Myles Textbook for Midwives

Jayne Marshall Maureen Raynor

17TH edition

Foreword by
Professor Jacqueline Dunkley-Bent

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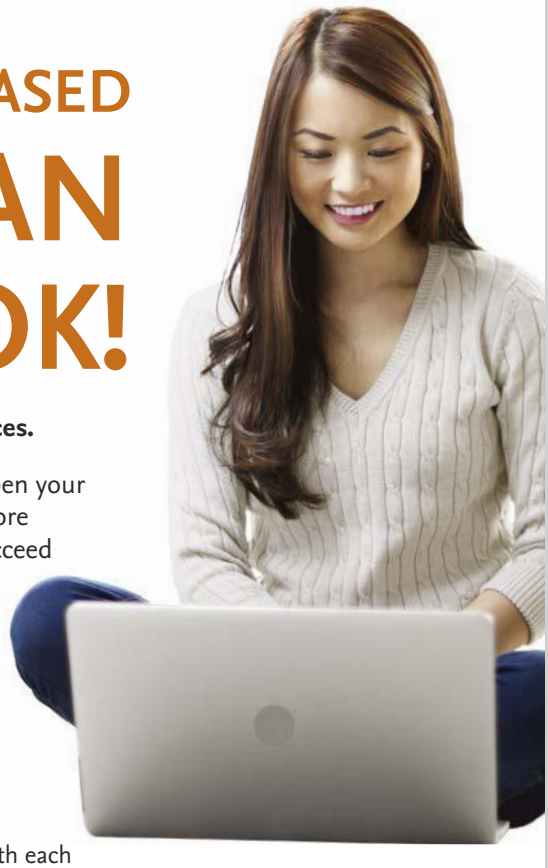

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Myles Textbook for Midwives

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17TH edition

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Edinburgh London New York Oxford Philadelphia St Louis Sydney 2020

First edition 1953
Second edition 1956
Third edition 1958
Fourth edition 1961
Fifth edition 1964
Sixth edition 1968
Seventh edition 1971
Eighth edition 1975
Ninth edition 1981
Tenth edition 1985
Eleventh edition 1989
Twelfth edition 1993
Thirteenth edition 1999
Fourteenth edition 2003
Fifteenth edition 2009
Sixteenth edition 2014

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ISBN: 978-0-7020-7642-8
IE ISBN: 978-0-7020-7643-5

Content Strategist: Alison Taylor and Poppy Garraway
Content Development Specialist: Veronika Watkins
Content Coordinator: Susan Jansons
Project Manager: Anne Collett and Louisa Talbott
Design: Amy Buxton

Printed in Poland

Last digit is the print number: 9 8 7 6 5 4 3 2 1

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SECTION 6 The Neonate

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FOREWORD

I am deeply humbled and honoured to write the foreword for this incredible text book. As the Chief Midwifery Officer for the NHS in England, I am passionate about the unique and significant contribution that midwives make to the maternity experiences of women, babies and their families. Globally midwives work tirelessly to provide the best maternity care for women and babies that women seldom forget. The old adage that a woman never forgets her midwife is a reality and I am keen that the memory is a positive one! The knowledge gained from the content of this textbook will provide an opportunity for student midwives and midwives to be the best that they can be.

Since the publication of the sixteenth edition of *Myles Textbook for Midwives* in 2014, the needs of childbearing women, babies and their families have continued to shape the provision of maternity care and the role of the midwife in contemporary society. More women in the United Kingdom are having babies when they are older, are of a greater weight and present with more underlying health conditions than ever before.

The proportion of mothers aged 35 years or older at the time of birth in England and Wales has increased year on year from 19.9% in 2010 to 23.4% in 2018, which continues a long-term increasing trend since the 1970s. More than half of women (50.4%) with a recorded BMI at booking were overweight or obese (up from 47.3% in 2015/16).[1] Inequalities in health outcomes continue to persist and perinatal mental health continues to drive the development of timely and appropriate short- and long-term healthcare.

Health care policy in the UK has kept pace with these changes and since the 2016 publication of *Better Births*,[2] the report of the national maternity review, the NHS in England and system partners have collectively come together to implement its vision, for safer and more personalised care across England and deliver the national ambition to half the rates of stillbirths, neonatal mortality, maternal mortality and brain injury by 2025. I am mindful that healthcare policy and its focus on maternity care is not universal, but the knowledge espoused in this textbook will undoubtedly support midwives worldwide to improve this care.

The midwife plays a significant and pivotal role in improving health outcomes, ensuring that care is personalised and safe. This contribution is usually unique and involves the development of a special relationship between the woman and midwife and sometimes the family too, if they are present. This relationship develops and flourishes if the same midwife provides antenatal, intrapartum and postnatal care and is associated with improved experiences and health outcomes. I am reassured that the seventeenth edition of the *Myles Textbook for Midwives* provides the depth and breadth of knowledge to support a student midwife and the continuing professional development of a qualified midwife, to deliver personal and safe maternity care.

The content of the chapters in this addition of *Myles* has kept pace with the everchanging needs of maternity care and the varied and sometimes complex needs and circumstances of women, babies and their families. This edition provides the reader with knowledge and the associated practical application for the development of firm foundations, from which further learning, and development can take place, particularly as midwives frequently traverse the fine line between the intrepid joy of new life and the hurt and despair associated with loss and a life unlived.

I am heartened to see the logical progression and flow of the chapters, that takes the reader on a journey of discovery, but more importantly a journey that builds a comprehensive picture of the childbirth continuum and the midwife's role.

Section one provides the context of midwifery practice with an appropriate focus on professionalism, a much-needed chapter within a societal context where social media and the digital maternity platform grows

[1]National Maternity and Perinatal Audit: https://maternityaudit.org.uk/pages/cr2019km

[2]National Health Service (NHS) England (2016) National Maternity Review. Better Births: Improving outcomes of maternity services in England: A Five Year Forward View for maternity care, London, NHS England: https://www.england.nhs.uk/wp-content/uploads/2016/02/national-maternity-review-report.pdf

and develops at pace, to support women of childbearing age to be knowledgeable and empowered to make decisions about their reproductive health.

Chapter five skilfully describes the hormonal cycles, fertilization and early development that educates and or reminds the reader of the midwife's role in the knowledge required to educate women and their families in the basic principles of genomics and the significance of appropriate sign posting for specialist support where this is available. The benefits of understanding the aetiology and pathophysiology of medical and obstetric conditions is an essential and significant part of a midwife's role and I am inspired by the depth and breadth of information in Chapter 26 that supports the preparation of the midwife, with knowledge to recognise the acutely unwell woman, maternal collapse and resuscitation needs.

Generally, the depth of physiology and its application to maternity care and the midwife's role is exceptional in this edition of *Myles* and reflects the contribution of multidisciplinary authors that adds to the authenticity and credibility of the content. I am confident that the foundational principles describe in this text book will provide the reader with the firm foundations required for learners to practise safely and qualified midwives to refresh their knowledge.

Reflecting on my experiences of knowledge acquisition and how I learn best, I am mindful that reading a text book in the absence of reflecting on what I have read and applying knowledge gained to practice, reduces the depth of my learning and limits my desire to read wider. I appreciate that this is not the experience of every learner, but I am absolutely delighted to applaud the authors of this edition of *Myles Textbook for Midwives,* for the extraordinary lengths they have gone to ensure that chapters conclude with reflective activities for self-assessment. I encourage readers to undertake these activities that promise to assist with knowledge acquisition and learning, remembering always that your presence is evidence that your midwifery purpose is necessary!

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PREFACE

It is a great privilege to have been approached a second time by Elsevier to undertake the editorship of the seventeenth edition of *Myles Textbook for Midwives*. It is nearly 70 years since the Scottish midwife Margaret Myles wrote the first edition and this book remains highly regarded as a seminal text for student midwives and practising midwives alike throughout the world, with adaptation to the African context and a recent translation into Korean.

Over the ensuing decades, many changes have taken place in the education and training of future midwives alongside increasing demands and complexities associated with the health and wellbeing of childbearing women, their babies and families within a global context. Furthermore the development of evidence-based practice and advances in technology have also contributed to major reviews of how undergraduate curricula are delivered to ensure that today's graduate midwives are able to rise to the many challenges of the multifaceted role of the 21st century midwife, ensuring they are fit for practice and purpose. The seventeenth edition has been developed with these issues in mind, as we both would expect midwives to provide safe and competent care that is tailored to the individual needs of childbearing women, their babies and families with a professional and compassionate attitude.

The content and format of this edition of *Myles Textbook for Midwives* has been further developed and enhanced in response to the collated views regarding the format and contents of the sixteenth edition that have been received from students and midwives from around the world. While we acknowledge that midwifery practice should always be informed by the best possible up-to-date evidence, we also appreciate that since some research studies are still ongoing or just emerging, it is impossible to expect any new text to contain the most contemporary research and systematic reviews on every single topic relating to midwifery practice. Consequently, this edition provides the reader with comprehensive reference lists, details of annotated further reading and links to appropriate websites.

The online multiple-choice questions have been updated, revised with additions made to reflect the focus of the chapters in this edition as readers appreciate their use in aiding self-assessment of learning. New to this edition are reflective questions at the end of each chapter for the reader to utilise as a means of self-assessment of the content and as a revision aid as well as for lecturers to explore issues with their students within the learning environment.

There has been some revision in the ordering of chapters to replicate the childbirth continuum and improve the logical progression. Throughout its history, *Myles Textbook for Midwives* has always included clear and comprehensive illustrations to complement the text and, as with the sixteenth edition, full colour has been used throughout this text and in response to feedback, new diagrams and contemporary images have been added where appropriate.

We are grateful that a number of chapter authors have continued their contribution to successive editions of this seminal text and we also welcome the invaluable contributions from new authors who have passion and enthusiasm to impart their knowledge and experience in specific subject areas. It is vital to retain the ethos of the text being a textbook for midwives that is written by midwives with the appropriate expertise. Our role as editors as well as midwifery educationalists is to encourage and nurture new authors who have the potential to publish their work as well as continue the legacy of Margaret Myles. Furthermore, the text continues to reflect the eclectic nature of maternity and neonatal care and consequently some of the chapters have been written in collaboration with members of the multiprofessional team. This highlights the importance of health professionals working and learning together in order to enhance the quality of care women and their families receive. This is essential whenever complications develop in the physiological process throughout the childbirth continuum. In all clinical situations, the presence of the midwife is integral and the role is significant in ensuring the woman always receives the additional care required from the most appropriate health professional at the most appropriate time.

Where appropriate, case studies of personal experiences from childbearing women and some

partners/fathers have been included to add depth to the contents of the chapter. Such contributions are invaluable to learning and, as editors we are indebted to these women and the fathers/partners who have unreservedly had to relive their childbirth experiences, often being a difficult and life changing event.

Since the sixteenth edition was published in 2014, there have been significant changes within the global context of midwifery education and practice that this text has aimed to capture. This includes the introduction of the Sustainable Development Goals, the *Lancet* series Global Framework for Quality Maternal and Newborn Care (presented in a new Chapter 8: Designing and implementing high quality midwifery care), employer-led supervision, the introduction of the Nursing and Midwifery Council's *Realising Professionalism: Standards for Education and Practice Framework*, safeguarding of vulnerable individuals and professional revalidation/continuing professional development (Chapter 2) that are fundamental to every midwife practising in the 21st century. We acknowledge that medicalization and consequential effect of a risk culture in the maternity services have eroded some aspects of the midwife's role over time. It is our aim to continue challenging midwives into becoming critical thinkers, compassionate leaders and effective change agents who have the confidence to empower women into making choices appropriate for them and their personal situation.

Recognizing that midwives increasingly care for women with complex healthcare needs within a multicultural society and take on specialist or extended roles, significant chapters have been added to make the text more contemporary. Chapter 12 explores the midwife's role in supporting women who have concealed their pregnancy; Chapter 18 examines the challenges that midwives face when women present with tocophobia (fear of childbirth) and Chapter 26 guides the reader through the principles of caring for the critically ill mother, including maternal resuscitation. This is a pivotal chapter given the increasing number of women presenting with co-morbidities and other complexities that may arise during pregnancy, labour and postpartum. Recognizing that not all pregnancies result in healthy babies, Chapter 38 explores end-of-life care provided to babies with life-limiting conditions within the context of legal and ethical issues and the dilemmas that families and healthcare professionals may face in such situations.

It is a great honour that the Foreword to the text has been written by Professor Jacqueline Dunkley-Bent, the first Chief Midwifery Officer for England. Her appointment to this role is pivotal in the history of midwifery in the United Kingdom in terms of strengthening midwifery leadership and recognizing the uniqueness of our profession and the importance of the role that midwives play in the lives of childbearing women, their babies and families.

We hope that this new edition of *Myles Textbook for Midwives* will continue to provide midwives with the foundation of the physiological theory and underpinning care principles to inform their clinical practice and support appropriate decision-making in partnership with childbearing women and members of the multiprofessional team. However, we recognize that knowledge is unlimited and that this text alone cannot provide everything midwives should know when fulfilling their multi-faceted roles. Nonetheless, it can afford the means to stimulate further enquiry and zest for continuing professional development.

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ACKNOWLEDGEMENT

As editors of the seventeenth edition of *Myles Textbook for Midwives,* we are indebted to the many authors of earlier editions of this seminal midwifery text whose work has provided the foundations from which this current volume has evolved. From the sixteenth edition, these contributors include the following chapter authors:

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During the development of our second experience of editing *Myles Textbook for Midwives*, the production team at Elsevier has continued to be invaluable in providing the support and guidance to us, in the updating of the textbook in order that it remains a contemporary and internationally renowned resource for midwives, student midwives and other allied healthcare professionals. In addition, we wish to acknowledge the support of friends, family and colleagues that has enabled us to accomplish the task alongside our academic work commitments.

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SECTION 1

The Midwife in Context

1

The Midwife in Contemporary Midwifery Practice

Maureen D. Raynor, Joy Kemp, Michelle Anderson

CHAPTER CONTENTS

Midwives are global citizens who require a broad toolkit of skills and knowledge in order to work collaboratively with women as equal partners in their care, and across professional boundaries with key members of the multidisciplinary team (MDT). Contemporary midwifery education and practice are driven by key global initiatives such as the United Nations' Sustainable Development Goals (SDGs) and the International Confederation of Midwives' international definition of the midwife (UN 2015a,b; ICM 2017).

THE CHAPTER AIMS TO

- explore the midwife in context, taking a number of influential social and global issues into consideration especially the midwife as a global citizen with due consideration of the UN Sustainable Development Goals, the European (EU) Directives and International Confederation of Midwives Education Standards
- explore the emotional context of midwifery
- explore the concept of family in contemporary society
- explore working with women from socially disadvantaged groups
- explore research and the midwife.

GLOBAL HEALTH: THE CONTRIBUTION OF MIDWIVES

Midwives as Global Citizens

It is important that midwives have an understanding of the global context of midwifery as today's health professionals must be global citizens who are culturally congruent, able to provide effective care to multicultural communities with diverse needs (Academy of Medical Royal Colleges, AMROC 2016; Flying Start NHS 2018; West et al. 2017). Additionally, there is much that can be learned from international engagement, which can

enrich and strengthen health services at home (DH 2014; THET 2017; Royal College of Physicians and Surgeons Glasgow, RCPSG 2017).

THE STATE OF THE WORLD: BETTER CONNECTED AND YET MORE UNEQUAL THAN EVER

Globalization means that the world is more connected than ever before; countries are becoming increasingly interdependent through greater economic integration, communication and technology, cultural dissemination and travel; this has the effect of making the world seem smaller (Labonté 2018). McLuhan and Fiore (1968) first described this connected world as a 'global village'. However, despite the world's greater connectedness, there is also growing inequity between and within nations and women, and children are often disproportionately disadvantaged.

Gender inequalities manifest themselves in every dimension of sustainable development (UN Women 2018). One person out of every nine in the world is under-nourished and women are often the first to go hungry; failure to reduce hunger is associated with increasing conflict and violence. While hunger grows, obesity is also rising which increases the risk of non-communicable diseases such as diabetes and hypertension (FAO et al. 2018). Provision of clean water and sanitation is also inequitable; in households without water, responsibility for water collection mainly falls to women and girls with adverse implications for their health and safety (UN Women 2018). There are 844 million people globally without access to water and this is directly linked to 289,000 child deaths per year. Additionally, one in three people do not have access to a toilet (WHO/UNICEF 2017; WASHWatch 2017).

Gender discrimination and violence against women and girls remains pervasive across the world. One in five women and girls have experienced physical and/or sexual violence by an intimate partner within the last 12 months, yet 49 countries have no laws that specifically protect women from such violence (UN Women 2018). The number of people living in extreme poverty has fallen but this decline has slowed and rates remain stubbornly high in low-income countries and those affected by conflict and political upheaval (World Bank 2018). The effects of climate change are also experienced inequitably; women commonly face higher risks and greater burdens from the impact of climate change in situations of poverty, and the majority of the world's poor are women (United Nations Climate Change, UNCC 2019). Conflict is a major contributor to humanitarian need and there is a complex dynamic between poverty, environmental vulnerability and fragility that continues to affect significant numbers of poor people (Development Initiatives 2018). An estimated 136 million people in 20 countries require protection and humanitarian assistance each year; this figure comprises a total of 34 million women of reproductive age including 5 million pregnant women (UNFPA 2018).

At least half of the world's population does not have full coverage of essential health services and the need to pay for health care can push families into extreme poverty. 'Universal Health Coverage' is an ambition shared by all countries within the United Nations (UN), which aims to ensure all people have access to quality health services without suffering financial hardship as a result of paying for health care (World Health Organization, WHO 2018a).

Although the global maternal mortality ratio nearly halved between 1990 and 2015 (Koblinsky et al. 2016), approximately 830 women still die every day from preventable causes related to pregnancy and childbirth. Additionally, there are an estimated 7000 newborn deaths per day and 2.6 million stillbirths per year (UNICEF 2018; Lawn et al. 2016). More than 92% of all maternal and newborn deaths occur in 73 low- and middle-income countries; however, only 42% of the world's medical, midwifery and nursing personnel are available in these countries (UNFPA 2014). Moreover, poor-quality and inaccessible care exist even in high- and middle-income countries (Lancet 2014; WHO 2018b; Koblinsky et al. 2016). A total of 214 million women and girls around the world, most of them in poor and vulnerable communities, have an unmet need for contraception, contributing to 25 million unsafe abortions each year (Starrs et al. 2018; International Federation of Gynecology and Obstetrics, FIGO 2018). In recent years there has also been a sharp rise in inappropriate and harmful obstetric intervention in childbirth with a global epidemic of caesarean sections (Lancet 2018). All of this means that for many women around the world they receive 'too little, too late' or 'too much too soon' (Lancet 2016).

TABLE 1.1 Core Components of a Right to Health	
Availability	Refers to the need for a sufficient quantity of functioning public health and healthcare facilities, goods and services, as well as programmes for all
Accessibility	Requires that health facilities, goods and services must be non-discriminatory in terms of physical accessibility, economical accessibility (affordability) and information accessibility
Acceptability	Health care must respect medical ethics, be culturally appropriate and sensitive to gender and the specific needs of diverse people groups
Quality	Services should be safe, effective, people-centred, timely, equitable, integrated and efficient. Quality is a key component of universal health coverage and includes the experience as well as the perception of health care

WHO (World Health Organization). (2017) Human rights and health. Available at: www.who.int/news-room/fact-sheets/detail/human-rights-and-health.

TABLE 1.2 The Seven Rights of Childbearing Women	
1.	Freedom from harm and ill-treatment
2.	Right to information, informed consent and refusal and respect for choices and preferences, including the right to companionship of choice wherever possible
3.	Confidentiality, privacy
4.	Dignity, respect
5.	Equality, freedom from discrimination, equitable care
6.	Right to timely health care and to the highest attainable level of health
7.	Liberty, autonomy, self-determination and freedom from coercion

White Ribbon Alliance. (2011) Respectful maternity care: the universal rights of childbearing women. Available at: www.whiteribbonalliance.org/wp-content/uploads/2017/11/Final_RMC_Charter.pdf.

THE RIGHT TO HEALTH AND RESPECTFUL MATERNITY CARE

Global health factors are focused on improving health and achieving health equity for all people worldwide (Squires 2018). Every human being has a right to the highest achievable standard of health without distinction of race, religion, political belief, economic or social condition (WHO 2017). Table 1.1 highlights the (WHO 2017) core components of a right to health.

The right to health encompasses the right to sexual and reproductive health and to respectful maternity care. Sexual and reproductive health rights also cut across other human rights, such as the right to privacy, the right to education and the prohibition of discrimination (United Nations Human Rights Officer of the High Commissioner, OHCRH 2019). Sexual and reproductive health are fundamental for women's full participation in society (Zuccala and Horton 2018). Sexual and reproductive health rights are important, not only for individuals' wellbeing and development, but for sustainable development (Starrs et al. 2018). However, progress towards the achievement of these rights has been slow for complex reasons.

Respectful maternity care is a concept that is based on respect for women's basic human rights and advocates for women to be free from disrespectful and abusive treatment at the hands of maternity care providers (Manning and Schaaf 2018). Table 1.2 details the seven rights of childbearing women charter from the White Ribbon Alliance (2011).

Health workers also have personal, employment and professional rights, including safe and decent working environments and freedom from all kinds of discrimination, coercion and violence (WHO 2016a). However, the recent global survey of 2470 midwives from 93 countries (WHO 2016b) found widespread experiences of: disrespect; subordination and gender discrimination; harassment; social isolation and lack of safe accommodation; salaries insufficient to meet basic needs; and a lack of

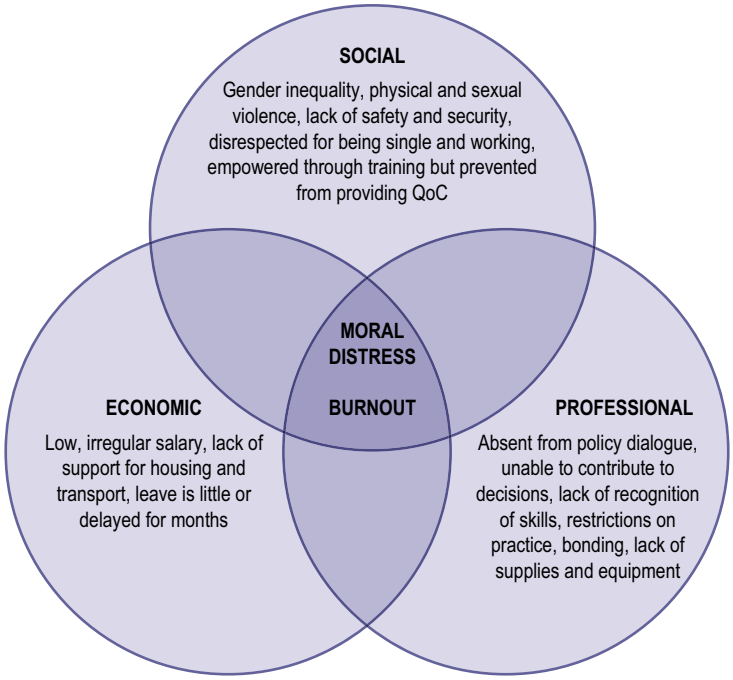

Fig. 1.1 Barriers to the provision of quality care by midwifery personnel. (Reproduced with permission from the World Health Organization 2016. Midwives voices, midwives realities: finding from a global consultation on providing quality midwifery care. Available at: www.who.int/maternal_child_adolescent/documents/midwives-voices-realities/en.)

opportunity for professional and leadership development. These experiences can lead to moral distress and burnout. Fig. 1.1 highlights the barriers to midwives being able to provide quality care (WHO 2016a).

MIDWIVES AND THE SUSTAINABLE DEVELOPMENT GOALS

In 2015, the 193 member states of the UN unanimously adopted the 17 sustainable development goals (SDGs), aiming to transform the world over the next 15 years. The SDGs built on the foundation of the Millennium Development Goals, which galvanized unprecedented efforts to meet the needs of the world's poorest (UN 2015a). Goal 3 relates to health, with the aim of ensuring good health and wellbeing for all. Within this goal there are subgoals relating to maternal and newborn health: to reduce the global maternal mortality ratio to fewer than 70 maternal deaths per 100,000 live births; reducing neonatal mortality to at least as low as 12 per 1000 live births; and ensuring universal access to sexual and reproductive healthcare services. The SDGs set ambitious targets for universal health coverage of essential health services by 2030 (UN 2015b). Fig. 1.2 sets out the UN SDGs.

Ultimately, sustainable development rests on the autonomy and empowerment of women and their health and wellbeing (Zuccala and Horton 2018). Midwives are central to achieving the SDGs. High quality midwifery care saves lives and midwives have the competence to meet 87% of women and their newborn service needs and to avert two-thirds of maternal and newborn mortality (Lancet 2014; UNFPA 2014; International Confederation of Midwives, ICM 2014a). No woman or newborn should face a greater risk of preventable death because of where they live or who they are; however, there is a global shortage of 17.4 million healthcare workers including 350,000 midwives (WHO 2015, 2016b; ICM 2014b). Investment in midwives is a key priority for the WHO (2016c). UNFPA (2014) suggests that investing in midwives could yield a 16-fold return on investment in terms of lives saved and costs of caesarean sections avoided, and is a 'best buy' in primary health care. It also frees other health carers to focus on other health needs.

Fig. 1.2 The UN's Sustainable Development Goals. (From https:// www.un.org/sustainabledevelopment/news/communications-material.) The content of this publication has not been approved by the United Nations and does not reflect the views of the United Nations or its officials or Member States.

The All Party Parliamentary Group on Global Health (2016) suggests that investing in nurses and midwives will have a triple impact: better health, greater gender equality and stronger economies.

THE DEFINITION AND SCOPE OF A MIDWIFE

The international definition of a midwife is provided by the International Confederations of Midwives (ICM 2017a) as delineated in Box 1.1.

Midwives are the primary (but not the only) providers of midwifery care (Renfrew et al. 2014). The ICM (2017a) International Definition of a Midwife, Global Standards for Midwifery Education (ICM 2013) and the Global Competencies (ICM 2019) provide a benchmark upon which individual regions or countries set their own frameworks for midwifery education and regulation. Table 1.3 details the ICM (2019) essential competencies for midwifery practice.

The provision of high quality midwifery should not be limited by politics or borders. However, even in high-income countries such as within Europe, maternity services and outcomes for women and their babies varies enormously (Euro-Peristat 2018).

In European law, midwives are governed by European Directive 2005/36/EC and Modernized Directive 2013/55/EU, which relate to the recognition of professional qualifications in practice. These directives strengthen midwifery education by setting minimum standards; they also allow midwives to move across borders and to practice their occupation or provide services abroad, provided they register with the relevant regulatory body in the host country. WHO (2015b) recommends that all midwives in the European region are educated to a minimum of degree level. In the UK, the Nursing and Midwifery Council regulates midwives and produces standards for midwifery education and competence, based on the ICM's international standards. Table 1.4 broadly outlines the global midwifery education standards (ICM 2013), which set benchmarks for the preparation of a midwife based on global norms. They are based on the values of trust in the midwifery education process, continuous quality improvement

BOX 1.1 The International Definition of a Midwife

A person who has successfully completed a midwifery education programme that is based on the ICM Essential Competencies for Basic Midwifery Practice and the framework of the ICM Global Standards for Midwifery Education and is recognized in the country where it is located; who has acquired the requisite qualifications to be registered and/or legally licensed to practice midwifery and use the title 'midwife'; and who demonstrates competency in the practice of midwifery.

(ICM 2017a)

Midwifery is defined as:

Skilled, knowledgeable and compassionate care for childbearing women, newborn infants and families across the continuum throughout pre-pregnancy, pregnancy, birth, postpartum and the early weeks of life. Core characteristics include optimising normal biological, psychological, social and cultural processes of reproduction and early life, timely prevention and management of complications, consultation with and referral to other services, respecting women's individual circumstances and views, and working in partnership with women to strengthen women's own capabilities to care for themselves and their families.

(Renfrew et al. 2014)

for midwifery education programmes, maintaining integrity through fair and honest education, fostering life-long learning and promoting autonomy for the midwifery profession.

Looking to the future, global midwifery education standards will need to prepare midwives for caring for women in conflict and crisis and make recommendations about adequate water and sanitation provision for student midwives and educators. Within Europe, the Erasmus programme provides opportunity to gain an international perspective by exchange programmes between students from different universities in different countries (European Commission 2018; UCAS 2018).

STRENGTHENING GLOBAL MIDWIFERY TOWARDS 2030

The evidence for midwives' contribution to global health is stronger than ever and the global momentum generated by SDGs provides a unique opportunity for advocacy aimed at strengthening midwifery and investing in midwives. The State of the World's Midwifery Report (UNFPA 2014) suggests a 'Midwifery 2030 Pathway' for all countries and any health systems designed to ensure provision of woman-centred sexual, reproductive, maternal, newborn and adolescent health care, through strengthening 10 key foundations. These include universal access to high quality midwifery care, a well-trained, regulated and managed midwifery workforce, supportive and accountable governments and strong professional midwives associations (ten Hoope-Bender et al. 2016).

The 2030 agenda compels midwives to have a strong voice, positioning themselves to help achieve high quality universal health coverage for all. However, although midwives can articulate solutions for achieving high quality maternity care, their voices are not always heard (WHO 2016a). Coming together in a professional midwives association gives midwives a stronger voice by combining their efforts, thoughts and ideas and giving credibility and power to the midwifery profession. The ICM promotes twinning between professional midwives associations for mutual strengthening (Survive & Thrive 2016; ICM 2014b, 2018). An example of this is the twinning initiative between the Royal College of Midwives (RCM) and the Bangladesh Midwifery Society; this project aims to strengthen midwifery both in Bangladesh and in the UK. (Further information about the RCM Twinning project can be accessed at: www.rcm.org.uk).

As well as partnering with other midwives, it is also important that midwives work in partnership with women to advocate for investment in midwifery; midwifery is a profession that is based upon a partnership between women and midwives aiming to promote health outcomes (ICM 2017b). Collaboration and partnership is also required with other health professionals, with other sectors and across geographical boundaries; improvements in global health can only be achieved through working together (Squires 2018). Within regions such as Europe, there is benefit in sharing success stories and learning from each other through collaborative working (Euro-Peristat 2018).

Achieving the vision for midwifery 2030 also requires political will and support from governments and policy-makers for each of the three pillars of midwifery: education, regulation and association development. Additionally, the provision of enabling practice environments for midwives with sufficient workforce and resources is vital, along with effective referral services to higher level facilities where necessary (UNFPA 2014).

TABLE 1.3 Essential Competencies for Midwifery Practice

1. General competencies	1a.	Assume responsibility for own decisions and actions as an autonomous practitioner
	1b.	Assume responsibility for self-care and self-development as a midwife
	1c.	Appropriately delegate aspects of care and provide supervision
	1d.	Use research to inform practice
	1e.	Uphold fundamental human rights of individuals when providing midwifery care
	1f.	Adhere to jurisdictional laws, regulatory requirements, and codes of conduct for midwifery practice
	1g.	Facilitate women to make individual choices about care
	1h.	Demonstrate effective interpersonal communication with women and families, healthcare teams and community groups
	1i.	Facilitate normal birth processes in institutional and community settings, including women's homes
	1j.	Assess the health status, screen for health risks and promote general health and wellbeing of women and infants
	1k.	Prevent and treat common health problems related to reproduction and early life
	1l.	Recognize conditions outside the midwifery scope of practice and refer appropriately
	1m.	Care for women who experience physical and sexual violence and abuse
2. Competencies specific to pre-pregnancy and antenatal care	2a.	Provide pre-pregnancy care
	2b.	Determine the health status of the woman
	2c.	Assess fetal wellbeing
	2d.	Monitor the progression of pregnancy
	2e.	Promote and support health behaviours that improve wellbeing
	2f.	Provide anticipatory guidance related to pregnancy, birth, breastfeeding, parenthood and change in the family
	2g.	Detect, manage and refer women with complicated pregnancies
	2h.	Assist the woman and her family to plan for an appropriate place of birth
	2i.	Provide care to women with unintended or mistimed pregnancy
3. Competencies specific to care during labour and birth	3a.	Promote physiological labour and birth
	3b.	Manage a safe spontaneous vaginal birth and prevent complications
	3c.	Provide care of the newborn immediately after birth
4. Competencies specific to the ongoing care of women and newborns	4a.	Provide postnatal care for the healthy woman
	4b.	Provide care to the healthy newborn infant
	4c.	Promote and support breastfeeding
	4d.	Detect and treat or refer postnatal complications in the woman
	4e.	Detect and manage health problems in the newborn infant
	4f.	Provide family planning services

Adapted from ICM (International Confederation of Midwives). (2019) Essential competencies for midwifery practice: 2019 update. Available at: www.internationalmidwives.org/our-work/policy-and-practice/essential-competencies-for-midwifery-practice.html.

It is important to involve professional midwives' associations in policy and planning for the midwifery workforce (Lopez et al. 2015). The quality of midwifery education is directly linked to the quality of midwifery care provision; students will only learn to provide high quality care when they are mentored by skilled midwives in a well-resourced and managed clinical learning environment (Kemp et al. 2018). Investment is required in career pathways and professional development for midwives including opportunities for leadership development. Exploring

TABLE 1.4 ICM (2013) Midwifery Education Standards

I. Organization and Administration	I.1.	The host institution/agency/branch of government supports the philosophy, aims and objectives of the midwifery education programme
	I.2.	The host institution helps to ensure that financial and public/policy support for the midwifery education programme are sufficient to prepare competent midwives
	I.3.	The midwifery school/programme has a designated budget and budget control that meets programme needs
	I.4.	The midwifery faculty is self-governing and responsible for developing and leading the policies and curriculum of the midwifery education programme
	I.5.	The head of the midwifery programme is a qualified midwife teacher with experience in management/administration
	I.6.	The midwifery programme takes into account national and international policies and standards to meet maternity workforce needs.
II. Midwifery Faculty (Teachers)	II.2.	The midwife teacher:
		II.2.a. has formal preparation in midwifery
		II.2.b. demonstrates competency in midwifery practise, generally accomplished with two (2) years full scope practise
		II.2.c. holds a current license/registration or other form of legal recognition to practise midwifery
		II.2.d. has formal preparation for teaching, or undertakes such preparation as a condition of continuing to hold the position
		II.2.e. maintains competence in midwifery practise and education
	II.3.	The midwife clinical preceptor/clinical teacher:
		II.3.a. is qualified according to the ICM Definition of a midwife
		II.3.b. demonstrates competency in midwifery practise, generally accomplished with two (2) years full scope practise
		II.3.c. maintains competency in midwifery practise and clinical education
		II.3.d. holds a current license/registration or other form of legal recognition to practise midwifery
		II.3.e. has formal preparation for clinical teaching or undertakes such preparation
	II.4.	Individuals from other disciplines who teach in the midwifery programme are competent
	II.5.	Midwife teachers provide education, support and supervision of individuals who teach students in practical learning sites
	II.6.	Midwife teachers and midwife clinical preceptors/clinical teachers work together to support (facilitate), directly observe and evaluate students' practical learning
	II.7.	The ratio of students to teachers and clinical preceptors/clinical teachers in the classroom and practical sites is determined by the midwifery programme and the requirements of regulatory authorities
	II.8.	The effectiveness of midwifery faculty members is assessed on a regular basis following an established process.
III. Student body	III.1.	The midwifery programme has clearly written admission policies that are accessible to potential applicants. These policies include:
		III.1.a. entry requirements, including minimum requirement of completion of secondary education

Continued

TABLE 1.4 ICM (2013) Midwifery Education Standards—cont'd

		III.1.b. a transparent recruitment process
		III.1.c. selection process and criteria for acceptance
		III.1.d. mechanisms for taking account of prior learning
	III.2.	Eligible midwifery candidates are admitted without prejudice or discrimination (e.g. gender, age, national origin, religion)
	III.3.	Eligible midwifery candidates are admitted in-keeping with national healthcare policies and maternity workforce plans
	III.4.	The midwifery programme has clearly written student policies that include:
		III.4.a. expectations of students in classroom and practical areas
		III.4.b. statements about students' rights and responsibilities and an established process for addressing student appeals and/or grievances
		III.4.c. mechanisms for students to provide feedback and ongoing evaluation of the midwifery curriculum, midwifery faculty and the midwifery programme
		III.4.d. requirements for successful completion of the midwifery programme
	III.5.	Mechanisms exist for the student's active participation in midwifery programme governance and committees
	III.6.	Students have sufficient midwifery practical experience in a variety of settings to attain, at a minimum, the current ICM Essential Competencies for Basic Midwifery Practice
	III.7.	Students provide midwifery care primarily under the supervision of a midwife teacher or midwifery clinical preceptor/clinical teacher.
IV. Curriculum	IV.1.	The philosophy of the midwifery education programme is consistent with the ICM Philosophy and model of care
	IV.2.	The purpose of the midwifery education programme is to produce a competent midwife who:
		IV.2.a. has attained/demonstrated, at a minimum, the current ICM Essential Competencies for Basic Midwifery Practice
		IV.2.b. meets the criteria of the ICM Definition of a Midwife and regulatory body standards leading to licensure or registration as a midwife
		IV.2.c. is eligible to apply for advanced education
		IV.2.d. is a knowledgeable, autonomous practitioner who adheres to the ICM International Code of Ethics for Midwives, standards of the profession and established scope of practise within the jurisdiction where legally recognized
	IV.3.	The sequence and content of the midwifery curriculum enables the student to acquire essential competencies for midwifery practise in accord with ICM core documents
	IV.4.	The midwifery curriculum includes both theory and practise elements with a minimum of 40% theory and a minimum of 50% practise
		IV 4.a. Minimum length of a direct-entry midwifery education programme is three (3) years
		IV4.b. Minimum length of a post-nursing/healthcare provider (post-registration) midwifery education programme is eighteen (18) months
	IV.5.	The midwifery programme uses evidence-based approaches to teaching and learning that promote adult learning and competency-based education

TABLE 1.4 ICM (2013) Midwifery Education Standards—cont'd

		IV.6.	The midwifery programme offers opportunities for multidisciplinary content and learning experiences that complement the midwifery content.
V.	**Resources, facilities and services**	V.1.	The midwifery programme implements written policies that address student and teacher safety and wellbeing in teaching and learning environments
		V.2.	The midwifery programme has sufficient teaching and learning resources to meet programme needs
		V.3.	The midwifery programme has adequate human resources to support both classroom/theoretical and practical learning
		V.4.	The midwifery programme has access to sufficient midwifery practical experiences in a variety of settings to meet the learning needs of each student
		V.5.	Selection criteria for appropriate midwifery practical learning sites are clearly written and implemented.
VI.	**Assessment strategies**	VI.1.	The Midwifery faculty uses valid and reliable formative and summative evaluation/assessment methods to measure student performance and progress in learning related to: VI.1.a. knowledge VI.1.b. behaviours VI.1.c. practise skills VI.1.d. critical thinking and decision-making VI.1.e. interpersonal relationships/communication skills
		VI.2.	The means and criteria for assessment/evaluation of midwifery student performance and progression, including identification of learning difficulties, are written and shared with students
		VI.3.	Midwifery faculty conducts regular reviews of the curriculum as a part of quality improvement, including input from students, programme graduates, midwife practitioners, clients of midwives and other stakeholders
		VI.4.	Midwifery faculty conducts ongoing review of practical learning sites and their suitability for student learning/experience in relation to expected learning outcomes
		VI.5.	Periodic external review of programme effectiveness takes place.

ICM (International Confederation of Midwives). (2013) Global standards for midwifery education. Available at: www.internationalmidwives.org/assets/files/general-files/2018/04/icm-standards-guidelines_ammended2013.pdf.

different ways of organizing midwifery care, such as midwifery social enterprises, may provide models for women's empowerment and health systems' strengthening (Institute of Medicine of the National Academies, INMA 2015).

Lastly, midwives and others must continue to fund and engage in research, adding to the growing body of evidence for the effectiveness of midwifery as a high quality and cost-effective solution to women and newborn's global health. Powell-Kennedy et al. (2018) suggest three interconnected areas for this research: first, evaluating the effectiveness of midwifery care; second, identifying and describing which aspects of care optimize or disturb physiological processes in the childbearing continuum; and third, determining which indicators, measures and benchmarks are valuable in assessing quality maternal and newborn care.

THE EMOTIONAL CONTEXT OF MIDWIFERY

Much of midwifery work is emotionally demanding, an understanding by midwives of why this is so, and exploration of ways to manage feelings can only benefit women and midwives. How midwives 'feel' about their work and the women they care for is important. It has significant implications for communication and interpersonal relationships with not only women and families but also colleagues. It also has much wider implications for the quality of maternity services in general.

By its very nature, midwifery work involves a range of emotions. Activities that midwives perform in their day-to-day role are rarely dull, spanning a vast spectrum. What may appear routine and mundane acts to midwives are often far from ordinary experiences for women – the recipients of maternity care. While birth is often construed as a highly charged emotional event, it may be less obvious to appreciate why a routine antenatal 'booking' history or postnatal visit can generate emotions.

What is 'Emotion Work'?

Emotional labour can be defined as the work that is undertaken to manage feelings so that they are appropriate for a particular situation (Hunter and Deery 2009). This is done in accordance with 'feeling rules', social norms regarding which emotions it is considered appropriate to feel and to display.

Sources of Emotion Work in Midwifery Practice

It is suggested that there are various sources of emotion work in midwifery (Hunter and Deery 2009), which can be grouped into three key themes:

1. Midwife–woman relationships
2. Collegial relationships
3. The organization of maternity care.

It is important to note that these themes are often intertwined, for example, the organization of maternity care impacts on both midwife–woman relationships and on collegial relationships.

Midwife–Woman Relationships

The quality of the midwife–mother relationship is vital to ensure quality of care as it combines all the essential threads of the midwifery service. Equally, a trusting relationship between the woman and midwife is fundamental (Hunter and Deery 2009; Dahlberg and Aune 2013; Drach-Zahavy et al. 2016).

Pregnancy and birth are not always joyful experiences (see Chapter 30), for example midwives work with women who: may have concealed their pregnancy (see Chapter 12); have unplanned or unwanted pregnancies; who are in unhappy or abusive relationships; who are fearful of pregnancy and childbirth (see Chapter 18) or encounter pregnancies where fetal malformations or antenatal problems are detected (see Chapter 13). In these cases, midwives need to support women and their partners with great sensitivity and emotional awareness. This requires excellent communication and interpersonal skills to establish trust (Lewis et al. 2017). Relationships between midwives and women may vary considerably in their quality, level of intimacy and sense of personal connection. Some relationships may be intense and short-lived (e.g. when a midwife and woman meet on the labour suite or birth centre for the first time); intense and long-lived (e.g. when a midwife provides continuity of care throughout pregnancy, birth and the postnatal period via models of care such as caseholding). They may also be relatively superficial, whether the contact is short-lived or longer-standing. There is evidence that a key issue in midwife–woman relationships is the level of 'reciprocity' that is experienced (McCourt and Stevens 2009; Lewis et al. 2017). Reciprocity is defined as the mutual exchange of something between two individuals or groups of people when each person or group gives or allows something to the other (Collins English Dictionary 2019). When relationships are experienced as 'reciprocal' or 'balanced', the midwife and woman are in a harmonious situation. Both are able to give to the other and to receive what is given, such as when the midwife can give support and advice, the woman is happy to accept this and in return affirm the value of the midwife's care. Achieving a partnership with the women therefore requires reciprocity.

At times, relationships may become unbalanced, and in these situations emotion work is needed by the midwife. For example, a woman may be hostile to the information provided by the midwife, or alternatively, she may expect more in terms of personal friendship than the midwife feels it is appropriate or feasible to offer. Some midwives working in continuity of care schemes have expressed concerns about 'getting the balance right' in their relationships with women, so that

they can offer authentic support without overstepping personal boundaries and becoming burnt out (McCourt and Stevens 2009). However, establishing and maintaining reciprocal relationships can also prove challenging.

Women want care from a midwife that is not only kind but is also attentive, intelligent and supportive. The woman also wants a midwife who is competent in her clinical skills to make the woman feel safe (Care Quality Commission, CQC 2018). Women's views of their maternity care experience are important. In England, a study by the CQC (2018) suggests that women are marginally more positive about their experiences of maternity care within the NHS than in 2015. The survey received 18,400 responses from women who gave birth in February 2017, across 130 NHS Trusts.

The fifth survey of its kind showed 59% of women reporting that they received help from members of staff within a reasonable amount of time after giving birth, a 5% increase in comparison to the last survey that was conducted in 2015. However, the majority of women (88%) felt they were 'always' spoken to in a way they could understand during labour and birth, and a high number 'definitely' felt they had confidence and trust in the staff caring for them (82%). Disappointingly, there were fewer improvements compared with the previous year. Postnatal care continues to remain less of a positive experience for women when compared with other aspects of their maternity journey. Information sharing and communication are the key areas where improvements are needed. Of equal concern is the fact that 15% of women reflected they are still not being offered choices about aspects of their care.

Collegial Relationships

Relationships between midwives and their colleagues, both within midwifery and the wider multidisciplinary (MDT) and multiagency teams are also key sources of emotion work. Much of the existing evidence attests to relationships between midwifery colleagues, which may be positive or negative experiences. Some reports investigating poor maternal and neonatal outcomes and avoidable harm, identified that a number of cases involved an element of substandard care, where poor communication, ineffective team work and interpersonal skills are common themes cited as particular areas of concern (RCOG 2017; Knight et al. 2019). Non-technical skills known as human factors (see Chapter 26) are essential within the MDT and collegiate relationship and effective communication are at the nexus of a strong MDT. This is where a positive work culture is fostered, collaborative working and shared decision-making are realized and where the safety of mother and baby are the core business of maternity care.

Undermining behaviour on the other hand in the form of bullying and harassment has no place in the workforce. There are a myriad of definitions for bullying and harassment but for simplicity, the definitions employed by Illing et al. (2013) are adopted for use within the chapter.

- **Bullying** may be intimidating, malicious, offensive or insulting behaviour, or an abuse or misuse of power through means that undermine, humiliate, denigrate or injure the recipient.
- **Harassment** is unwanted conduct related to a relevant protected characteristic, which has the purpose or effect of violating an individual's dignity or creating an environment for that individual that is not only hostile but is intimidating, degrading, humiliating or offensive.

The sinister and covert nature of bullying and harassment can often make it challenging to recognize, in that they may not be blatantly obvious to others, making it all very insidious. Nonetheless, in the UK, much work has been done around undermining and bullying behaviour within healthcare institutions relating to definitions, occurrence, causes, consequences, prevention and management. Illing et al. (2013) provide an illuminating report about the issue, and the RCOG and RCM have produced a toolkit to address this challenge within the maternity services. (The toolkit can be accessed at: www.rcog.org.uk/underminingtoolkit.)

The Organization of Maternity Care

Globally, the way in which maternity care is organized may also be a source of emotion work for midwives. The fragmented, task-orientated nature of much hospital-based maternity care creates emotionally difficult situations for midwives as it reduces opportunities for establishing meaningful relationships with women and colleagues, and for doing 'real midwifery'.

Midwives working in community-based practice, continuity of care schemes or in birth centre settings are more emotionally satisfied in their work (Sandall et al. 2016). Although there is the potential for continuity of care schemes to increase emotion work as a result of altered boundaries in the midwife–woman

relationship, there is also evidence to suggest that when these schemes are organized and managed effectively, they provide emotional rewards for women and midwives (NHS England 2016; Sandall et al. 2016).

Better Births

NHS England's (2016) National Maternity Review 'Better Births' transformative report considered how maternity services needed to change to meet the needs of the population and set out a clear vision for safe and efficient models of maternity care, including safer care, joined up across disciplines, reflecting women's choices and offering continuity of care along the pathway. This report is now driving much of the changes to the organization of maternity care in the UK (see Chapter 8). Globally, the midwifery framework by Renfrew et al. (2014) in the *Lancet* midwifery series focuses minds on providing models of care that are holistic and assure quality.

THE FAMILY IN SOCIETY

It is outside the scope of the chapter to explore all subgroups relating to the family. It can only offer a broad perspective of the modern family with some working examples to provide context. The family in contemporary society is part of social change that transforms with the modern trends in that given society. In other words, family function in any given society will be structured according to the overall changes that occur in all aspects of social life. Sixty years ago in Western societies, the so-called 'nuclear' family – a married couple with 2.5 children, was the norm. Transformation to family structures has meant that there are more diverse types of families today than ever before. A variety of families now exists within developed and developing countries, e.g. cohabiting couples, same sex couples, single parent families, childless families, etc. The main changes are a result of a variety of reasons, as postulated in Box 1.2.

Providing woman-centred care is a complex issue, particularly in a diverse society where individual's and families' health needs are not homogeneous and one size does not fit all. Listening and responding to women's views and respecting their ethnic, cultural, social, religious and family backgrounds is critical to developing a responsive midwifery service. Persistent concerns have been expressed about the poor neonatal and maternal health outcomes among disadvantaged and socially excluded groups (Marmot 2010; Knight et al. 2019), suggesting not all groups in society enjoy equal access to maternity services.

BOX 1.2 Some Possible Reasons for Changes to Traditional Family Structure

- Couples marry later in life
- More permissive society means that many couples choose to shun the patriarchal structure of marriage and choose to cohabit
- Fewer couples choose to marry
- Many women are now more career-oriented and the main 'bread winner', i.e. earner in households
- Better equality and opportunity in education and work for women; many now opt to pursue and fulfil their ambition of career/success rather than marry and have children
- Higher divorce rates
- Changes to partnerships (i.e. more same sex couples, more cohabitation, more people living alone, childless couples)
- Changes to children and families (i.e. higher rates of births outside marriage, women choosing to have fewer children, divorce rates and re-marriage, resulting in more step families/step children)
- Increased incidence of lone parent families (this could be due to a host of different reasons, e.g. individuals choosing to parent alone, relationship break down, divorce, death of a parent, displaced people seeking asylum/refugee status, etc.).

Figures from the Office of National Statistics (ONS 2017) reveal the following trend:

- In 2017, there were 19.0 million families in the UK – increased by 15% from 16.6 million in 1996.
- There were 12.9 million married or civil partner couple families in the UK in 2017. This remains the most common type of family.
- The second largest family type was the cohabiting couple family at 3.3 million families, followed by 2.8 million lone parent families.

Women from Disadvantaged Groups

There is strong evidence that disadvantaged groups have poorer health and poorer access to health care, with clear links between inequality in social life and inequality in health, demonstrating that inequality exists in both mortality and morbidity (Marmot 2010; Knight et al. 2019). WHO (2008) states that 'social justice is a matter of life or death' and refers to the social determinants of health as conditions in which people are born,

live, develop, work and age. This includes the healthcare system, which paradoxically is formulated and influenced by the distribution of wealth, power and resources at all levels. The social determinants of health therefore are largely responsible for health inequalities, i.e. the unfair and avoidable differences in health status seen within and between countries The development of a society, be that wealthy or impoverished, can be judged by the quality of its population's health, the justice meted out to health distribution across the social spectrum and the degree of protection provided from disadvantage as a result of ill-health (WHO 2008).

Women from Black, Asian and Minority Ethnic Groups (BAME)

Maternal and infant health inequalities between and within developed and developing countries is well documented (WHO 2015c; Jones et al. 2017; Alkema et al. 2016). Concerns have also been expressed with the way in which access to services, lifestyle choices, sociocultural factors, ethnicity and globalization of the market economy continue to generate differences in health outcomes for different groups, especially those who are more likely to be marginalized due to unconscious bias and institutional racism (Jones et al. 2017; WHO 2015c, 2018c).

There are health disparities in maternal and infant birth outcomes of BAME women giving birth in the UK compared with white women (Garcia et al. 2015; Aquino et al. 2015). Knight et al.'s (2019) report on the confidential enquiries into maternal deaths in the UK raised some sobering issues, highlighting the almost five-fold higher mortality rate among black women compared with white women for the triennium 2015–2017. Much work is therefore needed to identify and address the underlying causes of this difference.

To improve maternal health for women from a BAME background, barriers that limit access to quality maternal health services must be identified and addressed at all levels of the health system (WHO 2018c). The World Health Organization (WHO 2015c) recommendation on supporting 'culturally-appropriate' maternity care services to improve maternal and newborn health is welcomed. The UN (2015) and WHO (2018c) states that between 2016 and 2030, as part of the SDGs target, the goal is to reduce the burden of global maternal mortality ratio to <70 per 100,000 live births. To help achieve this vision, skilled, well-informed and culturally congruent midwives are central to the provision of safe and effective maternity care (Aquino et al. 2015; Garcia et al. 2015).

Teenage Parents

Data from Public Health England (PHE 2016) reflect that over recent decades, the under-18 conception rate has more than halved, to the lowest level since 1960s. This is the result of a concerted long-term evidence-based teenage pregnancy strategy, delivered with concerted effort by local government and their health partners. Teenage parents are no different from any other parent group; most manage extremely well with appropriate social support and these families want only the best for their children (PHE 2016). It is important to acknowledge that some young mothers and fathers do achieve a successful outcome to their pregnancy and parenting with appropriate social support via Family Nurse Partnership (FNP) (Olds 2002). Nonetheless, it is widely understood that there is a strong association between teenage pregnancy resulting in early parenthood and poor educational achievement coupled with wider health inequalities and social deprivation, e.g. poor physical and mental health, social isolation, poverty plus wider-related factors (Public Health England, PHE 2016). It should also be recognized that morbidity and mortality among babies born to these mothers is increased and that the mothers show a higher risk of developing complications, such as hypertensive disorders and intrapartum complications (PHE 2016; Knight et al. 2019). Many young teenage mothers tend to present late for antenatal care and are disproportionately likely to have some risk factors associated with poor antenatal health (e.g. poverty and smoking). Moreover, there is a growing recognition that socioeconomic disadvantage can be both a cause and effect of teenage parenthood. This affects the life chances not only for teenage parents but also the next generation of children. There are a variety of risk factors for early pregnancy affecting some young people entering parenthood that make them particularly vulnerable.

According to PHE (2016) these include:

- family poverty
- poor educational attainment due to persistent truancy from school by age 14
- slower than expected attainment between ages 11 and 14
- being looked after or being a care leaver.

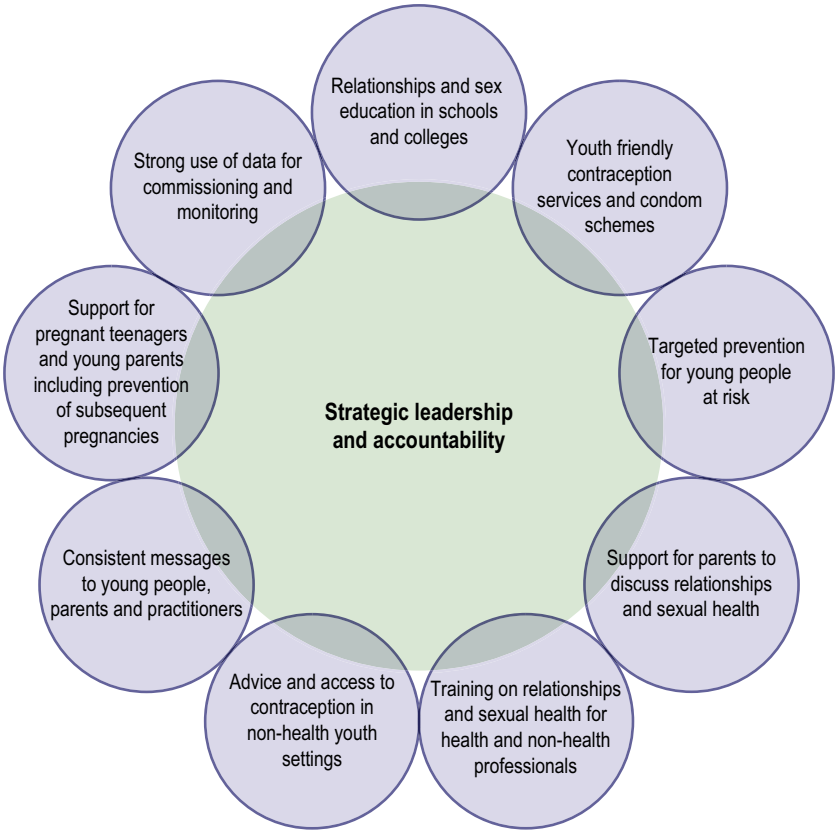

Fig. 1.3 Factors for the prevention of teenage pregnancies. (Adapted from PHE (2016), PHE Crown copyright 2019. This information (excluding logos) may be used free of charge in any format or medium, under the terms of the Open Government Licence v3.0.).

Furthermore, PHE (2016) identified that the above risk factors are reflected in the cohort of young parents in the FNP trial participants:

- 46% had been suspended, expelled or excluded from school
- 48% were not in education, employment or training at the time of recruitment.

Consequent to the above, some young parents will have missed out on the protective factors of:

- high quality sex and relationships education
- emotional wellbeing and resilience
- positive parenting role models and having a trusted adult in their life.

For a minority, these vulnerabilities may make parenting very challenging.

However, as mentioned previously, with appropriate support, young teenage parents can make an effective transition to parenthood. They can be assisted to develop good parenting and life skills to prevent a potential downward spiral and break the cycle of social deprivation and health inequalities by early intervention schemes such as FNP developed by Olds (2002). Fig. 1.3 identifies the factors highlighted by PHE (2016) for the prevention of teenage pregnancies.

Migrant Families

War, civil unrest and the fear of torture or persecution have resulted in many displaced populations worldwide. The number of families who are migrants and refugees throughout the world has continued to increase at a pace, with particular concerns for migrant and refugee women who are pregnant (ICM 2017c). The ICM (2017c:1) draws midwives attention to its International Code of Ethics (ICM 2014c) to convey the importance of midwives to '*respect the basic Human Rights of all*

people and to value cultural diversity'. The ICM (2017c:1) aptly and poignantly states that:

> *The health and well-being of migrant and refugee women may have been damaged in their country of origin or during their journey and may expose them to reproductive health risks, including sexual violence, unwanted pregnancies and exposure to sexually transmitted diseases.*

Javaweera (2016) identifies specific vulnerable categories of migrant women as being:

- asylum seekers
- refugees or those refused asylum seekers
- other undocumented migrant women
- women with no recourse to public funds that are supported by the local authority
- trafficked women
- some Roma women
- women with limited fluency in English
- migrants from the European Union (EU) with no health insurance card.

Midwives need to be aware of the complex needs of this group of vulnerable women who, in addition to the problems described above, have often experienced traumatic events in their home country, may be isolated from their family and friends and face uncertainty regarding their future domicile. Negative stereotypes and prejudice are damaging and can only lead to insensitive and ineffective care.

Women from Travelling Families

Travelling families are not a homogeneous group. Travellers may belong to a distinct social group such as the Romanies; their origins may lie in the UK or elsewhere such as Ireland or Eastern Europe, or they may be part of the social grouping loosely termed 'New Age' travellers or part of the Showman's Guild travelling community. As with all social groups, their cultural background will influence their beliefs about and experience of health and childbearing.

A common factor, which may apply to all, is the likelihood of prejudice and marginalization. Midwives need to examine their own beliefs and values in order to develop their knowledge to address the needs of travelling families with respect, plus provide a caring and non-judgemental service. An informed approach to lifestyle interpretation may stop the midwife identifying the woman as an 'antenatal defaulter' with the negative connotations that accompany that label. Moving on may be through choice related to lifestyle, but equally it may be the result of eviction from unofficial sites.

Some health authorities have designated services for travelling families that contribute to uptake and continuity of care. These carers understand the culture and are aware of specific health needs; they can also access appropriate resources, for example a general practitioner (GP) who is receptive to travellers' needs. A trusting relationship is important to people who are frequently subjected to discrimination. Handheld records contribute to continuity of care and communication between care providers, but the maternity service also needs to address communication challenges for individuals who do not have a postal address or who have low levels of literacy.

Homelessness

Homelessness is a complex concept; it knows no boundaries, no borders and no colour. It does not discriminate and is an issue that can affect anyone. This vulnerable population comprises a human kaleidoscope of people where health disparities are heightened. The homeless population constitute a heterogeneous community characterized by multiple comorbidities that make them more vulnerable:

- alcohol and drug dependence
- mental disorders illness
- infections, e.g. tuberculosis and HIV
- premature death.

Homeless individuals are often excluded from mainstream society; homelessness may arise for many reasons but the following risk factors may be implicated:

- those experiencing disputes and relationship breakdown
- those with learning difficulties and no/low educational attainment or unemployment
- alcohol or drug misuse
- mental health problems
- those in debt or lacking a social support network
- young teenagers who run away from home
- those subjected to domestic abuse/violence
- those who define themselves as LGBT – a number of adolescents become homeless after leaving home because of conflicts with parents regarding sexual orientation
- refugees or those seeking asylum
- individuals having contact with the criminal justice system.

Homelessness drives many to despair, as the daily struggle for safety, food, shelter, clothing and the bare necessities of daily living drives health to the bottom of the list in order of priorities. This in turn, exacerbates morbidity, complicates treatment and elevates mortality. Hirani and Richter (2019) attest that homelessness is a significant challenge to health care globally, with estimates of up to 100 million people worldwide who are homeless at any given time. Of particular concern, homeless women may have comorbidities and other vulnerability factors such as mental illness, poor nutritional status, substance misuse problems and infectious disease such as HIV, hepatitis B and C and tuberculosis (Rimawi et al. 2014).

A significant number of women who died in the UK had multiple and complex health problems or other vulnerability factors (Knight et al. 2019). Domestic and sexual violence is the leading cause of homelessness for women and families. Homeless women are far more likely to experience violence compared with women who are not homeless because of a lack of personal security when living outdoors or in shelters (Hirani and Richter 2019). Tackling vulnerability factors and complex physical and psychosocial health needs requires the midwife to develop cultural competence, which is held as a key strategy to reducing disparities and promoting health equity.

The Midwife Researcher: an Introduction

A midwife's work is consistently based on the knowledge gained from evidence. Midwives use this knowledge to provide high standards of care to women and families. It enables them to advocate for women and empowers midwives to keep developing knowledge and skills, both clinically and academically. It is an interesting question therefore, to think a little deeper about where this evidence comes from. Research, or perhaps more aptly put, the birth of all evidence, is becoming increasingly visible in the clinical environment globally. In the UK for example, this is largely due to the National Institute for Health Research (NIHR), which was set up in 2006 and is the overarching entity for all publicly funded research in the National Health Service (NHS). Among other initiatives, the NIHR setup local Clinical Research Networks (CRNs) to support the delivery of research across the NHS in England (NIHR 2018). There are 15 local CRNs in England, which tend to be divided by region. In 2016/17 the overall Clinical Research Network recruited over 665,000 people into clinical research studies (NIHR 2018).

International Confederation of Harmonization Good Clinical Practice

The ICH GCP is an international ethical and scientific quality standard for designing, conducting, recording and reporting trials that involve the participation of human subjects. Compliance with this standard ensures that the rights and safety of trial participants are protected. The basic principles of GCP originated from the World Medical Association's (WMA 2013) Declaration of Helsinki and aims to ensure that not only are trial participants protected but also that the data and reported results are credible and accurate. GCP was developed in response to historical tragedies such as the thalidomide scandal.

Any research study carried out in the NHS must meet the standards of ICH GCP (2016). The key principles of the ICH GCP (2016) are highlighted in Box 1.3

The Birth of Regulatory Frameworks

The conduct of research trials has not always been ethically sound. A number of experiments have been conducted over the last century, which led to dire consequences requiring the need for standards and regulatory frameworks ensuring the safety of all participants.

The Nuremberg Code was developed to serve as a foundation for ethical clinical research since its publication 60 years ago (Ghooi 2011). The Nuremberg Code was developed in response to a series of inhumane experiments which were conducted, mostly in concentration camps, on Jewish prisoners (Smith and Master 2014). These experiments included the study of the human body's resistance to low pressure, hypothermia, malaria, mustard gas, typhus and poison (Smith and Master 2014). During the Nuremberg trials (1945–46) the international military tribunal charged 23 Nazi doctors and scientists with war crimes and crimes against humanity; many were convicted and some sentenced to death (Smith and Master 2014). The Nuremberg Code is considered the historical basis for research ethics.

The Declaration of Helsinki was originally published in 1964 by the World Medical Association primarily to set international ethical principles for research involving human participants (Morris 2013). Once again, a number of studies preceding the declaration had involved

BOX 1.3 The Principles of ICH GCP E6 (2016)

Guideline to which all Clinical Trials should be Conducted

- Clinical trials should be conducted in accordance with the ethical principles that have their origin in the Declaration of Helsinki, and that are consistent with GCP and the applicable regulatory requirements.
- Before a trial is initiated, foreseeable risks and inconveniences are weighed against the anticipated benefit for the individual trail subject and society. A trial should be initiated and continued only if the anticipated benefits justify the risks.
- The rights, safety and wellbeing of the trial subjects are the most important considerations and should prevail over the interests of science and society.
- The available non-clinical and clinical information on an investigational product should be adequate to support the proposed clinical trial.
- Clinical trials should be scientifically sound and described in a clear detailed protocol.
- A trial should be conducted in compliance with the protocol that has received prior institutional review board (IRB)/Independent ethics committee (IEC) approval or favourable opinion.
- The medical care given to, and medical decisions made on behalf of subjects, should always be the responsibility of a qualified physician or, when appropriate, of a qualified dentist.
- Each individual involved in conducting a trial should be qualified by education, training and experience to perform his or her respective task(s).
- Freely given informed consent should be obtained from every subject prior to clinical trial participation.
- All clinical trial information should be recorded, handled and stored in a way that allows its accurate reporting, interpretation and verification.
- The confidentiality of records that could identify subjects should be protected, respecting the privacy and confidentiality rules in accordance with the applicable regulatory requirement(s).
- Investigational products should be manufactured, handled and stored in accordance with applicable good manufacturing practice (GMP). They should be used in accordance with the approval protocol.
- Systems with procedures that assure the quality of every aspect of the trial should be implemented.

CASE STUDY 1.1 Diethylstilboestrol

Diethylstilboestrol (DES) is a synthetic oestrogen. It was produced in London in 1938 and was prescribed from 1945 to 1971 to prevent miscarriages (Mastroianni et al. 1994). Early studies conducted at Harvard University found that DES was effective against a variety of pregnancy complications (Mastroianni et al. 1994). These studies were heavily criticized because they were conducted without the use of controls. However, despite this criticism, DES was approved by the Food and Drug Administration (FDA) federal agency in 1947 as a new drug application for the purpose of preventing miscarriages (Mastroianni et al. 1994).

Controlled studies on DES were carried out in the 1950s and the findings were very different. At the University of Chicago, every pregnant woman was enrolled into a clinical trial at the University's Lying-In Hospital. One half of the women were randomized to receive DES and the other half to receive a placebo. None of the women were told that they were part of the study and none of the women were told which drug they were taking (Mastroianni et al. 1994). This study found that twice as many of the mothers who had been given DES had miscarriages or smaller birth weight babies. Despite these studies, DES continued to be marketed as a drug to prevent miscarriage.

What are the ethical problems with this piece of research and how, now, might this piece of research be conducted differently?

the use of human subjects without consent, and would now be considered unethical and unacceptable within the scientific community.

The Declaration of Helsinki (WMA 2013) statement consists of the following general principles:

- risks
- burdens and benefits
- vulnerable groups and individuals
- scientific requirements and research protocols
- research ethic committees
- privacy and confidentiality
- informed consent
- use of placebo
- post-trial provision
- research registration
- public dissemination of results and unproven interventions in clinical practice.

Read Case Study 1.1 and then reflect on the WMA (2013) Declaration of Helsinki general principles.

CASE STUDY 1.2 Thalidomide

Thalidomide was used in the 1950s and 1960s to prevent morning sickness in pregnant women. It was first licensed in the UK in 1958 and was widely prescribed to pregnant women suffering with morning sickness.

During the time of thalidomide, the regulatory standards that are in place today were not present. Many of the medications taken by women during pregnancy had not been through robust clinical trials to investigate whether they would cause potential harm to the fetus. It soon became apparent that babies born to mothers who had taken thalidomide suffered severe teratogenic side-effects such as phocomelia (seal-like limbs in the fetus). Because of this, US senate hearings followed, and in 1962, the Kefauver Amendment to the Food, Drug and Cosmetic Act were passed into law to ensure drug efficacy and greater drug safety (Ray et al. 2016). For the first time, drug manufacturers were required to prove the effectiveness of their products to the FDA before marketing (Ray et al. 2016).

The consequences of unethical research can have extreme negative effects for participants. Between 1966 and 1971 seven cases of clear-cell adenocarcinoma (CCA), an extremely rare cancer, especially in young women, were found in teenage girls whose mothers had taken diethylstilboestrol (DES) a synthetic oestrogen during pregnancy. That same year, the agency responsible for food and drug administration (FDA) banned the use of DES as a preventer against miscarriage, but by that time it was estimated that 1.5 million babies had been exposed to DES *in utero* (Mastroianni et al. 1994).

Case Study 1.2 highlights the harm that can be wreaked on the lives of women and their families when untested drugs such as thalidomide are implemented without the regulatory standards and checks that now exist in contemporary practice around research on human subjects.

The Role of the Research Midwife

Globally, midwives play a pivotal role in the development of research; for example in the UK many NHS Trusts now employ research midwives to help coordinate the delivery of clinical studies within the maternity unit. Research midwives work within their local CRN to help support the delivery of local research. This research falls under the umbrella term of 'Reproductive Health and Childbirth' and is one of 30 specialties within the Clinical Research Networks. Other specialties include mental health, diabetes and injuries as well as emergencies (NIHR 2018).

The research midwife's job is important and diverse. Many research midwives are involved in the selection, setup and recruitment of clinical trials. Very often they will coordinate the study establish the process and play a large part in recruiting participants to research studies. The research midwife is often the core person in a trial on site (Luyben et al. 2013). Midwives are also integral to any multidisciplinary research team, as they are in a unique and privileged position to understand the needs of pregnant women, and as midwifery education advances many midwives are now equipped with the necessary skills required for research (Rowland and Jones 2013).

The research midwife has a duty to work within the regulatory frameworks of clinical research. There are research governance frameworks to guide good practice in the field of research. In the UK for example, the NHS Health Research Authority (HRA 2018) Research Governance Framework for Health and Social Care guidelines provide a structure for the governance of research in health and social care. This framework applies to everybody involved in clinical and non-clinical research (Fig. 1.4).

This policy framework not only sets out good practice in the management and conduct of health and social care research, but also the legal requirements and other standards (Health Research Authority, HRA 2017). It is primarily used to ensure the safety of participants and sets out operational procedures that should be followed by institutions conducting research (HRA 2017).

Box 1.4 identifies the statement of principles that serves as a benchmark for good practice that the management and conduct of all health and social care research in the UK are expected to meet.

In addition to the principles outlined in Box 1.4, the key values in Box 1.5 apply to interventional research only, i.e. where a change in treatment, care or other services is made for the purpose of research.

Frontline Research

The research midwife does not work in isolation, and with any research study or clinical trial individuals who are part of the Site Team have duties and responsibilities (Fig. 1.5).

A good proportion of the research midwives' time is spent on recruiting eligible participants for studies. All studies will have an inclusion and exclusion criteria

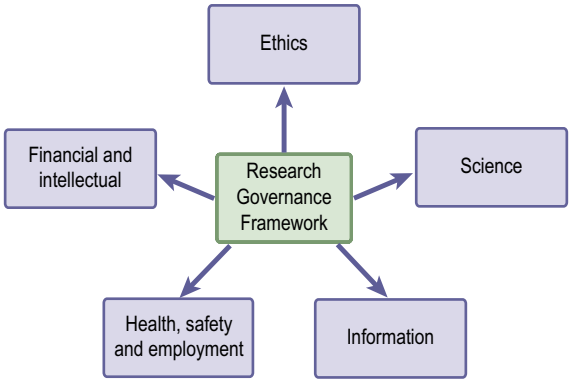

Fig. 1.4 The five domains of the Research Governance Framework for Health & Social Care. (From NHS Health Research Authority 2018.)

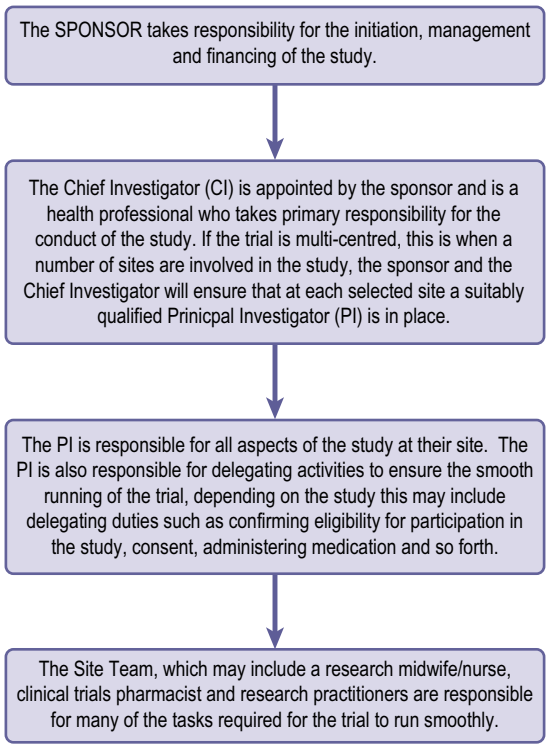

Fig. 1.5 Structure of responsibility for research study/clinical trial.

and it is important that this is followed when identifying potential participants for research studies. In some research studies/trials, eligibility has to be confirmed by a medical professional, in which case, the research midwife would refer onto the doctor designated to confirm eligibility for the study/trial. All information about the conduct of a trial can be found in the trial protocol, and this will outline the process for identifying participants.

Informed Consent

Informed consent is just as important in research as it is in routine clinical care. ICH-GCP states that informed consent is a process by which the subject voluntarily confirms his or her willingness to participate in a particular trial, after having been informed of all aspects of the trial that are relevant to the subject's decision to participate. Informed consent is documented by means of a written signed and dated 'Informed Consent Form' (ICH GCP 2016). Where research midwives/nurse are involved in the consent procedure it creates a bond of trust between the participant and the research midwife/nurse (Ray et al. 2016). This is because the research midwife is often the primary point of contact for the participant.

The safety of participants in any trial is of the upmost importance and respecting their decision of whether or not to participate in a research study is paramount. Everybody involved with the consenting process should be familiar with the study protocol, have knowledge of all available treatment options, have the time for a full discussion with the participant and be sensitive to the circumstances of the participants (NIHR 2018). A potential participant should never feel coerced into taking part in a research study and regardless of whether or not the individual chooses to participate clinical care should never be affected.

Read Case Study 1.3 and then answer the related questions.

Understanding the Basic Principles of Research

Understanding basic research principles are crucial in all aspects of health care. Whether this is to critique a research paper, or collate the latest evidence in healthcare practice. Research evidence is applied by midwives in day-to-day practice by gathering the best available evidence and applying it to health care and medicine. It is, quite broadly, the systematic investigation with the aim of advancing existing knowledge (Ray et al. 2016). Even if midwives do not choose to follow a research career path, a basic understanding of the principles of research helps inform all areas of midwifery practice and help to safeguard women and babies from harm. Integrating and normalizing research within clinical teams fosters a culture of research activeness, which benefits midwives and the very women for whom they care.

BOX 1.4 HRA (2017) Statement of Principles, Research Governance Framework for Health and Social Care

Principle 1: *Safety*
The safety and wellbeing of the individual prevails over the interests of science and society.

Principle 2: *Competence*
All the people involved in managing and conducting a research project are qualified by education, training and experience, or otherwise competent under the supervision of a suitably qualified person, to perform their tasks.

Principle 3: *Scientific and Ethical Conduct*
Research projects are scientifically sound and guided by ethical principles in all their aspects.

Principle 4: *The Woman as a Recipient of Care*
Service users and the public are involved in the design, management, conduct and dissemination of research, unless otherwise justified.

Principle 5: *Integrity*
Quality and transparency research is designed, reviewed, managed and undertaken in a way that ensures integrity, quality and transparency.

Principle 6: *Protocol*
The design and procedure of the research are clearly described and justified in a research proposal or protocol, where applicable conforming to a standard template and/or specified contents.

Principle 7: *Legality*
The researchers and sponsor familiarize themselves with relevant legislation and guidance in respect of managing and conducting the research.

Principle 8: *Benefits and Risks*
Before the research project is started, any anticipated benefit for the individual participant and other present and future recipients of the health or social care in question is weighed against the foreseeable risks and inconveniences once they have been mitigated.

Principle 9: *Approval*
A research project is started only if a research ethics committee and any other relevant approval body have favourably reviewed the research proposal or protocol and related information, where their review is expected or required.

Principle 10: *Information about the Research*
In order to avoid waste, information about research projects (other than those for educational purposes) is made publicly available before they start (unless a deferral is agreed by or on behalf of the research ethics committee).

Principle 11: *Accessible Findings*
Other than research for educational purposes and early phase trials, the findings, whether positive or negative, are made accessible, with adequate consent and privacy safeguards, in a timely manner after they have finished, in compliance with any applicable regulatory standards, i.e. legal requirements or expectations of regulators. In addition, where appropriate, information about the findings of the research is available, in a suitable format and timely manner, to those who took part in it, unless otherwise justified.

Principle 12: *Choice*
Research participants are afforded respect and autonomy, taking account of their capacity to understand. Where there is a difference between the research and the standard practice that they might otherwise experience, research participants are given information to understand the distinction and make a choice, unless a research ethics committee agrees otherwise. Where participants' explicit consent is sought, it is voluntary and informed. Where consent is refused or withdrawn, this is done without reprisal. A formal, structured risk assessment is only expected where identified as essential. The risk:benefit ratio will normally be sufficiently described and considered as part of review processes such as research ethics committee review, i.e. the HRA, the Administration of Radioactive Substances Advisory Committee (ARSAC), the Human Fertilisation and Embryology Authority (HFEA) or the Medicines and Healthcare products Regulatory Agency (MHRA). Either directly, or indirectly through the involvement of data or tissue that could identify them.

Principle 13: *Insurance and Indemnity*
Adequate provision is made for insurance or indemnity to cover liabilities, which may arise in relation to the design, management and conduct of the research project.

Principle 14: *Respect for Privacy*
All information collected for or as part of the research project is recorded, handled and stored appropriately and in such a way and for such time that it can be accurately reported, interpreted and verified, while the confidentiality

BOX 1.4 HRA (2017) Statement of Principles, Research Governance Framework for Health and Social Care—cont'd

of individual research participants remains appropriately protected. Data and tissue collections are managed in a transparent way that demonstrates commitment to their appropriate use for research and appropriate protection of privacy.

Principle 15: *Compliance*
Sanctions for non-compliance with these principles may include appropriate and proportionate administrative, contractual or legal measures by funders, employers, relevant professional and statutory regulators, and other bodies.

HRA (Health Research Authority) (2017) UK Policy for Health and Social Care Research. Available at: www.hra.nhs.uk/planning-and-improving-research/policies-standards-legislation/uk-policy-framework-health-social-care-research.

BOX 1.5 HRA (2017) Statement of Principles, Research Governance Framework for Health and Social Care. (Note: for use ONLY in Interventional Research)

Principle 16: *Justified Intervention*
The intended deviation from normal treatment, care or other services is adequately supported by the available information (including evidence from previous research).

Principle 17: *Ongoing Provision of Treatment*
The research proposal or protocol and the participant information sheet explain the special arrangements, if any, after the research intervention period has ended (e.g. continuing or changing the treatment, care or other services that were introduced for the purposes of the research).

Principle 18: *Integrity of the Care Record*
All information about treatment, care or other services provided as part of the research project and their outcomes is recorded, handled and stored appropriately and in such a way and for such time that it can be understood, where relevant, by others involved in the participant's care and accurately reported, interpreted and verified, while the confidentiality of records of the participants remains protected.

Principle 19: *Duty of Care*
The duty of care owed by health and social care providers continues to apply when their patients and service users take part in research. A relevant health or social care professional retains responsibility for the treatment, care or other services given to patients and service users as research participants and for decisions about their treatment, care or other services. If an unmanageable conflict arises between research and patient interests, the duty to the participant as a patient prevails.

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CASE STUDY 1.3 Mrs Jones

A maternity unit is involved in a study investigating the effects of a new medication to prevent postpartum haemorrhage. Mrs Jones is a primigravida and attends maternity triage contracting 3 in 10 min; she is 40+^{1} weeks' gestation. On examination, the cervix is 4 cm and she is diagnosed in established labour. She has a history of anxiety and presented to maternity triage 1 week previously with reduced fetal movements. The midwife looking after her thinks she might be eligible for the clinical trial and asks the research midwife if she would like to discuss the study with the woman. When the research midwife enters the room the woman is using entonox and appears to be finding the contractions difficult to cope with.

1. *Do you think it is an appropriate time to discuss a research study investigating postpartum haemorrhage with the woman?*
2. *When might be a good time to give information on the study?*

REFLECTIVE ACTIVITY FOR SELF-ASSESSMENT

1. What contribution can midwives make to global health?
2. What are the key aims of the United Nations sustainable development goals?
3. Discuss this statement: 'Transformation to family structures has meant that there are more diverse types of families today than ever before'.
4. What are the basic research principles?

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ANNOTATED FURTHER READING

Alkema, L., Chou, D., Hogan, D., et al. (2016). Global, regional, and national levels and trends in maternal mortality between 1990 and 2015, with scenario-based projections to 2030: A systematic analysis by the UN Maternal Mortality Estimation Inter-Agency Group. *Lancet*, *387*(10017), 462–474.

This study provides a comprehensive analysis of global maternal mortality trends based on the latest data from 171 countries.

Daniel, J. N. (2019). Disabled mothering? Outlawed, overlooked and severely prohibited: Interrogating ableism in motherhood. *Social Inclusion*, *7*(1), 114–123.

This article provides a feminist perspective of how disabled women are excluded from the ideology of motherhood and

the discrimination and marginalization mothers who are disabled encounter. This is a thought provoking read given that the chapter was unable to address the issue of disability due to work constraints.

Royal College of Midwives. (2016). (Update due 2019) Health inequalities and the social determinants of health. Available at: www.ilearn.rcm.org.uk.

This is an e-learning module that contains one short video and three soundbites. It explores social determinants of health in the UK and globally alongside its causes.

USEFUL WEBSITES

Care Quality Commission: www.cqc.org.uk
International Confederation of Midwives: www.internationalmidwives.org
United Nations: www.un.org
White Ribbon Alliance: www.whiteribbonalliance.org
Women's Health and Equality Consortium: www.whec.org.uk
World Bank: www.worldbank.org
World Health Organization: www.who.int

2

Professional Issues Concerning the Midwife and Midwifery Practice

Jayne E. Marshall, Julia Austin

CHAPTER CONTENTS

This chapter provides an overview of the key frameworks governing the midwifery profession and underpinning the professional practice of the midwife. Included is a resume of the regulation of midwifery and the demise of statutory supervision of midwifery along with the separate Midwives rules. It emphasizes how employer-led models of supervision are vital elements of leadership and clinical governance that support the provision of high quality maternity services and standards of midwifery practice. The concept of resilience is introduced to enable readers to contemplate their personal contribution in creating an environment that is conducive to protecting the wellbeing of themselves and colleagues within the workplace. The chapter also addresses the mandatory triennial revalidation process and the importance of continuing professional development in order for midwives to demonstrate they have maintained professional proficiency. Having knowledge of these various frameworks is essential to every midwife so they are able to function effectively as autonomous, accountable practitioners and provide care to all childbearing women, their babies and families that follows legal and ethical principles and is also contemporary, safe, compassionate and of a high quality.

THE CHAPTER AIMS TO

- identify the purpose of regulation of healthcare professionals in protecting public safety
- explain the role and functions of the regulatory body governing midwifery practice within the UK: namely the Nursing and Midwifery Council
- review the legal framework midwives should work within to maximize safety and minimize risk to women, their babies and families
- raise awareness of ethical frameworks and principles in supporting midwifery practice and empowering childbearing women
- compare the various models of employer-led supervision and their function in supporting professional leadership and the delivery of high quality midwifery care
- introduce the concept of resilience as a key component in developing a workplace that is compassionate and conducive to the wellbeing of all individuals
- affirm the value of continuing professional development and its contribution to the mandatory triennial revalidation

STATUTORY MIDWIFERY REGULATION

The statutory regulation of a profession provides structure and boundaries within a legal framework that can be understood and interpreted by both the professionals themselves and the public they serve and consequently, can be viewed as the basis of a contract of trust between the public and the profession. Regulation of midwifery should therefore play a key role in helping to improve women's experiences of the maternity services and preventing harm from occurring in midwifery practice.

It is essential that women and their families can be assured they are safe and are being cared for by competent and skilled midwives who are effectively educated and knowledgeable in contemporary midwifery practice. Consequently, midwifery regulation should *not* be viewed as an abstract concept but from how it is perceived in ordinary everyday healthcare terms, that is: *supporting the standard of care that women want* or *what midwives would want for themselves and their families*.

'Midwife' is a title protected in statute in the UK, which means that no-one can call themselves a midwife or practise as a midwife unless they are registered on the Nursing and Midwifery Council's (NMC) Register. This registration must be *active*, in that the midwife has met the triennial revalidation requirements to remain on the Register (NMC 2019a). There are just under 37,000 midwives on the NMC Midwives Register with an increase of 1000 midwives from the preceding year's statistics (NMC 2019b).

PROFESSIONAL REGULATION FROM AN INTERNATIONAL PERSPECTIVE

The goal of the International Confederation of Midwives (ICM 2011) *Global Standards for Midwifery Regulation* is to promote regulatory mechanisms that protect the public (women and families) by ensuring that safe and competent midwives provide high standards of care to every woman and baby, within the global context. The six key functions, as shown in Box 2.1, enable this to be achieved.

The ICM (2011) founding values and principles include recognition that:

- Regulation is a mechanism by which the social contract between the midwifery profession and society

BOX 2.1 Purpose of Regulation

The safety of the public is achieved through:
- Setting the scope of practice
- Pre-registration education
- Registration
- Relicensing and continuing competence
- Complaints and discipline
- Code of conduct and ethics

Adapted from the International Confederation of Midwives. (2011) Global standards for midwifery regulation. The Hague: ICM. Available at: www.internationalmidwives.org/assets/files/general-files/2018/04/global-standards-for-midwifery-regulation-eng.pdf.

is expressed. Society grants the midwifery profession authority and autonomy to regulate itself. In return, society expects the midwifery profession to act responsibly, ensure high standards of midwifery care and maintain the trust of the public.

- Each woman has the right to receive care in childbirth from an educated and competent midwife authorized to practise midwifery.
- Midwives are autonomous practitioners, that is, they practise in their own right and are responsible and accountable for their own clinical decision-making.
- The midwife's scope of practice describes the circumstances the midwife must practise in collaboration with other health professionals, such as doctors.
- Midwifery is a profession that is autonomous, separate and distinct from nursing and medicine. What sets midwives apart from nurses and doctors is that **only** midwives can exercise the full scope of midwifery practice and provide all the competencies within the scope.
- Wherever a registered/qualified midwife with a midwifery practising certificate works with pregnant women during the childbirth continuum, no matter what the setting, they are practising midwifery. Therefore when a midwife holds dual registration/qualification as a nurse, they cannot practise simultaneously as a midwife and a nurse. In a maternity setting, a registered/qualified midwife always practises midwifery.

The ICM (2011) further asserts that the following principles of good regulation provide a benchmark against which regulatory processes can be assessed:

- **NECESSITY:** is the regulation necessary? Are current rules and structures that govern this area still valid? Is the legislation purposeful?
- **EFFECTIVENESS:** is the regulation properly targeted? Can it be properly enforced and complied with? Is it flexible and enabling?
- **FLEXIBILITY:** is the legislation sufficiently flexible to be enabling rather than too prescriptive?
- **PROPORTIONALITY:** do the advantages outweigh the disadvantages? Can the same goal be achieved better in another way?
- **TRANSPARENCY:** is the regulation clear and accessible to all? Have stakeholders been involved in the development?
- **ACCOUNTABILITY:** is it clear who is responsible to whom and for what? Is there an effective appeals process?
- **CONSISTENCY:** will the regulation give rise to anomalies and inconsistencies, given the other regulations already in place for this area? Are best practice principles being applied?

Self-regulation of midwifery does not exist in all countries and consequently, regulations for midwifery education or practice are set by the national government or by another professional group who may be perceived as senior/superior. In many high-income countries, midwifery regulatory frameworks, in the main, reflect the ICM (2011) global standards, but with the exception that regulation is rarely midwifery specific, indicating the regulator's governance does not lie predominantly with **midwives** at Board level.

In Europe, midwifery is mostly regulated within an autonomous nursing and midwifery regulatory body, such as in the UK, or through a shared responsibility between a ministry and a midwifery or a nursing and midwifery regulatory body (Nursing and Midwifery Council, NMC 2009). Currently, France is the only country where midwifery is regulated by an autonomous midwifery regulatory body. In Denmark and Norway, the regulatory authority for all health professionals lies with the Board of Health.

The African Health Profession Regulatory Collaborative for Nurses and Midwives was established following the publication of the 'global standards' (ICM 2011) in order to convene a group of leaders from 14 countries spanning east, central and southern Africa who had responsibility for regulation. The aim of this Collaborative is to increase the regulatory capacity of health professional organizations with the consequential impact of improving the regulation and professional standards within each African region. Support is provided from

the Collaborative for between four and five countries each year to implement locally created regulation improvement projects. However, despite efforts to improve midwifery education and strengthen the midwifery profession through association, many low- to middle-income countries in Africa and other parts of the world have limited or non-existent regulatory processes. As a result, there continues to be a call for more work to be done in the development of legislation for midwifery regulation in these countries (UNFPA/ICM/WHO 2014; Castro Lopes et al. 2016).

Although midwifery is regulated in the USA, the legal status, definitions, regulations and scope of practice differ considerably across member states. In recent years, efforts have been made by the US Midwifery Education, Regulation and Association collective (USMERA) to achieve common goals that align with the ICM (2011) global standards for strengthening midwifery. In comparison, in New Zealand, there is a separate Midwifery Council, whereas in Australia, midwifery is regulated by a Nursing and Midwifery Board that has separate standards and code of conduct for nurses and midwives.

Self-Regulation in the United Kingdom

In the UK, midwives are members of a self-regulating profession. This is a real privilege, in that the standards for midwifery education and practice are set by midwives themselves. Self-regulating professions have regulatory bodies that are funded by their own professionals. In the case of midwives and nurses, their initial and subsequent retaining/renewal of registration fee payments is the sole funding that pays for all functions of the NMC.

It is acknowledged that the midwifery profession, as other health professions in the UK, is affected to varying degrees by national regulations that are set by others who are not part of the profession: for example, legislation for safeguarding vulnerable children or adults (Safeguarding Vulnerable Groups Act 2006; Department of Health, DH 2014; Her Majesty's Government, HM Government 2018a); medicines legislation (Human Medicines (Amendment) Regulations 2019); Health and Safety in the Workplace Regulations (Health and Safety at Work Act 1974). All midwives are bound by these national laws in the same way as others. However, during the late 1990s, power was devolved away from the UK Parliament based in Westminster (England) to the other three nations, enabling them to establish their own parliaments or assemblies: the Scottish Parliament, the National Assembly of Wales and the Northern Ireland Assembly. Consequently, each governing body is able to determine their own legislative framework to guide health and social care practice, albeit these are usually based on very similar principles.

Protection of the public cannot be achieved by the regulatory body alone and thus it involves a combination of statutory regulation, personal self-regulation, efficient employment practices and effective collaborative working with professional and educational organizations. It can, however, be difficult for individuals to act ethically and escalate concerns about practices within their employing organizations. It is here, where the regulator and regulation can support the midwife by offering appropriate guidance. The NMC can also work actively with other service regulators such as the Care Quality Commission (CQC) in England, Healthcare Improvement Scotland (HIS), the Regulation and Quality Improvement Authority in Northern Ireland (RQIA) and Healthcare Inspectorate Wales (HIW), to ensure early action is taken to prevent unnecessary harm to women, their babies and families.

The Professional Standards Authority for Health and Social Care (PSA) was established in 2003 (originally known as the Council for Healthcare Regulatory Excellence, CHRE) to oversee the nine health professions' regulators that are identified in Fig. 2.1. As an independent body, the PSA has the legal powers to monitor the performance of the regulators, holding them to account and subsequently providing annual reports to the UK Parliament on their performance. The PSA also conducts audits, reviews and investigations and can appeal fitness to practise decisions in the courts if it considers the sanctions applied by the regulators are inadequate to safeguard the public.

STATUTORY MIDWIFERY PROFESSIONAL REGULATION

Historical Context

While it is appreciated that the governments in Austria, Norway and Sweden had established the legislation that governed the practice of midwifery as early as 1801, it was not until a century later, in 1902, that the

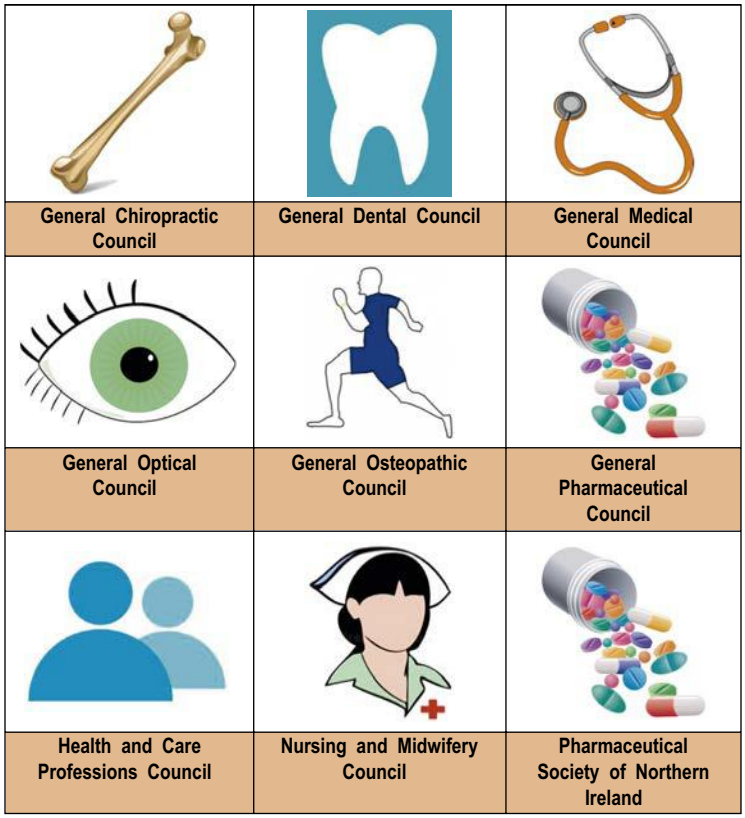

Fig. 2.1 Nine Regulatory Bodies in the UK.

first Midwives Act sanctioned the establishment of a statutory body: the Central Midwives Board (CMB) in England and Wales, followed by the Midwives (Scotland) Act 1915 and the Midwives (Ireland) Act 1918. In the UK, the drive for the legislation to regulate healthcare professionals so as to ensure the public receive quality care, arose from the profession itself, rather than political or public pressure. Professional self-regulation was developed in recognition of specialist skills and to ensure that only those individuals meeting such standards set by their peers gained professional status. The Pharmacy Act of 1852 was the first legislation in the UK to regulate health professionals (pharmacists and druggists) and establish the Pharmaceutical Society of Great Britain, which was followed by the Medical Act of 1858, which created the General Medical Council to regulate doctors in the UK.

The first Midwives Act in 1902 was promoted by individual members of Parliament through Private Members' Bills in the House of Lords and by others who supported midwife registration, rather than being initiated by the government of the time. All three Acts of the UK prescribed the constitution and function of the CMBs in each of the four countries and laid down their statutory powers, which included:

- maintaining a register of qualified midwives
- framing rules to regulate, supervise and restrict, within due limits the practice of midwives to keep the public safe
- arranging for the training of midwives and the conduct of examinations
- setting up professional conduct proceedings with the power to remove from the register any midwife found guilty of misconduct.

A series of further Acts of Parliament in 1926, 1934, 1936 and 1950 amended this initial legislation and were consolidated in the Midwives Act 1951 and Midwives (Scotland) Act 1951. However, all midwifery statutory bodies in the UK were dominated by doctors who had long opposed the regulation of midwives, unlike other

professional regulatory bodies that were mainly constructed of members of the occupation to be regulated. There was no requirement for even one midwife to be included on the Council of any CMB, which remained the case until the dissolution of the CMBs in 1983.

The Midwives Act was followed by the Nurses Registration Act in 1919, which established the General Nursing Council (GNC) for England and Wales, followed by the establishment of councils in Scotland and Ireland. The two professions were regulated separately until the Nurses, Midwives and Health Visitors Act 1979 established the framework of the United Kingdom Central Council for Nursing, Midwifery and Health Visiting (UKCC) in 1983. National Boards were established in England, Scotland, Northern Ireland and Wales to approve and monitor pre- and post-registration education and practice as well as be responsible for the supervision of midwives. This was the first time that midwives had been amalgamated in law with other professional groups as, up to this point, midwifery had remained independent of any nursing infrastructure. After much campaigning by the midwifery profession, in particular, the Royal College of Midwives (RCM) and the Association of Radical Midwives (ARM) who feared that the UKCC register and Council would be dominated by nurses and that midwives would lose control of their profession, a special clause was inserted into the Act and put into legislation the requirement for a statutory midwifery committee. The scope of the Midwifery Committee was for it to be consulted on all midwifery matters and to formulate the rules for the practice and supervision of midwives.

The main underlying principles of the Nurses, Midwives and Health Visitors Act of 1979 were the protection of the public and self-regulation by the three professions. This was achieved by the majority of members of the Council being elected by the three professions from the four countries of the UK. However, this created a dichotomy – between the public and professional interest – that has been central to the development of the regulation of the professions and has played a key part in recent reforms of midwifery regulation in the UK.

A decade later, an external review of the Nurses, Midwives and Health Visitors Act 1979 was commissioned by the DH, which resulted in a smaller, directly elected central council with smaller national boards. Regional Health Authorities (RHA) were assigned the responsibility of funding nursing and midwifery education, whilst the national boards retained responsibility for course validation and accreditation. This in essence established the *purchaser–provider model*, where hospitals were expected to contract with education providers for a requisite number of training places for nurses and midwives to fulfil their local workforce planning. These arrangements and the new streamlined structure of the UKCC and national boards were incorporated into the 1992 Nurses, Midwives and Health Visitors Act. Further consolidation of the 1979 and 1992 Acts incorporating all the reforms, resulted in the 1997 Nurses, Midwives and Health Visitors Act.

Further reform of the health professions was included in the Health Act 1999 that repealed the Nurses, Midwives and Health Visitors Act 1997 following a review of the function of the UKCC undertaken by JM Consulting in 1998, who had concluded that more effective regulation required the balancing of the interests of the professions with those of employers, service-users, educators and others. In tandem with the emergence of patient and women-centred care in the 1990s, professional self-regulation gave way to professional regulation in the public interest.

It was against this background that primary legislation was replaced with a Statutory Instrument by Order, which meant a departure from the normal practice of parliamentary procedure experienced during the previous century, involving professional scrutiny through all the earlier stages, including the publication of Green and White Papers. Section 62 (9) of the Health Act 1999 set out the Order for the establishment of the Nursing and Midwifery Council (NMC), which commenced operating in 2002. The Order encompassed the main recommendations made by JM Consulting (1998) and strengthened the accountability of the professions to the public in general and in particular, around fitness to practise.

The NMC took over the quality assurance functions of the UKCC and the four national boards, although some of the functions of the national boards in Scotland, Northern Ireland and Wales are provided by NHS Education for Scotland (NES), the Northern Ireland Practice and Education Council for Nursing and Midwifery (NIPEC) and Healthcare Inspectorate Wales. This development reunited standards for education with standards for practice and supervision of midwives on a UK basis. However, the creation of this UK-wide regulatory body,

the NMC, was contrary to the trend of Parliamentary devolution that had occurred in the late 1990s.

Midwifery Regulatory Reform

Public trust in the health professions' abilities and willingness to call those they regulated to account had failed in the late 1990s. In particular, two inquiries into failings within the NHS, the Bristol Royal Infirmary Inquiry (Kennedy 2001); and the Shipman Inquiry (Smith 2004) revealed a club culture among doctors, in which they placed their own professional loyalties and relationships before the safety of patients. The recommendations from the two inquiries concerned the regulation of healthcare professionals, including their education and training, assessment of competence, registration, continuing professional development (CPD) and revalidation. The government commissioned a further two reports (Donaldson 2006; DH 2006), which led to the publication of the white paper: 'Trust, assurance and safety: the regulation of health professionals in the 21st century' (DH 2007). This led to the introduction of the Health and Social Care Act 2012, resulting in significant reforms to the governance arrangements of all health profession regulators, moving from elected professional dominated boards to appointed boards consisting of equal representation of professionals and lay people. These reforms also improved the fitness to practise procedures and sanctions as well as advocated that all health professions adopt a form of periodic revalidation.

The Mid Staffordshire NHS Foundation Trust Public Inquiry (Francis 2013) and the University Hospitals of Morecambe Bay NHS Foundation Trust Investigation (Kirkup 2015) identified that the actions, motivation, responsibility and accountability of individual health professionals are important in upholding the standards of the profession and contributing to patient safety culture. Walshe (2003, 2009) however, claim that advocates of patient safety science see all, or most errors as being products of the system or organization of care. Such a sentiment was also supported in the Berwick report (National Advisory Group on the Safety of Patients in England 2013) who affirmed that a safer NHS depends far more on major cultural change than a new regulatory regime of rules, standards and control strategies.

The Parliamentary and Health Service Ombudsman (PHSO) in England, investigating the failures in maternity and neonatal care that occurred from January 2004 to June 2013 at Furness General Hospital (that later became the University Hospitals of Morecambe Bay NHS Foundation Trust), expressed concerns of the additional tier of regulation, which applied to midwives, namely the *statutory supervision of midwives* (PHSO 2013). The structural flaw permitting the local investigation of midwives by midwives, was viewed as leading to potential muddling of the supervisory and regulatory roles of midwives and the possibility of a perceived conflict of interest. As a result, the report recommended two principles for the future model of midwifery regulation that:

- midwifery supervision and regulation should be separated
- the NMC should be in direct control of regulatory activity (PHSO 2013).

Further consideration of the report by the PSA (2014) concluded that:

- there was a lack of evidence to suggest that the risks posed by contemporary midwifery practice required an additional tier of regulation
- the imposition of regulatory sanctions or prohibitions by one midwife on another without lay scrutiny is not in line with good regulatory practice.

As a consequence, the NMC commissioned an independent review of midwifery regulation by the King's Fund with the aim of recommending a future model that would be fit for public protection, be fair and proportionate and would give the NMC sufficient regulatory control to be accountable for its outcomes. The recommendation from the King's Fund was to remove the additional layer of regulation for midwives, that the NMC should restrict its role to the core functions of regulation and that the governments of the four UK countries, should consider other ways to ensure that the functions of supervision and professional development are provided by other organizations in the health system (Baird et al. 2015). A decision was subsequently made by the NMC to seek a change in its legislation to remove the additional tier of regulation, which included the supervision of midwives as a statutory function. Following consultation and debates in Parliament (House of Lords Hansard 2017), the Nursing and Midwifery (Amendment) Order 2017 was passed. However, these changes would be more far-reaching than just the removal of the supervision of midwives from statute as Gillman and Lloyd (2015) outlined. The changes included the

removal of the *Midwifery* section of the Nursing and Midwifery Order 2001 (Section 60), which provided the legislation for:

- the Midwifery Committee
- rules defining midwifery practice
- local supervision of midwives.

In addition, Part V of the 2001 Order relating to certain fitness to practise functions of the NMC relating to both midwives and nurses, was also amended.

The NMC stated that the changes would **not** affect:

- the separate registration of midwives
- direct entry to the register as a midwife
- the protected title of a midwife
- the protected function of midwives attending a woman in childbirth or
- separate competencies and pre-registration education standards for midwives (NMC 2017a).

The statutory supervision of midwives consequently has been replaced by an *employer led model of clinical supervision* based on the principles set out by the DH (2016) and are explored in more detail later in the chapter.

Statutory Instruments

The Nursing and Midwifery Order 2001: SI 2002 No. 253 (*The Order*)

The Nursing and Midwifery Order 2001 (*The Order*) is the main legislation that established the NMC and was made under Section 60 of the Health Act 1999. The Order, which sets out what the Council is required to do (*shall*) and provides permissive powers for things that it can choose to do (*may*), is therefore classed as *secondary legislation*. A series of orders made by the Privy Council and Rules made by the Council sit *underneath* The Order. The numbered paragraphs within The Order are referred to as Articles.

There are 10 parts to The Order that outlined the establishment of the Nursing and Midwifery Council, its role and function, which include:

- Part III: Registration that resulted in three parts of the Register:
  - Nurses
  - Midwives
  - Specialist Community Public Health Nurses: namely health visitors, school nurses, occupational health nurses, health promotion nurses and sexual health nurses.
- Part IV: Education and Training
- Part V: *Fitness to Practise*
- Part VI: Appeals
- Part VII: EEA *provisions*
- Part VIII: Midwifery specific Articles that established the following:
  - Article 41: The Midwifery Committee
  - Article 42: Rules specific to midwifery practice
  - Article 43: Regulation of the LSA and supervisors of midwives
- Part IX: *Offences* that include
  - Article 45: Attendance by unqualified persons at childbirth.

To change how the NMC operates in the main, requires legislative changes and since its existence, The Order has been subject to a number of amendments, which are detailed in Box 2.2: the most significant to the midwifery profession being The Nursing and Midwifery (Amendment) Order 2017: SI 2017 No. 321. This SI **removed** provisions relating to the Midwifery Committee, the local supervision of midwifery and the Midwives Rules (NMC 2012).

THE NURSING AND MIDWIFERY COUNCIL

Being the UK-wide regulator for nurses and midwives and for nursing associates in England, the role of the Nursing and Midwifery Council (NMC) is to ensure these professionals have the knowledge and skills to deliver consistent, quality care that keeps people safe. It is accountable to the Privy Council, the Department of Health and the Professional Standards Authority. The NMC is governed by a Council whose role is to ensure that the NMC complies with all relevant legislation governing nursing and midwifery practice, the main legislation being the Nursing and Midwifery Order 2001 (The Order) and adheres to the Charities Act 2011 ultimately holding the Chief Executive and Registrar to account.

Being registered with the Charity Commission in England and Wales and the Office of the Scottish Charity Regulator, the NMC should use all funds received from its registrants purely for the benefit of the public, i.e. in the regulation of nursing and midwifery, ensuring that better and safer care is always at the heart of its function. The Council is committed to openness and transparency and holds meetings in public at least six times a year to which anyone is welcome to attend.

Membership

Standing Orders made by the Council under Article 12 Schedule 1 of The Order establish the fundamental

BOX 2.2 Notable Amendments to the Nursing and Midwifery Order

SI 2001 No. 253 and Subsequent Rules

Statutory Instrument (SI)	Title
SI 2008 No. 1485	**The Nursing and Midwifery (Amendment) Order 2008** *This Statutory Order related to improving the governance arrangements of the NMC in order to maintain and improve public confidence.* *This included changes to the membership of the NMC from being mostly an elected committee to becoming fully appointed. This also applied to the composition of the Midwifery Committee.*
SI 2014 No. 3272	**The Nursing and Midwifery (Amendment) Order 2014** *This Statutory Order introduced powers to the NMC to enable it to carry out its fitness to practise and registration functions more effectively and efficiently by improving consistency in decision-making and reducing the time it takes to deal with cases. The amendment clarified the law regarding the sanctions that could be imposed by a Practice Committee, as well as introduced amendments to the composition of a Registration Appeal Panel.*
SI 2015 No. 52	**The Nursing and Midwifery Council (Fitness to Practise) (Education, Registration and Registration Appeals) (Amendment) Rules Order of Council 2015** *This Statutory Instrument relates to amending the Fitness to Practise Rules and the Registration Rules as a result of the Nursing and Midwifery (Amendment) Order 2014 (see above). These rules were to improve the NMC's fitness to practise procedure and enhance public protection.* *Rules relating to indemnity arrangements as defined in the Indemnity Order (SI 2014 No. 1887) were also incorporated in this amendment. These rules enable the NMC Registrar to request information for the purposes of determining the eligibility of an individual's registration, application for admission or renewal of registration, that they have or will have appropriate cover under an indemnity arrangement.*
SI 2015 No. 1923	**The Nursing and Midwifery Council (Fitness to Practise) (Education, Registration and Registration Appeals) (Amendment No. 2) Rules Order of Council 2015** *This Statutory Instrument relates to further amending the Fitness to Practise Rules and the Registration Rules as a result of the Knowledge of English Order 2015 (SI 2015 No. 806). The rules set out the details pertaining to registrants demonstrating competence in the English Language for safe practice as a midwife or nurse.*
SI 2017 No. 321	**The Nursing and Midwifery (Amendment) Order 2017** *This Statutory Instrument removed provisions relating to the Midwifery Committee, local supervision of midwifery and the Midwives Rules (NMC 2012).* *Part V of The Order was amended in respect of further updating fitness to practise processes for nurses and midwives to ensure they are efficient and proportionate. This included replacing the Conduct and Competence Committee and the Health Committee with a single Fitness to Practise Committee.*
SI 2017 No. 703	**The Nursing and Midwifery Order (Legal Assessors) (Amendment) and the Nursing and Midwifery Council (Fitness to Practise) (Amendment) Rules Order of Council 2017** *This Statutory Instrument related to amending the NMC Fitness to Practise Rules as a result of the Nursing and Midwifery (Amendment) Order 2017 (see above).*
SI 2018 No. 838	**The Nursing and Midwifery (Amendment) Order 2018** *The Order was amended to include provisions relating to the regulation of nursing associates (England only) and to make consequential amendments in that regard to other secondary legislation.*