

Essay

## 40 Years Hard Labour

Dame Lorna EF Muirhead DBE

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I'm sorry to say that there's hardly a word that is research based in this "40 years hard labour", but what surprises me is that my observation and experience is sometimes supported by subsequent research. This is an anecdotal account which I hope you will enjoy and find peppered with controversy, pearls of wisdom, and food for thought, but I expect it will not add one jot to the body of your knowledge, and most of you have probably not heard a lecture like this for some time. Not for my generation the PowerPoint lecture, but one written in longhand, which the author then performs. It is based on a chapter I was asked to write last year on essentially the same theme for a textbook for midwives.

Here goes!

The bell rang and I and three other new pupil Midwives, trying to master the art of palpation, left the antenatal clinic and rushed to labour ward to witness our first delivery.

It was 1964 when childbirth was not viewed as the normal life changing event, which it is today, but a frightening painful experience, which women had to endure in order to become mothers. It was a time when antenatal education was almost non-existent and women came to childbirth hardly knowing what to expect. Many were forced to deliver at home because there were not enough maternity beds for them to have their baby in hospital, which is what women then aspired to do. Hospital birth was becoming all the rage! Labours were longer and experienced without the support of husbands and family, who generally left them at the labour ward door, coming back later to see mother and baby.

Women laboured in Nightingale wards with only a curtain in between them. They often laboured with inadequate pain relief. 50 or 100mg of pethidine was the standard analgesia for labour, topped up by gas and air towards the second stage. However the women in Liverpool were very well treated in this respect, because they were given the Liverpool cocktail. A primigravida would be given 10mg of morphine, 100mg of pethidine, and 200mg of butobarbitone at two fingers dilated; topped up later in the labour by 100mg of pethidine and gas and air. They often woke up three days later and exclaim, "Did I have the baby!!" So much for bonding, but at least they were spared the agony of labour, and of course, as we all know, before the idea of bonding which came on board in the latter half of the 20th century, no mother had ever bonded or formed a meaningful relationship with her baby.

1964 predated epidural analgesia, so easily dismissed today, but not by midwives of my generation, who knew the onerous and draining experience of sitting with women in agony,

experiencing prolonged or painful labour for many long hours. When epidural analgesia was first used for such labours I was its most ardent supporter, and I remain so.

More women died in childbirth than they do today. The main complication which killed them was post-partum haemorrhage. The routine use of Syntometrin and the active management of the third stage of labour, which has largely eradicated this condition, certainly from normal vaginal delivery, was some way off. Physiological 3rd stage of labour was the practice of the day

The Triennial Confidential Maternal Enquiries (the forerunner of CEMACH) contained accounts of those deaths along with the deaths of women who had inhaled vomit at caesarean section, and died of Mendelson's syndrome. As a result, women in labour were fed a liquid diet of soup, jelly and ice cream, and sucked glucose sweets, anything which quickly became liquid and passed through the stomach, so that if general anaesthesia was required the stomach had no solid food within it, and of course there was no prophylactic antacid therapy. Perhaps when reviewing whether or not women should be fed in labour today, the reasons why they were ever not fed should be borne in mind.

My practice predates the describing of supine hypotension syndrome. Prematurity was considered to be anything under thirty-six weeks gestation. Special Care baby units did not exist, though there were a few premature baby units. Can you begin to imagine managing the complications of pregnancy and labour without specialist help for the baby you deliver? The choice, which all too often had to be made, was to deliver the woman if there was an indication to do so, and the child had to take its chance.

1964 predated the contraceptive pill and the abortion act and there were many unplanned pregnancies for married and unmarried women alike. It was a huge social disgrace to be pregnant out of wedlock, so much so that girls finding themselves in this situation used to go "on holiday" to another town where they delivered their child, often having it adopted, and then conveniently arrived back home "from holiday."

It will be difficult for today's midwife and obstetrician to

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Correspondence to Dame Lorna Muirhead.

lorna.muirhead@tiscali.co.uk

contemplate childbirth or the practice of midwifery and obstetrics within this context; just as in forty years time it will be difficult for the midwives and obstetricians of the day to contemplate the practice you do now. Professional life moves on, and goalposts and expectations constantly move.

The preoccupation of the professionals caring for pregnant women when I trained was to eliminate risk from childbirth. As professionals it was mandatory that we should do so, and women expected no less from us. After all, some women were still going to be churched following delivery (as it says in the prayer book) to “thank almighty God for vouchsafing to deliver them from the great pain and grave peril of childbirth.” The attempt to eliminate risk led to the use of antenatal screening, and routine procedures for all women, to make sure that they came to labour in the best possible condition to withstand its rigours. This of course is an unchanging principle. Invariably this means that some women, those who essentially remain within agreed normal parameters, could be said to have been over-monitored and over-treated, but this blanket approach to care has undoubtedly played a significant part in making birth here as safe as it is today. However, it could also be said, that in making it so, there is a danger of our becoming victims of our own success, resulting in some of those procedures which make birth safe, now being abandoned.

This is very much like the current thinking on vaccinating all children against measles. No one believes that all children who contract measles will be damaged or die, but some will, and since it is impossible to accurately predict those children who will, vaccination of all children is advised.

If many children were dying in this country during an outbreak of measles, there would be little reluctance in modern parents about having children vaccinated. But this is not happening, and parents can be forgiven for thinking that because they never hear of such tragedy they need not accept the very minimal risk associated with measles vaccination. Likewise birth is so successful and safe here, that we are letting down our guard.

I accept the idea of low-risk and high-risk pregnancy, but it is worth reminding ourselves that there is no such thing as a no-risk pregnancy, which makes me feel justified with meticulous monitoring and appropriate intervention of those in my care. Successful though birth is here at the beginning of the twenty-first century, success cannot be guaranteed prospectively. It can only ever be classified as successful, retrospectively.

But back to my first delivery!

As I approached the labour ward I felt mounting apprehension and anxiety, but at the same time excitement at the prospect of witnessing my first delivery. However the awful screams heard in the corridor meant that anxiety was my uppermost emotion. I had rarely heard such distress. As a nurse I had witnessed people badly injured and desperately needing help sounding so agonised, but this was a woman in the height of labour about to deliver her child. We, the three new pupils, stood at the foot of the bed, silent, frightened and fearful for the woman. She pushed, screamed and shouted, and then a non-breathing blue head suddenly appeared at the vulva.

There was a temporary silence.

“Why doesn’t someone do something,” I thought, “the baby is surely dead,” since hitherto anything I had seen that colour

and not breathing had been dead. The midwife in charge however was calm, tranquil and very unworried.

Another mighty scream and it was all over. Miraculously the child shuddered into life. I stood transfixed. I had just witnessed the most awesome, terrifying, painful experience I could imagine – but the mother, child in her arms, was now smiling. I left the room totally confused, found the nearest lavatory and I wept.

Eventually my time came to work on labour ward and during the following six months I would witness, and become involved in, the most exciting, unpredictable, totally absorbing, painful process called labour. I would help eighty-four women to deliver their babies and my lifelong passion for the care of labouring women and the desire to do something to alleviate the suffering involved with it would become established.

The labours, which, in common with all midwives I like best, are those which proceed normally and allow me to practise “autonomously.” However I strongly believe that midwives are there for all pregnant women, and my clinical practice over many years has embraced natural, normal, complicated, and alas fatal childbirth, the latter two of those requiring me to move into a different gear of midwifery and become an equal partner of a multidisciplinary team, working towards the optimum outcome for mother and child. Dear to me though “autonomous” midwifery is, it is secondary to doing what is necessary to secure the best outcome for mother and child.

And so, the first six months training was coming to an end. Perhaps I should tell you a bit about it. Midwifery was taught by Sister Tutors within midwifery hospitals. Each training hospital, every three months, took their required number of new pupils, who were not only guaranteed a job at the end of training – but indeed were expected, as new midwives, to work in their training hospital to give back some service. Midwifery training was divided into Part I, which covered all the theory of midwifery, and Part II, which largely involved public health and a time spent on “the district” which is now referred to as in “the community.”

So I bought a very old bicycle from a pupil midwife just returning from the district, was measured for my brown mackintosh and hat, and collected my midwife’s bag before cycling to the midwife’s house in the middle of a council housing estate in Birmingham. The plaque on the door read “Midwife’s house.” Inside lived two district midwives, and every three months two new pupil midwives came to live and work with them. It was like a monastic life, totally immersed in midwifery six days and nights a week. What a wonderful experience I had with Janet Webb and Doris Eaves! They lived and worked amongst those they attended and were regarded as pillars of the community. Dressed in their green uniform they looked like the woman on the Quaker Oats packet, and yes, both drove Morris Minor cars. They knitted baby clothes, they ran antenatal clinics, and they did some fifty deliveries at home each year. So life was very gentle in spite of the long hours which they had to be on duty and available. Whilst I was with them I did twenty-one deliveries. They were mistresses in the art of midwifery and taught me so much

Daily I would be given my work, which was to attend antenatal clinics, and to visit post-natal, women which we did for ten days. Such visits included bed bathing the mother – few had

bathrooms - bathing the child, making the bed, and checking temperature, pulse, respiration, lochia and the fundal height, and sometimes included Hoovering, or doing some shopping for the family.

I particularly remember one delivery I attended. A gravida four booked for home went into labour when I was in the midwives' house alone. There was a knock at the door, "Can you come to my mother" the little boy said. "She's going to have her baby." This mother, in common with most, had no telephone in her house. So I cycled carrying all the equipment I needed, and arrived at the house to hear sounds, which, had I been a little more experienced, I would have recognised as a woman approaching the second stage of labour. I ran breathless from my cycle-ride, up the stairs. Keen to do the right thing and get the procedures right, and frightened that I was on my own, I took out my razor to shave the vulva. (In 1964 it was not humanly possible to deliver without a shaved vulva!). One swift move of the razor and the head of the child appeared with the centre of its head shaved! Oh my goodness! What now! Seeing a bonnet which was laid out neatly on the dressing table ready to be put on the baby when it was born I seized it, and put it on the head still at the vulva. Was this the first child in history actually delivered wearing a hat? When Miss Webb arrived she complimented me on my putting on a bonnet, because the room was a little cold – no central heating, and only one bar of an electric fire. The mother smiled, and we kept our little secret.

The next three months taught me a lot. As I have said, women delivered their babies usually in the back bedroom of their parent's house. Few young couples had accommodation of their own. Houses usually had no bathrooms and no telephone. Midwives had to rely on the telephone box in the street to summon aid, if it was necessary.

Home birth, as ever, was wonderful when all went well, but if there was fetal distress, post-partum haemorrhage, sudden eclampsia, or a baby not breathing, all unpredictable conditions associated with labour, home birth was a nightmare. In such circumstances it was left to the husband to run to find a working telephone and ring the local hospital who would send out the flying squad.

The flying squad consisted of an ambulance, which was always available, which brought to the patient's house a team consisting of an obstetrician, an anaesthetist, a midwife and a medical student. With them they brought blood, and equipment necessary to deal with conditions like ante-partum haemorrhage, post-partum haemorrhage, retained placenta, delay in second stage, eclampsia, undiagnosed breech, or twins in the second stage. Some of these conditions were dealt with at home, but if needs be the patient's condition was stabilised before she was transferred to hospital. Flying squads were very much the predecessors of today's paramedics. The maternity services long ago knew, that to transfer a compromised pregnant, or intra-partum woman to hospital by ambulance could result in death, and so the idea of initiating treatment which would make the patient safe at the scene of their problem before taking them to hospital, was born.

Although the flying squad usually arrived within half an hour of being called, half an hour was a lifetime with a fitting woman, a woman haemorrhaging, or a second twin lying transversely. Perhaps this is why I do not share the

contemporary views about the merit of home birth, or birth in freestanding maternity units.

So my time in Birmingham ended – I had passed Part II and was now a midwife. I had no thought of going back to nursing. During my midwife training, I had met and fallen in love with a tall, dark, handsome Scot who was at university in Aberdeen. He was going to Liverpool University to do a PhD and so I looked in the midwifery journals for a post in Liverpool, and saw the advertisement for a staff nurse at Liverpool Maternity Hospital. I had never been to Liverpool – never heard the accent, and knew little about the area.

I arrived at Lime Street Station and walked up the hill to the hospital. The Matron, Emily Carter, met me. She had the face of a Madonna and was a visionary midwife, who ran a hospital with standards for women and midwifery, which were the very best of the day. I did not know then, just how lucky I was to be successful in getting a job. The local view was that you had to have a letter of recommendation from the Holy Ghost to be considered good enough to work there.

Unlike the place where I trained, Liverpool Maternity Hospital was a teaching hospital, which meant that it was attached to a medical school, and had the brightest and best doctors and midwives working at it. It was also much better staffed and had a much bigger budget. This was the workplace of Professor Sir Norman Jeffcoate, one of the most influential, if not the most influential, obstetricians in the world. Doctors used to come from all over the world simply to work with, and touch the hem of Professor Jeffcoate. James Minnit, the man who gave us "gas and air" was on the staff, and Charles Clark who did something with butterflies which resulted in our having anti-D which led to the elimination of babies stillborn, or born compromised because of rhesus incompatibility. This was a Rolls-Royce place, where excellence could be readily spotted, and I wanted to be part of that excellence.

I thought I had gone to work in paradise. Women laboured in single rooms in a state of the art labour ward. Their husbands were "allowed" to stay but only for normal deliveries. Liverpool was well ahead when it came to preparing women for labour and motherhood. It ran "mothercraft" preparation classes.

For labour, it offered women the Liverpool cocktail (or coughdrop as the locals called it). This was 100mg of Pethidine, 10mg Morphine, 200mg of Butobarbitone – given together when the cervix was 2cm dilated. It was topped up hours later with 100mg of Pethidine if required, followed by gas and air, given at the end of the first stage and into the second stage of labour.

Women slept throughout labour and often almost through delivery. Many a woman was heard to ask sometime later "Did I have my baby?" So much for bonding – but at least they were spared unwanted agony, and were very grateful for that.

It is often asked "Surely all the babies were born with low APGARS after all that analgesia?" I can assure you they were not. At that time, the mid 1960s, there was no resident paediatrician in most maternity hospitals, which meant that midwives had to deal with all the babies born. Believe me, if babies had been born compromised by the analgesia which their mothers were given in labour, the analgesia would have been modified! After delivery, women were served a tray of

tea. I had never seen this. A hurried drink from a communal teapot had been the norm where I previously worked – but a tray of tea!

In the post-natal wards women rested for ten days. Their babies lived in a nursery where they were looked after by midwives and nursery nurses, and only taken to the mother to be fed. Surprisingly, against modern thinking, mothers did manage to bond with them! Post-natal wards outside feeding time were tranquil places where women spent time getting over birth. Midwives had time to devote to assisting with breast feeding and teaching mothers how to bath and generally look after their babies. Post-natal wards were not, as they are today, like Heathrow airport, full of women coming and going with very little time on the tarmac.

I was exposed to Liverpool humour almost on my first day as I asked a woman I was booking: “Name; address; religion; next of kin?” “Oh,” said the woman, “I don’t have a next of kin.” “What about your husband?” I said. “Oh! He doesn’t have one either.”

The next week on labour ward, looking after a labouring woman, I said to her, “Don’t you think you ought to have something for your pain?” She seemed in agony to me. She retorted, “I don’t know! You’re the bloody midwife!” This response tells you something about the relationship between patient and professionals at that time. That woman expected me, a qualified midwife, to advise her and to tell her what I thought would be best for her. This today is called paternalism and is grossly unfashionable, but I see some merit in women asking the professionals whom they consult, what they think is best for them individually, and the professionals giving the women the benefit of their education, knowledge and experience. Why else are we professionals?

In 1970 the Peel report, now much castigated by many midwives, recommended on the grounds of safety that all births should take place in hospital. Today’s midwives are dismissive of Peel because his evidence was not “research based.” But can I remind us, that most of what we did then and do now, is not research based, indeed until relatively recently we midwives had little formal research to guide us, but we still had a very successful, progressive profession. Important though it is, let us keep research in its place as only one of the disciplines, which informs us about practice. What we did have in 1970 were statistics, presented in the Triennial Confidential Enquiries into Maternal Deaths, which catalogued where and why deaths and morbidity occurred. The report supported Peel’s conclusions that many of the deaths reviewed could have been avoided if the woman had been in the right place with the right equipment and the right level of expertise to hand. I share Peel’s view.

Post 1970 most babies were born in hospital, and statistical evidence supports the view that maternal and perinatal deaths declined. But with hindsight there were some problems. All women, normal or complicated, now booked under obstetricians, who consequently believed that they bore ultimate responsibility for all pregnancies. In the attempt to improve labour, especially prolonged labour, which was a common problem, obstetricians, at that time, rightly intervened in intra-partum care to rectify conditions like cervical dystocia and incoordinate uterine action, so rarely seen today that modern midwives will have to resort to midwifery history books to identify it.

However, soon interventions spilled over into normal labour, doctors believing that they had a duty to do what they considered best for all women in both complicated and normal labour. The professional accountability of the midwife being a practitioner of normal childbirth was poorly understood by obstetricians and I have to say by midwives as well. Those of us in practice at the time were just too busy getting on with the job to notice this insidious intervention in normal labour, or the erosion of our role. This is not a comfortable conclusion for me to reach, since it was my generation which was responsible for it. But let us not demonise doctors. They were doing what they thought was best for women, and I deplore the current anti-doctor attitude which some display. A strong, confident profession like midwifery does not need to demonise other professions, especially our obstetric colleagues who have played a vital part in making childbirth as good and safe as it is today. Now, there’s an unfashionable view! Midwives do not have the monopoly of altruism. We did not on our own, make the experience of childbirth the comparatively wonderful, safe experience which it is today in this part of the world.

For all the interventions of the 1970s and 1980s, do not for one minute think that all was bad for women then. I have no misty eyed nostalgia for childbirth at the beginning of my career or during those later years. On balance having a baby in this country gets better all the time and will continue to get better, provided we keep the best practise of yesterday and marry it with the best of today’s. Let us not be tempted to throw the baby out with the bath water. As a young midwife I could only see as far as I could see, because I was standing on the shoulders of the generation of midwives who went before me. Today’s midwives, and for that matter, today’s obstetricians can only see as far as they can because they are standing on the shoulders of my generation. When today’s midwives believe that they have found a better way of looking after pregnant women, they must avoid the temptation of rubbishing the efforts of the midwives who went before them, who like them, were giving care which conformed to the philosophy and best practise of their day.

Let me remind you about some of the advances for women in the 1970s and 1980s, since some balance needs to be given to the very negative attitudes to the management of childbirth at that time. Single rooms were provided for women to labour in privacy. The vast majority of women wanted effective pain relief during labour, and attention was paid to improving what was on offer. A marvellous innovation called epidural analgesia was introduced into labour-ward practise and midwives of the day adapted their management of labour, especially the second stage, so that the forceps rate did not rise dramatically, as one is led to believe. In my view, it is often incorrect management of the second stage of labour which leads to forceps or Ventouse delivery not epidural analgesia *per se*.

The introduction of continuous fetal monitoring meant that because the well being of the fetus could be clearly seen, relaxation of the time limits imposed especially on the second stage of labour was possible, and this was greatly welcomed. The second stage of labour was known to be a time of increased risk for the fetus, and my generation were exposed to catastrophic and unexpected intra-partum stillbirths. We welcomed continuous fetal monitoring!

Fetal scanning and choice about continuing the pregnancy in the case of abnormality became available. We are now at the time of the contraceptive pill, which gave women more control over their fertility, and the Abortion Act had been passed in 1967.

Special Care Baby Units (SCBU) were being set up everywhere, which meant that babies born spontaneously premature, had more chance of survival. It also meant that conditions in the mother, like severe pre-eclampsia, requiring very early delivery, became less of a problem. It would be good for today's midwives and obstetricians to pause and think about how difficult it was to manage those women who need early delivery without SCBU.

Organisations like the Natural Childbirth Trust, later to become the National Childbirth Trust (NCT), were born and set up classes in antenatal education and preparation for birth. However the NCT cannot, and does not take all the credit for this because many midwives ran the same sort of preparation classes.

This meant that for the first time women came to pregnancy and delivery with some idea of what to expect, and what a joy that was. What was not so desirable in this context, was that women soon began to have very fixed ideas about what they "wanted" from their childbirth experience, whether their actual childbirth performance could support this or not. This led to some disquiet amongst midwives who, until that time, were used to being consulted by pregnant women who asked for advice and usually took it. This is now called paternalism and, as I have said, is deeply unfashionable. However, in my view it is desirable for professionals to believe that they should know more than even the most well informed "consumer," and midwives know exactly what women want to achieve by the end of their pregnancy. We talk today about individualised care, but all birth plans in my experience, include most of the same things, and are not individual at all. We know that women want things to be as normal and uncomplicated as possible. They want to take home a healthy child and be proud of their achievement. They also want to be satisfied with the care they received. We want those things too! But midwives should also know that this sort of childbirth is not women's to demand, nor is it in the midwives' gift. It would be worth taking a few minutes to think about that. I hope I've managed to convince you that there were many good things which happened post-Peel.

By the late 1980s midwives could have been forgiven for believing that childbirth was very good in terms of women's and babies survival, but the price for this was the so-called over medicalisation of childbirth.

We were now at a time when fertility was largely under women's control, and when scans almost guaranteed the normality of the baby. There were major advances in the survival of neonates, and women experienced shorter labours and had choice about the method of pain relief. They laboured in private with the support of families. These advances had taken many years to achieve through the efforts of my generation of midwives. I do not accept a common view that everything which happened to women at that time was undesirable, or that women could not have been happy or fulfilled with their childbirth experience. But times change, and periodic review of the maternity services and midwives' practice is essential.

No one welcomed more than I did the recommendations of "Changing Childbirth", because it heralded the renaissance of autonomous midwifery in the care of low risk women. However I remain to be convinced that in order to achieve this, birth should be removed from hospital into the home, or into freestanding birth units. I completely support total midwifery care for low risk women, but my preference would be for it to take place in hospital with all emergency facilities to hand. The success of low risk birth in hospital lies in midwives and obstetricians "getting their act together," and having mutual respect for each other's role, as indeed they have done far more frequently than some would have us believe.

As a profession we should be concerned with equity of care. What removing birth to the home or birthing units has done is to provide a minority of women a place where a lot of attention has been paid to making a homely environment, and providing them with one-to-one midwifery support in labour. However today, the majority of women labour in hospital, where often less attention has been paid to the physical environment, and midwives frequently look after two or three women with varying risk factors at one time. Whilst congratulating midwives in birthing units and those involved in home births for the care they give, in my view, the fact that birth experience is generally so highly rated in those areas has much to do with environment and staffing ratios. If midwives worked in hospitals where similar attention was given to the physical environment, and where they were able to give one-to-one care to women with similar risk factors, I wonder what evaluations would be like. After all, one-to-one care is supposed to be available to all women. At the moment we are comparing apples and pears.

Changing Childbirth also failed to address adequately the needs of a very significant number of women for whom birth is complicated, or the practice of midwives who attend them. The experience of birth for these women is often viewed as second-rate, as is the practice of the midwife who attends them.

It seems to me that we live in a time where "good birth" and "good midwifery" is thought to be practiced at home or in birthing units, and anything else, especially birth in hospital, is "bad birth", and "not proper midwifery".

This is to be deeply regretted and does not serve mother or midwives well. I believe that midwives are there for all women, and although the practice I enjoyed most was that which I could do autonomously when everything remained normal, I had no problem at all in moving up a gear to practice midwifery within a multidisciplinary team, in the care of women experiencing difficulty. Many I know share this view.

Midwives have to guard against becoming too idealistic and too pure. As a profession we should make no apology about having a philosophy which supports non-intervention and normal birth, but we must beware that this philosophy does not become an ideology which results in our not intervening when it is necessary to do so. Having castigated obstetricians for intervening unnecessarily, midwives today must not be guilty of failing to intervene when it is essential. Herein lies the wisdom of practice.

It seems to be increasingly difficult for midwives as a profession to define, and what is meant by normal birth. We

seem to have problems in agreeing parameters of normality, especially around labour. This is probably because of the recent history of intervening unnecessarily in uncomplicated labour. It seems to me that what is seen as “good birth” today is actually “natural childbirth,” not “normal childbirth.” What do I mean by that? Well, natural childbirth, I would say is allowing pregnancy and birth to proceed as nature decrees, and without intervention. This means that most will be successful, some will be damaged, and some will die, very much as childbirth is in the developing world. However damage and death in childbirth is largely preventable in a developed society such as ours, and is therefore, I believe, totally unacceptable. That is why normal birth, which is the midwives’ role, should take place within agreed parameters, and when those parameters have been breached, there should be timely and appropriate intervention.

Another area that I think we should be concerned about is the choice agenda, and its implications for the midwife. “Choice” is a political word of the day, and it will pass. In saying this I give my critics the opportunity to say that I do not want women to have choice, but want to nail them to the bed and do things to them. This is far from the case. I see choice as very important. What I am concerned about is the manner in which choice extends into the technical and professional aspects of what we do. Midwives, it seems to me, are often too ready to support choice, and forget that in supporting it they also have a duty of care.

This view is reinforced when I sit on the Conduct and Competence Committee at the Nursing and Midwifery Council (NMC). There I see good midwives who have not thought this through. They believe they should support women even if they choose the most inappropriate care, and they fail to safeguard themselves by understanding that they are professionals who have this duty of care. If things go wrong and the woman then brings a complaint to the NMC, the midwife may find herself ultimately being deprived of practice. There is much for the pregnant woman to have choice about, but was choice ever meant to extend into those technical and professional areas for which we have been extensively trained, and for which we hold professional accountability? What a grey and fragile area this is!

I know that the secret of women being happy to take advice from midwives, appropriate to their individual circumstances, resides in the midwife-woman relationship. Of course there are midwives and women at the extreme, but generally midwives and women within their special relationship can come to an accommodation which serves the needs of choice, accountability, and duty of care. I could go on.

I worked for some 35 years as a clinical midwife at Liverpool Women’s Hospital, which sees some 8,000 deliveries a year. During that time I witnessed the joy of birth many thousands of times, sharing that moment with Liverpool families. I have also known the deep sorrow of seeing fourteen women die in the attempt. I have worked with truly outstanding, remarkable midwives and doctors, and have been inspired by their skill. I have shared with them the unparalleled experience of normal birth, but also many catastrophic situations over the years. I have seen them almost walk on water in these most dangerous and dramatic situations, and have driven home after my shift at such times almost bursting with the relief and joy of success.

I was amongst the first married midwives to work in Liverpool, and then had my own children before the days of statutory maternity leave. Those relatively few of us who had children at that time were in uncharted waters. We had to leave work, and draw out our superannuation, drawing what we thought would be a line under our professional life, since at that time almost all midwives were single and worked full-time. However, after my children went to school I was allowed the new, and rare privilege of working part-time which I did for many years, as part of the first generation of educated women to juggle home, children and a profession.

For a while I was content being part-time. Such an arrangement meant that I had the best of both worlds, at home and at work. However, it was not without its problems. A common attitude towards those who worked part-time was that they were only there for the pin money. They didn’t need any professional updating, except the statutory refresher courses every five years, and indeed they were not as dedicated as their full-time counterparts, and certainly they had no aspiration or hope of promotion. For all my faults, that description did not fit me. I was professionally and politically aware and was keen, at this prestigious hospital, to engage in all the innovations in practice which midwives became involved with, and to work any shift on any day, exactly the same as my full-time colleagues. Indeed during this time I was a frequent lecturer on study days for midwives, and wrote chapters in textbooks.

I have always been an articulate woman, who dislikes controversy, but hates injustice even more, and over the years I found myself championing many local causes for midwives. I became involved in my branch of the Royal College of Midwives (RCM), variously as its chairman, secretary, treasurer, and most taxing of all as a steward. In this role I was able to support midwives through grievance and disciplinary procedures, and although I found this role very rewarding it was a times very distressing.

However Liverpool humour often sustained me. For instance, while helping a colleague one day, in middle age, I seemed to get my words mixed up, when at the delivery of his child a man said at the crucial moment “Oh, I do feel funny.” “Put your hands between your legs,” I said. Quick as a flash my Liverpool colleague said, “It won’t make you feel any better, but it will take your mind off it!” Of course, what I thought I had said to the man was, “Put your head between your legs.”

On another occasion when I was hoping to have a cup of tea with colleagues the door bell went, and a man said to me, “Good morning, Sister. I’ve brought my wife for inducement. I was going to bring me ma with me. She’s had twelve. Me father’s a Roman Catholic and has no sense of rhythm.” Can you imagine what a fun day I had with him and his wife, as I looked after her in labour?

However I must not paint a saintly picture of myself. Due to constant changes, pressure of work, inadequate staffing levels, or whatever, some days I felt I had horns and a tail as I tried to be a good shift leader on a labour ward which too often resembled a war zone. On such days I didn’t like myself, and I dread to think what others thought of me, as I suspect we all do when we have such days. However my experience has been that colleagues - themselves under pressure, understanding the stresses and strains which take place increasingly often - are very forgiving, and take the view that it is the pressure

of work which is largely responsible for such behaviour. Not that this excuses it, but it does explain it. This is why those cups of tea together are absolutely vital: a time to put things right with each other, and to discuss the things going on in our lives which may affect our work.

Aged 50, my family grown, and my parents' dead, I felt I might have ten years or so before retirement to do something for myself. I did not want to study for a degree. What use would that be to the profession at that age? If I were to work for a degree it would be for myself, and probably in medical ethics. My husband has always believed that I would have achieved more professionally had I not married and had children. Whilst this may be true, I actually wished to stay in the clinical arena. What I did long for was some career progression for those who wished to continue as clinical midwives. Until recently there was none.

I had always had much to say, and held strong opinions about most matters professional, and in common with most midwives I had always been good at airing those views in the tearoom. I thought it might be more effective to do this where those views had some hope of being listened to, so I decided to seek election to the Council of the RCM. In order to do this I had to write a manifesto and do some serious reading. I was successfully elected, and it changed my life.

The papers for the first Council meeting dropped on my doormat in a huge bundle, which required very serious reading, and consideration. My initial reaction was that I had made a big mistake, but I told my husband I must go to Council at least once, because I had been elected.

In London, I walked into the debating chamber of the RCM Council and saw all the faces and met all the people I had hitherto only seen in our journal, "Midwives." I heard the debate, the passion, and the diverse opinions, and I was hooked. I loved every second of it. I would advise midwives to have the aspiration of being actively involved in our professional body, the oldest and largest midwifery establishment in the world, which we should cherish.

The things that I moaned about in the tearoom which seemed to me to be easy to address, in reality were not nearly so easy to resolve. I grew up politically and got so much more from my profession. I served my first term of three years, and almost on a whim put my hat into the ring for the Presidential election. I was successful, and began the most wonderful, fulfilling, exciting, and rewarding eight years as President, representing midwives nationally and internationally at branch meetings, seminars, government departments, and palaces. What a privilege it was to represent a profession so well respected and so well understood worldwide!

During this time I attended the one-hundredth birthday of our Patron, the late Queen Elizabeth the Queen Mother; had tea with her on two occasions; and sadly, some years later, I represented midwives at her funeral. I had lunch variously with the Queen and Princess Royal, and worked on the Council of The Kings Fund, whose working President is the Prince of

Wales. I was also the midwife on the RCOG Council, where I met Jim and Samina Dornan, and where I was honoured to be made a Fellow *ad Eundem* of the RCOG.

Each year the Prince of Wales invites Council members of the Kings Fund, and the great and good from London who work in the health service, to the King's Fund lecture at St James's Palace. On my first visit I sat in the throne room with red damask and gold leaf on the walls, the sun shining through open windows, listening to the soldiers marching and a band playing. What a contrast I thought, to my life yesterday morning when I was trying to run a hugely busy labour ward, and was longing for a cup of coffee. Sitting next to me was the President of the Royal College of Nursing, who said "You're not staying for lunch, are you? It will only be a couple of canapés and a glass of wine. I'll treat you to lunch at Fortnum, and Mason's." "Goodness!" I thought, "I believe I could get to like this lifestyle." Returning home to Liverpool later that day I travelled first-class, which was unusual, because Virgin Railway was offering a special ticket for £14. What a remarkable day it had been! Sitting at my kitchen table, telling my husband all about it, and eating some shortbread, some crumbs fell on to my dress. Brushing them away with my hand, the dress felt very strange. I looked down and to my horror, discovered that I had been to all those places that day with my dress on inside out.

During my time as president I travelled to Vienna, the Philippines and America. I also visited some one hundred and fifty midwifery units to meet and talk with midwives in the workplace. It was an enormous privilege, and I like to believe that if a part-time clinical midwife from Toxteth in Liverpool could do this, then any midwife can.

In 2000 I was awarded a DBE (Dame Commander of the Most Excellent Order of the British Empire) for services to midwifery. I cannot begin to express the pride I feel in that award for myself and for Midwives.

In 2004 my term of office as President, and retirement from clinical practice came together, the Presidency because my term of office had expired, and my clinical work because I underwent major surgery, and running around a labour ward on night duty and day-duty at the age of sixty two years, was no longer an option.

## EPILOGUE

Do I miss it? Yes, there is a huge sense of bereavement, and I find it difficult to think of my profession in which I have invested so many years marching on without me. However I do not miss the exhaustion, frustration, constant reorganisation of the health service, staff shortages, and shift work; but the essential business of midwifery, and the wonderful, talented, generous spirited professional people who are the NHS, I shall always miss.