand midwives know what it's like to feel assaulted at every turn by people determined to prove just how terrible your profession is. It doesn't do a hell of a lot for recruitment and retention I can tell you.

Zenia
midwife

This is My Hospital

I am a student midwife at THAT Manchester hospital. It has about 5,000 births per year. Many are high risk women or high risk babies. There are huge numbers of asylum seekers, teenage mums, homeless, drug addicts etc. Despite this, I have never once witnessed a midwife speak in a disrespectful way to a woman in her care and most try hard to give quality care. I have also had good support from my mentors.

I feel low risk mums are in the wrong environment in this type of regional hospital but many choose to birth here. There is too much medical intervention, too much paperwork and fear of litigation. The programme will have been edited to show the worst case scenario not the hard work, dedication, extra hours etc put in by midwives. No-one would choose to be a midwife unless they cared about women's birth experiences but the system can occasionally get you down so give those fellow midwives a break and hope the programme at least raises some funds so those of us desperate to be midwives can get a job.

student midwife

I understand exactly where you are coming from. The programme sensationalised a very understaffed underfunded unit and not all units are the same, although as you have probably heard some are worse than others.

As Mary said, the fight continues and don't to give up. Where would these women be if we all walked away defeated? I have days where I really struggle. The divide between midwifery school (university) and hospital is huge. We are taught up to date evidence based practice and it's going to take sometime to get through to the workplace.

The positive side is that the university where I study is preparing us to change current practice and give us up to date knowledge to take out there and move it forward to really take midwifery into the 21st century. Really it's great, very inspiring, but the times when I witness the horrors are so low. I have a fantastic brave head of midwifery, whose door is always open and who listens to my concerns and tears. She has picked me up from the floor at times, put me back together and I have regained my strength to carry on.

We are Women, we are Strong and as student midwives/midwives our strength is shared with Women we care for! Do you really want to defeat this amazing position of advocating for those women? This is where it all begins, from here on in I remain on my chosen path, at times need to be reminded of the magic! Please think again, you can be part of this struggle with your integrity, promoting Women centred care in a system that has reached crisis point, and change is imminent.

Take care,
In Sisterhood for all Women
Tabitha

Radical midwives and members of the ukmidwifery list care passionately about women and their babies.

Panorama evoked strong feelings which in turn provoked strong and honest responses which is why all postings have been anonymised.

CEMACH Report

The CEMACH report on perinatal mortality in 2005 came out in April. There has been no improvement in the perinatal mortality rate since the 1992 report (despite ever increasing caaesarean section rate) and this is despite improving perinatal mortality rates in premature babies.

The executive summary (p 10) states that there were 16,737 home deliveries of which 54% had intended to give birth in hospital and 29% were unbooked. 14 babies were stillborn or died in the first week of birth following planned home birth and four of these were said to be related to intrapartum events, three resulted from congenital anomolies and two were labelled as SID. For all other parts of the report neonatal death rates were consistently lower than stillbirth rates (more babies are stillborn than die just after birth) but for planned home births the number of neonatal deaths was double the number of stillbirths. This may just mean that homebirth midwives are good at knowing when to transfer a woman to hospital or it may mean that babies are better able to survive labour at home. (Or the numbers may simply be too small to be meaningful.)

CEMACH states that it was unable to work out a perinatal mortality rate for booked home births; there are no figures for planned home births (regardless of actual place of birth) and the number of women transferred to hospital during labour is unknown. CEMACH has collected these figures for 2006 (defined as 'delivery, at onset of labour, was planned to be at home') so for the next report at long last we should have an accurate total population figure for the PMR for planned home births for 2006.

One odd thing I noticed was that the figures for home births do not seem to match the numbers of purported home births – these figures (17% of 16 737, i.e. 2845) show a planned home birth rate of less than 0.5%, well below the figure stated in other Government documents which talk of a arising home birth rate (the 2006 Office for National Statistics, gives a figure of 2.6% home births). Or are Trusts counting the 83% of unplanned home births as if they had been planned to make their home birth choice figures look better? Maternity statistics still don't seem to make much sense to someone who has kept a close eye on home birth statistics for many years.

NICE Intrapartum Care

Continuing the theme of home birth, NICE has come under so much pressure to change its guidance on planning a home birth that it has reissued the chapter on place of birth for more consultation. It commissioned the NCC-WCH (National Collaborating Centre for Women's and Children's Health) to take another look at the figures. The resulting figures are pretty well meaningless in the absence of accurate transfer-in-labour rates but the main gripe is that NICE continues to use home birth statistics from Australia while failing to make use of the extensive UK study from the National Birthday Trust Fund in 1994, claiming that the comparison group was inadequate. Given that perinatal mortality rates have remained virtually unchanged since 1992, this seems more than a little perverse and smacks of bias against home birth.

Safety of Birth Enquiry

The Kings Fund is running an inquiry on the safety of birth and is asking midwives and other professionals involved in birth to respond. The closing date is May 30th, so get on to the internet as soon as you can and add your thoughts!

Rising Fertility Rate

The 2005 fertility rate was the highest since 1992 at 1.79/1000 but even so 20% of women in their mid-forties remain childless, although the kiddingaside website says that 25% of women in the Western world have chosen not to have children.

No funding for NHS CMM

For some inexplicable reason, the Social Enterprise Unit has found itself unable to allocate Pathfinder Funding for the NHS Community Midwifery Model.

The idea was to explore ways of funding midwives to provide caseload midwifery in the NHS at arm's length from hospital trusts and to implement a national contract for all midwives who wish to work in this way. Such contracts are not unprecedented – indeed this is the way most GP care is funded.

The CEO of the NHS Litigation Authority himself suggested this as a way forward, The Social Enterprise Unit has the following purpose: "The Department of Health's Social Enterprise Unit will be working with social enterprises to identify pathfinders that will lead the way in delivering innovative health and social care services. The learning from these pathfinders will be shared across the health and social care sector so that others can benefit from the pathfinders experience." The only maternity scheme to receive funding was a small company wanting to provide a birth centre and some community midwifery services in south Manchester, with salaried midwives. One wonders whether there there has been pressure from above to keep maternity care (and thus midwives) under the direct control of NHS trusts?

IMA asks for your continuing support in the campaign to resolve the Professional Indemnity Insurance issue for independent midwives. Independent midwives would far rather practise with insurance – but there is none available. They held a rally in Trafalgar Square on May 4th, International Day of the Midwife and other events are planned. Keep an eye on their website saveindependentmidwifery.org for further developments.

Purple Cow

Debbie Gould, in the *British Journal of Midwifery,* (April 2007, p 186) writes of using the 'purple cow' strategy for making you stand out from the crowd. Find what makes you remarkable and promote it.

Midwifery is remarkable in its simplicity and complexity Debbie says, and its 'purple cow' is that it empowers women, it is life enhancing and life changing and you can see it in women's faces following birth.

Facilitating this empowerment is achieved most easily, she says, through a holistic woman-centred evidence based social model of midwifery led care. The only argument that can possibly be made against empowering women is that women who don't achieve it will feel guilty that they have failed, a defeatist argument if ever there was one.

I rather like the idea of radical midwives being purple cows – add in a green mother and baby and you have true feminist colours! MJ

Healthcare Commission Maternity Survey

The National Perinatal Epidemiology Unit reports that it has identified unmet needs of women in their latest survey of 5,000 mothers, *Recorded Delivery: A national survey of women's maternity care 2006*:

- Lack of access to midwives as first pregnancy contact
- Inadequate antenatal education and poor quality of support
- Lack of information of access to appropriate sources (including health professionals)
- Staff working at this time lack the appropriate interpersonal skills to support more individualised care
- Lack of responsive and flexible postnatal care and support in the early days relating to breastfeeding and infant care and self care (especially for women who have had a more difficult birth) and more broadly in relation to practical baby care and the woman's role as a parent.

The NPEU has the following advice to service providers: Listen to women, remember what they say, treat as them individuals with kindness and respect; and carry on listening to women, both locally and nationally.

It is rather surprising that little was said in the conclusions about women being left alone in labour, 56% of women had been left alone by staff in labour; 18% of women reported being being worried about it. A further 6% said that they had been unable to have their partner present, usually because this was not allowed.

A more extensive survey is ongoing.

what's on

June 18
Birth, Culture and Society International Study Group
Henriette Raphael Room, King's College, Guy's Campus, London

Biomedical knowledge, culture, safety and maternal health policy: international perspectives

This one-day symposium is designed to bring together people to illuminate cross-national comparisons of the social shaping of biomedical knowledge production in obstetric science, and the relationship with maternal health policy in a global context
Organised by: Jane Sandall and Edwin van Teijlingen on behalf of the Birth, Culture and Society International Study Group
Contact :
Caroline Kirby-Smith, 0207 848 3023
Email Caroline.Kirby-Smith@kcl.ac.uk

Thursday June 21,
NHS-ConNeCT,
Enabling Mothers to Breastfeed for Six Months
Alexandra House, London.
£78.00
Information/bookings tel. 020 8993 3441 or e-mail:connect@national-childbirth-trust.co.uk

Royal Society of Medicine
Forum of Maternity and Newborn
Asylum seekers and the maternity services
Thursday 21 June 2007
evening meeting
registration at 5:30pm
Topics and speakers include:
The politics of asylum seeking and deportation - Cristel
Who are asylum seekers and what issues do they face? - Jacqueline Dunkley-Bent
The experience of providing care -
The experience of (not) receiving care - Felicity Ukoko
Fees: RSM members etc free; otherwise £10-25

Thursday, September 27
There's no place like home: Birth at home
evening meeting
This meeting will inform and support the facilitation of home birth.

For further information on the above meetings or to book on-line you can visit the Forum of Maternity & Newborn website www.rsm.ac.uk/maternity or you can contact Andrea Török on: 020 7290 2986, fax (+44) 020 7290 2989 or mailto:maternity@rsm.ac.uk

Please register by Tuesday 12 June 2007 to guarantee your place at the meeting.

July 7 London Euston
Jean Sutton – Optimal Fetal Positioning Study Day
cosy: £65
contact: Roma@allaboutthemusic.co.uk for booking and further details

Friday, September 28
Sandhurst, Berkshire
Supporting parents through the loss of a baby study day
organiser: Berkshire Birth
cost: £70 (to include lunch, refreshments and delegate pack) concession: £60 for NCT and full-time midwifery students
Disabled facilities available
info@berkshirebirth.co.uk
contact: 01344 780271

Writing for Midwifery Matters

Have you got something you want to get off your chest?

Have you coped with an unusual birth?

Do you feel strongly about the politics of midwifery and maternity care?

Write an article for Midwifery Matters *and share your feelings with your fellow midwives.*

email your story to margaret.jowitt@tiscali.co.uk or send it to her at 22 South Street, Ventnor, Isle of Wight PO38 1NG
01983 853472 (afternoons and evenings)

Self-improvement Toolkit for maternity units

Catherine Gulati, Chair and User Representative, Solihull and Eastern Birmingham MSLC

A new toolkit has been launched for maternity units called 'Focus on normal birth and reducing Caesarean section rates.' It is produced by the NHS Institute for Innovation and Improvement, and looks an extremely useful way for Trusts to review their approach. In the foreword, Mary Newburn of the NCT writes that it should "help staff and user representatives …think about what affects their unit's CS rates and work together on a range of related actions to facilitate normal birth and prevent unnecessary surgery."

If your Trust hasn't got a copy, they can contact enquiries@institute.nhs.uk or 0800 555 550, quoting NHSIDQVToolkit-C-Section".

The NHS Institute decided to look into caesarean section rates because they have been increasing (from 12% in 1990 to 24% in 2006) with no measurable improvement in the outcome for the baby. Also, the caesarean section rates for different units varied from 16% to over 30%.

The Toolkit was developed by a team comprising an obstetrician and two midwives, who visited units across the country with both high and low caesarean section rates. They concluded that there was a general belief amongst clinicians that maternity units applying best practice to pregnancy, labour and birth, will achieve a caesarean section rate below 20%, with aspirations to reduce this to 15%.

Having interviewed staff and observed practice, they identified the key features of units with low caesarean section rates, and developed five pathways:

1. Top Ten Characteristics (an overview of key features of the other four pathways)
2. Organisational characteristics
3. Keeping first pregnancy and labour normal
4. Vaginal birth after caesarean
5. Elective Caesarean Section

For each of these pathways the toolkit provides a list of behaviours and processes that Trusts believe contribute to low caesarean section rates. Next to each of these, there is a row listing the range of behaviours and processes seen in different units, progressing from those associated with high caesarean section on the left, to those with low caesarean section on the right.

The idea is that each maternity unit should hold a workshop or workshops to self-assess their current position with a multi-disciplinary group, including service users. Each individual should identify which description most closely meets their own perceptions, so this should lead to an open discussion about what is really happening. Alternatively, or in addition, a self-improvement workshop can use the pathways to agree priorities for change, and develop an action plan.

The layout of the toolkit seems to be very user-friendly. The charts are clear, and there is also a CD Rom so sheets can be printed off for workshops. There is guidance for workshop facilitators, templates that can be used for agendas and presentations, and templates for action plans. The CD Rom also includes case studies of successful practice and documents that can be adapted.

The toolkit has its limitations: the boxes on the right-hand side reflect the position of units with low caesarean section rates, not necessarily evidence-based best practice. Also, it can be difficult to identify which "box" most accurately describes the local service; some staff have commented that, while their Trust fits some descriptions of good practice on the right-hand side, they also know of examples of bad practice on the left-hand side. Nevertheless, the toolkit is presented as a way to provoke discussion and improvements, rather than dictating how units should function. The charts should be helpful for user representatives and staff to be more honest about their service; it is almost as if permission is given to make negative comments where appropriate, as this can be done by using the phrases listed in the charts.

The main problem for using the toolkit will be freeing up time for staff of all levels to take part in the workshops. There is no obligation to do so, although senior managers should see it as an opportunity to improve quality and reduce costs. Given the investment that has already gone into producing such a detailed and practical toolkit, it would be a tragedy if time is not set aside to use it to review services. Perhaps we should all be aspiring to caesarean section rates of 15%, with all the consequent benefits for women and their families, as well as for the wider NHS.

The Top Ten characteristics of services aspiring to optimal care:

- *We focus on keeping pregnancy and birth normal.*
- *We are a real team – we understand and respect roles and expertise.*
- *Our leaders are visible and vocal*
- *Our guidelines are evidence-based and up to date*
- *We all practise to the same guidelines – no opting out*
- *We manage women's expectations and prepare them for the reality of labour*
- *We are proactive about VBAC giving accurate information about risks and benefits*
- *If a Caesarean is planned, the process is efficient and effective*
- *We get accurate, timely and relevant information on our performance*
- *We work closely with our users and stakeholders.*

Our Water Baby by Amy Maclean and Jan Nesbitt www. thegoodbirth.co.uk £9.99

Since this book is aimed at children I asked my son Jonah to review it with me. He wants to be a midwife when he grows up so I thought he would enjoy the chance to read a book about a waterbirth. The book is very attractive and it makes you want to read it. Jonah's favourite page is the one after the baby is born where the whole family are sitting on the sofa together cuddling the new baby. The pictures are bright and cheerful and beautifully drawn and you can follow the story even if you can't read as demonstrated by my three-year-old daughter! It is simply told in language young children can understand and children can read for themselves. It is easy to understand the concept of where a baby grows and that it is born and is quite hard work and can make mummy uncomfortable, noisy and very tired but very happy.

The togetherness of the family during the birth of the baby is beautiful and adds to the message in the book. Birth is a family event and it is important for all members of the family to be included. Both children focus on the bike that Oliver gets at the beginning of the story but love the whole family getting in the pool!

My eldest son thinks it is neat and he has learnt how babies are born under water.

Jonah says: "I like this book because a baby is being born in it. I like the pictures because they tell the story without you having to read the words. The pictures are bright and cheerful. It is an interesting and happy story, and my sister says she loves it! I would read it lots of times, and tell my friends about it too." Jonah (age 7)

This is a lovely book for talking to children about waterbirth, with beautiful pictures. It is aimed at primary age children and even though the language used to write the book is simple the illustrations more than make up for the lack of detail. As I said above you can use the pictures to tell the story. It is in hardback version at the moment and retails at £9.99 so perhaps it is a book for a special occasion and is definitely one to keep and look at over and over again.

Andrea Simpson and Jonah Simpson

Dear reader,
I think the book will help our baby be born, because it is nice and gives us tips like what noises to make. Also, it will help other people know what to expect when they are having a baby in a pool. Me and my Mum, Dad and baby will put the pool in the garden in the summer just like they did in the book.
Best wishes,
Oliver J
xx

Oliver is eight and was around when his mum gave birth to his sister on the 3rd April in the pool at home. A short sentence below is from Linda his mum. "I thought the book was really good and shall be looking forward to getting a few to use within the practice for other clients."

Midwives Need More Support

Helpline

The ARM helpline is not just for mothers but also for midwives ring the

ARM Helpline

Sarah Montagu
01865 248159

07946 392728

if you need help

Local Groups are very important in supporting radical midwives who so often feel isolated in their workplace.

It is such a relief to meet like-minded people.

If you are running a local group please let us know about it so we can help publicise it in Midwifery Matters.

Contact Margaret on 01983 853472 (afternoons and evenings) or via email – margaret.jowitt@tiscali.co.uk

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

London
next meeting : Tuesday, July 3rd, Treadwells Bookshop, 34 Tavistock Street, Covent Garden, WC2E 7PB, 7-9.30 pm. All welcome. Go into the bookshop and ask to be directed to their meeting room. £2 to cover costs.
Roma@allaboutthemusic.co.uk

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

Maidstone 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 monthy basis to share good practice and ideas about midwifery in a supportive environment please contact Sarah G Montagu on 01603 614434 or email your details to s.montagu@virgin.net

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 01865 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.

South Wales
Meeting first Wednesday of every month
All welcome
Please phone or email for details
Annie Burrin
07814 082184
anne-marie.burrin@virgin.net

West Scotland
Meeting bi monthly, A mix of hospital midwives, independent midwives and students. All welcome. Please contact Linda Wylie on 01292 316596 for details.

Southampton

Following my appointment to the Steering Group I felt I should have a go at restarting a local ARM Group. There had been one in the past but as people moved on it had collapsed back in 2000.

Taking the bull by the horns I booked a room at the local maternity hospital and a wonderful student midwife downloaded the ARM logo and made some posters.

There were about a dozen at the first meeting, a midwife on duty even came in her supper break.

We have continued to meet monthly in a midwife's home and have had some interesting discussions over tea and coffee with various cakes and biscuites.

There have been a mixture of students and midwives both NHS and private but as yet we haven't had any consumers. Hopefully a piece in the next NCT newsletter will help there.

For our next meeting we have invited a speaker to talk about Aromatherapy and Reflexology. Lots of ideas have been offered for other speakers we are trying to use inhouse expertise so we don't have to pay.

Anyone in the area who would like more information can ring Elizabeth Parker 02380733666 or try work mobile 07775901312.

If you are running a local group please send details of where and when you meet so that other ARM members can come along to meetings. News also welcome. Please send information to: Margaret Jowitt, 22 South Street, Ventnor, Isle of Wight, PO38 1NG email margaret.jowitt@tiscali.co.uk

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)

Items for Sale

ORDER FORM

	£	P&P code	No. req.
Beechwood Pinard stethoscope (standard 7")	6.00	C	
Beechwood Pinard stethoscope (continental 13")	10.00	D	
ARM Badge (Pinard logo, blue/gold enamel, safety fastening)	3.50	A	
Calico carrier bag (Pinard logo)	1.50	A	
Baby T shirt (‘Born into the ARMs of a midwife’)	7.50	B	
Contour pen (rubber grip, retracting, black ink, ‘Midwifery Matters’)	1.00	A	
Jotter pad (6” x 4”, 50 sheets, small owl logo in corner)	0.50	A	
Car sticker (Logo: Pinard, ‘Midwifery Matters’)	0.60	A	
Car sticker (Logo: Owl on Pinard, ‘Pregnant? Be wise, choose a Midwife’)	0.60	A	
Mouse mat (Logo: Owl on Pinard, ‘Be wise, read Midwifery Matters’)	3.50	B	
Silver Miniature Pinard (2 cm) earrings (per pair)	15.00	A	
Silver Miniature Pinard (2 cm) pendant on silver chain	15.00	A	
ARM CD ROM of the first 100 issues of the magazine	25.00	C	
Vision for Midwifery Education (Report of the ARM Working Party, 1999)	1.50	C	
Childbirth Unmasked (stress hormones in labour) Margaret Jowitt	5.00	D	
Midwifery Matters (single back-copies)	2.00	B	
“Choices in Childbirth” (free leaflet)	see below for postage costs		
“What is a Midwife?” (free leaflet)	see below for postage costs		

Post & packing cost codes: A = 50p; B = £1.00; C = £1.50 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) ________________________________

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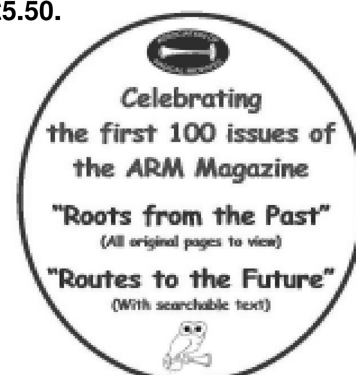
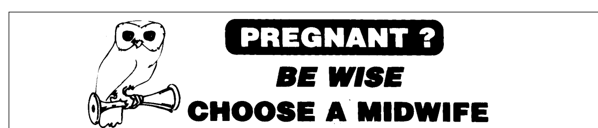
____Post code ________________

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



CD-ROM

car sticker



Orders to ARM Sales, Sarah Montagu, 16 Wytham St, Oxford OX1 4SU 01865 248159

Summer National Meeting Nottingham

Saturday, June 16th
9 am - 4.30 pm

Organiser: East Midland's Radical Midwives

Venue: Sure Start Children's Centre, Meadows

Kirby Gardens, The Meadows, Nottingham, NG2 2HZ

not far from City Centre – walking distance from main train station and bus stops,
free secure parking available

Programme of speakers to be confirmed

Discussion and Workshops

Dr Suzanne Colson: 'Biological Nurturing'

Dr Karen Worth: 'A GP friendly Home Birth VBAC: A personal view'

A.Lee, K-A Gifford, N. Grace et al: 'Independent Midwifery: Politics and Practice'

K.Pidgeon and friends: 'A Guide to Students on Surviving Midwifery in the NHS'

Regina Dengler: 'Pregnancy Massage'

cost: £15 members students £7.50 non-members £25
Garden, Lunch and refreshments included
Contacts: K.erri-Anne Gifford 0115 8470483 or Kelly Pidgeon 0177359062

Steering Group on Friday evening 15th from 6.30pm (for meal) at 8 Waterloo Rd, Radford, Nottingham NG7 4AU Accommodation available, bring some bedding.

Use AA routemap from Web to find places by postcode

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: _____________________________

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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

Thank you to all who have completed the Gift Aid form. Keep up the good work.

! STOP PRESS !

If this journal came to you by post, then it means you have paid the correct subscription, and I would like to say a BIG THANK YOU!

If your friend is trying to read it over your shoulder, because her own copy hasn't arrived, gently tell her that this is probably because she forgot to upgrade from the old subs rate (£25) to the new rate (£30 from 1st Jan 2006).

My reminder letter is possibly still lying on her desk, and I promise to send her missing journal as soon as I receive the correct subs, so she can sit back and read her own copy in comfort!!

With good wishes to all ARM members.

Ishbel Kargar
Membership Secretary

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

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

Subscriptions may begin at any time of the year, to cover 4 issues of *Midwifery Matters*, beginning with the most recent. Members are entitled to reduced entrance fee at all ARM meetings, part refund of expenses when attending the quarterly National Meetings (for details see inside front cover).

NAME: (please use BLOCK CAPS):______________________________

ADDRESS: ______________________________

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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.

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

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

Please make cheque/PO payable to ARM, and post to 62 GREETBY HILL, ORMSKIRK, L39 2DT.

(NB! If you choose to pay by Standing Order, please fill in both sections, and send the whole form)

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ASSOCIATION OF RADICAL MIDWIVES
STANDING ORDER FORM

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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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