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## copy deadlines

- Jan 1 for Spring issue
- Apr 1 for Summer issue
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Time for Labour?

Less than 50% of women now have a normal delivery (defined as one “without induction, without the use of instruments, not by caesarean section and without general, spinal or epidural anaesthetic before of during delivery.”)

The spontaneous delivery rate, at 64.9%, is at an all time low, and while elective caesareans are very slightly down, there has been an increase in emergency caesareans, forceps, inductions and epidurals (source: NHS Maternity Statistics 2005-2006, Information Centre, www.ic.nhs.uk).

At all stages up to birth itself mothers are being told that their body doesn’t work properly – it doesn’t even know when to start – you won’t be able to cope with the pain, you can’t push hard enough, you’ll have to have a Ventouse/forceps/caesarean, whatever, and so on and so forth and then suddenly once the baby is born and the danger of litigation is past they are thrust out into the wide world and left to get on with it; postnatal stays are minimised. The SPE as it is known is a classic experiment in losing their sense of identity. Both were becoming dehumanising patients and health care professionals as the ideology comes to be accepted as sacred.

The following passage comes from a book, an account of the Stanford Prison Experiment, *The Lucifer Effect*, by Philip Zimbardo, a social psychologist. Zimbardo took 18 students, divided them arbitrarily into prisoners and guards and put them together into a makeshift prison and recorded what happened. The experiment had to be abandoned well before the end of the planned fortnight – guards and prisoners alike quickly took on their roles the former becoming increasingly brutal, the latter rapidly losing their sense of identity. Both were becoming dehumanised. The SPE as it is known is a classic experiment in social psychology and shows the incredible power of the situation over the behaviour of individuals. You or I could find ourselves behaving like that in similar circumstances. Of course, it has absolutely nothing to do with midwifery – or has it? See if Zimbardo’s reflections ring any bells for you:

The sacred ideology in the case of obstetrics is, of course, that birth is an inherently dangerous event that can safely be managed only by a consultant obstetrician in the context of a highly technical environment with trained technicians following standardised protocols directly under his power. Such ideology gives carte blanche to treat women almost any way you want, despite the rhetoric of choice.

Scientific apologists such as Richard Dawkins and obstetricians such as Sara Paterson Brown and Nicholas Fisk might argue that it is inappropriate to use religious language in the context of medicine – ‘sacred ideologies’ are belief systems; modern medicine has nothing to do with belief but everything to do with science, they would say. I would say that science, particularly medical science, has its own belief systems which are just as capable of dehumanising patients and health care professionals as Zimbardo’s artificial prison experiment.

In contrast midwifery is not afraid to state the importance of the belief – for both mothers and professionals – that most women’s bodies most of the time are capable of giving birth safely. Midwifery acknowledges the importance of interaction between mind and body but however much scientific evidence is produced to support this belief the medical System is still sceptical.

What was all the more shocking about the Stanford Prison Experiment was that, despite knowing that it was only an experiment and that theoretically they could leave at any time, prisoners found themselves totally unable to exercise their right to leave when appearing before parole boards. This rings more bells for the maternity services. There is a rhetoric of choice but it seems virtually impossible for most women and many midwives to go against the dictates of the ‘standard operating procedure’ of the maternity System. Midwives and women have to resort to subterfuge to get round the System.

Many of these subterfuges concern time: women manipulate their LMP day to avoid induction nine months later; midwives are ‘woolly’ about deciding when labour starts, in order to avoid CTG monitoring; they avoid recording the time of onset of second stage to give women a bit more time to give birth and avoid an operative delivery.

Midwives are forced into trying to subvert the System to give their clients the best possible care and mothers who know what is best for them and their babies learn how to manipulate the System to get what they need. Will we ever manage to change the System itself?

In order to do away with this institutionalised System of childbirth we need to do away with these vast inhuman and inhumane institutions. One mother one midwife would go some way towards keeping the mother out of the institution and the institution out of the midwife. The NHS Community Midwifery Model is all there ready and waiting for implementation. Now that Blair control freakery is in the past will Gordon Brown be more willing?

Margaret Jowitt
“YOUR BABY’S BREECH”. Who’d have guessed what those three words would lead to? Well, the short answer is: anyone who works in a hospital knows exactly how a diagnosis of a breech baby can result in unmeasured chaos, negotiation and compromise. I was naïve. As a caseload midwife, I thought I would be able to give my woman an informed choice and then carry out her care according to her wishes. How wrong I was.

My colleague, Karen, saw my client, Fay, on Tuesday, on a day I was supporting another colleague of ours through knee surgery. She was 41 weeks and 3 days, having come in for a sweep and to discuss what she wished to do about an induction of labour. Fay is from Somalia and wasn’t keen on the thought of induction, which was fine with us. The plan was for Karen to give her a copy of the NICE guidelines and, if she chose not to be induced, to book a scan for 42+ weeks to look at Dopplers and amniotic fluid levels. However, on palpation, Karen was unsure what position this baby was in. Fay agreed to a sweep and her cervix was favourable, easily admitting a finger, but Karen was immediately suspicious of the soft and squidgy ‘head’ that she was feeling, so decided not to sweep and to investigate further. They ended up doing a scan, which confirmed that it was indeed a bottom. Fay’s consultant then became involved. His answer was simple: book her in for elective caesarean section on Friday. But Fay threw a spanner in the works when she told him that she didn’t want a caesarean. She wanted to have a vaginal breech birth and advised her to have an epidural. Karen, new to the hospital and wary of making decisions in labour, decided she didn’t want an epidural and would prefer to have only midwives, preferably me and Karen, in the room when she gave birth.

This is where the fun really started. Karen had seen two breech births, both very medically managed, and I had seen a grand total of none. I had, however, attended plenty of study days, practice sessions and the ALSO course, as well as Mary Cronk and Jane Evans’ study day, ‘A Day at the Breech’. I also spent my elective placement when training with Mary and had helped her reorganise all her breech birth Powerpoint presentations. My belief in a woman’s ability to safely birth her breech baby was strong and I was confident that I was up to the job. As it turns out, practically everyone else disagreed with me.

The following morning, at 6.30 am, Fay called to say her waters had broken and there was meconium. She was also contracting mildly. Although the fact that she was post-dates and the baby was breech were both potential explanations for the meconium, I asked her to meet me on the labour ward so we could check the heartbeat. By the time I fought my way through the traffic to get there, she was already in a room on the high risk side of the ward, doing a vaginal examination. Fay was found to be still in early labour (With mild and infrequent contractions for the past hour? What a surprise!) with a cervix that was similar to the previous day. A scanner was brought in and the registrar decided this baby was Left Sacrum Transverse, with extended legs and documented, for some reason, that there was ‘no cord above the neck’.

The registrar then began to exert pressure, bringing up the subject of epidurals.

“Fay does not wish to have an epidural,” I informed him. He shot a contemptuous quick glance in my direction before asking the couple if anyone had explained the benefits of an epidural to them? They said yes, but that they didn’t want one. He took this as a challenge and started talking about how an urge to push on a not-fully-dilated cervix could cause the breech to descend and trap the head. But, I asserted, that is much more of an issue with a premature baby, where the head is larger than the body, whereas in a term baby they’re roughly the same size. Another contemptuous look.

“And what about the side effect of epidurals slowing down the contractions,” I continued, “I mean, it’s not like we can put up synto on a breech!”

“Why not?” he asked.

“It’s not safe to augment a breech,” I ventured.

“I disagree with you on that point,” he said.

“Well, then I disagree with you right back,” I retorted.

Throughout the rest of the day, despite my best efforts to keep them at bay, a seemingly never-ending stream of doctors popped in uninvited to: “Do a quick review,” or “Have a quick look at the notes,” or “Just come to say hello.” Each and every one had their own, often conflicting, views on proceedings. The (very scary) labour ward consultant was next and she decided to repeat the scan because she wanted an estimated fetal weight, and to confirm that there was no cord around the neck, rather than ‘above’ it, as had been documented, quite possibly erroneously, earlier. This time the baby was found to be Right Sacrum Anterior – the opposite way round from the previous scan – and they estimated the weight at 3.5kg, which did at least seem to make them happy. The consultant asserted that it was ‘very very important’ for Fay to remain on the CTG continuously, but then complained that
the contractions weren’t very strong and that she needed to mobilise. Hmmm. Was she suggesting she should dance a merry jig around the machine? We had already been using the birth ball so Fay continued to use that while I conspired to find a loophole to discontinue the CTG. The fact that she wasn’t yet technically in labour was just the ticket and, much to everyone’s apparent disgust, we took it off so she could walk up and down the stairs for a bit.

Professional Teamwork?
Then the pressure to oust me as main carer began. The labour ward consultant quizzed me on my experience with breech birth and, upon learning that I had no direct experience, insisted that a doctor be present for the ‘delivery’. I explained that Fay did not wish to have doctors present but that I planned to find an experienced midwife to help me (admittedly a tough call in our unit). The consultant then took herself back into the room, told Fay that I had no experience (which she already knew) and I would have to have a doctor supporting me – okay? Fay, unsurprisingly in the face of what appeared to be a done-deal, agreed.

Next in was a registrar; who is well known in the unit for being egocentric and misogynistic, as well as asserting his own, often wild and unfounded, theories as gospel. Surprisingly, things went well at first. He accepted that Fay didn’t want an epidural; he agreed that induction/augmentation was inappropriate with a breech; and he even seemed mildly intrigued and relaxed about birthing on all fours. Then I happened to mention that Fay had had an FGM (female genital mutilation) reversal at 16 weeks pregnant.

“May I ask you a personal question?” he asked the couple. Without waiting for a response, he went on

“When you got pregnant, did you have full penetrative sexual intercourse, or did you” – oh and I swear to God this was the exact phrase he used – “just deposit your seed on the outside of her vagina?”

The couple looked confused. As well they might; I was pretty confused myself. He repeated it several times, continuing to use the frankly ludicrous phrase ‘deposit your seed’. I felt desperately uncomfortable but had no idea where this was going. Eventually, after a bit of a discussion, the couple, still clearly confused, said “Outside!”

“Ahhh” said the doctor, looking smug, then turned and left the room. I followed, to try to work out what that was all about. Outside the room, he turned to me and his SHO and said.

“If she’s never had penetrative sex, how do we know how big her vagina is?”

I was absolutely flabbergasted. So much so, that I completely failed to challenge him.

I made the mistake, at one point, of going to the loo. And what happens when you leave the room for a couple of minutes? Another doctor appears! This one had been and gone by the time I got back, taking with her the article on ‘Midwifery Skills Needed for Breech Birth’ by Mary Cronk that I had given to the couple. I found her sitting and reading it by the midwifery station and prepared myself for the worst. She was, however, reading out parts of the article out loud, such as “breech babies should birth by propulsion NOT traction”, then saying “I quite agree!” “Keep your hands off a breech that is birthing spontaneously – sit on them if necessary! Oh that is absolutely right!” Maybe this one will be okay, I thought. I approached her and introduced myself, as we’d not met before, and it transpired she was a new consultant. The only thing in Mary’s article with which she took issue was the all fours position because, as one would probably expect, she was only used to lithotomy. She expressed concerns around flexion of the head in all fours, so we got a doll and looked at the mechanisms together. She seemed dubious but game, so I asked her if she would be the one to come and support me for the birth: a move I later came to regret bitterly.

Meanwhile, Fay was quietly and calmly getting on with business of getting herself into labour, standing in the corner of the room, hugging the furniture with each contraction and barely making a sound. I made the mistake of telling the consultant when we planned to reassess and, shortly before that time, she came to me and said that she wished to do the vaginal examination (VE) instead – so she could make a ‘full pelvic assessment’. I said I would speak to Fay and see what she wanted. Fay made it abundantly clear that she wanted me to do the examination, and I conveyed this information to the consultant. The consultant, all smiles and condescending tone, explained that she wanted to know exactly what she was letting herself in and that it was all about her own ‘comfort zone’. I said that I would give consideration to her pelvis when I did the VE and let her know if I had any concerns (although I already knew I did not). She retaliated by asking me exactly what I would be feeling for when I did a pelvic assessment and what measurements I should hope to find. I found myself going red, while I blustered through a response about ischial spines and pubic arches, receiving a detailed and patronising lecture in return. Despite this, I managed to keep her out of the room while I did the VE, whereby I discovered that Fay had progressed beautifully to 7cm. My previous argument against continuous monitoring in early labour was now null and void. I talked to Fay about the CTG and explained why it was being recommended by the doctors but that ultimately it was her choice. She chose to go back on to the monitor and continued to stand and hug the furniture. By then, Karen had arrived to relieve me for a break so I eagerly took the opportunity to rush down to my spiritual home, the birth centre two floors down, for a cup of tea and a debrief on events with some like-minded colleagues.

I decided to speak to the Supervisor of Midwives on call, who happened to be one of my managers and also a friend, to let her know what was happening in case I needed some support later. However, my heart sank when she started the call with the words ‘Oh Mia, I’m so glad you called!’ I heard that you had a breech on the labour
ward and that you were planning to deliver it!” She sounded as alarmed as though she had just heard I was about to do a caesarean at home, on the kitchen table, using a butter knife. “Yes, it’s going to be fun!” I replied, trying to inject some humour into the situation. “Oh but Mia you have no experience and it’s really not safe for you to do this and you have to think of the woman and…” She continued in this vein for some time, while I tried to get a word in edgeways: “But… it’s just that… will you listen…?” Eventually, when I managed to tell her that one of the consultants would be in the room with me, she said “Oh thank God!” Well, thanks for the vote of confidence.

I began to realise that I was on my own here. The consultant was slowly turning into the control-freak from hell, the Supervisor on call seemed to think I was a liability, the labour ward co-ordinator on that night just happened to be someone with whom I had had a fairly explosive run-in only a few weeks previously, and my own Supervisor, whom I love dearly and who would have been the perfect support, wasn’t on call and anyway had a prior engagement that evening. I wasn’t worried about the birth – I genuinely believed that Fay could birth this baby beautifully – but I was terrified at the thought of trying to assist her in the midst of a battle for control. I just couldn’t see how I could win.

A few minutes later, Karen called and told me that Fay was beginning to push. I ran back up and was immediately cornered by the consultant, who wanted to talk to me about the ‘delivery’. She had decided that, as she was more used to breeches in lithotomy, this was the method she wanted to use. She approached the now-involuntarily-pushing woman and said “Now I know there are lots of position that you can deliver your baby and that you have discussed them with your midwife, but I’m much more used to doing it with your legs in stirrups so I’d like to do it that way — that okay with you?” Unsurprisingly, given her extreme vulnerability at that stage of her labour, Fay nodded her consent and the battle was lost.

We watched as, spontaneously, Fay began to bring her baby down the birth canal, which seemed to stretch perfectly well, thank you very much — penetrative intercourse or no. On three occasions the consultant knocked and entered (without waiting to be asked, naturally) but left us alone when she realised the birth was not yet imminent. We helped Fay on to the birth stool to bring the buttocks down, which worked well. Eventually, as the buttocks began to distend the perineum, the by-now-inevitable circus began. Lithotomy poles were put in place beside myself with rage but felt completely powerless to stop her, judging that indulging in fisticuffs over the perineum might be counter-productive, however tempting. I supported the body and waited for the nape of the neck to appear, before bringing the baby up using the Mauriceau-Smellie-Veit manoeuvre, the exact movement that would have happened automatically had she been allowed to birth on all fours. The head was not yet ready to come so, after feeling the heart rate beating reassuringly fast under my hand, I waited for a moment more. Over my shoulder I heard a creak and saw the consultant approaching with a set of forceps in hand. “Push!” Karen and I desperately implored, and without any further ado, the baby was born, with Apgars of 8 and 10.

Word spread quickly around the hospital about our unusual event. The next day when I came in to see Fay, cries of “Congratulations!” “Well done!” rang out wherever I went, and Fay herself could not have been more delighted with her baby and proud that she had done it all without a caesarean. But, away from Fay, I could not bring myself to feel proud or triumphant about our ‘achievement’. Instead I felt we had been cheated. Fay had been cheated out of the birth she had wanted, even if she did not — or chose not — to realise it. I also felt cheated: my first breech should have been a moment of wonder and exultation. I felt wildly angry about the underhand tactics used by the doctors. I felt the whole day had been an exercise in power, manipulation and control by the medical team and that they had laughed at us behind our backs for our foolishness in thinking we might be the ones controlling the situation. Most of all, I felt so thoroughly ashamed of myself. Ashamed for the compromises we made, ashamed for losing the ability to advocate for my woman, ashamed for being unable to defend Fay from the medical onslaught to which we had been subjected.

I try to look at the positives: she had the midwife she wanted at the birth, she birthed vaginally, both she and her baby were healthy. More than one colleague told me that I should be happy even for the ‘small steps’. But for me, small steps are not enough. Only a giant leap will be good enough for each woman.

In two months’ time I have a woman who wants a waterbirth with her twins. Wish me luck.
HypnoBirthing Childbirth Educator/Clinical Psychologist

Why I'm a HypnoBirthing® Practitioner

Mia Scotland

About 50 years ago, a young woman named Marie Mongan was pregnant. Inspired by Grantly Dick Read's work, she trusted herself and her body, and she wasn't scared. She told her caregivers that she wanted a natural, drug free birth. Despite an easy first stage of labour, she was anaesthetised against her will and delivered with forceps. The medics didn’t trust in her body, and they thought she couldn’t birth without ‘assistance’.

Trust in a woman’s ability to birth her own baby is a cultural issue which affects every aspect of our birthing practice. In order to help women to reclaim trust their own body’s natural ability to birth safely and calmly, Marie Mongan devised and incredibly powerful programme and called it HypnoBirthing®.

What is HypnoBirthing? It is both a philosophy and a technique. The philosophy is that every woman has within her the power to birth naturally, instinctively and easily. The program teaches women about their normal birthing bodies – how the right hormones (oxytocin and endorphins) make birthing easy, and how the wrong hormones (catecholamines) impede birthing and lead to intervention. An analogy with sex is often used. If a woman is frightened that sex will hurt, and that there will be blood on the sheet, she will tense up, and intercourse will actually hurt – it may not even be possible to complete the act. If a woman is relaxed and trusting, her hormones will release lubricating hormones and open up the vagina to make intercourse easy and pleasurable. Birthing is the same, in that it is highly sensitive to hormonal release, which in turn depends on having an atmosphere of privacy and trust. Women are also taught exactly how their uterine muscles work together to thin and open the cervix. This in itself is enlightening for women who have, up until this time, only considered their birthing bodies to be fraught with potential problems and difficulties.

Thus, armed with this positive information about a woman’s natural ability to birth, woman are then armed with powerful techniques to help to birth naturally. Deep relaxation leads to the release of oxytocin and endorphins (nature’s epidural), and minimises the release of catecholamines (the enemy of the birthing body). Self-hypnosis is a powerful method for deep relaxation of both body and mind. As we know, when women birth naturally, they ‘zone in’ or go to ‘another planet’ as Michel Odent calls it. The fact that women naturally go into hypnosis when birthing well, is the very reason that Marie Mongan originally decided to do a program of self-hypnosis for childbirth, and it is probably one of the main reasons why HypnoBirthing is such an effective program. Some people think that being in hypnosis means that they will be unconscious or controlled. Some dads joke about using the techniques to get her to do more in the house! However, within the first session, it becomes clear to parents that self-hypnosis is a state of deep relaxation, where the mum remains fully alert, fully in control and very focused on her body throughout. In addition to powerful hypnosis techniques, HypnoBirthing also teaches mums specific breathing and visualisation techniques designed to assist the birthing body to dilate without causing hyperventilation. See Lizzy in self hypnosis, staying calm and relaxed in the same position for hours, in between and during contractions.

Thus, HypnoBirthing teaches all these techniques as part of a whole package of antenatal teaching. It moves away from the medical (you don’t learn anything about complications) and moves toward the familial, viewing birth primarily as a loving event. For example, there is a part on the course about the importance of bonding with your baby before it is born, as well as taking care of yourself in pregnancy. Love matters. After all, isn’t that what having babies is all about?

So what is it like to be with a mum who is having a HypnoBirth? The beauty of being with a HypnoBirthing mum in labour, is that there is no alarm in her voice, no fear or panic, no worry or helplessness on dad’s part (dads are given a very specific role in labour, with specific jobs for him to do). And, of course, her labour will progress as nature intended – usually a lot faster than usual! I now suggest that mums write on their birth preferences sheet “please note that it is easy to underestimate progress in labour due to the calm nature of a HypnoBirth” in response to a string of primigravid mums whose midwives had failed to see that they were in labour and/or fully dilated. This happened to Abi for her first birth. She had to make numerous pleading phone calls to finally get her midwife to attend her three hour labour. Two hours after her birth, Abi described it as “amazing” and that she “actually enjoyed it”.

Apart from being aware that labour may progress quietly but quickly, what other ways are there in which an attending midwife can help a HypnoBirthing mum? The
The most important thing is quiet. When a woman is in hypnosis (and in labour), she is focusing and concentrating on her birthing body, staying connected with her baby (this is the case for all natural labour, as outlined by Odent in Birth Reborn). It should be clear in the mum’s birth preferences sheet that questions should be addressed to her birth companion, who is doing the rational thinking for her while she just does the zoning out.

Another important point for an attending midwife is that HypnoBirthing mums are taught to ‘breathe baby down’ instead of ‘pushing baby out’. This is fairly new to most professionals, although Mongan has been advocating this for nearly 20 years. Obstetrics is now becoming aware that neither babies nor mums do as well when forcefully pushing out (and certainly not with directed pushing) as opposed to gently assisting the uterine muscles to do their job naturally. If mum wants to breathe forcefully in response to an urge to do so, that is fine – but the mum is actively discouraged from holding her breath with force (which creates tension in the pelvis) or from pushing on demand. During the classes, mums readily accept this aspect of HypnoBirthing, having learned the power of directed breathing and the ineffectiveness of pushing, by practising birth breathing during bowel movements (similar in that they both involve an ejection reflex). Midwives struggle a little more with it. However, research is coming through that supports this most important part of the HypnoBirthing technique and philosophy – that when birth is natural, it is also gentle and easy.

The final point for an attending midwife concerns language. HypnoBirthing emphasises the power of the mindset. It argues that if you expect pain, or expect your body to need help, then you increase your chances of pain and intervention. So pain is never mentioned. The language of birthing is also changed. Instead of ‘contraction’ HypnoBirthers say ‘surge’. Instead of waters ‘breaking’ HypnoBirthers say ‘releasing’. This helps the mind to believe that birth is natural, comfortable, and easy. Once the mindset is right, the body will follow (an integral part of the mind body connection which is so important in hypnosis). When you are with a Hypnobirthing mum, she needs you to refrain from mentioning pain in any form (unless she mentions it first).

Is there an evidence base for HypnoBirthing? Does it work? While this question is understandable, it is somewhat misguided. Arguably, it is like asking, “does relaxing during labour aid birth?” Or, “is it good to have antenatal education”. Well, yes, given that most women want it, and knowledge is empowering. People ask “does it work” because HypnoBirthing claims to reduce labour time, reduce intervention rates, increase maternal satisfaction, reduce incidence of postpartum depression, reduce pharmaceutical pain relief, increase Apgar scores, reduce complications, reduce hospital stay, and reduce postpartum depression. An impressive list! Much of the evidence for the use of hypnosis in childbirth comes from HypnoBirthing studies in particular (Journal of Counselling and Clinical Psychology, 1990). We can see that HypnoBirthing could well save the NHS a great deal of money! Added extras of HypnoBirth include a relaxed pregnancy. Odent emphasises the overriding importance of taking care of pregnant mums and ensuring that they do not become stressed (The Caesarean 2004).

HypnoBirthing mums are taught powerful relaxation techniques which they practise daily for weeks before the birth. Odent also argues that antenatal scare tactics convince a woman that her pregnant body is flawed by nature, destined to go wrong. The educative component of HypnoBirthing classes goes some way to alleviating this.

**Criticsms**

It could be argued that HypnoBirthing practitioners should have a background in midwifery, or lengthy training. Marie Mongan is emphatic that HypnoBirthing needs to be kept simple. Do you need a gynaecologist to tell you how to make love, or how to get pregnant? You don’t need to know the internal workings of the sexual organs, you don’t need to know the physiology of ejaculation, and you don’t need to know what can go wrong. The basic anatomy is enough, and some information about how to relax and get into the mood, with some encouragement that it is easy and feels good.

Other people are wary that HypnoBirthing is American. This irrelevant – both nations share the same problems of male dominated, over-interventionist systems which have lost faith in women’s natural abilities to birth. There is now an Anglicised edition of the book to accompany the course (HypnoBirthing: The breakthrough approach to safer, easier, comfortable birthing). It has been published specifically because the demand in Britain is growing so fast. So Britain now has a tailor made programme. Hypnobirthing continues to spread right across the world – Singapore, Australia, Spain, Ireland, to name but a few, and in Jersey HypnoBirthing is used in around 15% of all births.

So, maybe you can see why I am a HypnoBirthing practitioner. I am a feminist, and HypnoBirthing provides me with a tangible, effective way to empower women and help them towards a natural birth, in a system which inadvertently does the opposite. I am a trained clinical psychologist and Hypnobirthing provides me with an evidence base to back up what I teach. I am a human, and I love to see, time and time again, the amazing positive births that the women that I teach are having.

Contact Mia@yourbirthright.co.uk, or phone 0845 8685904 (see www.hypnobirthing.co.uk for details of studies)

For more information about HypnoBirthing see Mia’s website at www.yourbirthright.co.uk.

To find a HypnoBirthing class near you or for information about training as a practitioner: www.hypnobirthing.co.uk.
Enabling Women with Diabetes to have a Normal Birth

Debbie Dooley

I have five children and I have been an insulin dependent diabetic for four years. I’m here to tell you about my home birth last July and I’d like to give you some background on my reasons for choosing to birth at home, even though ‘policy’ for diabetic mums is hi-tech hospital labour and birth.

My first three children were all born in hospital with normal labours and deliveries, although I was induced with babies two and three. I apparently had gestational diabetes in both of these pregnancies. However, neither of these births were monitored diabetically; I had no insulin or glucose infusions and my sugars were never tested during labour.

Time passed and 10 years later in 2003, I found myself pregnant again. This time I lost the baby at 17 weeks gestation, I had felt quite ill throughout the pregnancy and felt that things weren’t right, but just couldn’t put my finger on it. A couple of months later I was pregnant again. At five weeks I began to feel very unwell, dizzy, light-headed, sick, but more than ‘normal’ early pregnancy symptoms. A little ‘niggle’ in my head told me to get something checked out. So I popped round to my GP and asked him to check my blood sugar. It was 28.5. Panic stations ensued and I was ordered up to my local hospital and immediately put on to insulin. I was then diagnosed with Type II diabetes.

It explained the loss of my baby a few months earlier and the health problems I had been suffering.

Standard Procedures

During the pregnancy I mastered controlling my blood sugar and my levels were perfect. It was explained to me that I would be admitted to hospital at 37 or 38 weeks gestation, I had felt quite ill throughout the pregnancy and felt that things weren’t right, but just couldn’t put my finger on it. A couple of months later I was pregnant again. At five weeks I began to feel very unwell, dizzy, light-headed, sick, but more than ‘normal’ early pregnancy symptoms. A little ‘niggle’ in my head told me to get something checked out. So I popped round to my GP and asked him to check my blood sugar. It was 28.5. Panic stations ensued and I was ordered up to my local hospital and immediately put on to insulin. I was then diagnosed with Type II diabetes. It explained the loss of my baby a few months earlier and the health problems I had been suffering.

I went to my diabetic consultant and took a deep breath! To my surprise, they were both very open to the possibility of me having a home birth. Caesarean sections due to failure to progress, intervention due to failure to progress and so on.

I began to look into the possibility of a home birth. Initially I met with resistance from my family and friends so I just kept it to myself and started quietly to search the internet. I found a birth story on the AIMS website by Elaine Lawson, a diabetic mum who had successfully given birth to her son without a drip and at home. At last! I saw it could be done.

Following Elaine’s lead I started to look into lots of the myths of diabetic birth and slowly I began to realise that a home birth would be possible. In fact, more than that, I found more and more proof that maybe the procedures currently in operation were so outdated, they could actually be causing a lot of the problems encountered after the births.

The Sliding Scale (IV insulin/glucose) method could itself be responsible for the hypoglycaemic episodes in babies. Caesarean sections due to failure to progress, because of induction. Intervention due to failure to progress and so on.

... working with the consultants

At about six months pregnant, I drew up a detailed presentation for my obstetric consultant and my diabetic consultant and took a deep breath! To my surprise, they were both very open to the possibility of me having a home birth and after reading my proposal they both backed me up fabulously. The only thing bothering my diabetic consultant was the possibility of post partum test and it was a little bit low, so the midwife said she needed to feed. I am a militant breastfeeder so of course I put her to the breast. Another heel prick test showed some improvement but it was still low and they wanted to top her up with formula. I refused for as long as I could, but they began to put mounting pressure on me to top her up. Then one midwife came and told me if I didn’t let her have the formula, she would end up in SCBU with ‘all kinds of tubes and needles and a tube down her throat’. Of course I agreed.

I was so upset to see them trying to force feed my beautiful new baby girl with formula. She really didn’t want it, she was gagging and choking, but they persisted shoving the teat into her mouth. When they were satisfied that she had swallowed enough they left her. She then projectile vomited the whole lot back up. To my shame I let them do it several more times before my instincts kicked in and I refused to let them do it any more. Her blood sugar levels had dropped during all this and again I was left wondering what the point had been.

I breastfed my baby constantly for the next six hours and brought her levels up by myself, without any distress to her or me. I vowed then and there that if I had any more children I would do everything differently.

Planning a normal birth...

Two years later, when I was pregnant for the sixth time. I began to look into the possibility of a home birth. Initially I met with resistance from my family and friends so I just kept it to myself and started quietly to search the internet. I found a birth story on the AIMS website by Elaine Lawson, a diabetic mum who had successfully given birth to her son without a drip and at home. At last! I saw it could be done.

Following Elaine’s lead I started to look into lots of the myths of diabetic birth and slowly I began to realise that a home birth would be possible. In fact, more than that, I found more and more proof that maybe the procedures currently in operation were so outdated, they could actually be causing a lot of the problems encountered after the births.

The Sliding Scale (IV insulin/glucose) method could itself be responsible for the hypoglycaemic episodes in babies. Caesarean sections due to failure to progress, because of induction. Intervention due to failure to progress and so on.
haemorrhage as I was in my sixth pregnancy.

Again, I reassured him that the ambulance station was five minutes away from my house with the hospital only ten minutes away. I reiterated that I would not hesitate to transfer if I felt things were going wrong.

My sugar control was 'exemplary' to use my diabetologist's word; and I do stress that this is crucial for any diabetic mum considering having a home birth. All my research is based on having excellent control throughout the pregnancy and also being able to judge your own dosages. You have to be confident in your body's abilities and above all else 'know yourself'. I have had natural births with all my babies and have let nature take its course and just followed my instincts. Intervention and hospital birth takes the mum's instinct out of the equation and this is the travesty. What is more natural than giving birth? It is pure instinct.

... working with the midwives

I feel very lucky that I didn't really meet with much resistance on the surface of it, in fact after my obstetrician sent my birth plan and proposal to Lesley Price, the Supervisor of Midwives, I received a phone call from Lesley offering her support and the way she spoke to me was fabulous. She really gave me the confidence to stick to my guns to trust in myself that I could do it.

The only negative experiences came in the shape of one midwife and one obstetric understudy. I saw the midwife at my GP's surgery on my one and only visit. She was covering for my normal team of midwives and told me in no uncertain terms that I was being very foolhardy and putting myself and my baby at risk. She continued by saying that diabetic birth needs constant monitoring when there are so many things that could go wrong. Had I thought it all through? I tried to tell her about my re-search and my findings, but she really didn't want to know. I comforted myself with the fact that she wasn't on my 'team' so I was unlikely to have her attending me.

The discouraging doctor was at antenatal clinic. He tried to scare me, by telling me my baby had a very high chance of having shoulder dystocia and we could both encounter grave difficulties with a home birth. He tried so very hard to get me to agree to come to hospital, but I stood my ground and politely asked him to go and see my consultant. He did and when he came back he apologised and said that she had explained the situation. He looked quite bemused and I had the distinct feeling he was very much out of his comfort zone. In his mind, there was no leeway, I was diabetic, I should come into hospital, I should be induced, end of story!

Client centred midwifery

I would like to mention Therese, the attending midwife. She did my home visit and made no bones about how she felt about my decision, but she was totally wonderful about it. She was matter-of-fact and said that even though she didn't agree with all these 'new' home-births for high-risk cases, if she ended up being my attending midwife she would support me 100% and do her best to help me have a positive home birth experience. I was so grateful for her straightforward approach, but also for her honesty. Laugh-

A normal birth

I gave birth to my 9lb 5oz baby boy without any IVs, with no intervention, no tearing or episiotomy and, more importantly, nothing invasive done to my baby after the birth. I was active throughout the labour and even had my birth pool set up and raring to go. (see overleaf)

I had harvested my colostrum after wonderful advice from Jane McAllister, my diabetic nurse specialist, so it was sitting in the kitchen ready for the little man if he had shown any signs of hypoglycaemia, which he didn't. He went to the breast wonderfully and fed while he was still attached to the cord.

I had a physiological third stage, which helps the baby's glucose levels to stabilise, another thing not done in hospital and to my mind vital in diabetic birth.

So, in short, we need to change the management of diabetic birth, we need to try to show that it can be as natural as a 'normal' birth. As long as mum has good glucose control, which is vital, then there really is no need to make birth high-tech birth.

I feel so strongly about this and about breastfeeding that I am training to become a breastfeeding supporter and am hoping to help Jane with advising and supporting diabetic mums in understanding that 'naturally' is always the best way.

I'd like to thank Lesley for her support through all of this, and I understand she virtually 'ordered' her midwives to support me. Also, big thanks to Amanda Bellis and Ian O'Connell, for being open-minded enough to support my decision, and taking the time to read my research and wafflings. It was very important to me to have the backing of these two people as I respect them both so much and I hope I didn't let them down. And finally, thanks to Jane, who supported me with great enthusiasm and made me leave my ante-natal appointments with a smile and total confidence that YES I could do this!

So please everyone, listen to us, give us the choice and see us as women and individuals, not procedures.
Birth Story

Caiden Lewis Bate, born 09th July 2006

Debbie Dooley

I am a 39 year old, Type II insulin dependent diabetic, mum of five. It was Friday 7th July and I had reached the magic stage of 37 weeks. This meant it was all systems go for my home birth. Everyone was very excited as I was breaking new ground for diabetic women in the UK with one of the first ever planned diabetic home births.

It was important that I didn’t go over 38/9 weeks otherwise my home birth would be in jeopardy and an induction would be more likely. We had looked into various self-induction techniques to be started at 37 weeks, so I had everything planned for Friday night. A nice hot curry, followed by a massage with Clary Sage oil and then lots of sex – if practicable.

The curry went according to plan, but then we were both so tired we just went to bed and zonked. On the Saturday morning we decided to do the massage with the help of Cassie, our 2 year old. My partner, Ian, and Cassie spent about half an hour just massaging my bump with the oil. We then tried to go Asda shopping, but my hips and back were just so painful, I couldn’t walk very far, but I did walk much further than I had for a while.

We got back home and I was shattered so I sat on the sofa and had a chat with my best friend, Trudy on the phone. As I was laughing at something her little one, Livvy, had said, I suddenly felt a warm ‘bubble’ come up between my legs. My first thought was I had peed myself, but then suddenly there was much more of a gush! My waters had broken. I looked at the time, it was 4.55 pm.

Excitedly, I said to Ian, “Ermmm... Ian, my waters have broken!” I heard Trudy stop talking on the other end of the phone and it was all silent for a minute, so I repeated myself and Ian jumped up off the sofa and I laughed nervously. Trudy carried on talking and Ian ran around the house, sitting on my computer chair, kneeling on the sofa and floor. I’m not really sure what we said to each other, but I know I was still talking to Trudy when I suddenly realised that this was IT and the time had come to have my baby at home and prove to everyone that diabetic women could have normal uncomplicated births without interventions and hi-tech medical procedures. I was very nervous, I did believe in myself and my body, but even after all the months of planning and research, there was bound to be still a little niggle.

I bade goodbye to Trudy and promised to keep her informed of developments, then I rang the labour ward and asked for the community midwife to pop round. Then I rang my Mum and told her to come up as labour was imminent. In all four of my previous births, my babies have all been born within four hours of my waters breaking, so I didn’t anticipate this one being any different.

My Mum and sister arrived very soon, at the same time as the older kids arrived home from seeing their Dad.

Everyone was very excited and they all rushed around tidying up and getting bedding and clean towels while I sat and leaked.

My midwife, the wonderful Therese, arrived at 6 pm and told me my waters had indeed gone. She did my BP and temperature and listened to baby’s heart. All was well. She told me to get some rest while I could and she would come back at around 9.30 pm to see if anything had happened.

I sent my Mum home too and we all sat around just watching TV until Therese came back. She arrived promptly at 9.30 pm and did my checks again, all was well, but there were still no contractions. She then said she would leave me overnight and I was to ring her if anything ‘kicked off’. If not, then I was to go up to labour ward to be monitored for half an hour the following morning as my waters had broken and she would see me there.

I started to get slightly nervous at this point, thinking that I once I got up there they wouldn’t let me back home and I was also a little confused about why I was having no contractions. So, at 11 pm we all went up to bed and I hoped something would happen.

I had just dozed off and at 11.55 pm I was woken by a very bad, but definitely there. But I gave in and rang her. She arrived with the second midwife, Kate, in tow at around 6 am. After examining me, she said I was effacing slowly but definitely progressing and they would hang around for a while. Ian and the older kids were kept busy by filling up the birth pool in the dining room.

Things started hotting up at around 11 am when the ‘real’ contractions started to kick in, I had been wandering around the house, sitting on my computer chair, kneeling on the sofa, kneeling on the floor and sprawling all over my white leather sofa in the front room. I was reluctant to use the birth pool as I was worried about infection as my waters had broken, so after everything I didn’t use it in the end!
My Mum was fab at rubbing my back during the contractions and Therese was so wonderful, she talked so calmly to me, telling me to relax my body from the top down as each contraction hit me. Her method was almost hypnotic and one of my most vivid memories is of standing in the front room with her in front of me, holding my hands and telling me to breathe in deeply then let my whole body sag with the breath out. Ian was my rock, he was everywhere. If I wanted to lean on him, he was there; if I needed to get up he was lifting me; if I needed to sit down, he lowered me down. And all the time he held my hands and was always with me.

My girls were wonderful, they took over if Ian had to do anything and they fetched and carried, but mostly they talked to me and tried to help wherever they could. Chloe was a great videographer and got the whole birth on video and took pictures despite shaking and trembling and crying for most of the time!

My sister was wonderful with Cassie and kept her amused all the time it was going on. If she wanted to be with me she was and if not, then she took her into the other room or outside.

By the time I started to push I had decided I was sitting on the sofa in the front room and no one was going to move me. I asked for gas and air at around 11.30 am and then the contractions hit me in big style!!

I remember panicking a bit as the pains were very intense and the pushing urge was so strong. I seemed to be pushing for a long time but Therese was saying that the baby wasn’t coming down. I began to think about shoulder dystocia and I started to feel out of control and worried. Therese was so calm though, she soon had me back in check and I realised that Caiden couldn’t move down as I was sitting in the wrong position, in fact, I was sitting on his head! With a massive effort, as the contractions were coming back-to-back now, I bumped my bum down the sofa until I was half on and half off it, with one leg up on the sofa one leg on Ian’s thigh. I pushed about three times and the head crowned, then Therese told me to pant, which I did and I felt the rest of his head come out. I heard Cassie say, “What’s that?” and I realised she was actually standing behind Therese with her hand on her shoulder in prime position. With the next contraction his body slithered out and Therese lifted him up onto my chest. He was so warm and beautiful, I just kept saying hello baby, hello baby. At this point, Cassie said “It’s a baby!” with such wonder in her voice that I knew it was right for her to be there.

Everyone was crying, My Mum, my sister, my two girls and Ian, it was such a beautiful moment. I am so glad I had so many of the people I love around me. I just wish my other little boy had been there too.

Caiden didn’t cry at all and just lay there pursing his lips, Kate, the second midwife passed me the oxygen and I held it to his face for a few minutes and rubbed his back, although there was no worry as he was still attached to his cord. He was so calm and quiet and soon began to pink up so we knew there was no problem. He never cried at all and has remained a very placid and laid back little guy.

We left his cord to stop pulsating and he had his first feed while he was still attached to me. Daddy cut his cord around 15 minutes later and had his first cuddle while I started pushing again to deliver the placenta.

It took about an hour for the placenta to come out naturally, and Caiden fed wonderfully and helped it to detach.

Kate finally got to weigh him and he came in at a lovely 9lbs 5oz, not my biggest baby, but also not my smallest. Although I must admit he did feel bigger at some points!

I felt so comfortable in my own surroundings and Therese was the most wonderful midwife, she made the whole experience mine from start to finish. Even down to monitoring Caiden’s heartbeat during the labour was left to me to say when and where.

Most importantly, my blood sugars remained within the normal range and I have proved for diabetic mums everywhere that it can be done without the intervention and you can have the type of birth you want.

It feels so important to me to have an accurate record of this birth. I have been asked to write it up for the ARM and also for the Homebirth UK Group. I really do want to try to help move things forward for diabetic home birth.

I did this for myself and for Caiden, but if it can help other women experience a wonderful birth like I did, then I will do my best to help them.

(Written when Caiden was 9 days old)

Imagine that you are a midwife: you are assisting at someone else’s birth.
Do good without show or fuss.
Facilitate what is happening rather than what you think ought to be happening.
When the baby is born, the mother will rightly say:
“We did it ourselves.”

Lao Tzu, The Tao of Leadership (5th century B.C.)
A student’s call to ARMs

Aby Cairns

When I was thinking about writing an article for ARM, I wanted to focus on the positive aspects of my training and to examine those elements that have kept me inspired and urged me on.

I came into midwifery with a passion that has been brewing all my life, from the first look at my mum’s home birth photos of my brother, to the constant presence of NCT ladies coming to Mum’s classes at our old house (when we should have been in bed, but snuck down to watch all these mysteriously, magically rounded women). I suspect that much of what has kept me going is a deep desire to be around pregnant women and to help them in their experiences of birth. Mostly, I want to share with them the sense of wonder and joy I have in normal birth, to teach women, if possible, how to believe in this amazing process. This belief and passion in the normal process of birth could not have been taught to me. I feel it is ingrained in every fibre of my body – I am humming with it.

But even with this sense of purpose, it has been easy to find myself getting lost in the churning mass of hospital midwifery. There have been several shining points of inspiration that have brought me back again and again to the awareness of what I mean to people when I say: “I am a (student) midwife.” I can count the moments on one hand yet they have been enough to fill me up and save me from the sometimes overwhelming scale of work and commitment that this course demands.

‘Spiritual Midwifery’

I remember each moment with such clarity. The first one occurred during a community placement. Sitting in the staff room, feeling somewhat out of place, I sifted through the books on the shelf looking for something to read. I came across a crumbling old copy of Ina May Gaskin’s Spiritual Midwifery. This wonderfully colourful, utterly hippy book touched me right to my core. I was utterly absorbed by story after story that expressed the deep connection that some women and their families are able to make to childbirth. And I was completely in awe of this woman who had been able to communicate this truth and faith to so many people. It shouldn’t have been such a surprise to me that telling stories about natural childbirth should have such a profound affect on people’s experiences – after all this is the very gift my mother gave to me. But it was a potent reminder of the power of positive stories around birth.

When my older sister fell pregnant three years after her first, very traumatic birth, I sent her a copy of Spiritual Midwifery. I wasn’t at all sure she would read it, but alone her husband – they’re pretty strait-laced folk, and this book was full of kaftans and beards. To my amazement, not only did they read it, but I saw and heard them change their attitudes towards childbirth almost overnight. From painful memories of their epidural, instrumental delivery and postnatal depression bloomed an optimism and faith in their ability to birth unassisted by pharmacology or intervention. I say their ability, because a partner’s belief in a woman’s body can be just as powerful a thing as her own. What followed was a truly healing birth, a much sturdier baby than the first (who had apparently been too big for her!), born into water with my previously squeamish brother-in-law in the pool supporting my sister all the way. And afterwards, not a hint of the depression or breastfeeding problems that haunted her first birth.

Independent Midwifery

The second moment came when I first came into contact with the local independent midwives. I’d taken two years out from studying to have babies (two in quick succession!) during which time I had edited a collection of home birth stories. Having planned home births with both my children, I was staggered by how little narrative there was around this topic. With hospital births being the norm these days, the overwhelming majority of birth stories are inevitably medicalised, at least in the sense that they occur in an environment which I personally consider quite alien to a labouring woman. So I set out to provide an antidote, much influenced by my first reading of Spiritual Midwifery. The independent midwives in my area chose to include this book as part of their initial booking package for their clients, a fact which fills me with such a sense of pride and achievement. I was invited to attend one of their client coffee mornings, and jumped at the chance to get a glimpse of this whole other parallel world of midwifery. And boy did I get that glimpse. For the first time in my life as a student midwife I felt that I was part of something really meaningful to me as a midwife – here was a room full of women: midwives, mothers and their children; past, present and even future clients. There was such a sense of belonging and togetherness, such a feeling that this was what being with women meant. I feel a twinge of regret at all of the women I encounter in the NHS, a slight feeling of perhaps abandoning them to fulfil myself, but this was the midwifery I believed in when I entered the profession, and I want to be part of it. I want to work with women who need or require something outside the structure and formality of a national service. I want to personalise it, to truly become professional friends of these women. I want...
to be able to walk into a room where a woman is labouring and know her, know her family and know her (fully informed) wishes and to work in partnership to help her achieve them.

**ARM Meeting**

My latest moment of inspiration came just recently at an ARM meeting, where I attended a workshop by Suzanne Colson on Biological Nurturing. She presented her research on the reflexive and instinctive aspects of breastfeeding, where the mother reclines (not on her side), places her baby on her body and the baby self-attaches. This should not be an unfamiliar image for most midwives – the video of a newborn baby crawling up its mother’s body to self-attach is well known and the concept of re-birthing is practised by many as a way to ‘reset’ mums and babies following problems establishing feeding. But it was still a Eureka moment for me, listening to Suzanne, watching her videos and feeling the utter rightness of what she was saying and demonstrating. Finally I felt as though I had a real tool to use to help women facing the most demoralising situation – not feeling able to feed their baby effectively. I still find it hard to express what a complete turnaround this has been for me. I had considered myself quite good at breastfeeding support until now. But here I was feeling as though most of what I had been doing was reinforcing the idea that women and babies are pretty much stupid when it comes to feeding, they need to ‘learn’ it and be positioned accordingly. I have only just started to introduce biological nurturing into my own practice, but from my own experiences so far it is utterly convincing. I urge you to seek out this research and apply it in your practice, you will be amazed by how much you are able to help women. (For a short report on this workshop see p21 and Suzanne’s website: www.biologicalnurturing.com).

I am just coming to the end of my training. It’s been a long time coming (five years and two babies later) and I’m looking forward to it with mixed emotions. My future is certain, yet unknown. I’m going to be a midwife, but the how, where and to whom is another country as yet. It’s an exciting time – the possibilities are endless, yet this feeling of boundless opportunity does not seem to be shared by many of my fellow students. When I stop to ponder this it seems as though we’ve forgotten what we are, as though the concept of qualifying as independent practitioners has been somehow lost. Whenever I mention the word, people seem to shrink away from me as though I’ve just said something distasteful and rather scary. How is it that as students our landscape is so shaped and shuttered by the expectation of NHS midwifery? In essay after essay we are asked to reflect on the history of midwifery, the legal aspects of midwifery, the professional issues surrounding midwifery, and the concept of midwifery as a unique profession dealing with normality and proud in its professional autonomy. But even in the current climate of job shortages and uncertain futures for many newly qualified midwives, my plaintive protests of, “You could always work independently,” go unnoticed or unheard. The ongoing mantra about the heavy threat of litigation undermines us every step of the way. Whatever happened to lateral thinking? Who said every independent midwife had to work in intra-partum care? How about setting up some much needed ante-natal classes, or providing independent postnatal and breastfeeding support, or workshops on completing a birth plan, or… I could go on and on. If I could have one message heard it would be… for goodness sake (and the professions), respect your qualification.

Inspiration is a very personal issue. I don’t pretend to believe that my feelings on the matter are of any particular consequence to anyone else, but what I do believe, very strongly, is that student midwives are the future and must not lose sight of the fact that they are the instruments of change. Don’t be tricked out of your passion by the thoughts and feelings of others. Hold tight to what inspired you in the first place and you will find others shining back at you, ready to help you on your journey as a midwife.
Laura’s story

Lillian, 2004

When I had my first booking-in appointment and the midwife asked what hospital I’d like to go to, I said I’d like a home birth. This wasn’t really based on anything tangible like experience or research, but it sounded like a nice idea. The midwife seemed surprised and went on to describe how pain relief options were limited and how it was more common for women who already had children to have home births, as they knew what to expect.

I asked the midwife about her own childbirth experiences; she said that she’d had her three babies in the hospital because she needed all pain relief options due to her low pain threshold. Oh dear, that sounded like me. She wrote up my notes and put ‘home birth?’ I don’t think either of us at that stage thought there was much chance of it happening. I can’t even remember talking to Ant, my partner, about it that much at that stage.

At 24 weeks pregnant I started NCT classes. I remember that I went alone to the first class as Ant was working, but as expected everyone was thoroughly pleasant. My only disquieting moment came when at the end of the class the discussion descended into a free-for-all against Horrid Doctors. Feeling like I might well end up in hospital with every intervention going, I challenged this view, defending the doctors and their interventionist ways. Thankfully someone backed me and I didn’t feel a complete arse.

Interestingly, one of the group, whose baby was due first, was also a trainee midwife. Not only this but she was planning to have a home birth. Typical, is what I thought. Over the next few sessions my desire for knowledge about giving birth grew nearly as big as my belly. I was happy to go to the NCT classes, sign up for hospital classes, read books, look on the internet and soak it all up. Fairly quickly I bought into the idea that birth could and should be a natural process and one to look forward to, not to dread. I began to focus on the idea of a home birth. My main concern was, what if I couldn’t cope?

This was a concern that my partner shared. In the early days he was very worried about the impact it would have on me and the baby... you know, what if it goes wrong? But my confidence grew and I became clearer that I wanted a home birth. The discussions continued at home without any clear resolution and it was during this period that I started to talk more openly with friends and family about the home birth option.

I can honestly say that, with the exception of my sister, who’d had a baby the year before, the response was largely negative. Those who weren’t openly negative about the idea said things like, “You wait, when you’re in the throes of labour you’ll need every pain relief option going,” or simply asked, “What if it all goes wrong?” And everyone had a bad story to tell about giving birth; why do people do that? I felt patronised by the ‘you wait and see’ attitude and like a reckless risk-taker with the ‘what if it goes wrong’ brigade. Anthony was going to need some serious persuasion before he could really buy into the home birth option.

During one of the last NCT classes we watched a video of women giving birth. A mixture of home, water and hospital births were shown to us, none of which looked particularly appealing at 33 weeks pregnant. But the idea of labouring at home, being able to do exactly what I needed to do to get me through, became essential to me.

After the video we discussed how we felt about the births we’d watched. It was then that I raised my dilemma with the class. It was Aby (the aforementioned trainee midwife) who pointed out that if I opted for a home birth and the labour was going well I could stay at home but that at any point I could change my mind and go into hospital. If, on the other hand, I was booked for a hospital birth and the labour was going well at home I couldn’t at the eleventh hour opt to stay put.

This was a revelation! Knowing that I could change my mind at any point gave us both the confidence we’d so far lacked to commit to a home birth. I should add that the fact that we live only half an hour from the hospital also helped: I’m not sure we’d have felt the same if we’d been an hour away.

Aby also pointed out that at home you get one-to-one care (in fact, when the moment arrives, there should be two midwives). This was great. I’d heard friends complain that they were often left alone to deal with contractions and my poor old sister said that she’d pushed for hours exhausting herself for lack of guidance on the matter. The fact that I’d get one-to-one attention made me feel all the more special.

As the due date got closer I started to notice a little voice in my head: it said, “You can do it, your body was made for this, women have been doing it successfully like this for centuries.” It became a little mantra and it worked. I believed it more and my confidence grew. Yes, I was anxious – birth was an unknown quantity – but I knew
that this baby had to come out whatever and being positive about it made me feel stronger.

I resolved to confirm my intentions with the midwife at my next appointment. I thought I'd have a battle on my hands and I was sure she'd try and talk me out of it. Unusually, my mum was there for this appointment and while she hadn't voiced a view on home births either way it seemed to somehow make a difference with the midwife. Of course I'll never know, but I just felt like she wasn't going to question my judgment with my mum there!

A week before my due date my waters broke, just after lunch. My best friend Lorna happened to be staying with us for the night having come visiting from Rome. We called the midwife, even though I wasn't having contractions, to give them some advance warning, and I was introduced to the on-call midwife, Nicky, around 4 pm. She came back a few hours later to assess progress. There wasn't any. She gave me some good advice and said she'd come back tomorrow unless I needed her before then.

Ant and Lorna popped out for a takeaway at about nine o'clock; by ten the contractions had started and by eleven they were steady. The TENS machine I'd hired was great for the half hour before it broke and I ditched it. By midnight the contractions were coming thick and fast. The videos of births we'd seen at NCT showed women wandering around having a cup of tea in between contractions but this was not my experience. I wanted to call Nicky but Anthony seemed a bit hesitant, so we agreed to start timing the contractions. When we realised how close they were we called her straight away: they were coming 90 seconds apart.

Nicky arrived at 00:40 am and confirmed I was 4 cm dilated. Pain relief came in the form of a hot water bottle and my birthing ball. I got very hot and cold quickly and Anthony was fantastic at responding to all my requests. Together, in our bedroom, we focused on the contractions and rode them out.

At around one o'clock the pain got really bad and I was still only 5 cm dilated. (Five? Surely she meant twenty-five?) All I could think was if I've got another ten hours of this I can't cope and I'll have to go to the hospital. I remember having coded conversations with Nicky to this effect. To their credit Nicky and Ant kept me going.

Nicky suggested I went downstairs to have a bath. Before I got in I remember hanging onto the washbasin and retching and shuddering like a volt had gone through my body. Ant washed my back with the shower and I instantly hated it and wanted to get out. They persuaded me to give it a minute. I did and suddenly it felt wonderful, the pain eased. Nicky was great as she followed our lead and largely left us to it. I think something happened when I came down those stairs because within an hour of being in the bath I was ready to push.

I remember asking for gas and air but Nicky said that in the time it would take to set it up the baby would be here. It was then I thought: "Okay, you've done it, home birth, no drugs, enjoy the next few minutes."

The pushing bit was so much better for me than the contractions. I felt more in control and I was getting somewhere. I could feel our baby travelling down me with every push. I remember the hot pain when she was crowning, I remember panting for my life when I had to stop pushing to allow her head to come out of its own accord. But mostly I remember being so incredibly proud of myself for having a natural home birth and giving Ant the beautiful baby we'd wanted so long.

Lillian Rose was born at 3:25am and half an hour later we were all in our own bed having a cup of tea. An hour after that it was just the three of us (and Lorna, who had slept through most of the action). It was weeks later when Nicky told us that Lillian was her first home birth. Wow – what a great memory for all of us!

I feel incredibly lucky and privileged that the labour and birth was so textbook. And that's the issue: you just don't know what it'll be like. But for us, being so close to the hospital and having that one-to-one care during labour made it feel safe for us to take the plunge.

Did the home birth make a difference to us? For the first three months we just kept reliving it. We still do, but not quite so often. It is our most treasured memory, so far.
During the past few months I have been organising a placement with SAPEP, an HIV/AIDS project in Zambia, Africa. I hope my story will encourage you to make the most of similar opportunities during your training.

At the University of Nottingham, student midwives can negotiate an optional placement to observe midwifery care in a different organisation. This placement can be up to four weeks long and the student is responsible for making all the arrangements with the receiving organisation, setting realistic aims and objectives, and meeting all costs involved.

At 36, I fulfilled a long-held ambition and started my midwifery training. I wanted to make the most of this university experience as my first degree had taken over five years to complete alongside the challenges of juggling the demands of a toddler, work and paying the mortgage. Midwifery training has only been possible with the support of my husband and son being prepared to endure the hardships of giving up my full-time salary.

I had no particular mission to get involved with HIV/AIDS or Africa. It just happened, and I cannot really explain why. I have never been to Africa, I don’t know much about HIV/AIDS, I get really uncomfortable when it’s hot, and I am absolutely phobic about bugs. What on earth am I doing heading off to Zambia then? Why not a birthing centre, or a rural location in the British Isles? I wanted my midwifery training to be life enhancing, life changing and to look back in years to come with pride at what I had experienced. Travelling to Africa would give me a chance to be brave, connect with women from a different continent and use that to inform the rest of my life.

Wider Experience

Most of my training takes place in a consultant-led, high-tech, well-resourced environment. I wanted my placement to be a contrasting experience. Indeed, I would enjoy a placement working with independent or rural midwives assisting with homebirths. I decided to take the next logical step, to find a placement where midwives work in rural areas, relying on their midwifery skills alone as help is not guaranteed to be within reach. This led me to think about Africa.

I had heard about a student nurse, Helen Allen, who had been to Zambia for her elective placement and had been so moved by what she had experienced, took it upon herself to establish a charity called PEPAIDS (Peer Education Project against AIDS; www.pepaineds.org) to help raise funds for the SAPEP project in Zambia.

I managed to track Helen down through the internet and made contact. We chatted via email about what experience I was looking for and what SAPEP could offer, and the foundations were laid.

My first task was to liaise with my personal tutor and cohort leader to confirm the placement was suitable and that I could travel on the dates available. SAPEP prefer students to travel outside of the rainy season, so my university were extremely supportive in giving me some flexibility. I then spent some time finding out about Zambia. I had some reservations after looking at the safety and travel advice issued by the Foreign and Commonwealth Office on their website and reading up about Malaria and tropical diseases on the Health Protection Agency website. This was tempered by meeting students from my university who had already travelled to Zambia and spoke enthusiastically about how friendly and hospitable the people were, how easy it was to use the public buses to get around and how comfortable the guest houses had been. They told me how easy it had been to travel down to Livingstone or to Victoria Falls and how taking a canoe safari down the Zambezi was a must.

My next mission was to find someone to come with me. Although a few of my friends on the course considered the trip, it was my 23 year old midwife mentor who eventually decided this was for her. She qualified two years ago and felt that this would be a great opportunity to use the skills and confidence she has gained since qualification to work alongside midwives in Africa.

Next was the budget. Working out how much insurance, flights, accommodation, food, transport, visas, equipment, immunisations, anti-malarials and spending money would cost was a scary experience. I worked out that I needed just over £1,600 to cover the essentials for a three week trip. With no savings and living on a student budget, I needed to get creative if I was to raise the funds without adding to my debt burden.

Raising the money

The first thing I looked at was part-time work. I managed to get a few hours updating an NHS website, but this involved using my personal study days which put additional pressure on my studies.

My mum came up with an idea to raise some funds by selling junk from our garage and loft. This idea mushroomed and all my family and some friends had a clear out and one bright Sunday morning in March we raised over £200. The stuff that was too good for a car boot was auctioned on Ebay and made another tidy sum.

My wonderful personal tutor sent me details about an essay writing competition with a cash prize. I decided to have a go at entering and to my great surprise I managed to win second prize http://www.healthheacademy.ac.uk/scevents/StudentAwards

For my birthday in February my family all gave me money instead of gifts to help with the trip. Then my sister suggested that I apply to The Weakest Link to be a contest-
ant. I wrote off to the BBC and was eventually called for an audition. This was quite a nerve wracking experience as there were general knowledge tests, camera tests, a practice round with eight other hopefuls. The researchers even tried to test your resilience to insults from Anne Robinson by casting remarks and insults in all directions. I am still waiting to meet the real ‘Queen of Mean’ but watch out for the student midwife who goes blank when asked “What M cares for women in childbirth”. I then went on to explore whether any travel scholarships or awards were available. Making an early decision about where I was going was crucial in meeting the January and February closing dates of grant giving organisations. I made one application to the Iolanthe Midwifery Trust www.iolanthe.org and one to the University of Nottingham’s Alumni Association. I feel extremely lucky to have been awarded funds from both of these excellent organisations to help fund my trip.

Now I had the resources in place for the trip, I could really start to think about the practicalities and what I might be able to bring to the project. A professor from my university put me in touch with an editor at Elsevier Science who was looking for students to review midwifery textbooks. Elsevier kindly let me choose books to take to Zambia and donated £100 to PEPAIDS in lieu of payment for my reviews. In addition, I hope to find out if the local guidelines and protocols used in Nottingham may be appropriate to share with the team I meet in Zambia and to gain permission to send them to Zambia on my return.

Widening horizons at home

Organising this elective has increased my involvement with student societies in Nottingham. I am ashamed to say that I had stereotyped many societies as being for young students who like partying and drinking and that I was too old and frumpy to join in the fun. Getting involved with other students reading different subjects has been a truly enriching experience. I value their warmth and fresh perspectives and I feel that my enthusiasm and experience as a mature student are appreciated and useful. 12 months ago, I would never have believed that I would be sitting writing to you today as President of the ZambiAIDS Society at the University of Nottingham. I’m now part of a society that organises activities and events from hard house club nights, to quizzes, to talks – all to raise money for the SAPEP project in Zambia. I even have a Facebook www.facebook.com account now!

I’ve also become a member of the Student StopAIDS Campaign http://www.stopaidscampaign.org.uk/Student%20Campaign/studentintro.asp and have started writing to my local MP to urge him to sustain the momentum of the GB’s commitments to reduce the price of life-saving generic medicines for HIV/AIDS, achieving universal access to services preventing mother-to-child transmission of HIV/AIDS and to support sustainable health systems. Interacting with different students has been such an enriching experience and I would urge my fellow mature students who think they are too old to join in, to put those worries aside and get involved.

In May 2007, I attended the RCM conference in Brighton and listened to a presentation about the White Ribbon Alliance for Safe Motherhood (WRA) www.whiteribbonalliance.org. It was utterly inspiring and I urge anyone interested in maternal health to get involved and register free on their website. When I got home I emailed Brigid McConville from the WRA to ask whether there was anything I could do to support their work and I’m planning to attend a stakeholder event later this year and get involved in the Women Deliver initiative www.womendeliver.org which aims to create a focus on saving the lives and improving the health of women, mothers and newborn babies around the world.

More than midwifery

Now, as I look back over all I’ve written, I ask myself would any of this have happened to me if I hadn’t started training to be a midwife? Choosing to spend three weeks in Africa has brought me closer to my family, friends and mentors, and in turn, raised their awareness of the issues facing people in Africa. It has provided opportunities for me to meet and make friends with students from across the university, often young and energetic people whose enthusiasm is infectious. I’ve made connections with individuals and organisations striving to improve the health of women and children in resource-poor countries around the globe. As part of the awards from The Iolanthe Midwifery Trust and the University of Nottingham Alumni Association and through my involvement with the ZambiAIDS Society at my university and the WRA, I hope that I can help to promote not only the work of SAPEP in Zambia, but contribute to improving the world around us.

Planning this trip to Africa has made me feel more connected to the women of the world, even though I may never meet many of them. I feel a strong desire to use any opportunities I may be given to influence positive change for women in countries who do not have the opportunities or forums to influence their own destinies. All this, and I haven’t even stepped on the plane yet! Organising this placement has developed confidence and skills I never knew I had. It has encouraged me to be brave and has given me a purpose. It has helped me develop a wider perspective about the provision of midwifery care and to feel proud of the work midwives do in the UK. I know that these three weeks in September will change my life – they have already. Here I am, 38 years old, a mum, a wife, a sister, a daughter, a friend. I’m not the youngest or the smartest student. I’m struggling to get by from month to month on my student income, but I am loving every minute of my time as a student midwife. And somehow, with the support and encouragement of so many people, I’m off to Africa for the first time in my life. I would say to any midwives or students who have an opportunity to do something similar – go and grab your chance with both hands.
Dear Midwifery Matters,

The summer 2007 edition was wonderfully substantial and I felt moved to write and make a number of, possibly lengthy, comments.

Elizabeth Parker’s ‘Keeping the Wolf from the Door’ expresses in a positive way the kind of tactics which NHS midwives need to make in order to truly be their clients’ advocates and preserve normal midwifery.

In ‘Midwife to Midwife’ Mireia’s experience and Jane Evans’s advice underline the fact that any intervention, any interruption, of normal physiology has side-effects and risks.

It is my understanding that active management of the third stage is the default response in the vast majority of births in this country and, of course, active management of the third stage requires immediate clamping and cutting of the cord after the birth of the baby. The rationale behind active management of the third stage is that it prevents postpartum haemorrhage. And I may be wrong but it seems to me far more likely that the baby will need some encouragement to breathe than that the woman will bleed seriously. So why is this intervention, which is so routine that it often isn’t even seen as an intervention, so pervasive? I contend that it is because it serves irrational purposes for the health professionals. It is easier psychologically to take action than to wait patiently and observe. It has never been adequately risk assessed and I doubt it was ever introduced as a result of any objective research.

I think it is vitally important for the future of midwifery and childbearing women that radical midwives, who have a level of knowledge of the normal physiology of childbirth far greater than that of the medical profession, can articulate and justify their practice.

Which brings me to Margaret’s experience. I studied social psychology in the early seventies and much of the research we examined was concerned with authoritarianism, conformity and compliance. This was in order to understand what had happened in Nazi Germany and to prevent it ever happening again. So when I became a student midwife in the late 1970s I was well informed of the theory of the power of hierarchy but it didn’t prevent me from being complicit. At that time the recommendation was that all first-time mothers should have an episiotomy and that a previous episiotomy was an indication for a subsequent one. I was consciously critical of this. One of the reasons I had become a midwife was because I thought that childbearing was a feminist issue. Yet it took me about a year before I could develop a satisfactory tactic to avoid cutting women’s perineums with a pair of blunt scissors because somebody more senior had told me to. I felt as though I was colluding in the oppression of women until I became a community midwife in 1982 when I was free of the institution and I had sufficient seniority to determine my own pattern of practice.

Throughout my involvement with the NHS I have been observing how every attempt to make care more women centred or patient centred has been sabotaged. The power of the institution has been more dominant.

Margaret made her choice with regard to not telling the staff about her son but had she done so and they had persisted in trying to prevent her leaving it could be said that they were putting her son at risk. In any case, it could be said that they were perpetrating wrongful imprisonment. Nobody can be treated against their will except under a section of the Mental Health Act and even so they can only be treated for the conditions for which they have been sectioned. There is a precedent for this whereby someone sectioned for schizophrenia was refusing a leg amputation which was being recommended as a result of diabetes and his refusal was upheld by the courts. If anyone was putting these nurses’ registration at risk it was they themselves.

And this brings me to my last point. It seems that certain health professionals are becoming very combative. Debs Purdeu’s case was described and I know of another example where an independent midwife had transferred a client to hospital. The baby was delivered by caesarean section and both mother and baby were fine but the hospital staff, totally unjustifiably, told the parents that the midwife had behaved unprofessionally. There seems to be an implication that in the minds of some health professionals independent midwifery is in itself dangerous. I wonder whether there is an overt campaign among some medical staff. And yet I believe that independent midwifery specifically and radical midwifery generally embody a discipline of knowledge which is in many ways safer and at least equally well evidence based than the obstetric approach to normal childbirth.

Thank you for a stimulating and entertaining read.

Love,

Meg Taylor
76A Farleigh Road, London N1 6 TQ

Time to Reconsider Pethidine?
Dear Midwifery Matters,

As epidural anaesthesia can be risky to the mother, (two of my daughter’s friends suffered partial paralysis and permanent back pain for months) I wonder why pethidine as pain relief is never mentioned now. I know it is by no means perfect, but after particularly ghastly labours myself, years ago, I found pethidine the only thing that made things a bit more bearable, without the risks of paralysis and back pain that epidural brings. I’ve known several women, particularly when I was

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working as a maternity nurse, say the same.

On the subject of breech birth, although things were pretty grim for women back in the ‘60s and early ‘70s, the one thing that was good, was that breech births were virtually NEVER sectioned.

By subjecting most mothers with breech presentations to caesarean section, it is often overlooked that they are being subject to all the risks of C. section, namely subsequent uterine rupture in subsequent labours, increased risk of thrombosis and embolism, and risk of anaesthetic death and injury. Also, it is a tragedy that the midwifery skills of delivering breech babies safely, naturally, are being lost, with women and babies as the losers. A mother is much more likely to bond with and breast feed her baby after a normal birth, than after an operative delivery, thereby giving the baby the very best start in life, and protection from many potentially dreadful diseases, (such as diabetes, which can be devastating to a child and even blind a child).

Finally, on the subject of breast feeding I can’t understand why children aren’t educated about the importance of breastfeeding, in schools.

Thank GOODNESS for the A.R.M. Keep up the good work.
Best wishes,
Chrisie Haines

Carry on Sharing

I am so glad to have been told about the ARM when I was a student midwife. I didn’t use the resource much as a learner but 13 years on as a qualified midwife I have benefited from the discussion pages. Working in a busy consultant unit I’ve found promoting and defending normality a real challenge.

I am so encouraged to read about the same practice issues other midwives have in many realms. What is really important is the valuable support and advice on offer from knowledgable midwives who have the experience to comment coherently and to encourage younger practitioners.

Keep up the good work... it binds up the heart and fortifies the spirit.

Lesley H

Keeping up the Good Work in 2008

This month brings ARM’s AGM which is being held in Moffat, in the south of Scotland, as part of the Retreat/Gathering. The main business of the AGM is to elect members to the Steering Group, to receive the accounts and to organise next year’s activities. Next year looks exciting; the ICM Triennial Council and Conference is being held in Glasgow and we want ARM to be very visible there. This will take a fair amount of organisation and determination and the more people involved the better.

National Meetings

Another tasks at the AGM is to decide where the National Meetings will be. They take place usually on the third Saturday or Sunday of March, June and September and the second Saturday of December (we have debated having it on the 1st weekend of December though this will be very early to get the magazine out for this year) and we try to spread them around the country to give all members a chance to attend at least one meeting.

Running a national meeting is a good chance to get local members more involved in ARM. It involves finding a venue for Steering Group, (the night before the main meeting, nearly always at someone’s house) a venue for the main meeting (usually a community hall), finding some speakers (a chance to share good ideas that have worked locally, or to give someone a platform for their research) and organising catering. Guidelines are available to help plan meetings and Steering Group members are always happy to help on the day.

It would be helpful if the main venue could be a shortish taxi ride from a mainline railway station so that people have the chance to come for the day but on the other hand meetings out in the wilds are well worth the effort of getting there. Ring Sarah Montagu on 01865 248159 to book your date!

Magazine

Midwifery Matters plays an important role in keeping real midwifery alive when it seems some other midwifery publications have become little more than a vehicle for the propogation of obstetric research and marketing tools for formula milk companies! Midwifery Matters is written by radical midwives (and their supporters) for all midwives and provides a reassuring voice of sanity – no, you are not going mad, other people think like you too. No ‘peer reviewer’ will tell you what you can or can’t say, and if writing is not your strong point, why not buttonhole someone to help you write what you want to say. If you feel strongly enough about some aspect of midwifery to write about it for us we will publish it (although if you favour caesarean section for all, we might well find a few midwives to offer an alternative viewpoint!)

Local groups usually take on responsibility for an issue; it’s good to get a picture of what is happening around the country. For 2008, being the ICM triennial year, we will ask overseas members to contribute articles for the summer issue, to be published on the first day of the ICM conference. We are looking for three local groups to take on the spring, autumn or winter issues. All it takes is a planning meeting to decide on the broad content which can be themed or ad hoc, and to delegate someone to be the ‘nagger’ to chivvy people along to fulfil their commitment and send the articles along to Margaret when her deadline approaches (two months before publication). And in a couple of month’s time, people all over the country will know all about something that worked for you. You could take a camera to a birth and share a birth story with the rest of us; photo-birth stories are so inspiring. Or you might want simply to share your frustrations with midwives as eager as you are to give the best care to mothers and their families. So why not give it a go? Ring Margaret on 01983 853472 to discuss it further or tell Sarah (01865 248159) that you are offering to ‘host’ an issue. This avoids ARM twisting at the AGM!

Whatever your talents, ARM can find a use for them. Come join in the work and the fun!
Summer National Meeting Report
June 17, 2007
Nottingham

The Nottingham meeting was by way of being a farewell for Kerri-Anne who is off to the southern hemisphere again within the next few months. As always she and her colleagues gave us a lovely welcome and the catering was well up to the standards we have come to expect from her English home! A huge thank you to one of ARM’s stalwarts. (And the visiting children were well catered for as well, both in the morning at the creche in the next room to us and in the afternoon when they were whisked off to the Robin Hood Experience.) A good time was had by all.

ARM business

As usual the morning started with ARM business. Kerri-Anne chaired the meeting and started off with the magazine.

Magazine. Margaret thanked everyone who contributed to the Summer issue. The photo article on breech birth by Lynn Walcott had been particularly appreciated. She called for contributions, particularly from students, for the next two issues.

Yurt. ARM would be taking the yurt we bought following the 2005 AGM to six festivals this year. The yurt is a great way of getting ARM’s message out into the wider community. It provides a space for women to share their experience and have their questions answered. Members can get involved by joining the ARM egroup ARMyurt. Contact sarahmontagu@gmail.com. We did wonder at the meeting whether we should also have a section covering the menopause and celebrating grandmotherhood! We voted to buy a trailer for the yurt to make it easier to store and to transport.

ARM retreat. This is in its sixth year and this year will take place at a big house in Moffat, just inside the Scottish border. See page 34 for more details. There will be two study days but there will also be plenty of time for exchanging stories, caring and sharing and so on. We do our own cooking and shopping which keeps the price down to £95 for the whole week or £15 a night. This includes the evening meal but not lunch. This year we have instructions to bring sleeping bags rather than bed linen.

Student midwife conference. “Being and becoming a ‘with woman’ midwife” takes place on Wednesday, October 7th at the Jewish Centre in Oxford. We decided to hold our own conference as student members of ARM were disappointed by the RCM student conference, both in terms of cost and content. (The RCM student conference has now been moved to the week before Christmas, which will make it even less accessible for students.) The ARM student conference costs £25 including food. Speakers include Trisha Anderson, Jenny Hall, Stephanie Meakin, Jane Evans and Sarah Montagu. See page 36 for more details and application form.

International Confederation of Midwives (ICM). Pam Dorling, ARM’s representative spoke of what an incredible experience she has had with ICM. She has had two meetings of the central European region (no, the UK hasn’t migrated to central Europe as we know it, just that the ICM divides Europe up on a North to South axis rather than an East to West axis!) The meeting discussed ways of ensuring that ARM has a high profile at the ICM triennial Council Meeting and Conference which takes place in Glasgow next Spring. We decided that it would be wonderful to site the ARM yurt somewhere strategic to be a place for like-minded midwives to congregate. Failing that we would pay for a stall for one day and have members in sandwich boards advertising the ARM hospitality venue! We would hold events such as a storytelling dinner in the evenings. Morag, a Scottish member present, knew of an ecology/green centre that might be available for accommodation but it was quite a way out of Glasgow. We agreed to look for a house to rent for the conference week, both for ourselves and to offer accommodation to midwives from overseas. We need movers and shakers in Scotland to help organise venues and events. We will discuss this more at the retreat in September.

Pam and Katherine Hales will be ARM’s delegates to the ICM Council meeting and we still have space for an observer who will then take over from Pam as a voting member at the Durban meeting in 2011. Pam pointed out that although IMA used to send a delegate they no longer do so and it would be helpful to have an IMA voice on ICM.

European Midwives Association. Jane Munro is our representative on the European Midwives Association. It feels very different from ICM, with less political maneuvering and less of a hierarchy. It works via consensus and ARM has a clear presence with a strong voice.

Membership. Ishbel reported on the state of affairs following the subs increase. The latest UK mailing had been less than 1000 which was worrying. We decided to put adverts for ARM in the NCT magazine and the Practising Midwife.

After the business section of the meeting Sarah presented Hilary Rosser, who had served as ARM treasurer for about ten years, with her own calligraphy of: “Imagine that you are a midwife...” (Lao Tzu, The Tao of Leadership (5th century BC).

Following coffee it was time for a birth story, or rather a mother’s two birth stories as different as chalk from cheese. Karen is a GP in Nottingham and came to motherhood rather later than usual having her first child when she was 40 and her second at 43. Kerri-Anne had been involved in both births – in the first as a NHS midwife and
in the second as an independent midwife. The first birth followed a brilliant pregnancy but ended with SROM at 38 weeks with no signs of labour. At that time there was a 24 policy and Karen pushed this to 72 hours. A talk with her own GP brought forth the standard response: “Are you prepared to put your baby at risk?” What can you say to this, even if you are a GP yourself? Karen went in for an induction and, despite Kerri-Anne’s best efforts, after six hours and two hours of pushing went to theatre having signed a consent form for Kielland’s forceps and a possible caesarean which did prove necessary. Her baby was whisked off to the neonatal unit and it took Karen 14 hours to rescue her baby from there and after his experience it took him ten days to learn to suckle. Care had included giving formula against the mother’s wishes, a whole range of unneccessary tests, and Karen had to act like a lioness protecting her cub. Staff were abusive to her and her baby, and she found it very, very hard to fight in that situation. She had to fight for her partner to be able to stay. She particularly objected to the language they used to her baby, telling him he was a naughty boy for giving his mother a dry birth. On the other hand there were a few staff who treated her like a human being, with kindness and consideration.

For her second birth Karen opted for a home VBAC and had Kerri-Anne to help her deal with her fears and worries and to avoid doctors and hospital. As an independent midwife Kerri-Anne was able to give her as much time as she needed to prepare for birth, dealing with what went wrong last time. She had what she described as the perfect dream birth, being entirely in charge. It was absolutely wonderful, amazing. Looking back on it she found that it was almost like being converted to Christianity, her subconscious belief system had been changed. Kerri-Anne had lent her videos and books — Birthing from Within, by Pam England (see the review on page XXX) and Ina May Gaskin’s Spiritual Midwifery — and nagged her to read them. Second time round Karen avoided professional colleagues apart from one encounter with an obstetrician whom she found fairly supportive, but still one anaesthetist friend said, “Surely you should know better”.

It was shocking to find that a GP mother encountered similar problems to ‘ordinary’ women. She says that it has changed the way she now practices as a GP. It brought to light problems with the NHS culture, there is an undercurrent of antagonism at people pushing boundaries, whether they are patients or health professionals. Even if disparaging comments and attitudes are displayed behind the scenes, out of earshot of the patients, women do feel that antagonism and it affects the way they labour.

**Biological nurturing**

Before lunch we were treated to a presentation by Suzanne Colson of her work on biological nurturing which is a new approach to breastfeeding. She started by quoting discouraging statistics about breastfeeding, 20% have given up by two weeks, and 35% at six weeks — nine out of ten mothers stop before they would have wanted to. The problem is not lack of will on the part of women but either lack of support or the wrong sort of support. Ask any midwife how to support women and the answer given is usually ‘positioning and attachment’. We need to rethink our breastfeeding support. Suzanne videoed many mothers feeding babies and observed them almost frame by frame to see what happened in successful sessions. She concluded that, contrary to received wisdom, the human baby is not a dorsal feeder — it is a mistake to think that the baby should lie face up supported by his mother’s arms to feed. Rather the opposite — allowing the baby to lie on his tummy gives him the freedom to find the breast for himself.

In her videos Suzanne identified many of the neonatal reflexes (such as the Moro reflex and the stepping reflex) which the medical profession uses solely as a measure of neurological maturation. She wondered whether at least some of these reflexes were triggered by, and play a role in breastfeeding. She found that when mothers were in a reclining or semi-reclining position babies were able to find the breast and self attach. It was a real joy to watch Suzanne’s videos, listening to her commentary as she pointed out what to look out for, and to see the delight in the mothers’ faces as they finally experienced their babies feeding happily. It was a revelation to see babies finding their own comfortable position, watching the interplay between a baby’s feet and his mother’s hands as they engaged in a series of natural yet complex set of complementary movements for optimal neonatal positioning for feeding. The contrast between some midwifery methods of stuffing a breast into a baby’s mouth and a baby finding his way to his mother’s milk while a midwife looks on could not be more stark (although Suzanne did not show us the former, it brought back unpleasant memories for me).

Suzanne has received the prestigious Justus Akinsanya award from the Royal College of Nursing for her work and her website biologicalnurturing.com shows more but if you get the chance go and see her present her work herself, grab it, there is no substitute. And, when helping a new mother to breastfeed, think: “watch the baby’s feet”.

There were workshops in the afternoon and I took the chance to learn more from Suzanne. ARM meetings are a welcome antidote to that jaded and cynical feeling often engendered by the state of the maternity services. You come away inspired by midwives who have kept their passion for birth and their love for the women shines through.  

*Margaret Jawitt*
Where did this year go? I can’t believe I’m sitting down to write another secretary’s report, on the other hand, there have been so many changes and developments in the midwifery world, so even though it seems no time at all, lots has happened.

One of the biggest changes politically has been the renewed threat to the existence of independent midwives, with the reappearance of the drive to make professional indemnity insurance (unavailable for many years to independent midwives) compulsory for all health professionals. Although on the face of it, this seems to affect only those of our members who work independently, it in fact affects us all, as we may not be covered by a Trust’s vicarious liability if we do any work outside contracted hours, or if we give midwifery advice to a neighbour, or if we teach birth classes; the campaign initiated by the IMA and supported by ARM, has focused on persuading the Government to provide appropriate and affordable insurance for all midwives, regardless of where they work. There have also been other more positive policy initiatives, such as the publication of Maternity Matters, which has reiterated many of the features of Changing Childbirth such as choice, but also displayed a disappointing lack of attention to continuity of care from a known midwife in labour, and to ring-fenced funding that might ensure some of the pious policy hopes become reality.

There have been lots of developments within ARM itself as well; following some constructive discussion on the yahoo group for ARM steering group members, it was decided to hold an ‘away-day’ which allowed time for a face-to-face meeting at which we could talk through some of the issues about the over-all direction of ARM that we don’t get time to thrash out at the quarterly Steering Group meetings. We focused on three areas, education, PR and developing ARM’s role in supporting midwives. There are a number of new initiatives in the pipeline as a result, such as the ARM Student Midwives Conference, which promises to be an excellent event (see the advert elsewhere in this issue) and the new ARM flyer, which is intended to publicise ARM and what it does.

At the same time, we’ve continued to focus on our core activities. The ARM retreat in 2006 was held in a beautiful manor house in the depths of the Welsh countryside. There were workshops on ‘birth voices’ and on breech birth, as well as ample opportunities for skill-sharing, chat and support. This year, we’re looking forward to going up to Scotland which looks like being a brilliant week. The other national meetings have been in Guildford, Yorkshire and Nottingham, with an amazing variety of speakers and workshop sessions – see the separate notice about venues for next year, if you feel inspired to volunteer to host a meeting in 2008!

Local groups continue to provide an active role in supporting midwives locally and helping them to keep alive their vision of what maternity care could be like.

The ARM festival tent project has continued and as I write, we are in the middle of the festival season. There will be a full report in the Winter edition of Midwifery Matters; obviously the weather has made it more of a challenge this year – the Glastonbury mud had to be seen to believed, but it remains a unique way to reach out to women. The levels of appreciation for the opportunity the yurt offers to access information and discuss their pregnancies and birth are massive and make the hard work involved in getting the yurt from place to place and setting it up at each festival worthwhile. However, we still need a transport solution for the yurt – we’re still hoping for a trailer or horse-box or second-hand van to appear from somewhere to make it easier to get the yurt from one festival to another.

We’ve also contributed as usual to consultations and to other bodies such as the ICM, the EMA and so on; the NiCE intrapartum guideline went out to consultation in the normal way and because they received an unprecedented level of responses, they put the chapter on ‘place of birth’ out in a second draft for further comment, which we also responded to. It will be interesting to see what the guideline contains when it eventually appears in October!

It’s been another interesting and varied year and next year promises to be even more adventurous, with the student midwives conference, ICM in Glasgow and the proposed opening up of PCTs’ contracting models to include different providers so that midwives wishing to hold a case-load will be able to contract directly with their local PCT. ARM as always depends on all those who give so willingly of their time, energy and creativity to make ARM what it is, and I’d like to thank everyone involved in ARM for everything that they do to work towards better maternity services, better experiences for mothers and babies and better lives for midwives.

Sarah Montagu
This has been a busy year, mainly because of the subscription increase from £25 to £30, which was voted in at the AGM in September 2005. Subsequent issues of Midwifery Matters carried a notice about the new rate on the subs forms.

New members mainly use the new subs form, so they pay the correct rate. Renewals by cash/cheque are also okay, as members tend to send the money in with a completed subs form, which shows the current rate due.

Experience of the rate increase six years ago told me that just one announcement would not be enough for those paying by standing order; (it took nearly three years to get them all upgraded!) I was anxious not to have a repeat of that process, and the Steering Group supported me.

Early in 2006 there was a rather nice flood of upgraded standing orders, which then tailed off to a thin trickle. A reminder notice in the June 2006 issue of Midwifery Matters, and a direct mailing of more than 500 reminder letters perked up the response rate for a while. When each month brought yet more £25 standing orders, the Steering Group agreed to another direct mailing reminder to the 212 members who hadn’t yet upgraded their standing orders. This went out in January, giving the Spring 2007 issue as a final mailing for members still using the old subs rate, advising that £25 standing orders would henceforth be considered donations to ARM funds. This brought another 80 or so upgrades, and I responded by sending the missing Spring issues of Midwifery Matters.

At the time of writing there are still 127 members who will have not received the Summer issue of Midwifery Matters, (and won’t be reading this Autumn issue either!)

Okay, I know everyone is really busy, with work, family and other commitments, but I make things as easy as I can, by enclosing a form to be completed, (should I have enclosed an SAE? It was suggested, but I’m mindful of the costs).

Some people have asked why we don’t use Direct Debit, then ARM could just take the right amount from our bank account? We’ve applied for this, but most banks require several hundred transactions each week for this to be acceptable, and our numbers are too small. So we’re stuck with standing orders, and the resulting administrative headache!

On a brighter note, new membership numbers are encouraging, especially the numbers of student midwives joining us. This bodes well for midwifery of the future, though at present the garden isn’t looking too rosy!

I’ve played around with some facts and figures for those who enjoy this sort of thing, I hope Margaret doesn’t have too much difficulty translating my data tables into page proofs!

Looking forward to the Retreat in September, my annual true morale booster.

With best wishes to you all,

Ishbel Kargar

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**UK and Europe: New members 1 July 06 to 30 June 07**

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<td><strong>176</strong></td>
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**Payment method (currently paid-up members only)**

- Standing orders: 812
- Cash/cheque: 327
- Exchange journals (groups, etc.): 12
- Gratis/complimentary: 24
- **Total**: 1175

**Members not yet upgraded from £25 to £30**: 127

Therefore, actual mail-out of journals: 1048
This year has been a busy yet rewarding one for the Membership secretary and myself. The issue of reclaiming Gift Aid was tackled to the tune of £6,069.51 during this financial year! This made a considerable impact on the finances of the ARM which had made a loss overall during the last financial year.

Looking at the non audited figures here, it can be seen that we made a net surplus of almost £9,000 during this financial year. Removing the Gift Aid refund, this still leaves an overall net increase in income of almost £3,000. Part of the reason for this is a reversal in last year’s picture with goods sales exceeding goods expenditure. I intend to explore the feasibility of setting up on-line sales via the ARM website during this coming year. Any knowledgeable members of such a system please get in touch!

The major source of income continues, however, to be through members’ subscriptions and membership numbers are discussed within Ishbel’s report.

Other points to note are:

· The retreat appears to have run at a loss but this is not so as some accommodation monies were credited to the last financial year. The actual breakdown for the retreat shows an income of £2,617.00 and expenditure of £2,303.34 giving therefore a small surplus.

· National meeting income and Steering Group expenses have largely balanced themselves out over the year.

In conclusion, the finances are looking very healthy at present. Please contact me for more details or speak to me at the AGM in September when the fully audited accounts will be available.

Linda Wylie

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Local Contacts and Local Groups

Birmingham
Contact: Vanessa Whitaker 0121 429 1541 or vanessa_whitaker@lineone.net
We meet alternating months and welcome all, be you man, woman or beast!
Next meeting at 117 Willow Avenue, Edgbaston, B17 8HN on Wednesday 19th September. Would be great to see you.

South Bucks
Contact: Elaine Batchelor, 99 Queens Road, High Wycombe, Bucks HP13 6AH
tel: 01494 451946.
elaine@thamesvalleymidwives.co.uk
No local group at present, have tried and failed a number of times.
Good news: the local obstetric unit is becoming a midwifery led unit but this is already two years late in opening and still functions as an obstetric unit at the moment. Women in the area are worried that now all children's services and major A&E are at another hospital at least 30 minutes drive from Wycombe. Once the MLU opens, more emergency support will be withdrawn.

Cambridge
Contact: Gillian Pett, 29 Priamis Way, Stapleford, Cambridge CB22 5DT
Gillian.pett@nhs.net
Area covered: Rosie Maternity Hospital and surrounding area.
Group meets two or three times a year.
Next meeting September, on independent midwifery. Contact Gillian for date, time and venue.
Local concerns: high caesarean section rate, promoting normal birth.

Essex
Contact: Penny Champion, Gable House Stock Road Stock Essex CM4 9PH
tel: 01277 841709 ppbsc@btinternet.com
Area covered: Essex including hospitals in Chelmsford, Southend, Colchester, Basildon, Harlow and Independent practitioners practising in the area.
Local meetings: Usually one meeting every couple of months in one of the current midwives homes around the Essex area.
Start time 8pm but all very flexible. Penny co-ordinates the list of meeting and venues so please contact her.
Topics covered: As we have only been meeting for about 12 months we have spent all our meetings caring and sharing, we discuss current issues such as indemnity insurance and birth stories and we are very fortunate to have a great mix of NHS, independent and student midwives, all of whom bring a wealth of experience and support. We are planning to invite some speakers to the forthcoming meetings.

Maidstone area
Midwives Muddie, Joy Kemp
29 Woodpecker Rd, Larkfield, Aylesford Kent ME20 6QJ
Joykemp@blueyonder.co.uk

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

Mid Wales
Contact: Emily Fuller 1 Porth Farm, Church St, New Radnor, Powys LD8 2TE tel:01544 350309
Area: Mid Wales/Shrops/Herefords borders.
No group running at present, but very happy to organise one if there is interest.
Good news: Fairly high home birth rate in Powys and midwives are committed to promoting normality (no DGH in Powys).
Concerned about the possible closure of local birth centres in Powys.

Southampton
Contact: Emma Reynolds
Meetings: once a month and you are guaranteed good company and lively conversation at the meetings! We now have a yahoo group to keep in touch with each other and to let people know about when and where the meetings are happening.
If you think you might like to come along to a meeting, please join up and hopefully we will see you sometime.
http://uk.groups.yahoo.com/group/SouthamptonARM/?guid=224358609

Surrey/West Sussex
Contact: Andrea Dombrowe, 1 The Great Quarry, Guildford GU1 3XN
andredombrowe@gmail.com
tel: 01483 538615
Area covered: Surrey/W Sussex. Royal Surrey, Guildford, Farnleigh Park, St Peter's Chertsey, East Surrey, Kingston

Wigan/Bolton/St Helens
Contact: 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.

West Sussex
Contact: Aida (01730 812086) aidedastephens@tiscali.co.uk
Cathy (01730 231024) cathy@coomasaru-walton.com
All welcome.

Mid Wales
Contact: Emily Fuller 1 Porth Farm, Church St, New Radnor, Powys LD8 2TE tel:01544 350309
Area: Mid Wales/Shrops/Herefords borders.
No group running at present, but very happy to organise one if there is interest.
Good news: Fairly high home birth rate in Powys and midwives are committed to promoting normality (no DGH in Powys).
Concerned about the possible closure of local birth centres in Powys.

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.
Wigan Study Day

This was the second study day that Wigan ARM have hosted for Denis Walsh to speak and was once again a sell out with a waiting list. The day began on time with student midwives, NCT students, midwives, doulas and lecturers listening with rapt attention to Denis discuss normal birth, labours, rhythm of labours, women’s own templates for their own unique labours for them. There was much discussion about the invasive vaginal examinations that are performed, the benefits of water over a syntocinon trolley to regulate and enhance labours that are deemed ‘slow to progress’. There was opportunity to discuss midwives’ own experiences and wisdom when women’s labour do not match partograms and guidelines. There was plenty of reflection during coffee and the lunch break with midwives and student midwives from around the North West sharing their observations, knowledge and intuition. Indeed, the day reinforced the importance of students’ and midwives’ own observations of birth and encouraged them to write up unusual labour and births and share their skills and insight with each other.

The ‘hot pot’ was once again enjoyed by many and the raffle was enjoyed by all, prizes being Denis Walsh's new book, second prize a ticket to our next October study day where Denis is a speaker, and third an ARM ‘goody bag’ prepared by Ishbel who was kept busy on our ARM stall.

The day overall was a reminder that as midwives we are ‘experts at the normal’ and for midwives and students who work surrounded by IVAC and syntocinon trolleys and IV poles that they have within them the information and research to change practice and support each other and women. The discussion and lecture notes were an antidote to the current emphasis on abnormality and labour ward emergencies currently high profile in obstetric units. This is no doubt all very relevant but ‘skill drill’ on normality is also very relevant. The thick handout of references that Denis provided covering first, second and third stage is essential for every labour ward and could be laminated and circulated to all medical and midwifery staff. The section on how we can change practices would be a good topic to begin reflection and discussion groups in units, good practice debates, interesting labours and births, running alongside clinical issues groups.

Denis has been asked to speak for seven days at St Thomas's Hospital in London to all midwifery staff and obstetric staff. It will be interesting to see how this week of normality will influence their normal birth rates. Hopefully, more obstetric units will follow this excellent example.

Huge thanks go to Wendy Blackwood for setting up the room and ‘hotpot’, Danielle and Vicky (student midwives) and Jude (doula) Louise Brown (midwife) and of course Ishbel and Lois for ensuring the day was once again a huge success.

Lesley Price

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

A stimulating and enjoyable day was had by all
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
Discussions about the merits and demerits of the doula is a recurrent theme on the ukmidwifery list and has become more pertinent recently with the reluctance of hospital trusts to employ enough midwives to care for women. The discussion below took place earlier this year. It was suggested that doulas are: “a disgrace to the midwifery profession.”

‘On their side’
You can’t blame women if they look to a doula for support if they aren’t getting it from their midwife. Hearing some of the dreadful stories on the homebirth list, I’m not surprised that women want someone ‘on their side’ but of course, ideally, that would be their midwife.
Cerys

Mothering the Mother
I agree that when it comes to birth, doulas are performing a role which midwives should be performing. I’m not so sure that is the case for postnatal doula-ing where it is more about mothering the mother and there I feel it does our society no credit that they are needed. I would be interested in other views on this.
Jennifer

Postnatal Doula
I am a postnatal doula. As well as working with private clients I also work with my local Sure Start where I support women who are new to this country and have absolutely no one else here to support them with a new baby. They often don’t speak English either. I see my role with all my clients as ‘mothering the mother’ and I do whatever is necessary to support their new role as a mother – without taking over the baby in any way. That can range from scrubbing the kitchen floor, finding a bed for the baby or clothes for it, supporting breast feeding, or finding out about benefits and registering the baby’s birth.

With private clients it is usually more a case of enabling them to get enough rest and to support them while breastfeeding but they too, usually don’t have a mother figure around and that is why they pay me. And yes, that is sad.

I agree that if midwives could practise the way they want to then there probably would not be a need for birth doulas but the truth is that in many hospitals these days they can’t. Imagine how terrifying it must be to give birth alone in a busy hospital with nobody by your side most of the time. And how frightening it is to come home with your first baby with no one to show you what to do.
Lesley

Why the Hostility?
I’m rather disheartened by some of the downright hostility towards doulas. I had an independent midwife and a friend to support me during my last labour. My friend (also an NCT teacher) acted as a doula for me and it was fantastic. I felt so well looked after, having two wonderful women sharing in my care – in very different roles. My friend gave me lots of massage, reassured my husband, made tea for everyone, spent a lot of time ‘talking me up’, came with me for walks round the block (something suggested by my midwife as a strategy to move my very long labour along) and generally made herself useful.

My midwife was EXHAUSTED by the end of my 36 hours in active labour and I’m sure was quite happy to have someone else there who was happy to do some of the ‘donkey work’ like emptying the sink bowl!
Although some doulas can overstep the mark, being insensitive, and being disrespectful or ignorant of the expertise of midwives is not intrinsic to the role of the doula. I have to say though, I’ve been very shocked by how inadequate the doula training courses I’ve investigated so far appear. How can four days training qualify someone who has no previous training or education in this area to sell their services as a birth supporter?

Wendy

Benefits for Midwives
I have actually been quite distressed by some of the negative responses to doulas.
I have now been an independent midwife for two years and have had doulas present at three births. For two the doulas had been booked before the woman decided to use me and for the third the doula came to look after the other two children and the woman became established in labour (rapid!) as soon as the doula arrived. I have also had doulas present at births I attended in the NHS.

In all cases I enjoyed working with the doulas, they looked after me as well as the couple and as I invariably worked alone it was a joy to be made tea and given food when the partner was too involved with the labour to do so.

What many of us who have the privilege to be able to give continuity of care forget (and it’s not so very long since I was a community midwife, stretched to my limit) is that it is all so much less scary for women to approach labour with someone who understands the process and believes in a woman’s ability to birth

Risks of Doulas
I am a midwife and I now have three degrees after six and a half years of full time study. I resent the ability of a doula – who might complete a two-day course or indeed, no course at all – to advise, educate and inform pregnant women under the guise of ‘discussing options’ and ‘writing a birth plan’. How is a doula qualified to discuss options and educate women when they are not educated on the interpretation of research?

While I know that some doulas act strictly as a birth support person, I have come across a few doulas whose advice extends to issues about epidurals, caesareans and management of a post-dates pregnancy. Doulas may be highly trusted by their clients and this leaves the client vulnerable to accepting the doula’s advice (we often take the advice of people we trust). What is most concerning is that the woman has no recourse if something untoward comes of this advice as the doula is not registered or qualified.

I feel strongly that women need to know this.
Melissa

The Group

Non-members of ARM are welcome to join the group. To join, go to http://health.groups.yahoo.com/group/ukmidwifery
Discussions about the merits and demerits of the doula is a recurrent theme on the ukmidwifery list and has become more pertinent recently with the reluctance of hospital trusts to employ enough midwives to care for women. The discussion below took place earlier this year. It was suggested that doulas are: “a disgrace to the midwifery profession.”

‘On their side’
You can’t blame women if they look to a doula for support if they aren’t getting it from their midwife. Hearing some of the dreadful stories on the homebirth list, I’m not surprised that women want someone ‘on their side’ but of course, ideally, that would be their midwife.
Cerys

Mothering the Mother
I agree that when it comes to birth, doulas are performing a role which midwives should be performing. I’m not so sure that is the case for postnatal doula-ing where it is more about mothering the mother and there I feel it does our society no credit that they are needed. I would be interested in other views on this.
Jennifer

Postnatal Doula
I am a postnatal doula. As well as working with private clients I also work with my local Sure Start where I support women who are new to this country and have absolutely no one else here to support them with a new baby. They often don’t speak English either. I see my role with all my clients as ‘mothering the mother’ and I do whatever is necessary to support their new role as a mother – without taking over the baby in any way. That can range from scrubbing the kitchen floor, finding a bed for the baby or clothes for it, supporting breast feeding, or finding out about benefits and registering the baby’s birth.

With private clients it is usually more a case of enabling them to get enough rest and to support them while breastfeeding but they too, usually don’t have a mother figure around and that is why they pay me. And yes, that is sad.

I agree that if midwives could practise the way they want to then there probably would not be a need for birth doulas but the truth is that in many hospitals these days they can’t. Imagine how terrifying it must be to give birth alone in a busy hospital with nobody by your side most of the time. And how frightening it is to come home with your first baby with no one to show you what to do.
Lesley

Why the Hostility?
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Melissa
her baby. This is not always available in the NHS and not all women can afford an independent midwife. Why would we want to undermine a choice for women to be supported by known, sympathetic, and often very knowledgeable women?

We do not need to feel threatened by doulas. I have met many doulas in different circumstances and have been humbled by their unflinching desire to support women, often in hostile environments. In many cases I believe they are more ‘with woman’ than some midwives. They are only a threat to us if we are insecure in our own ability to be ‘with woman’.

A good doula is a godsend. They do not (well mostly do not) believe they are there to replace midwives, but to complement them. I could go on, but I think I’ve got the bulk of what I feel off my chest...

But just to stir up debate...

Personally I would love the opportunity to have doulas as apprentice midwives as an alternative entry into the profession. So many good potential midwives are put off by the medically orientated and ‘masculine’ training we have to go through and they end up as doulas instead. They are a loss to midwifery, not a danger. Think I’d better duck now while things are thrown at me.

Meg

Not convinced

Well, I dunno – certainly the hours are unconducive to women with families and the academic side can be daunting (though I personally feel that research-saviness is important) but the ‘sitting next to Nellie’ approach to training didn’t serve us well in the past either.

Sometimes I think it can also be about all the nice part and none of the can carrying... -({

Jennifer

That’s me

I am one of those potential midwives put off by the medical aspect that was required of me in my third year as a student midwife, so I am training to be a doula.

At all times trainees are taught that we are strictly forbidden from offering ‘advice’ or getting in the way of the midwives. We are not experts and should not act anything like a midwife. We are there because women want us there as informed birth-partner support. When, arguably, the most important element of birth is that women feel safe, it is wonderful that families have the option of booking a doula for free, at a reduced rate or at an affordable rate. Nobody working exclusively as a doula is particularly well-off!

Instead of campaigning against doulas, or seeking to undermine or almost demonise their role, perhaps the battle should be refocused on exactly WHY midwives are increasingly unable to be ‘with woman’ and why so many women go into labour worrying about who their attendants are going to be.

In a perfect world all midwives would be able to give continuity of care and the demand for doulas would decline, but at the moment, simply making doulas illegal would further worsen the situation for women.

Alice

ex student midwife, natal hypnotherapist, trainee doula and trainee NCT antenatal teacher

Interpreting Research

Melissa, there are a few things I wanted to raise from your post about doulas’ lack of education on the interpretation of research:

I understand where you are coming from here, but I have to say that intelligent people are likely to be able to interpret research and not having a degree in it doesn’t prevent anyone being able to do this. I think it’s important that women have someone to ‘discuss options’ with, and most often when talking to midwives about women’s ability to give truly informed consent, the theme I hear is that they don’t have time to go through everything in as much detail as they might like. We can’t presuppose the level of knowledge any doula has can we? Just as, in my experience, we can’t suppose that a health professional we are dealing with has read all up-to-date knowledge and debriefed him/herself to advise from an evidence based perspective even when it doesn’t suit.

Regarding the doulas whose advice extends to issues about epidurals, and so on, and their position of trust: I agree – I don’t think it is a doula’s place to offer ‘advice’ on any issue but if a woman chooses to take it, she has made a choice that she is responsible for. Women should be in a position to trust their midwife or obstetrician and if they are not, and therefore don’t feel able to take their advice, I think that is the issue.

You are concerned that the woman has no recourse if something untoward comes of this ‘advice’: I wonder what recourse I would have about my midwife four years ago booking me in for induction for 40+9 which ended in a caesarean? After all, on reflection, it doesn’t seem a very good piece of advice given that two scans gave totally different due dates. No recourse would be my guess because I chose to take her advice after all. There are huge amounts of rubbish being spouted daily by everyone, including health professionals, but we don’t hear of many women being recompensed. To me this all comes down to two issues:

Firstly, we need to restructure the maternity services so that there is time for women to get to know and trust a midwife through the whole journey.

Secondly, parents need to take responsibility for the choices they make, particularly in pregnancy when they have time to look at information and seek opinions. At least by hiring a doula, parents are starting to do this and what they decide from there is surely their choice.

I am sure there are good and less good doulas. I wonder whether, if their services were free, we might feel more easy about it. I love the idea of women having women to call on during labour just for companionship etc. I’d rather money didn’t change hands and that this was a service for communities by communities, not called by any particular name. How far this is workable when childcare and travel has to be arranged I don’t know.

Just my thoughts

Sarah (mother)

Research Aptitude

I’d agree that a spontaneous ability to get to grips with research is unlikely, but it may not be necessary (or sufficient) to have studied it formally. I doubt my grip on these things, despite three degrees all involving substantial elements on health research! As for access to the medical literature, if they have internet access, any Tom, Dick or Harrynet can get hold of these things. Even years ago, the BMJ was stocked in the public library in my city.

Advice tells someone what to do with information – implicitly or explicitly.

Jennifer

Lack of Research Evidence

The idea that you can get a balanced viewpoint from research is misleading as often midwifery and ‘natural healthcare’ points of view have not been similarly evaluated. For example, if I was having a breech baby and wanted an unbiased evidence-based view of my options, I wouldn’t be able to find an RCT looking at spontaneous vaginal breech birth with competent practitioners vs planned caesarean section with a good surgeon would I? I’d have the ‘Hannah’ Term Breech Trial shoved under my nose as the definitive evidence for caesarean. The bias is there in the lack of research evidence for some things. I also doubt the ability of some professionals to present the range of options just because of their own prejudices and fears.
I think we are setting too much store in some people to behave in a professional manner if we base all our decisions solely on what we are told by health care professionals. Many HCPs are advocating things which common sense tells us is ridiculous and illogical and I think as part of being responsible parents (to be) we should be considering everything, not just the bits our midwife/obstetrician has time to tell us.

As for the difference between advice and information, isn’t it the difference between “if I were you,” or “I think you should,” type conversations versus active listening followed by, “You might find it helpful to read x, y, z or talk to Mrs Whoever who had a similar situation to you”.

It’s interesting to see the different views of health professionals.

Sarah (mother)

Supporters, not professionals

I feel that the role of doula is like the role of breastfeeding supporter. LLL, NCT, ABM and BfN supporters are often not midwives or health professionals. These supporters help breastfeeding mothers with information and encouragement, not advice. They aim to empower the breastfeeding mother to overcome any obstacles and make informed choices about infant feeding. Doulas have a very similar philosophy – we do not give advice, tell couples what to do, or interfere in their relationship with their HPs. We are there purely as a friend and helper; a role, by the way, that is not new. Lay birth attendants have been around for ever, in many cultures.

Both lay breastfeeding supporters and doulas have been shown to have a positive affect on outcomes. But then, as a lay woman, maybe I am not in a position to read a study and assess it! I feel uncomfortable with a midwifery view that only HPs can assess evidence and advise women accordingly. Isn’t their role to present options and help women make their own decisions and choices?

Once again, doulas should not be making clinical decisions for their clients, or giving advice. We offer only practical and emotional support. Maybe people hear about doulas giving advice. After listening to a client, sometimes for hours, saying very little, perhaps offering a suggestion or two, I see the woman think her way round a subject, come up with her own solution to a problem, or option as to what to do next, then thanks me for my “advice”. It makes me smile, as I’ve done nothing but listen, sometimes given her a hug, and maybe signpost her in a direction where she could find out more information.

Change of Direction?

I have been wondering whether if I am forced to give up independent midwifery, I could become a doula. I wrote to the DoH and received the response below. It seems to be suggesting that I can’t/shouldn’t ever attend a woman as a doula as I will be judged as a midwife. Thoughts, anyone?

Rosie

Q. Could you also forward to me your proposals for bringing doulas in line with PII requirements. Doulas provide support to women in labour or is it OK for them to practise without insurance as they are not recognised as a ‘profession’ but rather as a lay body?

A. Doulas are not registered professionals and therefore fall outside of the policy initiative.

Q. Perhaps this is the answer for independent midwives? We call ourselves doulas rather than midwives!

A. Only registered midwives and doctors (and those in training for these roles) can attend professionally upon a woman in childbirth; doulas provide additional support for women. Any registered midwife who attends a woman as a doula will still be considered to be practising as a midwife because s/he will be using their knowledge and expertise gained as a midwife.

Not registered

Ah, but you won’t be registered will you, because they won’t allow you to register without insurance will they? And anyway you won’t have kept up with your PREP etc will you?

Margaret

Retraining

A doula organisation also tells me I would be expected to do one of their training courses before I can be a doula, the suggestion being that I don’t know how to support women since I’m a midwife.

Rosie

Mostly Good

I personally know four doulas, two of them very well. The first is my friend who is a qualified legal exec, mother, did three years of midwifery training (caught all of her 40 babies) but left the course due to politics of midwifery and life! Having worked with her, she is absolutely awesome as a doula.

The second doula I have had the pleasure of working with this weekend – she has been fantastic. Her role did include labour support (she had known the couple throughout their pregnancy with me only coming into equation at last minute), she also did shopping, ensured people were fed – she was fantastic. She also has many other qualifications under her belt.

The third doula I know more socially – I know the women she helps are VERY happy with her support and the area she works in, is not so supportive of women’s choice, so she is invaluable! The fourth perhaps trained at the same place as Mary’s doulas!

There are always going to be ‘dodgy’ doulas, as there are midwives, health visitors, doctors. I do appreciate what people have said regarding level of training, regulation and I understand their concerns. I can’t really suggest a solution especially as knowing how midwifery training is currently undertaken and that the regulation/support of midwifery could be MUCH better. However, just thought I’d give my positive two pennorth!!!

Liv

Midwife and friend of doulas

I decided to become a doula after over two years of being a student midwife, and was surprised to know that I was required to do a course as part of a recognition process. I had already supported hundreds of women in labour so attended the course fully expecting it to be one of these things that you just do because it is expected of you, rather than expecting to learn much.

However, I ended up learning so much. Firstly, you learn what exactly the role of a doula is and how best to get along with midwives, doctors and so on. Most people seem to be concerned that some doulas have argued with the midwife or not understood their role, so having a clearly defined role and learning about the limitations of doula-ing is very, very important. You do not give advice, you do not have a clinical role.

I fail to see how independent midwives can simply accept becoming a doula instead of being able to practise midwifery. They are not the same at all and without appropriate orientation to the new role from experienced doulas, I don’t think this would be an easy transition. I don’t doubt that an independent midwife would be able to support a woman in labour – there is not a doula in the country that would suggest that – but the role of a doula is not a natural ‘step down’ from a midwife, it is a unique and distinct profession in it’s own right.

As part of doula training you learn the physiology of birth and breastfeeding. And I have to say that despite attending a prestigious London midwifery course for over two years and working with some of the best NHS midwives in the country, I had never been so inspired and well informed about natural birth physiology until this aspect of the doula training. I’m sure optimal birthing environments and not stimulating the neo-cortex were touched on in my midwifery studies, but certainly
not in such an in-depth and practical way
as in the doula training. I would have made
an atrocious doula had I not done the
training.

Alice

Passionate about Midwifery

If I am forced out of practising
midwifery because of PII (professional
indemnity insurance) which is becoming a
distinct and very real possibility, then I do
need to think about what I can do to earn
a living. I would sooner chew off my leg
than return to NHS midwifery. All the
reasons that caused me to leave in the first
place are still there and four years on
things seem to be getting worse, not
better, certainly where I live.

I have devoted the last 12 years of my
life to supporting women through preg-
nancy and birth and I am every bit as
passionate about it now as I was when I
started, although I have to confess to losing
my rose tinted spectacles somewhere
along the way.

I am enormously saddened and
terrified at the thought that if I can’t
practise midwifery I may never witness
another birth. I have frequently considered
NCT antenatal teaching, in fact I was all set
up to doing it prior to starting my mid-
wfery training, but then did that instead.
I don’t regard becoming a doula as a ‘step
down’ but I would rather be a midwife
because that is who I am and what I am. It
defines me. My every waking moment and
every breath I take. I keep thinking about
doing something completely different, even
to the extent of answering an ad in my
local paper the other week, but when it
came to it I couldn’t bring myself to fill out
the application form. At least as a doula
I would be around birthing women. Maybe
that would be some kind of torture,
though?

I feel many of your comments about
midwifery training are true and valid –
there are many aspects of the training
which are absolutely grim. My Head
of Midwifery Education told me very
clearly that the aim of the course was
to turn us out at the end of three years as
‘saf e practitioners’. I felt then and still feel
this to be a very lowly aim. Oh for the
ARM midwifery school! However, some-
where along the line, my training did equip
me for my midwifery journey, testament, I
suppose, to the fact that I’m still here.

I am also fascinated about where the
line comes about not giving advice?
The doulaS I know and love and work with
frequently all give advice I would consider
to be midwifery such as when to go into
hospital, what to do if your waters go,
when to phone the midwife/hospital, when
to get in the pool, put on the TENS and so
on. Do you never do this? What do you
say if asked one of these types of questions
and I find it hard to believe you never are?
What is this advice if not clinical? Or is a
midwife just someone who sits in a corner
keeping her contemporaneous notes and
performing a VE every so often?

Alice

Doulas and Advice

‘Advice’ and ‘Information’ can be
confused too. Most doulas will have access
to good information on subjects that can
be passed to the woman as necessary, but
the way this information is put across has
to be in an atmosphere that always
promotes the choices of the woman,
rather than in an expert/advisory capacity.

If asked when to go to hospital, SROM,
phoning the midwife and so on, I’d ask
women what advice their midwife has given
them as the advice can vary with the
particular hospital trust. I suppose I could
be asked, “What do people usually do?”
and I could give general information
relevant to local practices, but all the while
reiterating that I am not the expert and
they need to find out for themselves.

Sometimes doulas will refer clients to
sources of further information such as
informed choice leaflets and various
websites. For example, if asked, “When
should I get into the pool?” I could refer to
information provided by experts in that
field, so the advice and information isn’t
coming from me, but an expert source.

The danger of giving any advice as a
doula is the risk of giving the wrong advice.
On our courses we go through birth
physiology and breast feeding and so on
but to expect us to be qualified enough
after these 2.3,4 day courses to be able to
give reliable advice would be to undermine
the entire midwifery profession! So we
shouldn’t at all.

I feel that to give advice on as you say,
when to put TENS on, when to get in pool,
when to ring the midwife... is all quite
clinical stuff and I specifically left midwifery
because I didn’t want this clinical/advisory
role. I don’t want to tell parents what to do.
Most doulas don’t either. We just love
being with a pregnant woman, getting
excited with her in supporting her plan her
birth, giving unconditional positive regard
and empowerment during labour and
offering practical and emotional support
postnatally.

I’m interested though in how I have
over the issue of giving ‘advice’ when they
accompany women into hospital as a ‘birth
partner’ when the trust doesn’t offer them
contractual status as a midwife?

Alice

PS. Actually, while saying that doulas
shouldn’t give advice, I do give one bit of
advice to everyone I meet. Friends, family,
and I will continue to give it to clients as it
is legally correct... That women have the
right to make informed choices about their
care!

IMs in Hospital

Alice, you say you’re interested in how
independent midwives get over the issue of
giving ‘advice’ when they accompany
women into hospital... I’m rather inter-
ested in this one too since, according to
the DoH, if I am a registered midwife I am
a midwife and will be judged as such. So in
situations where I have transferred a ‘high
risk’ woman, let’s say, failure to progress
with a history of two previous sections,
where I have been paying really close
attention throughout labour to her and her
baby’s wellbeing, then, when I transfer I
find that no one comes near us for some 45
minutes or so, despite my phoning ahead
and the labour ward staff being fully
conversant with the situation, what do I
do? Do I slip my sonicaid out of my bag
and have a quick listen in or do I sit back
and think, well, no longer my responsibility,
my role was to get her here and hand over,
which technically I have done as soon as I
enter the hospital.

Rosi e

Midwives and the Duty of Care

Hi Alice. I found your reply to Rosie
fascinating concerning ‘not giving advice’
especially the phrase ‘I could refer to the
information provided by experts in that
field, so the advice and information isn’t
coming from me, but an expert source’.

It occurred to me that as an independ-
ent midwife that is what I do most of the
time. That is, I give information to the
women and they make the choices. Now,
does that mean that I am not doing
‘midwifery’?

Only in an emergency or when I
believe that to make certain choices would
result in morbidity or mortality for
example, do I ‘strongly recommend’
anything.

I would say that perhaps the only
difference between us is, then, that I have a
responsibility, that you as a doula do
believe you have – the responsibility for
the suggestions/advice/recommendations
that I give.

I also have a duty of care, to the
woman, and my profession – doulas do not
have ‘duties’ neither do they have a
regulatory body to ensure safety for the
public. Am I wrong?

Having said all that – I consider myself
a supporter of doulas – you may find it
hard to believe! I have a lovely friend who
is a fabulous doula (she’s really a ‘midwife’ –
but that’s my whole argument – let’s not
get into that). In fact when my daughter was pregnant, it was my doula friend’s classes that I suggested she go to, and she did – I trusted that she would give my daughter excellent information.

In an ideal world, I would be working with doulas all the time, but they would be the mothers, sisters, aunts, daughters and friends of my clients. My honest opinion? Being a doula is not a profession – it is a vocation – the vocation to be a midwife if it is not your ‘daughter, sister, aunt or friend etc’.

Stop sitting on the fence, you lot, and get out there and train as midwives!

Lynn

Woman-centred Care

What, go back to living on around £500 a month, working with a different mentor every day who all have conflicting advice and want you to practise their way and act like you’re an alien who has fallen out of space when you turn up for your shift, treating your clinical assessment paperwork as the most abysmal job ever and asking you what they should write, having another night where I ‘catch’ three babies inappropriately attended due to lack of staff, constantly feeling under pressure to take on the workload of overstretched staff e.g. when they ask you to do 10 CTG checks on women in the A/N ward whilst they have their lunch and you’ve never even used the CTG before!

There are a multitude of things I could add here. Although some days and mentors were brilliant they were few and far between! I simply don’t want to. As I have already said, I left midwifery in my third year because I am not a midwife in my heart. I don’t want to be clinically responsible for the care of mums and babies. I left my studies due to professional burnout amongst other things. Perhaps it would have been different had I been at a different trust, but if I’m honest, I increasingly didn’t even enjoy doing VEs or making ANY kind of clinical assessments. I didn’t want to turn into the bossy boots midwife me was slowly but surely becoming!

Being a doula seems more ‘me’. I can support families throughout the childbearing period without having any kind of advisory/clinical role. I can understand how some midwives may take umbrage at this, but I know that most doulas would not want to become midwives and that doulas exist because women want us. I missed being at births, and I don’t have many sisters/aunts/friends who I can support and whose births I can attend. If someone wants to pay me to support them in a non-clinical role then this is something I am delighted to do. My true passion is in being truly woman-centred and for me, being a doula is the best way. I don’t care if I never use another pair of sterile gloves as long as I live!

Alice

Fellow Birth Junky

So you’re birth junky Alice, just like me! (who isn’t trying to have a go at anyone and who hasn’t taken ‘umbrage’ just enjoying this debate!)

Rosie

Yup!

Absolutely Rosie!! Actually I have to say that I read one of your Practising Midwife articles on becoming an independent midwife which really inspired me and gave me the incentive to carry on being a student midwife for a little while longer than I would have done otherwise. I thought, “Well, I can just go into independent practice after qualifying, if I find a nice group to work with who will have me”.

But as I say (and in answer to Lynn’s comments too) it was increasingly evident that even IMs have to make clinical decisions, and whilst being ‘with woman’ is one definition of ‘true’ midwifery, another is that as defined by the NMC rules and of course means that you fulfil a somewhat advisory/medical role at times, which just isn’t me, essentially.

Alice

Heigh Ho

Ah, well, I’m glad it kept you there a bit longer, if not long enough. I wonder if one of the key differences between those of us who go independent and those of us who don’t is that we try and give women the time and space they need to make their own decisions about what to do next?

And while it’s often difficult for a woman to make decisions in labour while she needs to be labouring, there are inevitably times when she might have to and not be looking to her caregiver to be making them for her? I do think then when women get used to making their own decisions antenatally they find it easier to make their own decisions during labour and afterwards as parents.

Not so long ago I overheard a comment from a midwife on a labour ward who said ‘you can make a woman do what ever you want’. Yes, I have no doubt you can, but it’s certainly not the kind of midwifery I would aspire to.

Rosie

Midwife or Doula?

Hi Alice

I’m really fascinated now, by you, not the ‘debate’. I’m really not convinced. The first ‘requisite’ I’d say to be a midwife, is to be a ‘birth junky’. You cite an enormous list of ‘reasons’ why training as a midwife in this country is such a trial – financial and stress being the common ones. We’ve been there – we do know what you are talking about. It is almost like a ‘test’ – if you can survive this, you can survive midwifery.

But, to be a midwife, at the moment, in this country, this is what you have to do. And, yes, as the only option I believe women like you need to stick it out. Then whether or not you decide to go down the independent route is a whole other issue – it is not without its own stresses – but at least you can serve women completely. How can it not be stressful for you as a doula supporting a woman in hospital? At least as a midwife when I’m with my clients, I have the ‘clout’ of being an autonomous practitioner and can support my women by more than just giving information. (Indeed, I would argue that despite Trusts not giving us contracts, we are always actually practising as midwives even if not overtly clinically).

I am most interested in your statement ‘I don’t want to be clinically responsible for the care of women and babies’. I would go as far to say that that is actually the attitude of many midwives – hence hiding behind policies and guidelines. (I bet that statement will upset some? But it is what I believe). Essentially, what I am saying, Alice, is that you are clearly a great loss to the midwifery profession – and I can’t believe you would’ve stayed a ‘bossy boots’ midwife!

Lynn
book reviews


I made the mistake of reading this book on the train, the 11.05 from Oxford to Paddington isn’t the best place to be moved to tears but I found myself completely caught up in Chrissy’s description of her journey through hope, uncertainty, pain and loss. Having conceived after waiting for many years for a baby and having planned a home birth in the care of independent midwives, the path she ends up travelling is very different, as polyhydramnios develops, scans follow, and she and the baby have to rise to meet one challenge after another. Her prose is vivid and compelling; the portrayal of the varied emotions as she moves through the months of her pregnancy allows the reader to walk some of the way with her and her husband.

I feel this is an important book for every midwife to read, even though the vast majority of the women we care for are never touched by experiences of this kind. The immediacy of the writing reminds us of how it feels to be pregnant, of how the words, attitudes or gestures of carers can have a massive impact on the women we care for, for good or ill. It also makes it clear that the path to motherhood encompasses far more than just the outcome.


I had assumed that this was a new edition of Pam England’s book but it appears in fact to be a UK version of the original book, which was first published in 1998. There are aspects of this book that I really like; however, there are other bits that seem to have been awkwardly tacked on for the English edition, and some bits that I don’t like at all.

To start with the positive, the focus on women’s deep-seated knowledge of their own bodies and ways of tapping into their own resources for coping with the work of birth is a refreshing change from the usual process orientated books on childbirth. Some of the ideas for birth art workshops, for enabling women to express deep-seated feelings about their bodies and about their pregnancies are exciting and creative, although some of it comes across as almost stereotypically American touchy-feely. There is also a welcome emphasis on encouraging women to trust their own feelings, rather than accepting what ‘experts’ or professionals tell them they ought to be doing or feeling. The book takes a holistic approach and offers ideas for using all sorts of different methods to access resources or to explore different levels of experience.

However, the adaptation for the UK edition is patchy to say the least; for instance there is a bit in the home birth chapter about the community midwifery system and about the option of independent midwives (though I’ve never heard of a GP providing funding for an independent midwife!), but the bits in the chapters for fathers on what to expect after a hospital birth seem to me to be purely American (‘most hospital still insist that the baby be taken to the nursery for about three hours for an examination, bath and rewarming’, ‘your baby will be given eye ointment to prevent infection that could lead to blindness’ – and even though she talks about ‘asking for more information on these standard procedures’, she doesn’t seem to advocate parents informing themselves sufficiently to challenge the idea that their baby ‘will be given’ all these things).

There are some bits of dietary advice which I didn’t agree with, for instance it’s a long time since women have been advised to eat liver while pregnant. However, the bit that I could hardly believe I was reading came in the chapter on breast-feeding where she advocates the husband giving a bottle to the baby at night from 3-4 weeks – airily adding that this can be EBM or formula, despite having said just the paragraph before that breastfed babies don’t need to be supplemented with formula. Even if it is EBM, giving bottles at night is a clear route to reduced prolactin levels and why, oh why perpetuate the myth that all babies need to take a bottle and in order to do so, must be introduced to a bottle early or they’ll never take one?

I was expecting to really enjoy this book, from things other people had said about it, but despite the positive aspects of it, I was left feeling disappointed overall, partly because I felt it had been insufficiently ‘translated’ for the English market, partly because of the inappropriate advice on feeding but mainly because the parts on the spiritual and emotional aspects of birth seemed to be more superficial than I had expected, almost a touch patronising as if the authors assumed that the readers would never have explored those sides of birth and would need ‘nannying’ through the process of accessing their feelings and emotions.

I’ll keep the review copy with the books in the ARM yurt, and I feel it will be a book to dip into from time to time, rather than to use as a definitive guide to preparation for the birth of a baby.

Sarah Montagu
**Friends in Parliament**

professional indemnity, but we do not want to create a situation in which we make life impossible for independent midwives. That is why we are working closely with their representative organisations to try to find a solution. Before professional indemnity was required of midwives, secondary legislation would be required in this House. We are not at that stage yet, and we intend to do absolutely everything we can to work with midwives to see a satisfactory way forward.

**Maternity Beds Crisis**

to be an uphill struggle to convince the general public. There has been 50 years of propaganda that hospital is the best place to be born, where all the technology and expertise is available just in case it is needed. Just in case obstetrics has a lot to answer for; once in place it’s very difficult to justify all that technology unless it is well used, isn’t it? And with an increasingly technological society with a passion for the latest gadgetry, any attempt to convince the public that midwives and not gadgets are the key to safe birth is likely to fall on deaf ears.

Meanwhile, down the road in Reading women booked for the Royal Berkshire Hospital have been told to get a map to guide them to any of six hospitals in the area because the hospital may be full when their time comes. The Royal Berkshire Hospital is the third busiest hospital in England but it still seems unable to plan its activities even with six or more months warning. When it is impossible to ration beds by waiting list, as is done in other specialties, the only way of limiting resources is to plan for high bed occupancy rates which inevitably leads to strains on the system at times.

The consequences of having high bed occupancy rates are already being reflected in morbidity (caesarean section at the very least) and mortality, to say nothing of an increased workload for the midwives, both in hospital and the community. One wonders just how far the system can be stretched before something gives? At the moment it seems that women are doing all the stretching and the giving; mothers and midwives are paying far too high a price for short term financial expediency. The whole of society suffers when it treats families with disdain. It seems so obvious to radical midwives that one-mother-one-midwife throughout pregnancy, labour and postpartum is the answer. How long will it take us to convince the health economists?

---

David Cameron is getting ready for a ‘bare-knuckle fight’ to save maternity beds according to a press cutting given me by my friend Sue (who works alongside me in the GP surgery where I crunch figures for the local PCT). There has been an 18% reduction in maternity beds since Labour came to power ten years ago, down from 10,781 in 1997 to 8,883 today. At the same time hospital deliveries have risen from 585,000 to 593,000 (and caesarean sections have increased from 17% to 23.5%). The leader of the opposition was speaking after a visit to Horton General Hospital in Banbury where staff are ‘distressed’ at the ‘downgrading’ of their midwifery unit which will become a midwifery led unit and send seriously ill babies nearly thirty miles away to Oxford.

Of course we all know that at long last health economists are seeing the value of midwifery led care. In the current climate, birth centres should be less at risk of closure, but it is going
Male Fears around Birth: Thoughts from the ether

Does the thought of childbirth scare me because a) I’m a cowardly male, b) it’s the unknown that I’ve little knowledge of due to our fractured society or c) medical portrayal on TV makes it out to be something that is scarier than it probably ought to be portrayed? I genuinely don’t know. I do know that a few people I care about have gone through it recently, and it wasn’t easy for any of them. Hmm...

Uh, yeah. If it was up to me? NICE men would not be present at births. All it does is scare them out of their wits for no good reason. There is pain and horror and screaming and S**LLOADS of blood, but, as the mother, you get FLOODED with oxytocin (the hormone that gives you orgasms), and the second the child is actually out you are overwhelmed with bliss for several hours. The man doesn’t have the oxytocin; he just sees the pain and screaming and blood, with no hormonal high to dull the horror.

I think it’s the unknown, it makes sense; birth is always done elsewhere, away, and treated as something scary to an extent. While it was more dangerous in the past, it was more understood generally, people knew about it more; I’ve been present at a calf ing, but never been in the same building as a childbirth knowingly, which means I just haven’t had contact with it.

Childbirth scares you because you’re not made to give birth, is the way I see it. The same as when I was younger the thought of babies made me run screaming, but my attitudes have changed as my lady hormones have kicked in.

And women were not designed/evolved/whatever-you-like to give birth lying on their backs with their feet in the air. Grrr doctors. My sister very recently had her baby, she chose a water birth and said it was actually quite nice!

Aye; until this topic came up, I assumed on the back was the only real option because that’s what I’d seen. To be informed vehemently that it’s a bad idea surprises me, but then the partial point of this is to dispel media stupidities.

Yeah, it is an unknown thing, not much is taught about it in schools, and it should be. Sex and reproductive education is severely lacking. It’s like the teachers think if the kids are taught about it, they’ll go out doing it. They do it anyway! because they don’t know about it!

Surprise, surprise

Around half of due dates given by midwives are outside the baby’s actual arrival date by more than a week, according to a study by Dr Marion Macpherson of Queen’s Medical Centre, Nottingham.

“There are a huge number of births that are overdue,” she says, “there are so many changes that can happen it is very rare for births to be predicted accurately.”

The child trust fund provider Family Investments funded her to interview 530 women about their pregnancies. Just 22% of due dates were accurate to within two days, while 18% said the due date was out by seven to ten days. A further 28% had dates that were out by even longer. With 78% falling outside the +/- two days one wonders why there is such emphasis on the EDD?

More on timing

An insert in The Times on Saturday, August 4th showed the peak time for birth to be 1 pm. I thought it was a misprint, all the evidence I have seen shows the early hours of the morning, not the afternoon, to be the time when most babies are born. How much of this shift is owed to intervention and what are the implications?

Science of Cabbage Leaves

A midwife asking New Scientist readers whether anyone knew why lining the bra with cold cabbage leaves helps with swollen, painful breasts, milk suppression and mastitis received a few replies. The editor informed her that cabbage has been described as a poor man’s poultice but that RCTs to confirm it are thin on the ground. However, RCTs are not necessary to detect the various anti-inflammatory chemicals and phytohormones which are released with heat, either by blanching in boiling water or letting the warmth of the breast do the trick – according to Vivienne Tuffnell, who also wonders whether the vine leaves preferred by Greek women contain the same chemicals.

Aptly named Richard Eden, a botanist, says that in the presence of water and the brassica (cabbage) enzyme myrosinase, a glucosinolate compound, sinigrin (potassium myronate) forms ‘mustard oils’ which are noted for their healing properties – but must be treated with caution because they can burn.

As a mere wordsmith I’m wondering whether there is a philological link between bras and brassicas?
ASSOCIATION OF RADICAL MIDWIVES
Student Midwives Conference:
Being and becoming a ‘With Woman’ Midwife

Wednesday 7th November 2007
Oxford Jewish Centre, Jericho, Oxford

Programme
08:30 - 09:15 Registration, Coffee & exhibition
09:25 Chair’s Welcome and opening address
09:30 Taming the tigers or waking the dead?
   Jenny Hall
10:00 Desperately seeking normality.
   Stephanie Meakin
10:30 Trust in birth: feel the fear and do it anyway!
   Tricia Anderson
11:30 Title TBC (clinical skills),
   Jane Evans
12:00 Water, birth and a rough guide to getting wet!
   Sarah Montagu

12:30 - 13:15 LUNCH & EXHIBITION

13:15 - 14:15 WORKSHOPS
14:30 Title TBC, Sandra Arthur
15:00 Students’ Perspectives
16:30 Closing remarks and address
16:45 Finish

Workshops
1. Caring and sharing – a chance to debrief and discuss difficult issues
2. Hypnobirthing and Relaxation skills
3. Bullying and assertiveness drama workshop
4. Antenatal classes – facilitation skills and dealing with the stresses
5. Massage skills for pregnancy, for labour, for life
6. Maternity services – helping women find their way through
7. Independent midwifery – ways of working
8. Clinical skills – building confidence (for students due to qualify soon)
9. Yoga for pregnancy, for labour, for life
10. The NHS bullying culture, Supervisors of midwives and support

Please indicate first and second choices of which workshop you would like to attend on the booking form

BOOKING FORM

The ARM Student Midwives Conference:

Name: ................................................................................
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Where are you studying? .........................
Are you an ARM member? .................

Do you have any special dietary requirements? .................................................................
1st Choice for workshop (see above, right) ........................................................................
2nd Choice for workshop (in case 1st choice over booked) ........................................

Please send this form along with a cheque for £25 (payable to the Association of Radical Midwives) to:
Dot Parry, ARM, 4 Hermitage Road, Manchester, M8 5SP

*Fee includes lunch and refreshments: non-kosher food can NOT be brought in to the centre.

Please note: If you would like me to send confirmation of your booking, a receipt and or directions by post, please send me a SAE. Otherwise I will confirm your booking by email.

Autumn 2007 ISSUE 114 Midwifery Matters 35
Wigan ARM Group & Wigan, Leigh, Atherton & Tyldesley Home Birth Groups

MOTHERS & MIDWIVES SHAPING THE FUTURE

“The Power of Birth”

Ashton-in-Makerfield, Wigan
Saturday, 6th October 2007, 9.30 - 4.30

Effective teams who like each other: an alternative view on safe motherhood, Soo Downe
Do midwives have the power to influence maternity services? Denis Walsh
Cervical reversal/regression, Lois Bowman
Being a doula and having a doula, Jude Robinson
Diabetic home birth, Debbie Dooley
Independent midwifery, Judith Kurutac
Attachment (the importance of skin to skin), Jane Wallsworth
Home/hospital water birth audit, Ann Clayton

Fees (including lunch and refreshments): midwives/professionals £40 students/others £20

Enquiries: Lesley Price 01942 747902 Amanda Benko 01204 468314
(No bookings will be taken by phone)

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Introductory Course:
15th – 20th September 2007

Introductory Day:
Saturday, 8th September 2007

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**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;
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- 200 leaflets @ £5.00;
- 300 leaflets £5.50.

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

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**CD-ROM**

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ARM Annual General Meeting

Moffat, Scotland
Sunday, September 16th

‘Empowering Midwives, Empowering Women’

The AGM will take place during the retreat which is being held in Scotland in Moffat, “a 19th century spa town in the south of Scotland three minutes from the M74. Moffat is an outstanding conservation town with modern amenities. Offering free parking, a ‘double’ High Street, lots of specialist shops, cafés and hotels, beautiful Station Park and many super walks.”

AGM business will take place in the morning. Be prepared for a little gentle persuasion/encouragement/peer pressure to offer your services to ARM as a Steering Group member, national meeting organiser, ICM/ARM activist, magazine contributor! Or just come along and test your powers of resistance! Caroline Hollins-Martin will teach you how later on in the day (by which time it will be too late!) in her workshop on ‘Empowering Midwives, Empowering Women’.

venue: Well Road Conference Centre, Moffat DG10 9BT
fee: £5 to cover lunch
Steering Group meeting Saturday, September 15th. All welcome to attend. Come and see how ARM works.

Retreat Workshops

Wednesday, September 19
Sharing the Skills, Breech Birth
Mary Cronk and Jane Evans
Fee: £45
Book through the following website: www.sharingtheskills.co.uk
overnight accommodation may be available through the Retreat, to be booked separately.

Thursday, September 20
Waterbirth
Jenny Davidson
Fee: £45 (some reduced price places for student midwives - contact Linda please).
Book with Linda Wylie, 4 Darley Place, Troon, KA10 6JQ.
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.

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

ARM ANNUAL HOLIDAY/GATHERING/RETREAT
Well Road Centre, Moffat DG10 9BT
14th to 21st September 2007

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Signed: ___________________ Date _______________________

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Your booking form and payment will be acknowledged with a receipt, together with a map of the location and travel directions.

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Lift required from _____________________ area/train station (e.g. Dumfries,)

If your car sharing requirements match with someone else’s, I will contact you to check how you would like this information to be shared.
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(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).

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Independent Manager Research Not practising Retired

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