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Margie Polden Memorial Lecture: Empowerment – a gift bestowed or withheld

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Abstract
This paper explores the areas in which health professionals can work in collaboration with women and their partners so as to enable them to have a birth experience that is both empowering and fulfilling. It also examines areas where an impact on maternity service provision might be made. The delivery of high-quality healthcare services should address patient safety, the effectiveness of care and the patient experience. In order to become an active participant in rather than a passive recipient of care, mothers need to enter into an effective collaboration with health professionals. The author provides physiotherapists with an opportunity to: review their own perceptions and beliefs about labour and birth; explore the kind of working relationships that they have with their clients; and reflect on the language they use when talking about labour and birth. Since the publication of *Changing Childbirth*, there has been much rhetoric about ''choice'' and ''shared decision-making'' in all recent UK policy documents, and yet the reality for many women today is that the medical model still wields enormous influence over maternity service provision. However, obstetric physiotherapists who are involved in delivering antenatal classes can play a major role in empowering mothers-to-be and their partners to recognize that they can have an impact on the kind of labour that they might experience.

Keywords: childbirth, empowerment, labour, maternity services, midwifery.

Introduction

I feel very honoured to have been invited to speak to you today in memory of Margie Polden. When I first attended a meeting of the Obstetric Association of Chartered Physiotherapists (OACP) in London in the mid-1970s, I felt a bit of an outsider. I was a National Childbirth Trust (NCT) antenatal teacher, and had recently completed my OACP training. In those days, the NCT was rather frowned upon by some health professionals. Margie, who was also a member of the NCT, understood this, so she immediately took me under her wing, and I think of her with great fondness for that alone. I can also remember the fantastic conference dinner at the Roman Baths and Pump Room in Bath. It was during the coach trip to this meeting that Margie and Jill Mantle conceived *Physiotherapy in Obstetrics and Gynaecology* (Polden & Mantle 1990). This book was the first of its kind for physiotherapists, and it was to become like a bible to me. I cannot tell you how many times I have consulted it over the years.

The word midwife means ''with woman''. Perhaps a strapline for women's health physiotherapists could be ''there for women''? Margie certainly was. She was a truly inspirational physiotherapist, always bubbling with enormous energy, and so full of passion about the work that she was doing with pregnant and postnatal women. I feel sure that empowerment was something Margie held dear, hence the title of my talk.

Empowerment and relationships

As an antenatal teacher for over 40 years, I have primarily chosen to focus on labour and birth, highlighting some key issues. I trust that those of you who work predominantly in gynaecology

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will be able to adapt some of the following messages to complement your own practice, which is, of course, so often about treating the direct results of the pregnancy or the type of birth that the woman has had (e.g. incontinence and prolapse).

I will explore the areas where our influence can enable women and their partners to achieve a birth experience that is empowering and fulfilling for them, one that creates very positive memories, whatever kind of birth they have. I will also look at where we might make an impact on maternity service provision.

Lesley Page, my midwife friend and colleague, and the current president of the Royal College of Midwives (RCM), recently said to me: "Women want to have a *safe* transition to parenthood, and they want the experience to be *positive and life-enhancing*. Quality maternity services should be defined by the ability to do both."

Delivering high-quality healthcare services has been the stated aim of all four countries of the UK for some considerable time now, and these provisions should address:

- patient safety;
- the effectiveness of care; and
- the patient experience.

In 1992, the House of Commons Health Committee report on maternity services, which led to the paper *Changing Childbirth* (DH 1993), challenged the pattern of maternity care provision based on the medical model, stating that:

> "Becoming a mother is not an illness. [. . .] [I]t is the mother who gives birth and it is she who will have the lifelong commitment that motherhood brings. She is the most active participant in the birth process." (HC 1992, p. 4)

In other words, in order to become an active participant in rather than a passive recipient of care, a mother needs to enter into an effective collaboration with health professionals. The House of Commons Health Committee statement (HC 1992) clearly challenged the "doctor knows best" ethos, and the following quote demonstrates the anxiety that some maternity service health professionals exhibited about this questioning of their authority.

In an earlier paper that was published a few years after my third child was born, an obstetrician wrote, "It is not widely appreciated that pregnant women are not only emotionally unstable, they are intensely egocentric" (Francis 1985, cited by Cook 1997). He went on to warn that encouraging women to participate in decision-making "can result in a fierce demand to dictate" (Francis 1985, cited by Cook 1997). Other reports lamented the restrictive choices that women were offered because of the rigid hierarchical organization of maternity services (Cook 1997). As Jo Green said:

> "[R]emember that moment in Monty Python's *The Meaning of Life* where a woman giving birth, surrounded by machines going ping, asks what she should do and is told, 'Nothing! You are not qualified.' That is rather the way it was then." (Sutton 2012, p. 126)

Hence, an organization like the NCT, which campaigned tirelessly to empower women and has always given them a voice, and challenged providers to ensure that practices and policies are based on evidence, was viewed with suspicion in some quarters.

I am pleased to say that things have moved on considerably since then, although there is still much room for improvement.

I hope that this talk might provide you with an opportunity to:

- review your own perceptions and beliefs about labour and birth;
- explore the kind of working relationships that you have with your clients; and
- reflect on the language that you use when talking about labour and birth, whether you are working with women during pregnancy or postnatally, or even treating grandmothers for prolapse.

Without even realizing it, we can be very influential. The language that we use can be so powerful. Do we inspire couples to have confidence in the woman's ability to birth her baby by the way in which we talk about labour and birth, the amazing adaptations of the ligaments during pregnancy, and how upright positions can help; or do we add to their anxieties in our antenatal classes? What difference will it make to a woman's endorphin levels if the midwife admitting the woman to the labour ward declares, "Oh, you're *only* 3 cm dilated – a long way to go yet", instead of saying, "That's great, you're *already* 3 cm dilated – well on your way"? Do we enable our patients to recognize the characteristics of the latent phase of labour by showing them the graph found in most midwifery textbooks that illustrates the potentially different rates of dilatation over the hours of the latent and then the

active phases of the first stage? When treating women postnatally (or talking to their mothers, who wield quite an influence on the next generation), words must be carefully chosen. Does the language that you use when talking about labour, and the possible causes of incontinence and prolapse help to educate your patients about the factors that might make it easier for them to avoid problems during childbirth? Or do we, perhaps inadvertently, lead them to believe that having a Caesarean section might be a better option?

Women will have their own ideas, beliefs, aspirations and perceptions about labour and birth, and these will be influenced by many different factors. As Margie Polden wrote in her chapter on preparation for labour, ''It is essential that physiotherapists do not impose their own opinions on the client'' (Polden 1990, p. 167). I know that this advice is not always easy to follow, particularly when wards are understaffed, and staff are overstretched and short of time.

Since *Changing Childbirth* (DH 1993) was published, there has been much rhetoric about ''choice'' and ''shared decision-making'' in all recent UK policy documents, and yet the reality for so many women today is that the medical model still wields enormous influence over maternity service provision. It is true to say that this paradigm is not always based on the best available evidence, and that discussions about risk and safety dominate. Routine admission traces, episiotomies, labouring in bed and Caesarean sections for breech presentations are examples of practices that still persist today in many places, long after evidence has suggested that these procedures should be discontinued or used more cautiously. Such practices contradict the National Institute for Health and Clinical Excellence (NICE) clinical guideline, which states that, ''All women in labour should be treated with respect and should be in control of and involved in what is happening to them, and the way in which care is given is key to this'' (NICE 2007, p. 6).

In NCT classes, we teach people about informed consent/shared decision-making using BRAIN, an acronym for ''benefits, risks or repercussions, alternatives, instincts, nothing'' (Box 1).

Box 1. Informed consent/shared decision-making using BRAIN (i.e. benefits, risks or repercussions, alternatives, instincts, nothing) (adapted by the present author from a National Childbirth Trust teaching idea, originator unknown).

- Is this an emergency or do we have time to talk?
- What would be the *benefits* of doing this?
- What would be the *risks or repercussions* if we did this? That is, if we do this, what other procedures or treatments might we need as a result? (Cascade of intervention!) Are there any long-term effects?
- Is there an *alternative*, i.e. is there anything else we could try first or instead of X?
- What are my *instincts* telling me?
- What would happen if we do *nothing* (e.g. watchful waiting for the next 30 min, 2 h or another day)?

Some years ago, a couple arrived at one of my NCT classes who were rather upset. The woman had had a bleed, and following a scan, she was told by the obstetrician that she had a vasa praevia (VP) and would have to undergo a Caesarean section. The UK Obstetric Surveillance System, which is currently conducting a study of this condition, describes VP as the foetal vessels coursing through the foetal membranes over the internal cervical os and below the presenting part, unprotected by placental tissue or umbilical cord. This poses no major danger to the mother, but is associated with significant risk to the foetus (Nair *et al.* 2014).

This couple entirely understood the need for a Caesarean section, but having looked up VP on the Internet, they could not comprehend the obstetrician's stipulations, i.e. that it would have to be done under general anaesthetic, and therefore, her husband could not be present. I could not understand these either. The next day, I happened to be speaking at the Royal College of Obstetricians and Gynaecologists (RCOG) Management of the Labour Ward course, and during coffee and lunch, I asked approximately six different obstetrician colleagues for their views. Each one of them said, ''Of course she needs a Caesarean, but I would do it under spinal and with the husband present. Tell them to get a second opinion.''

The couple did just that, and their photographs represent their very positive experience of their daughter's birth. By trusting their instincts, gathering more information, and being provided with support by their midwife and me, they felt empowered to seek a second opinion, and their birth experience was totally changed.

Many years ago, I came across a Beverley Craven song called ''Memories'', and the words of the chorus resonated with me:

> ''Everything she's going through will be her memories
> When she's older and wiser
> She's making her history
> And everything we're going through will be our memories
> I'm gonna make them worth remembering
> For years. . .''

I often quote these words when giving talks about labour and birth. For an individual woman, it is a day that she is likely to remember for the rest of her life, and not only for what happened, but also for how she was treated and heeded. For example, did she feel empowered to make choices and believe that she was involved in decision-making, or did she think that she was disempowered, with no control over what happened to her and her baby?

Here is a poignant quote from one woman who had an emergency Caesarean section: ''Being stuck on the bed with the monitor, I found it very difficult to manage contractions. I don't feel I had any control over my birth experience, it was a terribly lonely day where I tried the best I could, but I felt there was nobody who listened to my needs or gave me support'' (Newburn & Singh 2003, p. 24). What history was she making that day? What were her memories of her baby's birthday?

Some might say that women with high expectations of the kind of birth that they would like will only be let down and disappointed when the delivery does not go their way. I cannot count the number of times that I have heard couples say that the midwife looked at their birth plan and then told them that they might as well tear it up.

In a well-designed comparative study called *Greater Expectations?* (Green *et al.* 2003), Jo Green and her colleagues compared the management of labour and birth, and women's expectations and experiences in 2000 with the findings of their 1987 study entitled *Great Expectations* (Green *et al.* 1998). The original was a prospective study of 825 women who had been booked to give birth in six hospitals in England. The participants completed three questionnaires, two before birth and one 6 weeks afterwards. The questions covered both subjective and objective aspects of birth, and particularly focused on elements of control.

The results of *Greater Expectations?* showed that women valued giving birth with a minimum of drugs in both time periods, even though the use of epidurals had increased dramatically from 19% to 59% between 1987 and 2000 (Green *et al.* 2003). Women in 2000 appeared more anxious about pain and had a reduced faith in their ability to cope with labour, a change that particularly affected first-time mothers. I would bet that this is worse today – the media has a lot to answer for!

Green *et al.* (2003) emphasized the importance of women feeling in control of themselves and their environment, and how this affected their satisfaction, fulfilment and postnatal well-being. Those women who expected breathing and relaxation to be useful were more likely to find that this was so, and had higher satisfaction levels. Those who expected to feel in control were more likely to achieve their goal, and had higher emotional well-being scores.

In an interview (Sutton 2012), Jo Green talked about how some parents nowadays wonder what is so bad about medical intervention. A study that she published with Helen Baston in 2007 suggested that they may not actively want such interventions, but are more likely to accept these, if offered a choice (Green & Baston 2007).

Jo Green's next words should resonate strongly with those who are involved in antenatal education:

> ''The ways in which women are helped to deal with pain affects internal control; the extent to which they feel that they are actually cared about, rather than care being something that is done to them, affects external control. Both contribute to satisfaction and emotional well-being. [. . .] Most parents, especially those giving birth for the first time, will be anxious about pain and their ability to cope with it, and effective birth preparation should be addressing that. High levels of antenatal worry about labour pain predict poor obstetric and psychological outcomes. Women who, antenatally, are in favour of interventions are more likely to get them but their obstetric and psychological outcomes are generally poorer than women who find other ways of coping.'' (Sutton 2012, p. 126–127)

Walsh (2009) suggested that, in the context of a fragmented model of care within a clinical environment, one with little continuity and patchy one-to-one support in labour, it is understandable that epidurals are a welcome relief. He wrote, ''it is important not to confuse system failure with women's preferences'' (Walsh 2009, p. 91).

Although it has been suggested that more ready access to epidural anaesthesia for pain relief is associated with a reduction in post-traumatic stress, a review by Ayers (2004) indicated that other factors, such as lack of support, loss of control, violation of expectations and uncontrollable pain, can be responsible for traumatic stress responses. However, more research is needed in this area.

In reporting the findings of a recent survey capturing women's views on dignity in childbirth, Alison Brodrick (2014) also explored issues of choice, control, respect and satisfaction. She concluded that midwives hold the key to ensuring that women reflect positively on their birth experiences, and as an absolute minimum, they should be asking themselves, "How will she remember this?"

The *Concise Oxford English Dictionary* defines the verb "empower" as: "give authority or power to; authorize" and "give strength and confidence to" (Pearsall 2002, p. 467). This suggests a relationship in which there is an imbalance of power, one where empowerment may be bestowed or withheld. In contrast, many of the working definitions of empowerment suggest a process in which individuals acquire or assume power, emphasizing the ability of individuals to take control of their own lives.

Osterman & Kottkamp (2004, p. 190) described empowerment as "not something given but something emanating from the self [. . .] a willingness and drive to act professionally and responsibly, grounded in a sense of self-esteem, competence, and autonomy" (see also Fletcher & Buggins 2000).

In order to feel empowered people need:

- clear unbiased information, communicated in an accessible form;
- to be listened to;
- to be treated with respect and dignity;
- to be trusted to make their own decisions;
- to experience non-judgemental attitudes; and
- to be encouraged and motivated.

Table 1. Differences between the expert advisor/passive recipient and active partnership models

Expert advisor/ passive recipient	Active partnership
Define needs	Listen to their needs and concerns
Identify problems	Enable them to explore problems
Give advice	Encourage them to select appropriate solutions
Prescribe care	Offer various options, encouraging
Assess and manage	them to weigh up the pros and cons

We could use the contrasting lists in Table 1 defining the differences between the expert advisor/passive recipient and active partnership models to review how we work with pregnant or postnatal women and their partners.

The International Confederation of Midwives (ICM 2008) embeds the importance of relationships with clients/women within their code of ethics. This code advises that:

(1) "Midwives develop a partnership with women in which both share relevant information that leads to informed decision-making, consent to a plan of care, and acceptance of responsibility for the outcomes of their choices." (ICM 2008, p. 1)
(2) "Midwives support the right of women/families to participate actively in decisions about their care." (ICM 2008, p. 1)

Normalizing birth and reducing unnecessary interventions

In recent years, maternity policy in all four countries of the UK has been directed towards offering women access to midwife-led services. Wales, England and Scotland each explicitly focus on promoting normal birth and reducing unnecessary interventions, and Northern Ireland is developing more community midwifery units. Nevertheless, a review of the trends shows that there is still much to be done (Table 2).

Table 2. Birth trends in England and Wales from 1955 to 2009 (Dodwell & Newburn 2010)

	Year		
Variable	1955	1990	2009
Home birth rate (England and Wales)	33.4%	1.0%	2.9%
National Health Service hospital birth rate (England and Wales)	60.2%	97.9%	96.5%*
Induction rate (England)	13.0%	18.3%	20.2%
Caesarean rate (England)	2.2%	11.3%	24.6%
Instrumental rate (England)	4.4%	9.4%	12.1%

*2008.

It is easy to understand why the RCM felt the need to set up the Campaign for Normal Birth in 2005 (RCMNB 2014). As a member of the original steering group, I spent many hours debating with midwives from across the UK. We discussed what the barriers to normal birth were, and how to support midwives so that they, in turn, might feel empowered to support women to have the kind of birth that they wanted. There is strong evidence to support the idea that the kind of care women are most likely to prefer leads to improved outcomes.

A recent Cochrane Review of midwife-led continuity models and other types of care for childbearing women (Sandall *et al.* 2013) compared data from 13 trials involving 16 242 participants. Eight of these trials involved women with a low risk of complications, and five included those who were considered to be at a high risk of such problems. The above authors examined outcomes for mothers and babies, and compared midwife-led care with medical-led or shared-care models. Where midwives were the main providers of care throughout, women were less likely to experience regional analgesia [average risk ratio (RR) = 0.83, 95% confidence interval (CI) = 0.76–0.90], episiotomy (average RR = 0.84, 95% CI = 0.76–0.92) and instrumental birth (average RR = 0.88, 95% CI = 0.81–0.96). Furthermore, they were more likely to experience no intrapartum analgesia/anaesthesia (average RR = 1.16, 95% CI = 1.04–1.31), spontaneous vaginal birth (average RR = 1.05, 95% CI = 1.03–1.08), attendance at birth by a known midwife (average RR = 7.83, 95% CI = 4.15–14.80) and a longer mean length of labour (mean time difference = 0.50 h, 95% CI = 0.27–0.74). There was no difference between the groups for Caesarean births (average RR = 0.93, 95% CI = 0.84–1.02). Women were less likely to experience preterm birth (average RR = 0.77, 95% CI = 0.62–0.94) or foetal loss before 24 weeks' gestation (average RR = 0.81, 95% CI = 0.66–0.99), although there were no differences in terms of overall foetal/neonatal death (average RR = 0.84 95% CI = 0.7–1.00). Based on this evidence, Sandall *et al.* (2013) concluded that all women should be offered midwife-led continuity of care and encouraged to ask for this option, although caution should be exercised in applying this advice to women with substantial medical and obstetric complications.

The philosophy behind midwife-led models is normality, continuity of care and being tended by a known, trusted midwife during labour. The emphasis is on the natural ability of women to experience birth with minimum intervention (Hodnett *et al.* 2005). Words like "trust" and "relationship" come to mind.

Currently, the National Health Service mandate states that every woman has a named midwife who is responsible for ensuring that she has personalized, one-to-one care throughout her pregnancy and birth, and during the postnatal period, including additional support for those who have maternal health concerns. However, in 2010, the Care Quality Commission survey of women's experiences found that 43% did not see the same midwife every time or almost every time during pregnancy, and 75% had not met any of the staff who cared for them during labour and birth (CQC 2010). In a 2013 survey, more women than in 2010 felt that they were treated with kindness and understanding, and had confidence and trust in the staff caring for them during labour and birth (CQC 2013). Furthermore, more women were able to move around in order to find the position that made them most comfortable during labour and birth, which is good news.

However, of the 8000 comments coded for this report, 10% related to continuity of care (n = 889) and only one in 10 of these was positive. Seven hundred and eighty-five women felt that the continuity of care was inadequate. Some of the comments concerned a lack of continuity of care across midwives, but complaints were also raised about a lack of consistency with regard to the consultants who were seen during antenatal care (CQC 2013).

For many years, home birth has been a very contentious issue, and even with the strong evidence provided by a robust trial such as the Birthplace Cohort Study (BERP 2013), there are still those who believe that it is safer for women to give birth in a huge obstetric unit in case complications arise. However, this attitude fails to recognize that there is an increased and not easily explained likelihood of woman with straightforward pregnancies undergoing unnecessary interventions. In a Cochrane Review of supportive care during labour, Hodnett *et al.* (2013) suggested that modern obstetric care frequently subjects women to institutional routines, which may have adverse effects on the progress of labour. In a report of an observational study in Scotland exploring the impact of a midwife's presence or absence in the delivery room, Ross-Davie *et al.* (2014) highlighted a correlation between midwives staying, and

women's experience and mode of birth. The above authors cited the CQC (2013) survey findings, observing that women who had operative births more frequently reported being left alone at a time when this worried them in early labour than women who experienced a normal vaginal birth (18% of women who had an emergency Caesarean section and 17% who had assisted birth compared with 13% who had a normal vaginal birth).

Influencing maternity service provision

As stated above, high-quality healthcare has been defined as care that is safe, effective and takes account of the patient experience.

There is good evidence that the normal birth rate can be used as an indicator of the quality of midwifery care. Practices that evidence suggests will increase opportunities for normal birth without compromising safety or women's experiences can be monitored to show impact locally; for example:

- providing continuity of care;
- offering birth at home or a birth centre;
- providing birth preparation classes;
- ensuring one-to-one midwifery care for labouring women;
- encouraging mobility and upright positions during labour; and
- offering access to immersion in water for pain relief in labour.

There is evidence – and in some cases, it is very strong evidence – that the above practices increase the quality of care by improving outcomes as well as providing treatment that is personalized and responsive to women's needs (Dodwell & Newburn 2010).

How many of these practices could you influence? Do you truly believe the evidence, or are you in the risk-averse, just-in-case and labour-is-only-normal-in-hindsight camp?

If you, as an obstetric physiotherapist, are involved in delivering antenatal classes (e.g. teaching breathing and relaxation, birth positions, and massage), then you have a major part to play in empowering couples to recognize that they can have an impact on the kind of labour that they might experience. Do you really believe, as the evidence shows, that women who trust in these methods use far less pharmacological pain relief? How do you get that message across to the couples you teach?

Hodnett *et al.* (2009) undertook a pilot study investigating the impact of the physical environment on women and practitioners by making simple but radical modifications to a hospital labour room. These changes included the removal of the standard hospital bed, and the addition of equipment to promote relaxation, mobility and calm. Women were then randomly allocated to either the modified or typical labour rooms. Although the pilot only involved a small number of participants, the outcomes indicated that the physical environment modification had a positive effect on women and care providers. The philosophy of mobilization in active labour was increasingly supported in the modified environment.

Do you just accept the labour room environment as you find it in your trust, or do you challenge "the lying on a bed which dominates the room" model that still predominates? The 2010 RCM survey found that 49% of women gave birth in a supine position despite the evidence that mobility and upright positions improve outcomes (Michel *et al.* 2002; RCM 2010, 2012; Walsh 2012; Westbury 2014).

Do you use evidence to empower couples to have the confidence to change the birth environment, to put into practice what I hope you teach them about relaxing in positions suitable for use in labour?

As Margie wrote all those years ago, "[T]here is little use in being able to relax perfectly while lying on your side but unable to release tension in prone kneeling if during labour that is the one position that relieves your backache" (Polden 1990, p. 167).

Do you have a poster of the RCM's evidence-based Campaign for Normal Birth (RCMNB 2014) hanging in your parenthood education space? I found these to be really helpful for empowering couples when they ask, "Are we allowed to move the bed so she can mobilize and get more comfortable?" The Ten Top Tips (RCMNB 2014) are:

(1) wait and see (trust the normal process);
(2) build her a nest (enable the endorphins);
(3) get her off the bed (gravity is our greatest aid, enabling mobility);
(4) justify intervention (avoid a cascade of interventions);
(5) listen to her (get to know her);
(6) keep a diary (as a source of learning);
(7) trust your intuition (important for both mother and midwife);
(8) be a role model;

(9) be positive (give her constant reassurance); and
(10) from birth to abdomen (skin-to-skin contact).

How many of you have heard of maternity services liaison committees (MSLCs)? The MSLCs were set up in 1984 following a governmental review of maternity services. The Department of Health, Social Services and Public Safety guidelines (DHSSPS 2009) state that these are multidisciplinary independent advisory groups that make recommendations to the commissioners of maternity services. The MSLCs operate in all four countries of the UK, and should be chaired by a service user and include strong maternity service user representation, as well as providers and commissioners. The NCT VOICES workshops were developed to provide support and training for MSLCs, and over the past 15 years that I have been running these intensive courses, I have very rarely seen obstetric or women's health physiotherapists involved.

The International Code of Ethics for Midwives states that, "Midwives empower women/families to speak for themselves on issues affecting the health of women and families within their culture/society" (ICM 2008, p. 1). Like MSLCs, multidisciplinary forums provide opportunities for this to happen.

In Tower Hamlets in London, the MSLC has developed a very robust model of engaging with women from different ethnic backgrounds, and it has been successful in changing practice and improving maternity services for women in that area. In Brighton, the MSLC uses social media very successfully to ensure that women's views are fed into decision-making by the committee (RCM, RCOG & NCT 2013).

In the July 2014 edition of *The Practising Midwife*, POGP Chairman Doreen McClurg concluded her article on peripartum and pelvic floor dysfunction by stating that women who have had third- or fourth-degree tears should be routinely seen by a physiotherapist (McClurg 2014). I wonder how often that happens in the majority of trusts?

Incontinence is a larger problem than many people realize, as the RCM/CSP online survey found (CSP 2014; Galloway 2014). Large numbers of women stay silent about the problem as a result of their embarrassment. One in two said that they had never told anyone about their incontinence, and three-quarters said that they had never sought help from any health professional (CSP 2014; Galloway 2014). These are just the kind of issues that MSLC members should be concerned about, and physiotherapists need to participate in those discussions about the provision of effective services. I hope that you will go back to your trusts and find out more about the MSLCs, and perhaps think about getting involved.

During more than 40 years as an antenatal teacher, I have heard countless stories from the thousands of couples with whom I have had the pleasure of working. They told me about the things that were most important to them, and I hope that I have now explored a few issues that will help your work with the women whom you see.

I will finish with a favourite quote from Murray Enkin, a Canadian obstetrician, whom I heard speak in 1989:

> "Care during pregnancy and childbirth is both an art and a science. By the term 'art' I refer to those essential yet unmeasurable components of care that count even though they cannot be counted; the empathy and judgement that permits care to be personalized for each woman and her family. By 'science' I refer to the extent to which care is based on evidence that it is effective [so] that it achieves the desired effect." (Enkin 1989, p. 48)

I wish you all the very best for the future, and hope that you can combine being both artist and scientist in your role.

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Gillian Fletcher MBE trained as a physiotherapist in London, and then worked in a gold mines rehabilitation hospital in South Africa, where she specialized in spinal injuries. In 1971, she gave up work as a physiotherapist to become a full-time mother. Gillian later completed her obstetric physiotherapy training at The London Hospital in 1975. She has been an NCT antenatal teacher since 1972 and a tutor since 1987, and was president of the organization from 2000 to 2005.

Since 1997, Gillian has run NCT VOICES multidisciplinary workshops for MSLCs liaison committees across the UK. With permission from the NCT, she developed VOICES work across other areas of healthcare, such as cancer, Alzheimer disease, multiple sclerosis, diabetes and coronary heart disease. As a member of the Patient Experience Team affiliated to the national Clinical Governance Support Team (CGST), she worked on the Delivering Healthy Babies and the CGST/Picker Institute Patients Accelerating Change projects.

Gillian is a trained facilitator, and has been a lay representative on several national committees at the RCM, RCOG, Nursing and Midwifery Council, Postgraduate Medical Education and Training Board, as well as the board of the NICE National Collaborating Centre for Women's and Children's Health. Her work in patient and public involvement draws on this experience. She focuses on empowering health service users to work in sustainable and effective partnerships with professionals, commissioners and researchers in order to develop and monitor health and social care services, and health-related research.

Gillian was awarded her MBE for services to healthcare and the NCT in the 2011 New Year's Honours List.