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Re:Birth project

'Normality' and the role of the midwife in statutory rules and midwifery textbooks in the UK: an analysis of the language

Introduction

Since the publication of the Morecambe Bay investigation (Kirkup 2015), there has been significant debate in the UK about the use of the term 'normal birth' and the role of the midwife in promoting normality and normal birth. In response, the Royal College of Midwives (RCM) embarked on a multifaceted project, called the Re:Birth project, in 2021. This project sought to consult widely on the language used in the UK to describe different types of birth. The method and results of this consultative process have been described and published elsewhere. This paper describes a further key part of the Re:Birth project.

This part of the Re:Birth project sought to understand the evolution of the concept of normal birth and its relationship with the role of the midwife. This was done through analysing the language used in the UK's statutory midwives' rules, codes of practice and in midwifery textbooks. The two midwifery textbooks analysed were *Mayes' midwifery* and *Myles textbook for midwives*, which have been the dominant midwifery textbooks in the United Kingdom (UK) for over 80 years.

Background

During the 110 years of their existence many iterations of midwives' rules have been produced by five professional statutory regulatory bodies (PSRBs), including the Scottish Central Midwives Board and the Northern Ireland Council for Nurses and Midwives.

The first *Rules* (Central Midwives Board (CMB) 1907) was published as a result of the first *Midwives' Act* (Midwives' Act 1902) and subsequent iterations were a legal blueprint for the role of the midwife until they were removed from statute in 2017. By contrast, the codes of practice were guidance around the rules but not statutory publications.

In 2013, the Parliamentary and Health Service Ombudsman published a report in response to a number of unexplained deaths at a maternity unit in Morecambe Bay (Kirkup 2015). The Ombudsman's report recommended that midwifery regulation around supervision was removed from statute. As a result, the Nursing and Midwifery Council (NMC) commissioned The King's Fund to provide a review of midwifery regulation (including supervision) and make recommendations. Their overall conclusion was:

> '*The NMC as the health care professional regulator should have direct responsibility and accountability solely for the core functions of regulation. … This means that the additional layer of regulation currently in place for midwives and the extended role for the NMC over statutory supervision should end' (*Baird et al 2015:23).

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In 2017, this recommendation came to fruition, with *The Nursing and Midwifery Order 2001* being amended to remove separate midwifery legislation. This amendment removed midwifery supervision, also the midwives' rules and codes of practice.

The midwives' rules and the textbooks have influenced and informed midwives' professional scope of practice, as well as their professional identities and aspirations, thus determining the language and ethos of midwifery practice as it has developed over this time.

The first section of this paper explores the language around birth, normality and the role of the midwife through the *Midwives' Rules* from 1980 to the final iteration in 2012. It also includes relevant, complementary national and international publications, such as the codes of practices, the EU Directives and the International Confederation of Midwives (ICM) definitions of a midwife.

The second section explores the same language through the dominant midwifery textbooks of the period.

Rules review methodology

The timeframe for this review was from 1980 to 2021, given that midwives on the NMC register today have practised during this period of time.

Between 1980 and 2012, there were seven iterations of the midwives' rules (separate rules existed for Scotland in 1980) and four iterations of the code of practice. The code of practice and the rules were eventually incorporated into one publication: the *Midwives' Rules and Code of Practice* (1998), which later became the *Midwives' Rules and Standards* (2004). In these joint publications, only the *Midwives' Rules* were subject to statutory legislation. Northern Ireland also published a separate document *The Role of the Midwife* (1983).

The year of publication, title of the publication, relevant PSRB and relevant countries are presented in Table 1.

Table 1. List of documents included in the review

Date	Title	PSRB	Countries
1980	Midwives' rules of 1980	Central Midwives Board	England & Wales
1980	Central Midwives Board for Scotland rules	Central Midwives Board for Scotland	Scotland
1983	The role of the midwife	Northern Ireland Council for Nurses and Midwives	Northern Ireland
1986	Handbook of midwives' rules	UKCC*	England, Scotland, Wales, N Ireland
1986	A midwife's code of practice for midwives practising in the UK	UKCC	England, Scotland, Wales, N Ireland
1989	A midwife's code of practice for midwives practising in the UK 2nd edition	UKCC	England, Scotland, Wales, N Ireland

1993	Midwives' rules	UKCC	England, Scotland, Wales, N Ireland
1994	The midwife's code of practice	UKCC	England, Scotland, Wales, N Ireland
1998	Midwives' rules and code of practice	UKCC	England, Scotland, Wales, N Ireland
2004	Midwives' rules and standards	NMC	England, Scotland, Wales, N Ireland
2012	Midwives' rules and standards	NMC	England, Scotland, Wales, N Ireland

*** UKCC (UK Central Council for Nursing, Midwifery and Health Visiting)**

Each version of the midwives' rules and code of practice was read and manually searched for the following words: 'normal', 'natural', 'physiological', 'birth'. The number of times each word appeared in each publication was recorded in a spreadsheet. The context of the word was noted and its relevance to the role of the midwife. Any other notable use of language or interpretation of the role of the midwife was also recorded. The status of the woman in relation to the midwife and/or the care she received was also noted through the language of the documents.

Findings

The findings are presented chronologically, under the heading of each of the five relevant PSRBs, with a discussion of the terminology in the documents and its meaning for midwifery practice.

Central Midwives Board (England and Wales) and Central Midwives Board Scotland

The Central Midwives Board (CMB) was set up as a result of the first *Midwives' Act* (1902) and existed until 1983. The CMB was only relevant to midwives working in England and Wales, although there was an equivalent board in Scotland. The purpose of the Boards was to provide better training for midwives and to regulate their practice. The first *Rules of Conduct* was dated 1907 (CMB 1907), with 25 further iterations dated between 1909 to 1979.

Only one iteration of the midwives' rules was published by the CMB (England and Wales) in the time period searched (CMB 1980). The words 'birth', 'normal' and 'natural' did not appear anywhere in the document. There were five references to the word 'physiology' under 'Subjects to be included in the course of training' (Schedule II, Rule 23). These referred to understanding anatomy and physiology of the female reproductive system, also physiology of pregnancy, labour and the puerperium. In these midwives' rules, there was a strong focus on the dominance of medical practitioners over midwives, for instance: 'Rule 37 Duty to carry out instructions of registered medical practitioner'. There was no mention of the rights or wishes of the woman and her family, or the professional autonomy of the midwife.

This version of the midwives' rules did not refer to the *Midwives' Directive (80/155/EEC)* (Council of the European Communities 1980), which is the European Union requirements for

all EU midwives, so it is assumed the 1980 rules were published before the Directive. In the Directive, there was one mention of 'deliveries' in Article 4, activities of a midwife, which stated that midwives should be enabled '*to conduct spontaneous deliveries'* (Council of the European Communities 1980:8).

The Central Midwives Board for Scotland published separate rules in 1980 (CMB for Scotland 1980). These were longer and more detailed than the rules for England and Wales, including much more specific detail about who could and could not be a midwife. For instance, it stated: '*student midwives shall normally be between the ages of 20 and 50 years'* and, in addition to general and sick children's nurses*, 'could previously be 'registered mental nurses'* or *'registered nurses for mental defectives*' (CMB for Scotland 1980:7056). As in the England and Wales version, the words 'birth', 'normal' and 'natural' were not in evidence but women were referred to as 'patients' with labour and delivery being discussed under the section 'home confinements'.

Northern Ireland Council for Nurses and Midwives

The only publication found that was specific to Northern Ireland was *The role of the midwife* (Northern Ireland Council for Nurses and Midwives 1983). This was published before the amalgamation of the three professional bodies to become the United Kingdom Central Council (UKCC) in 1983 and is not a set of rules. The document includes the term 'normal childbirth' in the context of the scope of practice. It states:

> *'It appears to be readily acknowledged that the midwife is responsible for the care of normal childbirth* …' (Northern Ireland Council for Nurses and Midwives 1983:3)

This is the only midwifery-related professional body publication in the 1980s to use the term 'normal' when referring to birth.

UK Central Council for Nursing, Midwifery and Health Visiting (UKCC)

The UKCC was founded following the *Nurses, Midwives and Health Visitors Act 1979*. It was the regulating body for all four countries of the UK so, for the first time since regulation in 1902, midwives in England, Scotland, Wales and Northern Ireland were governed by one set of rules. The UKCC was superseded by the NMC in 2004.

During this period, there were three versions of midwives' rules (UKCC 1986a, 1993, 1998), with three separate codes of practice (UKCC 1986b, 1989, 1994) and one integrated *Midwives' rules and code of practice* (1998). This section discusses both the midwives' rules and the codes of practice.

UKCC 1986 and 1989

In the *Handbook of midwives' rules* (UKCC 1986a), the words 'normal', 'natural' and 'physiological' did not appear. There was only one mention of 'birth', which was in the definition of mother and baby: '*means a woman and her baby whether before or after birth …'* (UKCC 1986a:6). In Rule 40 (Responsibility and sphere of practice), it stated that '*a practising midwife is responsible for providing midwifery care to a mother and baby during*

the antenatal, intranatal and postnatal periods' (UKCC 1986a:15). This is the only reference to the boundaries of a midwife's practice within the *Handbook* and makes no reference to the level of risk of the mother or baby.

A practising midwife was defined at the beginning of the *Handbook*:

> '… *practising midwife means a midwife who attends professionally on a woman during the antenatal, intranatal and/or postnatal period or who holds a post for a which a midwifery qualification is essential and who notifies her intention to practise to the local supervising authority*' (UKCC 1986a:6).

This definition, with minor amendments, held until 2012. Rule 40 also stated that a midwife must call to her assistance a medical practitioner if she detected a '*deviation from the norm*' (UKCC 1986a:15). The word 'norm' is not defined within the *Handbook*. As in 1980, the word 'deliveries' appeared in the context of the activities of a midwife in the *Midwives' Directive (80/155/EEC)*; activity 6 stated '*to conduct spontaneous deliveries including where required an episiotomy and in urgent cases, a breech delivery*' (Council of the European Communities 1980:8). The *Midwives' Directive (80/155/EEC)* was included in full in *A Midwife's Code of Practice* (UKCC 1986b).

In this code of practice, there was a notable change of emphasis from 1980 in the language relating to the autonomy and accountability of the midwife. In the introduction it stated: '*Each midwife as a practitioner of midwifery is accountable for her own practice in whatever environment she practises*' (UKCC 1986b:1). This illustrated an increased level of midwifery autonomy from the medical dominance in the 1980 rules. There was an asterisk by the word 'her' with a footnote '*all references in the female gender include the male*'. In the guidance around Rule 40 (Responsibilities and sphere of practice), it stated:

> '… *within the team, the midwife has a defined sphere of practice and is accountable for her actions, professional judgement and the care she gives to mothers and babies*' (UKCC 1986b:3).

In the second edition of the code of practice this was amended to: '*the midwife has a defined sphere of practice and is accountable for that practice'* and *'the conditions in which midwives practise vary widely, whether in the home or hospital or elsewhere*' (UKCC 1989:4). It is interesting that the words 'professional judgement' were removed from this version of the code.

In the 1986 *Handbook*, there was no equivalent to Rule 37 (Duty to carry out instructions of registered medical practitioner) included in the 1980 version of the rules. In the code of practice, again under the explanation of Rule 40, it stated: '*… the responsibilities of the doctor and the midwife are inter-related and complementary therefore the necessary degree of cooperation can only be ensured by a mutual recognition of their respective roles*' (UKCC 1986a:4). There was no explanation as to how these roles differed, other than outlining the midwife's role through the activities of a midwife, which were also included in the code of practice (UKCC 1986b:2). However, there was a developing ethos towards midwife

accountability and autonomy when compared to the more hierarchical relationship within the 1980 rules.

In the second edition of the code of practice (UKCC 1989), there was greater emphasis on joint accountability for care: *'the responsibilities of the midwife and the doctor are interrelated and complementary. However, each practitioner retains the clinical accountability for their own practice*' (UKCC 1989:4). In this code of practice, there was also more detail about the midwife discussing situations with the supervisor of midwives when a medical practitioner was not available for the birth. It stated she is to '*agree and record appropriate arrangements … as necessary*' (UKCC 1989:8). In the 1986 code of practice (UKCC 1986b), the midwife had merely to 'inform' her supervisor of midwives, suggesting a greater emphasis on accountability of the midwife by 1989.

In both the 1986 and 1989 codes of practice, there were sections on the midwife's 'responsibility for competency in new skills'. In 1986, it stated: '*some of the developments in maternity care become part of the role of the midwife and will require all midwives to acquire competence in new skills*' (UKCC 1986b:4). In 1989, the idea of acquiring competence had moved to become an educational responsibility and it was stated: '*some developments in midwifery care can become an integral part of the role of the midwife and are then incorporated into the basic preparation of the midwife*' (UKCC 1989:5). This reflected a more dynamic role for the midwife, in which new skills were incorporated into midwifery education.

UKCC 1993, 1994 and 1998

The rules published in 1993 and 1998 were similar to those of 1986, in that the word 'birth' only appeared in relation to the definition of a mother and baby whether '*before or after birth*' (UKCC 1998:8). The other words identified in the search did not appear. However, there was slight variation to Rule 40 (Responsibility and sphere of practice) in the 1998 rules: where a '*deviation from the norm*' is detected, a midwife should now '*call a registered medical practitioner or such other qualified health professional who may be reasonably expected to …. assist her*' (UKCC 1998:18). This illustrated a different level of responsibility for the midwife and widened the concept of the multi-professional team beyond just midwives and medical practitioners.

The 1994 code of practice (supporting the 1993 rules) used the word 'birth' for the first time. This was used in the context of 'home birth' and replaced the words 'home confinement' used in previous versions (UKCC 1994:20). This version also expanded the guidance supporting Rule 40 Sphere of practice, and, for the first time, introduced the concept of 'risk' and 'risk factors'. This replaced the previous terminology 'deviations from norm', which was used in the 1986 and 1993 rules. It could be interpreted that the reference point for childbirth was now 'risk' rather than the 'norm' from which there was variation. This is reflective of increased medicalisation at a time when women themselves were demanding more choice (Department of Health (DH) 1993).

The 1994 code of practice also introduced the concept of informed decision making for women when risk factors were present and stated: '*you should discuss her wishes with her*

… so that the mother may make a fully informed decision about her care' (UKCC 1994:9). This was the first reference towards partnership working and considering the woman as an equal decision maker in her care. Given that these rules were published directly after *Changing childbirth* (DH 1993) it appeared to be echoing the call for increased maternal choice reflected in this policy document. This philosophy was a long way from the 1980 rules in which the midwife was instructed to '*comply with the wishes of the* [registered medical] *practitioner …*' (CMB 1980:17 Rule 35b) and where there was no mention of the wishes of the woman at all.

In the 1998 rules, the code of practice was integrated for the first time (UKCC 1998). In both the 1994 and 1998 versions of the code of practice, the ICM definition of a midwife was included (ICM 1990). In both versions of the rules it stated: '*as a midwife you have a defined sphere of practice and you are accountable for that practice*'. However, this sphere of practice was not defined but only mentioned in Rule 40 as follows: '… *in an emergency or where a deviation from the norm which is outside her current sphere of practice becomes apparent …*' (UKCC 1998:17).

Nursing and Midwifery Council (NMC)

The NMC came into existence as a result of the *2001 Nursing and Midwifery Order* and remains the current PSRB for all nurses and midwives across the UK. The NMC initially retained a Midwifery Council, which was enshrined in the *2001 Nursing and Midwifery Order*. This provided the voice of midwifery in the new PSRB. However, with the demise of separate midwifery legislation in 2017, this was disbanded.

NMC 2004 and 2007

The first *Midwives' rules and standards* (NMC 2004) retained much of the content from the 1993 and 1998 UKCC publications. However, the format was different, as each rule was supplemented by a standard and guidance to explain it in more accessible terms. In the definitions, the word 'childbirth' appeared for the first time. This was defined in the guidance as:

> '*Childbirth is more than the act of giving birth. For a woman it is a continuous process from conception, through pregnancy, labour, birth and beyond. It is essential that anyone providing midwifery care during this time has the appropriate knowledge, skills and competence to do so*' (NMC 2004:5).

The word 'birth' also appeared in the definitions, under the term 'attendance upon' (NMC 2004:4).

The 2007 version of *Midwives' rules and standards* did not update the rules but included the 2005 EU legislation (European Parliament and the Council 2005) and the ICM definition of a midwife (ICM 2005). In the ICM definition the words 'normal birth' appeared for the first time. The definition of midwifery care stated: '*This care includes preventative measures, the promotion of normal birth, the detection of complications in mother and child …*' (NMC 2007:43).

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The term ‘normal birth’ did not appear in any other context in any of the rules or codes of practice, except in the ICM definition of the midwife (ICM 2005). However, the word ‘normal’ appeared in the definition of an emergency for the first time. Under the definition, it is stated: ‘*normal processes, such as spontaneous labour at term, would not usually be considered an emergency ...’* (NMC 2004:6).

In the 2004 *Midwives’ rules*, the wording of the section on Responsibility and sphere of practice (now Rule 6) remained very similar, with labour and birth still described as ‘intranatal’. In the standard, there was much more emphasis on partnership working. It stated that a midwife: ‘*c) should work in partnership with the woman and her family d) should enable the woman to make decisions about her care based on her individual needs, by discussing matters fully with her and e) should respect the woman’s right to refuse any advice given’* (NMC 2004:18). This is the most detailed guidance on woman-centred care in any iteration of the midwives’ rules.

The guidance provided under each rule was much more detailed than in the previous codes of practice and specified how the rule should be put into practice. For instance, in a situation where a woman ‘rejects’ advice, it was stated:

> ‘*you should seek further guidance from your supervisor of midwives to ensure that all possibilities have been explored and that the outcome is appropriately documented. The woman should be offered the opportunity to read what has been documented about the advice she has been given*’ (NMC 2004:20).

Giving the woman the opportunity to read what had been documented demonstrated a further increase in the level of autonomy for women. The guidance went on to state that the midwife must continue to give the best care she can, seeking support from other health care professionals as appropriate. As in the previous rules, the terms ‘risk’ and ‘potential risk’ were used with reference to situations outside the norm.

The 2004 rules also demonstrated an increased level of autonomy for the midwife, which was most clearly demonstrated in the guidance. For instance, 6.5 stated:

> ‘*You are accountable for your own practice and you cannot have that accountability taken from you by another registered practitioner, nor can you give that accountability to another registered practitioner*’ (NMC 2004:19).

When compared to the CMB 1980 rules, in which the role of the midwife was subservient to the medical practitioner, this was clear progress for midwives in statute regarding level of accountability.

NMC 2012

The 2012 *Midwives’ rules and standards* was much more concise and provided less clarity of explanation. For instance, the definition of ‘childbirth’ remained the same, but the guidance around what this meant for the midwife was removed. This meant that the definition of childbirth was reduced to: ‘*childbirth includes the antenatal, intranatal and postnatal periods*’

(NMC 2012:6). No further context as to what this meant for the role of the midwife was provided, unlike in the 2004 rules.

The 2012 version also pared back the sphere of practice (now termed Obligations and scope of practice rather than Responsibilities and sphere of practice) to just one rule:

> '*A practising midwife, who is responsible for providing care or advice to a woman or care to a baby during childbirth must do so in accordance with standards established and reviewed by the Council and in accordance with article 21(1)a of the Order*. (NMC 2012:13.)

While only the rules were bound by statute, a midwife's practice was measured against the standards set by the NMC and she was expected to meet the required level of these standards in her practice. She could be held accountable to the NMC through fitness to practise if these standards were not met. The standards were therefore tantamount to law even though they were not enshrined in statute.

In 2017, the ICM revisited the definition of a midwife (ICM 2017), summing up the key components of what a midwife does. Promotion of normal birth and accountability of the midwife were retained in this definition, and included partnership working with women:

> '*The midwife is recognised as a responsible and accountable professional who works in partnership with women to give the necessary support, care and advice during pregnancy, labour and the postpartum period, to conduct births on the midwife's own responsibility and to provide care for the newborn and the infant. This care includes … the promotion of normal birth…'* (ICM 2017:1).

This analysis of the language of birth and the role of the midwife through nearly 40 years of statutory documents reveals not only the development of midwifery autonomy but also that of women. In 1980, the rights or wishes of women were not mentioned or even alluded to in the rules. By 2012, midwives were required to discuss all aspects of care with women (and document these discussions) so that women could make an informed decision about the care they received. However, it is 10 years since the last publication of the *Midwives' rules* and midwifery practice has changed considerably during this time. For this reason, the Re:Birth project is taking a timely look at the language of childbirth today, and finding out how midwives, maternity care professionals and service users believe this should be expressed.

Language in textbooks

In parallel with the statutory midwives' rules, the language in midwifery textbooks is also of interest in understanding the concept of normality and the role of the midwife.

There are two main midwifery textbooks in the UK: *Mayes' midwifery* and *Myles textbook for midwives*. These have dominated the midwifery textbook market for decades. The earliest *Mayes' midwifery* was published in 1938; *Myles textbook for midwives* was first published in 1953. There have been 15 editions of *Mayes' midwifery* and 17 editions of *Myles textbook*

for midwives. We sampled four editions of each textbook from 1980 to 2020 as outlined in Table 2.

Table 2. List of textbooks included in the review

Textbook	Date	Editors	Edition
Myles	1981	Myles M	9th
Mayes'	1982	Sweet B	10th
Mayes'	1997	Sweet B	12th
Myles	1999	Bennett VR, Brown LK	13th
Myles	2009	Fraser D, Cooper M	15th
Mayes'	2011	Macdonald S	14th
Mayes'	2017	Macdonald S, Johnson G	15th
Myles	2020	Marshall J, Raynor M	17th

Textbook review methodology

We searched each edition for the same words as we looked for in the rules: 'normal', 'natural', 'physiological', 'birth'. We also explored the texts for references to the role of the midwife and the wider context of midwifery practice. Any reference to government policy which appeared to shape practice was also identified and discussed.

Findings

Mayes' and Myles 1980s and 1990s

In the textbooks of the 1980s, the dominance of medicalisation was evident, with reference to the midwife as the '*practitioner of normal obstetrics*' (Myles 1981:1). This was a very different understanding of the word 'normal' in relation to the midwife than that in subsequent editions. Of the midwife's role, Myles stated:

> '*It would now be considered a retrograde step for a midwife to take sole charge of an expectant mother, thereby depriving her of the scientific expert care that only the obstetric team can provide*.' (Myles 1981:2).

This language did not suggest that the midwife was a practitioner in her own right, which was, however, recognised in *Mayes'* 1982 textbook: '*because of the specialised role of the midwife and the fact that she is a practitioner in her own right …*' (Sweet 1982:13). However, *Mayes'* also used language such as 'patients' when talking about the women and 'confinement' when referring to birth (Sweet 1982), therefore reinforcing the medicalisation of midwifery in a parallel way to Myles (1981).

In the 1982 edition of *Mayes'*, continuity of care was discussed when referring to community midwifery and it was stated:

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> '… *this not only increases the job satisfaction of the community midwife but is also safer for the patients and gives them the continuity of care with their own doctor and midwife which they so much appreciate*' (Sweet 1982:555).

It should be recognised that the general practitioner (GP) was much more involved in care during pregnancy and childbirth in the 1980s than at the present time. This edition of *Mayes'*, however, included much stereotyping of women and families. For instance, in a section headed 'What is a family?', it stated:

> *'The family as we tend to know it – husband, wife and children – is a nuclear, conjugal or elementary family, a small residential group or single economic unit, a unit for rearing children.'* (Sweet 1982:11).

This provided a very narrow and stereotyped viewpoint of 'family' which was very different to that conceptualised in later textbooks and very different from our understanding today.

By the 1990s, post-*Changing childbirth* (DH 1993), the textbooks began to reflect the developing philosophy of 'normal' or 'natural' childbirth. In the 1999 edition of *Myles* (Bennett & Brown 1999) it was recognised that *Changing childbirth* started from the premise of childbirth being a normal physiological event, rather than from the previous stance that childbirth was innately hazardous and needed medical intervention.

In defining the midwife, the authors stated: '*The midwife is the expert in normal midwifery and has an obligation to care for mothers and babies*' (Bennett & Brown 1999:6). The authors also stated:

> '*Midwives see birth as a social event as opposed to a medical one and it is part of their remit to preserve this normal family context for women even when there are deviations from physiological expectations*' (Bennett & Brown 1999:4).

'Normal' and 'normality' were therefore used as the dominant language of midwifery practice, which was a philosophical shift away from the medicalised language of childbirth seen in the textbooks a decade earlier.

Mayes' in the 1990s defined the midwife in a similar way: '*… the midwife, as an independent practitioner of normal midwifery … has the limits of her practice clearly defined*' (Sweet 1997:4). This text also referred to the *Changing childbirth* report (DH 1993), seeing it as part of the '*groundswell of opposition to the medicalisation of childbirth from the consumer*' (Sweet 1997:8) and stated:

> '*To an increasing number of women, natural childbirth is the ideal and they are turning to the midwife to help them achieve* [this]' (Sweet 1997:8).

Having said this, it also stated:

> '*Notwithstanding the disputed efficacy of the dominant culture of obstetrics in childbirth* … [the author] *cautions against the romanticised notions of childbirth in pre-modern times and in non-Western cultures*' (Sweet 1997:995).

It seems there is a dichotomy here about what the midwife ought to be and the dominant medical paradigm midwives (and women) appeared to be fighting against.

Mayes' and Myles 2000–2011

In *Myles* (Fraser & Cooper 2009a) the idea of promoting normality was taken one step further. In discussing the midwife and professional autonomy, the authors suggested that the midwife had a different approach from the rest of the health care team:

> '*The worldview of midwifery is to have confidence in normal or physiological processes, rather than feeling that these could fail at any moment. This worldview requires a different knowledge base, research interest and skill set in midwives*' (Page 2009:44).

There was much more emphasis on the importance of the relationship between the midwife and the woman, which appeared as the first heading in the textbook: 'Midwives, women and their birth partners' (Fraser & Cooper 2009b:3). This chapter talked about the midwife as the 'woman's advocate', with much greater emphasis on the woman's right to informed choice than in previous editions.

In the context of normal childbirth, Fraser & Cooper (2009b) debated the definition of 'normal', stating: '*A difficulty of definition arises over whether any interventions can be classed as being "normal" and from whose perspective*' (Fraser & Cooper 2009b:4). They discussed the classification of 'routine' versus 'normal', where procedures such as ultrasound had become routine and were therefore considered to be normal, a debate which continues today. They talked about the midwife's ability and skills to cope with uncertainty and that the role of the midwife on the one hand, involved being '*independent practitioners with their "normal" caseload*' (Fraser & Cooper 2009b:4) while also being able to manage complications and work with the multi-professional team. The idea of uncertainty in midwifery is interesting because it implied that the role of the midwife could not be clearly delineated, as it was in the previous decade.

Mayes' textbook of the same period (Macdonald & Magill-Cuerden 2011) used the terms 'normal' and 'natural' birth but there was no debate about what that meant. It also introduced the 'ubiquitous concept of risk' (Donnison 2011:29) which was the first mention of 'risk' as a discussion in the textbooks.

This edition of *Mayes'* textbook discussed the future of midwifery and stated:

> '*… the future of midwives proper (as opposed to those acting under medical direction in interventionist birth, in fact as maternity nurses) is bound up with normal birth.*' (Donnison 2011:30.)

The idea that midwives could only be 'proper' midwives if they protected normality is a strong standpoint in this chapter and could be seen as controversial.

The importance of the birthing environment was also recognised in this edition:

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> '*Practitioners of normal birth and women themselves know how significant the birth environment is for the experience and outcomes of normal birth*' (Walsh 2011:489).

However, it also stated:

> '*It could be argued that normal labour and birth are under threat with only about 47% of women in England having a drug free normal birth*' (Walsh 2011:483).

Having reclaimed the language of 'normal birth', it appeared that the likely outcome of birth being normal was once more being challenged by an increase in interventions and medicalisation.

Mayes' and Myles 2017 to date

In the 2017 version of *Mayes'*, the term 'normal birth' appeared in the text 24 times (Macdonald & Johnson 2017). There was, for the first time, a definition of what normal birth was and what it was not: '*defined as births without induction, caesarean, instrumental delivery or episiotomy but including epidurals and other anaesthetics*' (Macdonald & Johnson 2017:43).

This is interesting because midwives in previous generations might have included episiotomy as an element of normal birth, given that this is listed as one of the activities of a midwife in the *European Directive 2005/36/EC* (European Parliament and the Council 2005). There was also a change in the interpretation of 'normal' when discussing the care continuum:

> '[The care continuum] *has made the midwife the recognised expert of the normal with this continuum, both for women with a low-and high-risk pregnancy …*' (Johnson & Macdonald 2017:1151).

It was not clear from the text how normality was perceived within high-risk care, but this was a novel definition of the role of the midwife within the textbooks.

When discussing the role of the midwife, the 2017 edition of *Mayes'* suggested a more conflicted role than in previous texts. In the opening section, it stated:

> '*Many* [midwives] *are disillusioned by the gulf between their aspirations to be true midwives, or 'with women', and the hurried reality of care ruled by medical direction and managerial imperative*' (Donnison & Macdonald 2017:44).

In this quote, the tensions between medicalisation, midwifery and workload were recognised. There was also acknowledgment that the role of the midwife was being delegated, with particular reference to postnatal care. The authors stated:

> '*Midwives do need to challenge what this loss of one significant aspect of care means for the women and babies, and equally importantly for midwives and midwifery itself*' (Johnson & Macdonald 2017:1151).

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In the latest edition of *Myles* (Marshall & Raynor 2020), the role of the midwife in the UK was replaced by the definition of the global midwife. Under 'definition of a midwife', there was reference only to the ICM definition (ICM 2017) and to the EU Directives *European Directive 2005/36/EC* and *Modernized Directive 2013/55/EU (*European Parliament and the Council 2005, 2013). There was very brief mention of the new NMC *Standards of proficiency* (NMC 2019) which regulate all midwives' practice in the UK:

> *'… each midwife must meet the Standards of Proficiency for Midwives (NMC, 2019) which stipulate the knowledge, understanding and skills that all midwives must demonstrate to be eligible to enter the UK NMC professional register*' (Marshall & Austin 2020:46).

Given that these proficiencies encapsulate the definition of a midwife in the 2020s, this would seem to be very scant mention in a textbook of 1016 pages.

In this edition of *Myles* (Marshall & Raynor 2020), there was also a section on the family in society, which was very different to that in the 1980s textbooks (Raynor et al 2020). There was clear acknowledgment of the changes to the traditional family, including recognition of fewer marriages, increased number of lone parents, same sex couples and asylum/refugee families. This was a very different definition of 'family' from that in *Mayes'* 1982 textbook (Sweet 1982).

For the first time in either textbook, there was a chapter on fear of childbirth (Snapes 2020). The author stated:

> '… *it may be that the medicalisation of childbirth has decreased women's confidence to give birth, while also producing a normative frame of reference*' (Snapes 2020:439).

In the chapter relating to first stage of labour, it was stated:

> '… *definitions of normal birth in high income countries can be contentious, due to the inclusion of some common but nonetheless interventionist practices*' (Jackson et al 2020:448).

There was also a short section on the language of childbirth, which included:

> '… *the word delivery has been replaced by the term birthing or birth as these appear more suitable when discussing the concept and practice of normality within midwifery*' (Snapes 2020:455).

These concepts appear to be paradoxical. On the one hand, the language of normality is being promoted, while on the other, some women appear to have lost confidence in the process of normal birth and a range of medical interventions are being included by some in the definition of normal birth.

Conclusion

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In this review, the concept of ‘normal birth’ and ‘normality’ was not found to have played any part in the statutory definitions of the role of the midwife over the last 42 years. The review of the midwives’ rules and codes of practice highlighted the developing role of the midwife and of women in society. It also highlighted a growing level of autonomy of the role of the midwife in relation to medical colleagues and a greater role for women in making choices about their care.

This evolution was also reflected in the review of the midwifery textbooks. The concept of normality and the role of the midwife in supporting and promoting normal birth first appeared in midwifery textbooks during the 1990s and has continued to be described since. However, the wider role of the midwife in providing universal care for all women, including those requiring medical interventions and the role of the midwife in promoting public health and mental health, has also developed in the texts over the last 10 years and is replicated in the most recent NMC Future midwife standards.

This review highlights that the role of the midwife has evolved continually over the last 42 years and the language of midwifery and maternity care has also reflected this evolution. The developing role of the midwife and the language used in our rules, standards and textbooks, reflects changes in society and the role and needs of women. Midwifery and the language we use to describe birth has never stood still and will continue to evolve. The debate that led to the Re:Birth project and the findings of the Re:Birth project reflect this social change and will help inform the language used by midwives and other maternity professionals.

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