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Maternity care in action~ Antenatal Care

A report of a conference held at the King's Fund Centre on 10 February 1983 edited by Imogen Pennell

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King Edward's Hospital Fund for London

MATERNITY CARE IN ACTION - ANTENATAL CARE

Report of a conference held at the King's Fund Centre on 10th February 1983

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MATERNITY CARE IN ACTION - ANTENATAL CARE

Report of a conference held at the King's Fund Centre on 10th February 1983, to discuss the first report of the Maternity Services Advisory Committee, "Maternity Care in Action - Part I - Antenatal Care".[1]

The MSAC's report on antenatal care suggests ways in which health authorities and the professions can examine their current activities, with a view to making the best use of the skills and resources available in hospitals, community services and general practice to provide a more personal and satisfying service for all concerned.

The purpose of the conference was to consider how health authorities and the professions could "take on board" the guidelines contained in the report.

Chairwoman's introduction Jean Coussins, Chairwoman of The Maternity Alliance and Deputy Director of The Child Poverty Action Group

Ms Coussins opened the conference by welcoming "Maternity Care in Action", the first report of the Maternity Services Advisory Committee (MSAC). Her first thought on reading the Report was that it was in danger of doing herself and all her pressure groups colleagues out of a job ! She commended it as a constructive and imaginative document, notable for its plain English and a readable style unfamiliar in DHSS publications.

Jean Coussins praised the Report for giving specific thought to the underprivileged groups of women that pressure groups are particularly concerned with. Similarly, it recognised the importance of welfare rights. She hoped that everyone would take their cue from the Report and she felt very encouraged by its whole tone and detail - though there were naturally a few controversial areas. The conference should be seen as part of a continuum from the Report, bringing us closer towards implementing its recommendations.

Particular thanks were due to Alison Munro, who had chaired the Maternity Services Advisory Committee with such success, as well as to the rest of the Committee - which included two other lay members. Together they had produced a dramatic and positive Report. Ms Coussins then introduced Mrs Munro, the first speaker of the day, to discuss issues raised in the Report and how best to implement its guidelines.

"Maternity Care in Action : Part I - Antenatal Care". Implementing the guidelines. Alison Munro, Chairman of the Maternity Services Advisory Committee and Chairman of Chichester Health Authority.

Mrs Munro began by observing that there was no lack of reports on maternity care from every interested organisation. Why, then, had the DHSS seen fit to establish the Maternity Services Advisory Committee? The impetus had come, she said, from the Short Committee many of whose members believed that Departmental initiative was vital if anything was to be achieved in this field. There were also growing pressures from two other quarters. First, despite improvements in the perinatal mortality rate it was still too high, particularly in comparison with rates achieved by other western countries. Secondly, people like Jean Coussins - representing numerous consumer pressure groups - were getting through to ministers. So, despite some initial reluctance, the DHSS decided in the summer of 1981 to set up the Maternity Services Advisory Committee.

The composition of the Committee

The Committee consists of three consultants and two professors - representing both obstetrics and paediatrics - and two general practitioners. There are seven midwives representing every level in the nursing hierarchy from R.H.A.s down to the grass roots, and one is a health visitor. There is a regional treasurer, a district administrator, a district medical officer, Mrs Munro herself as Chairman of a health authority and two lay representatives. The wide geographical spread from which Committee members were drawn reflected the range of antenatal performance found in England and Wales.

Mrs Munro reported that there was, at the outset, a considerable clash of professional interests and an attempt to establish roles. The consultants in particular saw the Committee as a lever for increasing resources, but Mrs Munro took the view that if the Report over-concentrated on resource needs at a time of great financial pressure throughout the NHS, the Committee's recommendations would simply be shelved.

Reviewing the evidence on antenatal care

The MSAC started from the assumption, shared by the bulk of professional opinion, that there is a clear correlation between on the one hand perinatal death and the incidence of handicap, and on the other, the failure to take up

antenatal care - or take it up soon enough. The Committee was not short of advice about why women were reluctant to take it up. Lay organisations revealed an enormous groundswell of feeling about this. Nobody, asserted Mrs Munro, can put their head in the sand and hide from consumer criticism of the maternity service. It is very strong and there is some foundation for it.

Numerous accounts have been published by women of the dreadful experiences they have had when visiting hospital antenatal clinics. The main criticisms were that clinics are often inaccessible, expensive in travel cost and very impersonal. Women are treated like statistics, waiting for long periods, often with small toddlers and nowhere for them to play under supervision. Women are sent to and fro for tests and, when it finally comes, the consultation was often brief and unsatisfying. Underlying everything was the complaint of a lack of personal interest by doctors and midwives. Women rarely met the same staff twice and, when they did, staff had no time to listen. Mothers were leaving the consultation in tears and frustration because it had failed to satisfy their needs.

Some groups, notably the poor and the ethnic minorities, are particularly ill-served by the maternity service. Nor has health education in schools succeeded in conveying the value to mother and baby of antenatal care and early confirmation of pregnancy.

The Maternity Services Advisory Committee's commitment to change

In Mrs Munro's experience, the Health Service is rich on theory and very poor on action. Yet she was determined that her Committee would bring about changes in antenatal care. She pointed out that many excellent reports on different care groups have been published in recent years but, being big and expensive, they go largely unread even by health authority members. Hence Mrs Munro's determination to produce a slim report that everyone can read from cover to cover, at a price every authority and professional group can afford. The aim was to outline the basic elements of good practice and provide a checklist that everybody - lay or professional - can use as a guide to action in their own district.

Redressing the balance between hospital and community services

The main trend identified by the Committee was the enormous shift of maternity care from G.P. and local clinics into the hospitals. Consequently hospital staff and clinics have become grossly overloaded and the professionals involved have been unable to give a sufficiently caring service. At the same time G.P. and midwifery skills in the community have been seriously eroded. General practice in some inner urban areas may be underdeveloped, with elderly single-handed G.P.s relying heavily on deputising services, but elsewhere many G.P.s are now committed to achieving high standards of maternity care. Those who are motivated, trained and up-to-date are capable - in association with the midwifery service - of taking a greater responsibility for the "low risk" mother and giving a much more sensitive service.

It was clear to the MSAC that a local organisation was needed to evaluate the local resources both in hospital manpower, and among interested G.P.s and the midwifery service, to examine ways of spreading the load more evenly. Thus hospitals could concentrate on providing specialist services for women at risk, while routine antenatal care could be dispensed in the community. To oversee this - and the other recommendations for change made in the Report - the MSAC urges that a Maternity Services Liaison Committee be set up in every district. Mrs Munro pointed out that this is also strongly supported by both the Royal College of Obstetricians and Gynaecologists and the Royal College of Midwives.

Confirmation of pregnancy and initiation of care

The Report emphasises the importance of confirming pregnancy early and introducing women to the antenatal services as soon as possible. However, Mrs Munro said she was amazed at the inadequacy of current provision for pregnancy testing. G.P.s are apparently reluctant to do tests themselves as costs are not reimbursed. Incredibly, many G.P.s still send patients away until the pregnancy can be detected by physical examination. If there is evidence of lateness in either **a)** confirming pregnancy or **b)** between getting it confirmed and going for an initial assessment, authorities need to know whether the fault lies with the G.P. or the hospital.

Mrs Munro said that alternatives must be available for women - especially young girls - who do not want to see a G.P. Are family planning clinics

and the midwifery service well-known to women and ready to help? The MSAC had looked at the do-it-yourself pregnancy testing kits sold by chemists. It would cost very little, Mrs Munro suggested, to have a leaflet with these kits informing women about the possibility of inaccurate results, the need for early confirmation and where to go for help. All these factors must be investigated by local liaison committees.

The initial assessment

It does not really matter who does the assessment as long as there is local agreement. The Committee was more concerned about what it should cover. The object is to draw up a provisional plan of each woman's medical and social needs. The definition of medical risk must be agreed locally by clinical consensus. This would determine which women should be seen continuously in hospital. The Committee drew attention to the many risk factors which are social rather than medical and are more amenable to treatment by the G.P., midwife or health visitor in the community (e.g. heavy smoking, drink and drug problems or nutritional deficiencies). Finally, many risks arise only during labour and in such cases there is no reason why all the antenatal care should be undertaken by the hospital.

The Committee placed great emphasis on defining the needs of the 'whole woman', urging that she be involved in formulating the provisional plan for her antenatal care - and for labour and delivery too. The mother must be active in her own care and unless her views are taken seriously her cooperation cannot be assumed. Against a background of a widespread consumer criticism, the impression that the initial assessment makes on a woman is crucial.

Subsequent care

There is no doubt, said Mrs Munro, that where a woman is at low risk the G.P. is in an ideal position to care for her in her total home and family circumstances. The Report also emphasises the midwife's role as a professional in her own right rather than the hand-maiden of the doctor. Midwives themselves wanted to get away from a task orientated role as form-fillers and specimen collectors. They wanted the opportunity to care for the 'whole woman' and knew that they could meet the mother's need for discussion and reassurance better if they did so. The Committee felt that

far more of the antenatal care of low risk women should be entrusted to midwives.

Unfortunately, said Mrs Munro, 'shared care' is an area where complacency abounds. Much of it is, in reality, compartmentalised care. Women themselves are acutely aware of the lack of rapport between specialist and G.P. Continuity can be achieved only through a conscious effort to understand each other's role and by improving communications.

In cases where the hospital does the bulk of antenatal care, the Committee was keen to see the development of peripheral clinics - i.e. taking the hospital out into the community.

Mrs Munro stressed the importance of antenatal education. It should give a woman the opportunity to discuss her own wishes regarding childbirth with the staff as well as informing her about the practices they normally adopt. She should have a full understanding of any test being offered and have the right to refuse it.

Organisation of hospital antenatal clinics

Even in a fairly well-run clinic, Mrs Munro had been amazed at what the average woman puts up with without complaint. In Checklist D the Report sets out to remedy the familiar deficiencies - e.g. in the general environment, provision for children, the booking system - so that everyone can review facilities in their area.

In conclusion, Mrs Munro warned of the enormous built-in inertia in the health service. Change will only be achieved with inspired leadership and enthusiasm. She urged conference participants to seek out an enthusiast to chair their local Maternity Service Liaison Committee. Finally, Mrs Munro called on every member of a health authority or C.H.C. to take their cue from the Report and actively seek improvements in antenatal care in their area.

Questions and discussion

Discussion centred on the respective roles of general practitioners and community midwives. The opening speaker, a G.P. obstetrician for thirty years, said he was convinced that women wanted personal service by personal doctors in personal surroundings. Women needed to know that if their own G.P. does not provide antenatal care, they can go to another doctor for this service without prejudice. But another contributor, from the National Childbirth Trust, claimed that newly pregnant women should have access to much more information than this. If they knew all the choices open to them before their first visit to a doctor, they could deal more confidently with the unenlightened G.P.s who tend to assert their own preferences for care, pre-empting a woman's own choice.

Another speaker questioned the assumption that G.P.s are necessarily best placed to give antenatal care in the community. She said it was a myth that women knew their G.P.s - especially young women expecting their first baby. Such women were more likely to form a relationship with a midwife, yet midwives are accessible only through a doctor.

A representative from the Royal College of Midwives said it was totally impractical in staffing terms for a midwife to be attached to the average G.P. with 20 to 30 pregnancies per year. She acknowledged the need for midwifery liaison with G.P.s, but believed that community midwives should have their own clinics to which G.P.s can refer. Only in this setting were midwives likely to achieve the special relationship that they can offer to women, listen to their problems, support them and provide the information they need. These midwives should have the right to refer patients to the consultant in an emergency, keeping the G.P. informed. Another speaker who supported midwife-run community clinics suggested that they would be particularly useful in areas with poor standards of G.P. antenatal care. She was curious to know the objections of consultants and G.P.s to this idea.

Dr Gordon Taylor (MSAC) put a G.P. view. He said that patient needs could best be met by the primary care team of G.P., midwife and health visitor working together. Midwives should indeed have a fuller role but if they move outside the primary care team isolation will occur, as well as the ethical problems of direct referral.

Next, a consultant obstetrician commented that his colleagues saw no role for midwives apart from G.P.s because care would be too fragmented.

A researcher from the Polytechnic of North London, who is completing a survey of maternity care in the community, remarked that many of the women she interviewed felt too inhibited to talk freely with the midwife when they saw her in the presence of the (male) G.P.. Moreover - despite the good intentions of the doctor - this situation is also inhibiting for the midwife. Hence if the best use is to be made of midwives it is important that they see women separately, and in many surgeries this is not physically possible.

The Chairwoman of a F.P.C. (and wife of a doctor) thought that more G.P.s would undertake shared care if they knew they could do their own deliveries. But in her experience, consultants are too ready to take G.P. patients over and consequently G.P.s feel they are unable to practice proper maternity care. Alison Munro said that G.P. beds in hospitals are often underused but that if doctors want to do more obstetric work this should be discussed by the local Maternity Services Liaison Committee.

Mrs Munro observed that much of the discussion had centred on the issue of "roles", as it had earlier on the MSAC. The Committee endorsed the joint Report of the RCOG and RCGP advocating the development of G.P. obstetric training. Mrs Munro noted, however, that the modern G.P. has a rather different role from the old 'family' doctor, particularly in relation to young women. Local MSLCs should be able to identify which G.P.s are keen on maternity work - Mrs Munro's own research had revealed that many G.P.s claim fees for antenatal care though they are actually doing very little.

In answer to a query about how to achieve commitment to change in the Liaison Committees, Mrs Munro replied that motivating the Committee is crucial to implementing the Report. It does not matter who chairs the committee as long as he or she is an enthusiast.

The theme for the next part of the conference was antenatal care in hospitals, in which two speakers - a midwife and an obstetrician - described recent innovations in antenatal care at their respective hospitals.

The midwife's contribution to antenatal care in hospital Caroline Flint, Antenatal Clinic Sister, St. George's Hospital

At present, began Mrs Flint, maternity care is a medical experience with social implications whereas it should be seen as a social experience with medical implications. She welcomed the MSAC Report's potential for bringing the services that the professionals provide more into line with the care that women themselves want.

The task of antenatal care should be to consider the 'whole woman' and to befriend her. You don't rush in and palpate someone's abdomen when you first meet them. You talk to them. In her own clinic, Mrs Flint and her staff have been revising their procedures by thinking of the pregnant woman more as an honoured guest to be welcomed than as a patient to be booked. Using the analogy of friendship as a guide to good practice they invite a woman along, ("hello ... looking forward to seeing you ... here's how to get here ... here's what's going to happen ..."). When she arrives the midwife greets her, offers her a drink then they sit down together and take time getting to know each other. At St. George's there is a list of questions designed to help the midwife get to know each woman.

The midwife begins by introducing herself and, as Mrs Flint demonstrated, the terms in which this is done tend to determine the relative formality or intimacy of the ensuing relationship. Each woman is then asked what name she would like to be known by. The next few questions are about her family support and her past conditioning to childbirth:

- What size family do you come from?
- What sort of births did your mother have?
- Did she breast feed or bottle feed you all?
- Do your family live near to you?
- Will they help you at all when you come out of hospital after the baby is born?

The answers to these questions reveal important differences in attitude.

- What about your job - will you be going back to work after the baby is born ?
- How do you feel about that ?
- What about where you are living - have you enough room for a baby and is it alright to take a baby back there ?
- What about this pregnancy - how did you feel when you realised that you were pregnant ?
- What about now - how do you feel about it now ?
- What about the baby's father - how did he feel about it ? And now ?
- What about your family - how have they reacted to your pregnancy ?

These questions should elicit any doubts about the pregnancy and indicate the degree of support or aloofness of others involved.

- Have you had anything to do with babies and little children before ?
- Have you been in hospital before ?

The answers may reveal anxiety - or easy familiarity.

Asking, "were you ever away from your mother when you were little ?" can help to pinpoint women with disturbed patterns of mothering in their own lives.

It is important to take a serious interest in a woman's own views about labour and birth and ask

- Is there anything worrying you about being in hospital ?
- What about labour - is there anything special you are hoping for ?

Finally, Mrs Flint would ask "Is there anything else you would like me to write down about you?"

Mrs Flint went on to show some slides to illustrate how her clinic at St. George's is organised to provide more women-centred antenatal care.

The first slide showed a volunteer selling tea and coffee from a stall. A poster on the wall behind seeks more volunteers, as the clinic has to depend on them for many of its humanising touches.

A number of activities are provided to make good use of any waiting time. Books on various health topics are available for women to read, and books are also provided for children. A tour of the wards is laid on at every clinic. The clinic also has a display of models showing the physiology of reproduction, along with other health education material, nutritional charts, etc. Audio-visual aids are also laid on - usually in the form of a film. There is also a stall selling nearly-new baby clothes and a creche where children can play is run by volunteers. Each woman gets a personal welcome from the midwife, who sits down to explain what will happen at the clinic today. New mothers are invited back to the clinic to talk about their experiences of having a baby to a group of prospective mothers. One of the aims throughout is to try to make contacts between the women attending the clinic. To help create a friendly atmosphere, the chairs in the waiting area are arranged in circles.

Mrs Flint explained that 120-130 women attend each clinic and that 38-40 per cent of them are seen only by midwives. She envisaged an increasing sharing of responsibility between doctors and midwives in the future. Her role model was the general practitioner obstetrician because, she said, when he does it well, he does it beautifully. His patients are not 'processed' because everything happens in one room. Mrs Flint's clinic had likewise tried to ensure that the whole consultation takes place in one room. She believed it was good practice to observe a woman as she enters the room, to note her build and demeanour. Weighing her provides the opportunity to discuss what she is eating; while checking her blood pressure you can ask how much she is resting.

Mrs Flint said she was re-appraising the role of the consultant at the antenatal clinic. She believed that junior doctors and midwives should be

doing the consultations but have access to the consultant for guidance when necessary. A 'consultant' midwife could play an analogous role.

From April 1983 Mrs Flint will be leading a team of four midwives practicing total continuity of care (i.e. giving all antenatal care, delivering and caring post-natally) for 200-250 women a year. In her view, without such total continuity, no one stage of maternity could ever be satisfactory. To achieve this, the midwife must be free to exercise to the full her combination of medical and social skills. She is the key to humane woman-centred care.

Questions and discussion

A discussion arose about the perennial problem of 'waiting' and how to improve time-keeping among medical staff. Mrs Flint said she had tried 'nagging' the doctors to come on time and starting clinics later, but with little success. She was now attempting to reorganise the appointments system according to the time women actually 'go in' rather than basing it on hypothetical targets. A speaker from Chelmsford described a very effective approach adopted in her area, where the medical photographer made a video recording of a session at the antenatal clinic. This fly-on-the-wall view of women's actual experience had more impact on the District Management Team than any verbal arguments.

Lessons from St. Mary's Richard Beard, Professor of Obstetrics and Gynaecology, St. Mary's Hospital

Professor Beard began by promising that his talk would be less sanctimonious than the title suggested! He went on to say that from its origins at the beginning of this century the objectives of antenatal care have never been properly defined. It has therefore been difficult to judge its effectiveness. He believed it was a first class example of preventative medicine. In the past it was clear that of women who presented with medical problems, antenatal attenders seemed to do better than non-attenders. At the same

time it was not appreciated that those who attended were usually of a higher social class, more highly motivated and, not surprisingly, they had a better outcome.

Professor Beard defined the objectives of antenatal care as an attempt to ensure that "the physical and emotional wellbeing of the mother is maintained throughout pregnancy, and the health of her baby". He believed that the emotional environment of pregnancy was a very important concern of antenatal care. This was a tendency these days to concentrate on the physical environment at the expense of the emotional environment.

Factors contributing to a good emotional environment include: a supportive partner, the absence of adverse socio-economic factors (housing, salary, etc.), supportive professionals who are sympathetic and understanding, and a good clinic environment. A bad emotional environment, on the other hand, is characterised by an absence of support from partner or family, poor socio-economic conditions, social isolation, unfriendly clinics, prolonged separation of mother and new baby. The importance of all these factors can be appreciated when they are translated into physical terms. Animal studies have demonstrated that anxiety produces abnormal function of the uterus, which can lead to prolonged labour and may even result in foetal asphyxia due to constriction of the blood vessels. An important article was published in 1980 from a study of 28,000 deliveries in a Guatamalan hospital.[2] There were two groups of mothers, those who had a friend or husband with them during labour, and those who did not. The difference in outcome was staggering, with accompanied women having shorter labours, fewer caesareans, less foetal distress, etc.

The dilemma of modern antenatal care, said Professor Beard, is that the physical setting of the hospital is best able to provide investigative facilities and expertise but is ill-suited to provide for a woman's emotional wellbeing. A local clinic or G.P. obstetrician is much nicer from a woman's point of view, but there are ways of improving the hospital to meet her emotional requirements more effectively. Clinics must be as friendly and inviting as possible to create a feeling of trust and security in the mother. Professor Beard went on to outline the main defects of the present system of hospital antenatal care:

1. There are too many visits per woman (often 14-16), resulting in overcrowded clinics, poor continuity of care and very brief consultations.

2. Antenatal classes are poorly attended, usually because they lack interest and objectivity.

3. In-patient care is often used for complications of pregnancy which could be managed on an out-patient basis.

4. Most clinics are poorly designed and decorated.

However, Professor Beard pointed out that obstetric care in the community also has many deficiencies. A dedicated G.P. is ideally placed to provide antenatal care but for historical reasons many G.P.s have opted out. Others continue to provide a poor quality service because there is, unfortunately, a financial incentive to do so. Shared care usually fails because there is no integration between the G.P. and hospital systems, and the mother fails between the two.

Professor Beard then began to describe ways in which his own hospital had been trying to solve some of the problems he had raised.

1. <u>Reducing the numbers attending the clinic</u>

There are three approaches to this -

(i) to reduce the frequency of visits to the hospital antenatal clinic. Marian Hall from Aberdeen has shown that women with uncomplicated pregnancies need 6-8 visits at most (and fewer still for multiparous women);[3]

(ii) increased development of shared care;

(iii) development of peripheral clinics as in the Sighthill initiative.[4]
Professor Beard had planned to set one up but solutions (i) and (ii) were working so well that it was considered unnecessary.

The Professor spoke of the need to develop an agreed programme of shared care with G.P.s and he showed a slide to illustrate his own. The aim was (a) to time visits to key stages in pregnancy and (b) to seek genuine shared care by alternating visits between G.P. and hospital:-

	CARE BY WHOM	PURPOSE
1st visit	G.P.	Diagnosis and counselling
2nd visit (within 2 weeks of 1st visit)	HOSPITAL	Booking, screening, risk selection
16 weeks	G.P. (Hosp. if amnio. required)	
20 weeks	HOSPITAL	For early interuterine growth retardation
26 weeks	HOSPITAL	Screening for diabetes
30 weeks	G.P.	Routine (blood pressure and urine)
33 weeks	HOSPITAL	Assessment for malpresentation
36 weeks	G.P.	Routine
38 weeks	HOSPITAL	Pelvic assessment. Mother's attitude to labour determined
39 weeks	G.P.	Routine
Term & thereafter	HOSPITAL	Routine
4 weeks postnatal	G.P.	Pelvic examination and contraceptive advice.

This system had greatly reduced crowding at Professor Beard's antenatal clinic and meant that about 80% of the women attending had to wait no longer than 20 minutes. The main problem had been lack of interest among local G.P.s. However, a few were very enthusiastic, had attended joint meetings and had been offered diagnostic facilities in the hospital.

2. Continuity of care

Professor Beard remarked that while continuity of care certainly produces the most satisfied mothers, it is difficult to achieve because doctors are in short supply and rapid turnover is built into the system. However, at St. Mary's it has been possible to attach a midwife to every consultant clinic and ensure that all low risk mothers see her throughout their pregnancy.

The Professor believed that ideally staff should be specially selected for work in the antenatal clinic, as some are much better at communicating than others. This had worked in the case of midwives but, again, was not feasible for doctors because of the current need to use anyone who is available.

St. Mary's have introduced a system whereby every mother carries her own complete medical notes. As a result fewer notes go astray, and women like it because they feel more involved in their care. This involvement is further encouraged through a booklet issued by the hospital to all mothers. It stresses the flexibility of the hospital's approach so as to comply with individual wishes, while also explaining the normal routines. A major section is devoted to answering common queries. Such a booklet, commented Professor Beard, allows women to understand hospital procedures, formulate relevant questions, and make informed choices.

The Professor went on to talk about the large number of mothers attending St. Mary's who have emotional problems and the 28% who are unmarried. He considered that creating the conditions for discussing personal problems was a vital part of antenatal care. Hence the importance of making women feel welcome at the clinic. A woman's social circumstances are recorded in her notes - e.g. What are her plans for work ? Was the pregnancy planned ? What was her reaction ? What was her main social support ? What kind of accommodation did she have ? What was her experience in any previous confinement ? Social workers play a major counselling role at every clinic, and afterwards all the staff meet together to discuss problems that have arisen.

To conclude his talk, Professor Beard described how changes had been initiated in his own hospital. With so many staff involved every innovation needs

interminable discussion. At St. Mary's the form for discussion is a working group consisting of the obstetric and paediatric consultants and representatives of the junior doctors, midwives, G.P.s, social workers etc. They meet once a fortnight at 8 a.m. Despite some initial grumbles, attendance is excellent - as everyone is afraid of missing something - and much progress has already been made.

Questions and discussion

There was some discussion about the difficulties of attracting women from ethnic minorities to antenatal classes. Professor Beard acknowledged that it is a problem 'we have not yet begun to solve'. However, Lady Limerick (a lay member of the MSAC) drew attention to a new book. 'Health in the Round - Voluntary Action and Antenatal Services'.[5] This contains many examples of ways in which volunteers - working with professionals in the NHS - have been used to meet the antenatal needs of ethnic and other minority groups. Lady Limerick felt that the book would provide useful ideas to others wanting to tackle this issue.

A representative from the Royal College of Midwives asked Professor Beard what sort of introduction junior medical staff are given when they first come to work in his antenatal clinic. She reported that in many maternity units this task was either left to the sister in charge or neglected altogether. This often leads to problems of communication and practice between doctors and mothers. The speaker thought responsibility should lie with senior medical staff.

In reply, Professor Beard said that at St. Mary's a letter is sent to new staff, with a checklist of about 20 items which they are required to attend to within the first two weeks. They are asked to meet the clinic sister, social worker etc. and are given introductory talks. The problem is that the present system demands that junior doctors are thrown in at the deep end, with full responsibilities from the start. The Professor thought that a week of acclimatisation was needed while a doctor learns how the clinic works. This would have to be hammered out with the administration.

In answer to a query about the need for duplicate copies of medical records carried by mothers, Professor Beard said various solutions are possible. In complicated cases (e.g. diabetes) at his clinic records are photocopied. Computerisation was particularly helpful and enabled the hospital to send G.P.s a full summary of every pregnancy.

There were three speakers to take up the theme of antenatal care in the community, a General Practitioner, a Director of Midwifery Services and a Health Visitor.

General Practitioner care Gordon W. Taylor, General Medical Practitioner, Reading and a member of the Maternity Services Advisory Committee

Dr Taylor's first theme was the aim of antenatal care "to ensure as far as possible the health and wellbeing of the woman and the unborn child". No personal prejudices or professional jealousies must affect this aim. He was joint author of a West Berkshire study which had produced a document, 'How safe is G.P. Obstetrics?', this compared low risk patients booked in G.P. maternity units with similar series in other areas without G.P. units. [6] It is no good promoting G.P. obstetrics because it is congenial to G.P.s unless it is known to be safe and in the patients' interest.

The second theme was that cooperation is crucial in antenatal care. Success depends on (a) professional cooperation between consultant, G.P. and midwife, and (b) cooperation between patients and the professionals. Here Dr Taylor reminded strong supporters of consumerism that litigation destroys trust and threatens liberty. The American situation, where confrontation predominates, is inimical to good health care. Dr Taylor believed that cooperation was vital.

His third themes was the pressure on clinics and the need for greater flexibility in the use of professional staff. One result of focussing antenatal care in hospital clinics is that "staff may concentrate on the routine physical examination at the expense of their other functions" (1-7 in the MSAC Report). Dr Taylor warned against hiving off this work to primary care for administrative

convenience. G.P.s believe in family medicine and the continuity of care they can provide so naturally. The good G.P., midwife and health visitor have between them an enormous wealth of information about their patients' social and personal circumstances - information that hospitals are now talking about collecting. Dr Taylor welcomed efforts to make hospital labour wards and clinics more "homely", but he believed that home and the community are the natural place for natural events to take place. Hospitals could not compensate for this when their primary function is to provide specialised clinical care for difficult cases. It is a different attitude - and has to be.

Dr Taylor's fourth theme was the role of the G.P. in the initiation of care. The MSAC Report stresses the key role of the primary care team but on the matter of pregnancy testing in particular, he criticised the lack of support from both the Department of Health and the districts. His own district had recently sent out a letter stating that routine pregnancy tests were being abandoned through lack of money. Adequate provision was essential, said Dr Taylor, if G.P.s were to be effective and meet the just needs of their patients.

Dr Taylor then drew attention to paragraph 1.10 in the Report, on the importance of tapping the midwife's skills. It also cites a basic tenet of British medical practice - referral - in which the professional has a certain amount of expertise which is used to its limit, at which point someone with greater expertise is brought in. The midwife should play a much greater role in low risk pregnancies. Dr Taylor also drew attention to paragraph 3.8, which indicates the degree of autonomy that the primary care team should expect in relation to the consultant.

The fifth theme was subsequent care. Paragraph 4.1 in the Report refers to the high proportion of routine antenatal examinations taking place in hospital and the unsatisfactory conditions which result. Yet it is totally unnecessary for 120-150 women to be herded into a hospital clinic and waiting 2-3 hours, commented Dr Taylor, when it is so easy to organise antenatal care in the primary health setting. The average G.P. with a list of 2,200 has some 20-25 pregnant women in his practice each year. If each visited him ten times, the family doctor needs to see only five patients per week in an antenatal clinic to satisfy the total antenatal requirements

of his patients.

Statistics show that a large proportion of expectant mothers already receive some antenatal care from a G.P.. The real question, according to Dr Taylor, concerns the quality of care they are getting and the ratio of hospital attendance to G.P. care in a shared care arrangement. As a G.P.'s fees for antenatal care are not paid on an item of service basis, it requires a conscientious approach to provide the best shared care.

Theme six was intrapartum care. Paragraph 4.12 in the Report refers to "the importance of maintaining skills by continuing to manage an adequate number of deliveries". Dr Taylor argued strongly that if the policy of closing G.P. maternity units without offering proper alternatives continues, it will not be possible to provide a really good shared care service. G.P. obstetrics had been well nigh squeezed out in recent years. Dr Taylor urged that the policy enunciated by the RCOG and RCGP and supported in the MSAC Report - that there should be facilities for G.P. intrapartum care in every district in Britain - be taken seriously and implemented.

In the remaining time Dr Taylor went on to relate his six themes to the situation in West Berkshire. He wanted to destroy the myth that it is a county populated by gentry. It has problems like anywhere else. Reading is a busy commercial centre with an expanding population of 110,000. It has a high crime rate and a high rate of drug abuse. Anything achieved in the field of maternity care is not, Dr Taylor maintained, due mainly to some geographical advantage.

In 1968 West Berkshire produced a guide to good practice, which in effect became a booking policy. With a perinatal mortality rate of 35-40 per 1000, the area was a black spot in the Oxford Region, and consultants, G.P.s and midwives got together to consider what they could do about it. They recognised that some G.P.s were booking high risk cases into G.P. maternity units, and so produced a booking policy. This was updated in 1980. According to Dr Taylor it remains a comprehensive and extemely valuable guide. He regretted that in many areas G.P.s and consultants still had not got together to formulate a proper booking policy.

Dr Taylor felt that in West Berkshire good cooperation between the professionals had created an integrated service. The agreed booking policy

initiates care. Primigravid referral is advised but patient choice is respected. There is an understanding that referral to a consultant clinic does not necessarily mean a transfer of booking. Sometimes transfer is in reverse - the consultant may refer a low risk patient back to the G.P. for G.P.M.U. delivery. The consultants or their team members visit the G.P. units to see their patients, and give advice if problems arise in G.P. cases. There are also occasional meetings between consultants, the District Medical Officer and G.P.s to discuss more general problems.

There are four G.P. maternity units in West Berkshire, one at the Royal Berkshire Hospital and three peripheral units 8-20 miles from the consultant unit. Last year these four G.P. maternity units had 726 deliveries out of a total of 4,329. In 1982 the overall perinatal mortality rate for West Berkshire was 7.49 per 1,000 - one of the lowest in the country. There was no stillbirth or perinatal death on any of the G.P.M.U.s during the year. Dr Taylor would not have it said that it is dangerous to book with a G.P. for confinement - the evidence shows that it is safe.

Questions and discussion

Most of the discussion centred on the problem of how to raise the standard of G.P. antenatal care. The first speaker acknowledged the achievements of good primary care teams but thought they were rather uncommon. She pointed out that many inner urban areas have single-handed, elderly G.P.s and asked how standards could be improved when refresher courses are not compulsory (as they are for midwives every five years). If we want to revitalise community care, she said, an urgent task is to address the issue of inadequate general practice. A midwife manager concurred. Single-handed G.P.s presented enormous problems. In her last post she was responsible for supplying midwifery support to 120 G.P.s with just 14 community midwives.

Professor Beard said that concentrating maternity services in hospital had undermined G.P. skills and most have lost interest. Younger G.P.s must be encouraged to qualify in obstetrics and take refresher courses. Dr Taylor maintained that the vast majority of junior doctors are vocationally trained, taking a six month obstetric post and going on the obstetric list. New arrangements for the operation of the obstetric list put strong pressure on

doctors to attend refresher courses.

In answer to another question, Dr Taylor said that there were 18 home confinements in West Berkshire last year. Booking policy was opposed to home deliveries but there is a list of G.P.s willing to look after patients requesting one against medical advice. Dr Taylor thought that there was little demand for home births in his area because most women are satisfied with the choice offered by the G.P. unit.

The final contribution concerned income support. Over 60,000 babies are born into families on supplementary benefit and the number is growing. The speaker believed that the whole primary care team should take greater responsibility for informing pregnant women not only about financial entitlements, but about free milk and vitamins - for which the take up rate is only six per cent.

Making effective use of midwive's skills Isobel Waterhouse, Director of Nursing Services (Midwifery), West Berkshire Health Authority

In West Berkshire all community midwives are attached to G.P.s, said Miss Waterhouse, but unfortunately not all practices have an attached midwife. This is partly a problem of resources but also because there are G.P.s who do not recognise the skills of the midwife or the contribution she could make to their team.

Most pregnancies in West Berkshire are diagnosed by the G.P. and the information passed to the midwife. There are no innovative schemes for confirming pregnancy and the Maternity Services Advisory Committee's Report caused Miss Waterhouse and her colleagues to look at this. Midwives and health visitors are now discussing the possibility of jointly providing a phone-in service to give information to women about what facilities are available. Occasionally women are referred to the midwifery service from other sources, such as social services. These mothers are often not registered with a doctor and the midwife will help her join a G.P.'s list. The family planning service also alerts midwives to the need for antenatal care among their clients.

Miss Waterhouse went on to question the assumed link between initiation of care and booking for confinement. She believed that the traditional concept of booking is becoming outmoded. It is used in all sorts of ways. A patient books for a consultant unit, G.P. unit for home confinement but her initial booking often bears little relationship to the actual place of delivery. The consultant unit complains of late bookings but this does not imply negligence on the woman's part, just that she has been getting her antenatal care elsewhere in the service. Some women book for the consultant unit and with monotonous regularity deliver themselves at home. Miss Waterhouse suggested that instead of booking for a specific type of delivery that may be against the wishes of the mother, it was preferable to care for her within an integrated service in the way most acceptable to her and to deliver her in the most suitable place according to the circumstances at the time.

Initial assessment plays a very considerable part in the care of a pregnant woman. The extensive information that is ideal for patient care is, said Miss Waterhouse, best gleaned in the informal surroundings of the mother's own home. Moreover, this early visit establishes a relationship between the mother and community midwife, and increases a woman's confidence in the service. Miss Waterhouse wanted to see a system in which every booking history would be taken in the home rather than interrogating flustered patients in the impersonal atmosphere of a clinic.

In a large area such as West Berkshire, antenatal care varies considerably both according to obstetric need and the relative skills and experience of G.P.s and midwives. Because some G.P.s see no need for a midwife in their clinic, some antenatal care is carried out by midwives in the patient's own home. Other G.P.s leave all antenatal care to the midwife while claiming the fee for this care. As a manager, Miss Waterhouse thought this money would be better spent on the midwifery service. At present some midwives play a very full role in G.P. antenatal care while others are confined to urine testing, weighing and clerical duties. One G.P. told Miss Waterhouse that he needed a midwife because he had neither a receptionist nor a chaperone.

In West Berkshire all pregnant women are visited at home by the midwife at least once, but more visits are made to those who do not see a midwife at the G.P.'s surgery so that the mother knows and has confidence in the midwife who will care for her post-natally. In cases where a woman fails to attend

the clinic the community midwife will visit her to discover the problem and, at the same time, carry out antenatal care. This happens particularly where women live in remote outlying villages and transport is difficult.

Miss Waterhouse then described recent developments in antenatal care in West Berkshire which make clinics more accessible to a scattered population. Two of the G.P. units - one very remote - now hold consultant clinics to provide care throughout pregnancy. This has been achieved with very little money but considerable ingenuity from the midwives. The visiting consultants have greatly helped to cement the team approach and enable G.P.s and midwives alike to be fully conversant with developments at the consultant unit in Reading. Another benefit to the patient is that where there are areas of doubt, consultant advice can be sought on the spot without making a consultant unit booking. The growing confidence of consultants in the abilities of community midwives had led to a considerable reduction in the number of antenatal patients in the wards. Now, when a woman has raised blood pressure at the clinic, the midwife visits her at home to keep a check on it, liaising with the consultant as necessary.

One area in which West Berkshire midwives play an increasing role is with women who fight for the right to a home confinement. Miss Waterhouse said it was very common to find that it is not so much a home confinement that they want, as a more flexible service than they think will be available in hospital. A home delivery is never refused but they are rare because through discussion it becomes clear that the kind of experience women are seeking can be satisfactorily provided within existing institutions.

The aim in West Berkshire is to decentralise antenatal care so that the only women attending the antenatal clinic are ones who really need to see the consultant. It would therefore be counterproductive, Miss Waterhouse believed, to start a midwives clinic in the consultant unit.

She concluded that "Maternity Care in Action" had given a major impetus to changes already under way in West Berkshire.

Questions and discussion

There was some discussion about the difficulty in achieving continuity of midwifery care - particularly at confinement itself - when staff work on a rota system. A further hindrance is the rigidity of health district boundaries within which midwives have to practice. It was agreed that geographical integration of midwives and G.P.s was needed to improve both continuity of care and professional cooperation.

One participant was concerned about Miss Waterhouse's comment that some doctors claim fees for antenatal care they do not provide. He suggested that, if true, such a misuse of public funds was a matter for the Family Practitioner Committee or even the Director of Public Prosecutions. In response a midwifery supervisor recalled a personal experience of inadequate care by a G.P., with responsibility being assumed by the midwife. When the supervisor reported this to the local F.P.C. she discovered that the Committee could not accept a complaint from another professional - it had come from the public. Miss Waterhouse then confirmed similar experiences, commenting that at present midwives do not have much redress. Jean Coussins suggested that the DHSS officials present might follow up the issue and take appropriate action.

The role of the health visitor Shirley Goodwin, Honorary Secretary, Health Visitors' Association

After all that has been said today, began Shirely Goodwin, what is left for health visitors to do in the provision of antenatal care? Yet there is general agreement among the professions that health visitors should be involved. In 1981, for example, the Health Visitors' Association published a report, "Health Visiting in the 80's", which recommended home visits to antenatal clients as a priority even in a period of service cut-backs.[7] Last year the Health Visitors' Association and the Royal College of Midwives published a joint statement confirming that health visitors should participate with midwives in designing and teaching antenatal classes, as well as making home visits during pregnancy to establish contact and explain the services available to the mother after the birth.

According to Ms. Goodwin, reports such as these have rather antagonised midwives. There is a feeling that health visitors should focus their skills and expertise on child health services, rather than encroaching on the midwife's territory. Some G.P.s also have a limited view of the health visitor's contribution, seeing her as little more than a financial benefits advisor. Ms. Goodwin believed that health visitors should play a more instrumental role, complementary to other health professionals. The objective of antenatal care is to ensure not only the delivery of a healthy infant by a healthy mother, but also - and this is the health visitor's role - to deliver parents and baby into family and community relationships.

Ms. Goodwin suggested that one of the main features of the health visitor's role in antenatal care is as a neighbourhood and community worker. She has long-term and continuing contact with families, individuals and institutions in her area. She knows all the members of the primary health care team, local hospitals, schools, playgroups, etc. and keeps in touch with workers in other services such as the DHSS office, the housing department, social services, community health projects, etc. She maintains contact with voluntary organisations such as Wel-care, Women's Aid, local N.C.T., self-help groups, mutual support groups, etc. The health visitor's routine encounters with these agencies provide her with information and personal contact which she can offer to the expectant mother. She can also put parents in touch with each other to help overcome the social isolation they often experience.

Ms. Goodwin felt that the social opportunities afforded by antenatal classes are vastly underused. Their potential is exemplified by the New Parents' Attachment Scheme recently launched at Lisson Grove Health Centre in London, in which pregnant women are put in touch with mothers in the neighbourhood and invited to a series of discussions run by a health visitor and counsellor, starting at about the sixth month of pregnancy and continuing until the babies are about three months old.

"Maternity Care in Action" refers to the difficulties of providing antenatal care for high risk and disadvantaged groups. This is a field where community health services are now making a unique contribution by employing health visitors with special responsibility for various high risk groups. Ms Goodwin

cited the example of a health visitor employed jointly be several health authorities to look after travelling families in East London.[8] A recent article in the Health Visitor Journal described how her special knowledge of travellers' life style and beliefs help her to motivate women to accept the need for antenatal care. Without her, most of these women's pregnancies would probably not be identified at all.

Ms. Goodwin then described her own work as a health visitor for homeless families in Ealing. Many of the priority cases she visits in local hotels and hostels are pregnant women with daunting problems. Often far from home, they need advice about local G.P.s, clinics and hospitals. As they cannot prepare meals in the hotels where they live, they badly need information about nutrition. Many are very young single women with little family support and living on supplementary benefit. They often need help in dealing with the DHSS and information on welfare rights. These disadvantaged women now have access to antenatal facilities they would probably not have had otherwise.

For Ms. Goodwin the health visitor's unique contribution to antenatal care is as a neighbourhood and community worker, at the interface between institutional health knowledge and community knowledge. The other main feature of her role - acknowledged in "Maternity Care in Action" - is to facilitate the psychological and emotional transition to parenthood.

"Prevention" is a key word in health visiting and, to be effective, the health visitor must literally "come before", meeting the prospective mother before the birth. However, pregnant women do not usually report receiving much attention from health visitors. In a recent study in Redbridge and Waltham Forest only one per cent of women cited the health visitor as their main source of information about pregnancy.[9] Nine per cent cited antenatal classes, 29% their own reading, and 0.7% cited midwives. On the other hand, the Cambridge Early Parenthood Project found that the involvement of health visitors during pregnancy undoubtedly brings benefits in the post-natal phase.

Another definition of "prevention", said Ms. Goodwin, is the Shakespearean usage meaning "guidance". The health visitor can be seen as a guide for the childbearing year and beyond, particularly for young mothers who often seek mothering themselves at this time of upheaval. Such a guide must

also be an interpreter, whether it be of medical jargon or of tensions between members of the family. And a guide directs people to services and resources in the community, as well as cautioning about hazards along the way. Finally, the health visitor should be a reference point for people moving from one stage of life to another - unchanging, reliable and familiar.

Ms. Goodwin ended by praising the MSAC Report for mentioning health visitors in all the right places: they have a small but significant and continuing part to play in antenatal care.

Questions and discussion

In response to a question, Ms. Goodwin confirmed that community action and political action are now seen as legitimate fields for health visitors. They also have an important "enabling" role, helping others to set up groups (e.g. mother and toddler) for themselves. She noted that there had been a shift over the last 150 years from a community approach to public health to the one-to-one relationship found in social work. Many of us, said Ms. Goodwin, now think that this is an inappropriate model for health visiting.

An administrator speculated on how mothers feel about the massed ranks of the professionals lining up to assist, advise and support. Would the recipient of all this attention be crushed in the melée? Each profession was too anxious to display its wares. They must come out from behind their barricades to make the MSAC Report's recommendations work on the shop floor. Local maternity services liaison committees should provide the forum for hammering out roles to achieve a successful collective approach to delivering care and supporting the pregnant woman. The speaker believed that these were the issues that the conference needed to go away and consider.

Jean Coussins said she was grateful for this contribution because she wanted to end by focussing on what everyone at the conference could do in the following months towards implementing the Report. In a show of hands, more than half of those present indicated that as yet they had no maternity services liaison committee in their area.

Mrs Alison Munro was shocked at this degree of inaction. She emphasised that it was the health authority's responsibility to set up a liaison committee. They must put it to their district, select a chairman/woman and appoint their members. She also reminded the conference of the Report's strong insistence on the importance of lay people. The lead, she said, must come from the DHSS itself. No circular had yet appeared. Regions did not seem to be doing anything either. Lady Limerick (a lay representative on the MSAC) urged that the liaison committees take on lay members. A motivated lay person can provide a great stimulus for change, she said, as well as learning a lot about professional views and problems. A representative from the Royal College of Midwives believed that the committees must be properly constituted, with membership openly discussed, and not just have a consultant calling the tune. She added that strong links were needed with Local Medical Committees and Family Practitioner Committees.

Sir Anthony Alment (Consultant Obstetrician and member of the MSAC) warned that if liaison committees were left in the hands of consultants and G.P.s - as on many other committees - change would not be achieved. The Maternity Services Advisory Committee really did work together to a common purpose initiated by active consumerism. Lay participation was, in his view, crucial and would give the liaison committees much greater potential. If consumer information and ideas are neglected, the professionals will retreat into their old way of thinking that they know best. Now, for the first time, the interests of women must have primacy.

A general practitioner commented that there was a danger of institutionalising patterns and repeating the mistake of expecting women to conform instead of providing for their care. What the Report omits - and the conference too - is the issue of education. Responsibility for professional standards currently lies with the individual professions and the speaker maintained that professional education is a largely unexplored area through which many inter-professional differences must be resolved.

Chairwoman's summary

Drawing the conference to a close, Jean Coussins said that despite her initial misgivings, she thought it had been very useful to have mainly professionals meeting together to discuss these issues. So often it was a matter of keeping the peace between consumers and professionals, and false polarisations tend to arise when professionals close ranks. But today, said Jean Coussins, many healthy and productive disagreements had come out.

She concluded that two specific tasks urgently needed to be undertaken. First, the DHSS should send a circular to regional health authorities urging that local maternity services liaison committees be established. Second, at grass roots level, community health councils, pressure groups and professionals must seek out that local enthusiast who could be pursuaded to chair the liaison committee. As the conclusion to the Report points out, "We are confident that if district maternity services liaison committees achieve the consensus that has been realised between the different groups on the maternity services liaison committee, the quality of antenatal care locally is bound to benefit". Ms Coussins said that this must indeed be true.

Imogen Pennell
King's Fund Centre
June 1983

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APPENDIX I

KING EDWARD'S HOSPITAL FUND FOR LONDON

King's Fund Centre

MATERNITY CARE IN ACTION - ANTENATAL CARE

Conference on Thursday 10th February 1983

Attendance List

	Ms M ABBOTT	Midwifery Sister	Queens Medical Centre
	Mrs L M ADAMS	Maternity Social Worker	St Helier Hospital
	Miss M E ADAMS	Senior Tutor	Queen Charlotte's Maternity Hospital
	Sir Anthony ALMENT	Consultant Obstetrician and Gynaecologist	Maternity Services Advisory Committee
	Mr N A AMANN	Deputy House Governor and Secretary	Queen Charlotte's Maternity Hospital
	Miss M BAKER	Nursing Officer	Princess Margaret Hospital
	Miss J M BARRITT	District Nursing Officer (Health Visiting and School Nursing)	Winchester Health Authority
	Mrs E BASTERFIELD	Sister - Antenatal Clinic	Royal United Hospital
*	Prof R BEARD	Professor of Obstetrics and Gynaecology	St Mary's Hospital Medical School
	Mr M N BELTON	Unit Administrator	Newcastle General Hospital
	Mrs V BOLTER	Secretary	Newcastle C H C
	Mr C N BOURNE	Member	Oldham Health Authority
	Mrs C BOYD	Research Officer	Maternity Alliance
	Dr M E BRENNAN	S C M (Health Care Planning)	West Midlands R H A
	Mr M BROWN	Principal	D H S S
	Mrs M CALLAS	Sister - Antenatal Clinic	St Richard's Hospital
	Mrs H CAWTHORN	Senior Sister - Antenatal Clinic	Wycombe General Hospital
	Miss J M CLARK	Member	Redbridge and Waltham Forest F P C
	Dr E CLOAKE	Senior Medical Officer	D H S S
	Miss D COUP	Nursing Officer (Community Midwifery Service)	Oldham Health Authority
*	Ms J COUSSINS	Chairwoman Deputy Director	Maternity Alliance Child Poverty Action Group
	Miss R J DAVIES	Senior Sister - Midwifery	Middlesex Hospital
	Miss M L DEVERELL	Member	Bedfordshire F P C
	Ms E ENGLEDOW	Nursing Officer (Midwifery)	University College Obstetric Hospital
	Miss J EVANS	Consultant (Obstetrics and Gynaecology)	Oldham Health Authority

Mrs J FARIS	Nursing Officer	Jessop Hospital for Women
Mrs E K FELLOWS	Senior Nursing Officer (Acting)	Bromsgrove General Hospital
Mrs M G FISHER	Member	Shropshire C H C
* Mrs C Flint	Antenatal Clinic Sister	St George's Hospital
Ms A FOSTER	Project Officer - Planning	King's Fund Centre
Dr A M GILLARD	Head of Midwifery Services	Royal Sussex County Hospital
Miss S D GOLDIN	Nursing Officer/Health Visiting	Community Nursing Centre - Reading
* Ms S GOODWIN	Honorary Secretary	Health Visitors Association
Mrs J GOUDIE	Divisional Nursing Officer	Princess Mary Maternity Hospital
Mrs M GOW	Divisional Nursing Officer (Midwifery)	Wycombe General Hospital
Miss J GREENWOOD	Divisional Nursing Officer	Paddington & N. Kensington Health Authority
Miss G D GROOCOCK	Director of Midwifery Services	General Hospital - Kettering
Mrs A B HAGEL	Senior Lecturer	Newcastle upon Tyne Polytechnic
Miss F A S HAINES	Principal Nursing Officer	Queen Charlotte's Maternity Hospital
Mrs J HARDING	Member	Winchester C H C
Mrs E HAY	Nursing Officer - Community	St Richard's Hospital
Ms C HUMPHREY	Research Fellow Department of Applied Social Studies	Polytechnic of North London
Ms J HUNTINGTON	Fellow in Organisational and Professional Studies	King's Fund College
Miss P M JENNINGS	Representative	Royal College of Midwives
Miss A JOHNSON	Director of Midwifery Services	Harrogate General Hospital
Miss A M JUDSON	Paediatric Nursing Officer	Maternity Services Advisory Committee
Mrs P KELLY	Member	Redbridge and Waltham Forest F P C
Mrs S KENT	Assistant Sector Administrator	Hope Hospital
Miss M R KIBBLE	Antenatal Clinic Sister I/C	Princess Margaret Hospital
Miss A KING	Nursing Officer	D H S S
Dr J L KOPELOWITZ	Chairman	Newcastle F P C
Dr M KOZAK	Antenatal Project Officer	Warwickshire Health Authority
Miss B R LAMBERG	Director of Midwifery Services	Bedford General Hospital
Mrs D LEWIS	Member Maternity and Child Health Working Group	Wycombe C H C
The COUNTESS OF LIMERICK	Member	Maternity Services Advisory Committee
Ms M McCUSKER	Representative	Spastics Society

Dr M McKENDRICK	General Medical Practitioner	Maternity Services Advisory Committee
Mr A MONKS	District Administrator Dudley Health Authority	Maternity Services Advisory Committee
Miss P MOSELEY	Acting Divisional Nursing Officer (Midwifery)	Hope Hospital
Mrs A MOUNTFORD	Nursing Officer - Health Visiting	Enfield Health Authority
Ms S MOWAT	Divisional Nursing Officer (Community) Tower Hamlets H A	Maternity Services Advisory Committee
* Mrs A MUNRO	Chairman	Maternity Services Advisory Committee
Mrs L E MURRAY	Director of Maternity Services	St George's Hospital
Miss C A NIGHTINGALE	Senior Nursing Officer (Midwifery)	St Richard's Hospital
Dr A PATERSON	General Practitioner Member, D.M.T.	Oldham Health Authority
Ms I PENNELL	Rapporteur	
Miss V E PETERS	Nursing Officer (Midwifery)	Harold Wood Maternity Unit
Mrs E M PRESCOTT	Director of Nursing Services (Midwifery)	Burton District Hospital Centre
The Honourable Mrs L PRICE	Member	Maternity Services Advisory Committee
Miss E PROCTOR	Divisional Nursing Officer (Midwifery)	Grimsby Health Authority
Mr A PURKISS	Representative	Natioanl Council for Voluntary Organisations
Mrs RANI BANGA	Assistant Secretary	Ealing C H C
Miss A RIDER	Representative	Royal College of Midwives
Ms B ROWLAND	Midwifery Sister ANC	Royal Sussex County Hospital
Mr J R SAUNDERS	Consultant Obstetrician	Bedford General Hospital
Ms M SCRUGGS	Member	Association of Radical Midwives
Mrs J SIDDLE	Member	Wirral C H C
Mr A SILVERSTONE	Consultant Obstetrician	University College Obstetric Hospital
Mrs M SNELL	Director of Nursing Services (Midwifery)	St John's Hospital
Mr C SMITH	Senior Principal Administrative Assistant	West Midlands R H A
Mrs S STANLEY	Antenatal Sister	Jessop Hospital for Women
Mrs F A STOKES	Member	Nottingham C H C
Mrs G SUNDERFORD	Senior Midwife Teacher	Oldham Health Authority
Miss J SWAN	Regional Nurse - Service Planning	North West Thames R H A
Miss S Y TAN	Sister (Midwifery)	Shrodells Maternity Hospital

* Dr G W TAYLOR	General Medical Practitioner	Reading
Miss M I TAYLOR	Director of Nursing Services (Midwifery)	Barratt Maternity Home
Mr R J THORNE	District Administrator	Oldham Health Authority
Miss V M THRESH	Regional Nurse (Planning)	West Midlands R H A
Miss G K A TILT	Director of Midwifery Services	Greenwich and Bexley F P C
Mr R TOULMIN	Assistant Secretary	D H S S
Mrs A TRUESDALE	Representative	National Childbirth Trust
Miss B J TUCKER	Nursing Officer - Midwifery	Royal United Hospital
Dr M S B VAILE	S C M	Maidstone
Mrs M VAN HOORN	Health Visitor	Parkway Health Centre
Miss A R VAN WOERDEN	Director of Midwifery Services	Nuneaton Maternity Hospital
* Miss I L WATERHOUSE	Director of Nursing Services (Midwifery)	West Berkshire Health Authority
Mrs A WOOD	Chairman	Hertfordshire F P C
Mrs H WOOD	Midwifery Sister (Community)	Bromsgrove General Hospital

* denotes speaker