re:birth

summary report

Foreword

In every aspect of our lives, language matters – and in health and care settings, it's even more important. How we communicate with each other can determine the quality and impact of the care given and received, which is why developing a shared language is so important.

Pregnancy and birth are extraordinarily personal, and personalising care is central to good outcomes and experience. There has been a great deal of debate in recent years about the language around birth, and the impact it can have. During this project, for example, women were keen to tell us how terms such as 'failure to progress' or 'lack of maternal effort' can contribute to feelings of failure and trauma.

There has been particular debate around the term 'normal birth'. Despite being the term used by organisations including the International Confederation of Midwives and the World Health Organization, it has often taken on negative connotations in the UK, and particularly in England.

In 2020, the Royal College of Midwives, which counts the majority of midwives practising in the UK among its membership, took the decision to address this, and to try to develop an agreed shared language, working with maternity staff, users of maternity services and others involved in the care and support of pregnant women and families. Over the course of 18 months, the consultation has involved nearly 8,000 people from across all four UK nations. The project has been ably guided and supported by our project oversight group. We are immensely grateful to the members of the project oversight group and all those who took part in the project for giving their time and sharing their experiences.

How we use language inevitably evolves over time, but we hope that the Re:Birth project will help to embed a shared, respectful way of discussing labour and birth.

Shirley Cramer CBE
Chair, Re:Birth project

What language do people need?

Those working in maternity services need terms that are:

1. Clear, descriptive and unambiguous

2. Consistently understood between individuals and professional groups

3. Specific enough to identify differences in the mode of labour and birth.

Those using maternity services need terms that are:

1. Non-judgmental, non-hierarchical, nor value-laden

2. Descriptive and technically accurate

3. Reflects their actual experience, not what others assume the experience to be.

Introduction: Why Re:Birth?

In the UK, there has been an increasingly heated debate around the term ‘normal birth’. The word ‘normal’ is universally used to describe a range of other physiological states, such as ‘normal blood pressure’, ‘normal lung function’ or ‘normal fetal growth’. Similarly, its use in relation to labour and birth has evolved across the world as a standard way of describing the physiological process of labour and birth. It is included in the International Confederation of Midwives’ definition of the midwife’s role.

Many…believe that the language used by professionals needs to be reviewed and, in a sense, reborn. Hence, Re:Birth

However, some have argued that the term ‘normal’ suggests that other births, those that include medical interventions, may be viewed as ‘abnormal’, despite a positive outcome for both mother and baby. Some women have described feeling that their birth has been defined as ‘abnormal’ as very difficult. Others have asserted that the particular focus of some professionals on supporting or encouraging one type of birth has led some to steer women towards or away from certain choices.

These public conversations have raised questions not only about the terminology around normal birth, but about all the terms we use to describe different types of birth.

How can we ensure that the language we use helps support safe and high quality care? Which terms serve our maternity community best?

Many of those involved in maternity care, including the Royal College of Midwives, believe that the language used by professionals needs to be reviewed and, in a sense, reborn. Hence, Re:Birth.

The project

The aim of the Re:Birth project was to find language around labour and birth that could be shared and understood both by those delivering maternity care and those receiving it. The project was led by the Royal College of Midwives and a multidisciplinary, multisectoral stakeholder oversight group.

The project used a range of qualitative and quantitative methods to gather views about the preferred descriptors for types of birth in the UK. We asked participants to help define and test what worked – and what didn't. This collaborative sequenced approach has been vital in finding common ground. These approaches included a series of online listening groups, an online voices survey gathering qualitative views and a final online survey gathering quantitative data. For more detail about the methods we used, go to www.rcm.org.uk/rebirth-hub/. The project heard from a total of 7,822 people between the Listening Groups (n=110); the Voices Survey (n=764) and the final survey (n=6,948). Over a third, 37% (n=2,885), of these participants were service users; that is, women and people who had been pregnant, given birth, supported their partner or family member's birth, or who hoped to become pregnant. Around 50% of these people had given birth in the last five years. Nearly half of the survey participants, 48% (n=3,732), were midwives, student midwives or maternity support workers, 5% (n=403) obstetricians or obstetric anaesthetists and 10% (n=799) were a range of other people, including other healthcare professionals, doulas, antenatal educators, birth workers, researchers, members of the maternity service improvement community and midwifery lecturers.

Around 71% (n=5,512) of survey participants (N=7,712) were from a White British or Irish background and 12% (n=935) were from minority ethnic communities, as compared with 14% of the UK population. People took part from across the four UK nations, and 147 from countries outside of the UK.

In the Listening Groups and the Voices Survey, we asked the participants to share with us their experiences, and their views about the language used in maternity care to describe labour and birth. We asked what people found helpful, less helpful and what they thought was important about the terms. These responses provided rich insights into the needs of service users and health professionals.

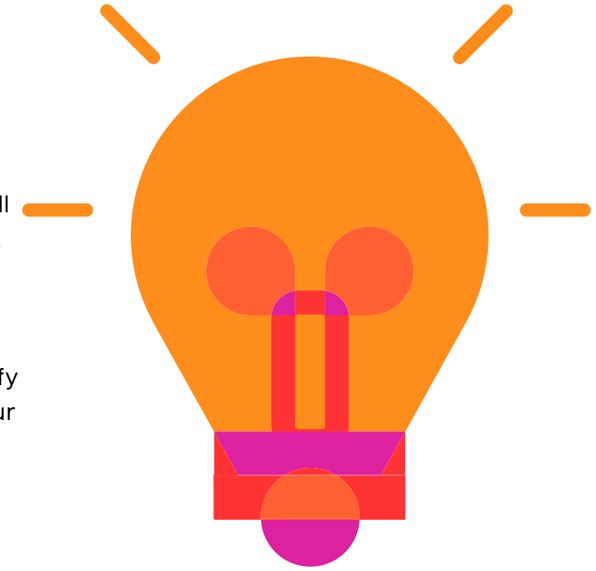
The project heard the views of 7,822 people

The aim of the Re:Birth project was to find language around labour and birth that could be shared and understood both by those delivering maternity care and those receiving it

Strengths and limitations

This is the first project of its kind to consult the maternity community directly on their preferred language to describe labour and birth. Its collaborative approach has sought at all stages to include diverse perspectives. Using a combination of qualitative and quantitative methods has made space for the complexity and nuance in this debate, while also enabling us to identify preferred terms for some specific labour and birth scenarios. The qualitative findings were invaluable in providing context to the survey responses.

This project has been limited by time and resources and pragmatic decisions around method have been required. The terms we consulted upon were restricted to those generated by early stages of the project. Participants were only asked to respond to five vignettes, which do not represent all possible labour and birth scenarios. However, in combination with the qualitative findings, we have been able to identify some key principles relating to language that can be used in many other contexts.



This is the first project of its kind to consult the maternity community directly on their preferred language to describe labour and birth

The role of the midwife

Midwives have many different roles in caring for women, birthing people and babies during pregnancy, labour and birth. The scope of the midwife's work is set in statute in the UK and is defined by the NMC Standards of Proficiency for Midwives (standards-of-proficiency-for-midwives.pdf). This document describes how midwives provide universal care for 'all women and new-born infants' by supporting their physical, psychological, social, cultural, and spiritual safety, and 'optimising normal physiological processes' in all circumstances. In addition to universal care, midwives provide additional care to women and newborns with complications and support public health and positive lifestyle choices. The need for midwives to 'optimise normal physiological processes' is important for all women, whether they experience a straightforward pregnancy, birth or postnatal period, or have complications where medical assistance or interventions are used. The role of the midwife as set in statute and in the NMC standards is not affected by this project or any of its findings.

Midwives provide universal care for all women and new-born infants by supporting their physical, psychological, social, cultural, and spiritual safety

What we heard

Everyone we heard from fundamentally wanted the same thing - for women, birthing people and their babies to have good outcomes, to feel like their labours and birth experiences were as positive and empowering as possible and that their wishes were listened to, heard, understood, respected and responded to. This was a shared vision, regardless of their personal experience, their language preferences, or their role in the maternity community.

We heard from service users that language is important to their experiences of maternity care. The words that health professionals used to speak to them about their labours and births made a difference to how they felt, regardless of outcomes.

Many of the women and birthing people we heard from in the Listening Groups and through the Voices qualitative survey, were less concerned with how their baby was born, than that their labour and birth were safe, and they had a positive experience. A 'positive experience' meant feeling safe, listened to and that they had autonomy and choice over what happened to them. Clear terms, understood by everyone, helped women to make informed decisions about their care. When health professionals used language to describe a labour and birth that a woman didn't share, it made her feel dismissed, or that the person caring for her did not understand her experience.

Women who shared their thoughts with us in the Listening Groups and the Voices Survey were clear that they wanted all births to be valued and supported by their maternity professionals. They wanted language that was descriptive rather than value-laden. They told us that the use of language in maternity care, including words that implied 'failure' or 'incompetence' or 'lack of maternal effort', contributed to feelings of failure and even trauma around their birth experience.

Many of the women who participated liked to describe their own births as simply a 'birth', or 'vaginal' or 'caesarean' because these kinds of terms felt factual, they encompassed different types of birth and did not imply a hierarchy, where one mode was favoured or valued over another. The Listening Groups and Voices Survey identified that the word 'normal' was a loose term, used to refer to very different types of labours and births. For some it described a labour and birth where a woman did not need any medical assistance; for others, it

referred to any kind of vaginal birth.

When we asked participants in the Listening Groups and Voices Survey to pick particular terms to describe different types of birth, there were problems identified with any and all of the terms put forward by the participants. However, participants were united in their preference for the term 'birth' rather than 'delivery'.

Overall, during the Listening Groups and the qualitative Voices Survey, we found there was no one preferred term. Instead, service user participants asked for health professionals to reflect the language they themselves used when speaking to them about their labours and births.

Women and service users asked for terms to describe labours and births that are:

- Descriptive and technically accurate
- Non-judgmental, non-hierarchical, nor value-laden
- Reflects their actual experience, not what others assume the experience to be.

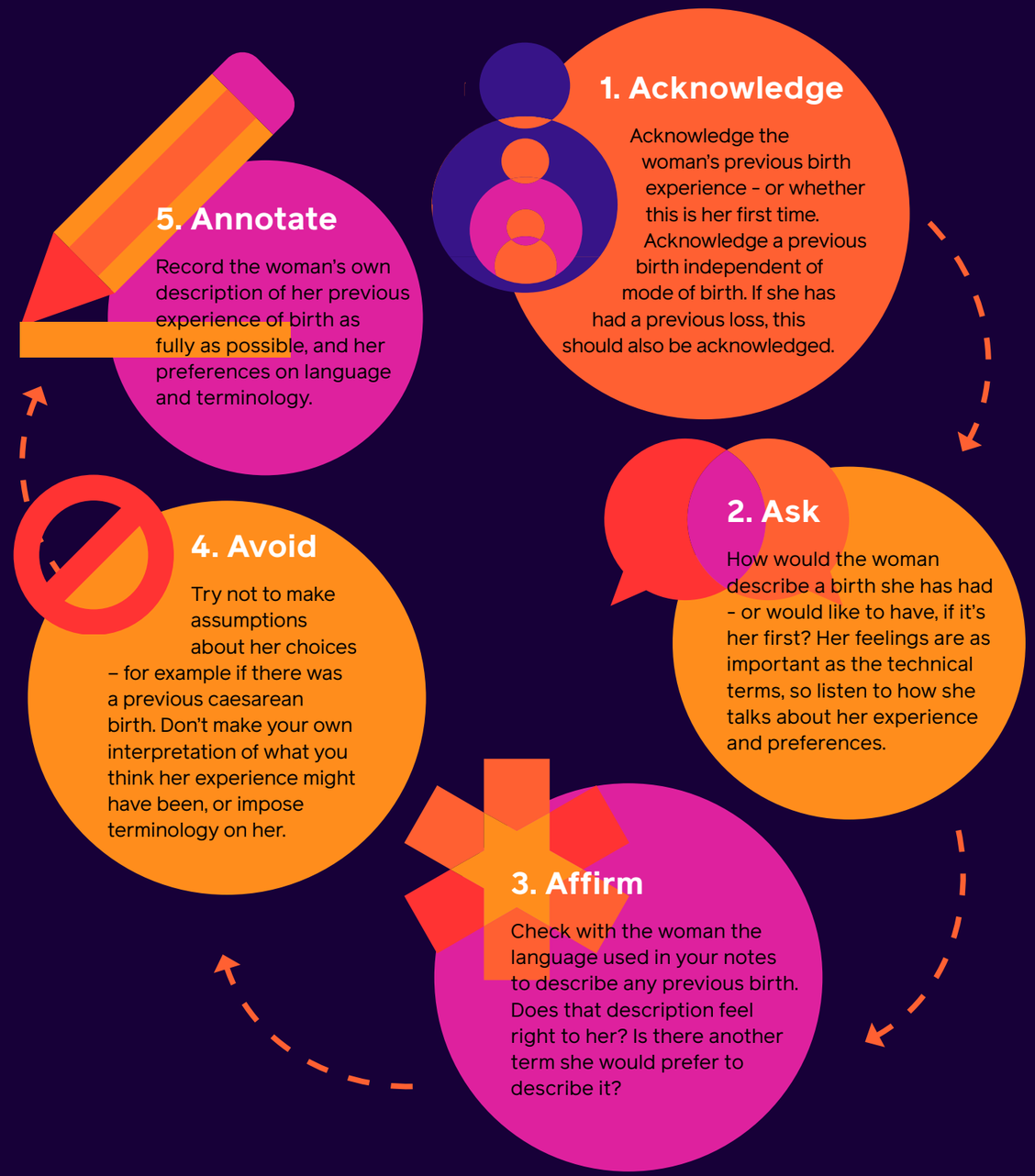
The findings from the Listening Groups and Voices Survey led the project team to the view that we could not support or recommend the use of any particular term over another in conversation with women, birthing people and their families. In response, we have produced easy-to-follow guidance - the 5As - to support health professionals when having these discussions to provide personalised care.

Health professionals supported this kind of personalised approach when talking to pregnant women, but also needed specific terminology to describe different types or modes of birth in medical records, professional conversations, audit, research, and reports. This is so the range of short-, medium-, and long-term outcomes of different types of labour and birth can be monitored and so that appropriate care can be instigated in subsequent pregnancies based on previous labour and birth history.

Health professionals asked for terms that are:

- Clear, descriptive and unambiguous
- Consistently understood between individuals and professional groups
- Specific enough to identify differences in the mode of labour and birth (e.g. 'vaginal' would not be distinctive enough).

The 5As



What the final survey told us

In the final survey, we asked people which terms they would like to see used in professional conversations, notes, reports, research, and audit, to guide health professionals in the language they should use in these contexts. The final survey presented five different vignettes describing a labour and birth, with an additional question relating to caesarean birth. Respondents were given a range of possible terms to describe each vignette and question, including key terms suggested during the Listening Groups and Voices Survey. We did not include terms that could not offer enough distinction between modes of birth, for example, 'birth' or 'vaginal birth'. We also added 'assisted' and 'unassisted' and 'with/without interventions' as these have been increasingly used in audit and reports in recent years.

We asked respondents to choose one term that was their most preferred to describe each vignette; and to note any terms that were acceptable to them and any that they felt should not be used.

The five vignettes in the survey do not present every possible labour and birth scenario. The findings provide some principles and guidance on preferences that can be translated into other situations.

For example, we did not ask about vaginal breech birth. However, the term vaginal breech birth meets the principles and preferences expressed in the project for being unambiguous, clear, descriptive and specific. It also uses the word 'birth' rather than 'delivery'. Some terms could be used together to give a more detailed description if that is felt to be necessary. For example, a woman may have a spontaneous labour followed by a birth with forceps.

In formal records, consistent language is important to support safe and accurate clinical handover

While flexibility and personalisation are important in face-to-face conversations, the feedback from the listening groups and voices survey showed that in formal records, consistent language is important. It supports safe and accurate clinical handover and enables audit data to be shared and compared.

The most popular terms in the Re:Birth survey are below:

Spontaneous vaginal birth

(n=5,020, 89%)

Lily was close to her due date when her labour started on its own. She laboured without needing help, apart from the support of her midwife and partner. Lily's labour progressed without any drugs to speed it up (no syntocinon infusion) and she gave birth to her baby vaginally without forceps or ventouse. Lily and her baby were both well afterward.

Birth with forceps

(n=5,314, 93%)

Chantelle's labour started on its own (without an induction) when she was close to her due date. She laboured without needing any help apart from the support of her midwife and birth companion. At the end of the labour, Chantelle, with her midwife and obstetrician, decided she needed help with forceps to give birth. For Chantelle's story, we are interested in describing her birth (not her labour). What do you think about the options for describing this sort of birth?

Induced and/or augmented labour

(n=5,157, 89%)

Aisha's labour was started through an induction and she had drugs during her labour to strengthen her contractions (syntocinon infusion). She decided to have an epidural to help with her labour pains. She gave birth to her baby vaginally without the need for forceps or ventouse. For Aisha's story, we are interested in the terms used about her labour, not her birth. Which terms do you prefer to describe this type of labour, that included syntocinon and an epidural?

Unplanned caesarean birth

(n=4,733, 83%). 'In-labour' was also very popular (n=4,664, 82%)

Sarah's labour started on its own, when she was close to her due date. But, as time went on, Sarah and the people caring for her agreed that she needed to birth by caesarean, which is how her baby was born. This caesarean could be described as 'emergency', 'unplanned' or 'in-labour'. What do you think about these terms?

Planned caesarean birth

(n=5,761, 99%)

While she was pregnant, Jo and her care team agreed that her baby would be born by caesarean. This caesarean could be described as 'elective', 'planned' or 'pre-labour'. Which do you prefer?

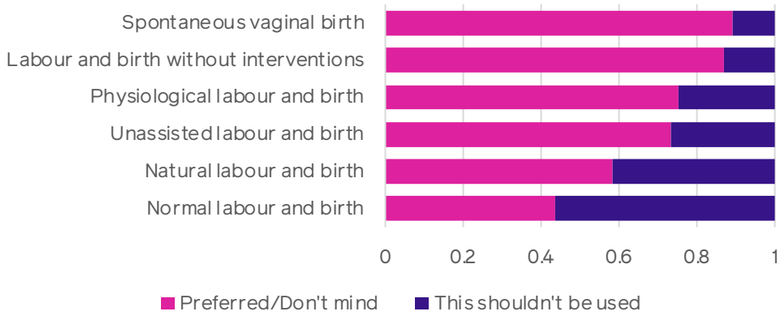
Caesarean birth

(n=5,560, 97%)

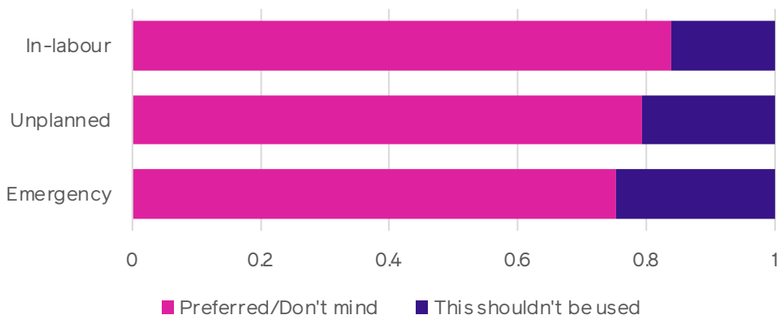
There are lots of other terms in use for what we often call a 'caesarean'. These can be used with the words from the previous questions to describe both types of this birth. Which terms do you prefer?

The following charts give more detail about the choices made by the respondents in the final survey. As the qualitative findings showed, there was also a mixed response to these terms. Most of these words were acceptable to most people, with a few triggering strong feelings against them.

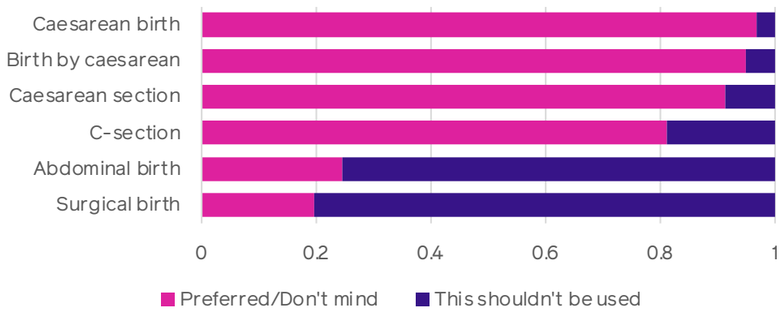
Preferred term for clinical notes, research and audit: Spontaneous vaginal birth



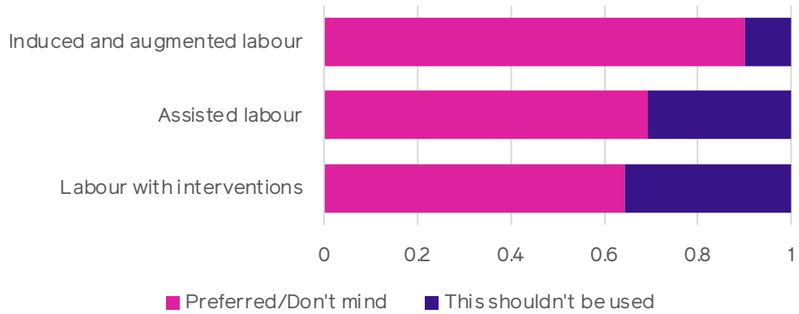
Preferred term for clinical notes, research and audit: Unplanned caesarean birth



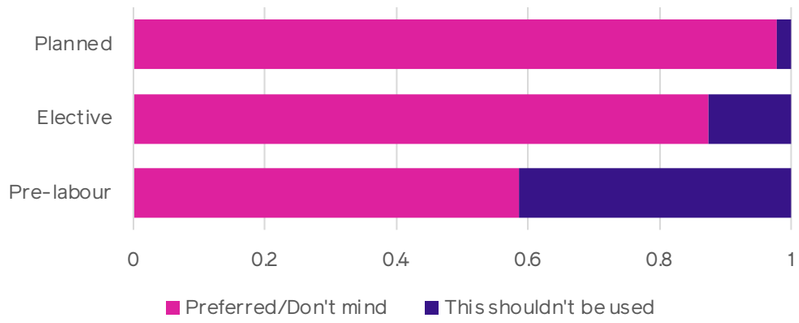
Preferred terms for use in clinical notes, research and audit: Caesarean birth



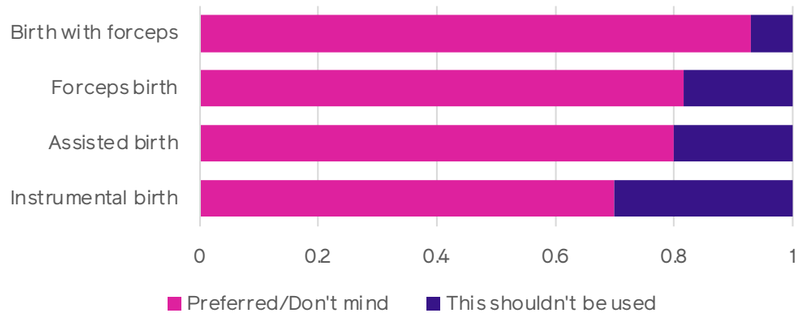
Preferred term for clinical notes, research and audit: Induced and augmented labour



Preferred terms for use in clinical notes, research, and audit: Planned caesarean birth



Preferred term for clinical notes, research and audit: Birth with forceps



1. The data was weighted according to the study population
2. Both 'unplanned' (n=4733) and 'in-labour' (n=4664) were popular terms amongst the Final Survey respondents to describe this type of caesarean birth. Obstetricians preferred 'in-labour' whilst other groups preferred 'unplanned'. We recognise the shortcomings of both. The Project Oversight Group supports the use of either term where appropriate, especially 'unplanned' in conjunction with 'planned caesarean birth'.

Recommendations

All births should be valued. Maternity professionals should always seek to ensure that those in their care know that they work to ensure that their labour and birth experience, whatever the type or mode of birth, will be empowering, positive, supported and safe.

The language we use to describe different types of labour and birth is an important element of the care experience of women and their families. It has a significant impact on their autonomy, their decision-making and feelings about labour and birth. No one term was preferred or rejected by all respondents, including 'normal birth'. Using personalised language in conversation helps to ensure they feel respected, heard, and understood. Health professionals should ask women to describe their previous births and then reflect the language they prefer to describe their planned or past labours and births wherever possible. Women who are pregnant for the first time should be asked what language feels right for them to describe the type of birth they hope to have.

Health professionals may need to advise women that their electronic notes might require them to pick the agreed technical, professional language from established lists to record previous types of birth, but that free text can be used to describe women's own preferred language.

The Re:Birth project sought to find commonality of language, a shared lexicon that could be used by clinicians and service users alike. The conversations that ensued were enlightening and underlined how the use of language – whether good or poor – can have a significant impact.

The Re:Birth project has identified the following preferences of the participants for health professionals and researchers to use when describing type of labour and birth in notes, professional conversations, reports and audit for common scenarios:

Birth

Participants in the listening groups preferred the term 'birth' as the overarching term to describe all births, rather than the term 'delivery' which has commonly been used.

Spontaneous vaginal birth

A labour and birth starting spontaneously (without induction) and progressing without the need for medical interventions (oxytocin infusion or instruments for birth). This term covers both the spontaneous nature of the labour, without significant medical interventions such as induction and oxytocin, and the spontaneous vaginal nature of the birth, without the need for instruments. If a labour or birth need to be described separately, for example where a labour was spontaneous but a followed by a birth with forceps, an appropriate term might be 'spontaneous labour followed by a birth with forceps'. Another example might be where there is, 'induced labour followed by spontaneous vaginal birth'.

Induced and/or augmented labour

A labour using medical intervention (including induction or augmentation using oxytocin infusion). Where the birth then takes place without using instruments, this is an augmented/induced labour with spontaneous vaginal birth.

Birth with forceps/ ventouse

A birth where instruments are used. A woman may have a spontaneous labour with the need for an instrumental birth. In this case, the recommended description would be 'a spontaneous labour, followed by birth with forceps/ventouse'.

Caesarean birth

The overarching term for an operative caesarean section is caesarean birth. This may be a planned caesarean birth or an unplanned caesarean birth. There was very little difference (around 1%) in the number of individual people who preferred or didn't mind the terms 'in-labour' and 'unplanned'.

When using the Robson Criteria or Royal College of Obstetricians & Gynaecologists' categories to provide further detail, we recommend the use of caesarean birth in place of caesarean section for all types of caesarean birth.

Acknowledgements

Re:Birth is a collaborative project led by the Royal College of Midwives, working with representatives from across maternity care, including staff, advocacy groups and service users. As well as the many thousands of people who took part in the Listening Groups and Voices Surveys, the project was supported by a project oversight group, the membership of which is listed below, alongside those who supported the management of the research.

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Contributing organisations

- British Association of Perinatal Medicine
- Maternity Engagement Action
- NHS England and NHS Improvement
- Obstetric Anaesthetists' Association
- UK Consultant Midwives Network
- Welsh Government

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