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# Can Maternity Care Move Beyond Risk?

## *Implications for midwifery as a profession*

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### **Abstract**

Maternal and infant mortality rates are reassuringly low in developed countries. Despite this, birth is increasingly seen as risky by women, health professionals and society in general. In wider society, women are subjected to a litany of risks regarding birth, including sensationalising negative incidents by the media. Within maternity care, both structural and operational factors contribute to heightened risk perceptions. Women are processed through a system where risk-management strategies can take precedence over individualised care as health professionals attempt to protect themselves from implication in adverse outcomes and litigation. This results in increasingly interventionist care, depriving women of psychosocial safety in the birth process.

Midwifery, as a profession promoting trust in normal birth, is threatened by this dominant medical model of maternity care and interventionist birth practices. Midwives need to act to reclaim their role in promoting normal birth, while balancing considerations of risk with the principle of woman-centred care.

### **Keywords**

Risk, Childbirth, Midwives, Women, Intervention,

## Introduction

Changes in society, including higher levels of education in the population and higher expectations of health services have resulted in a belief that risk can be controlled or even prevented and nowhere is this more apparent than in maternity care. The focus of birth has shifted from accepted uncertainty towards risk prevention resulting in increased employment of clinical governance and risk-management strategies (Scamell and Alaszewski, 2015). As a consequence, the language of birth has evolved to incorporate words such as 'hazard', 'harm', 'blame', 'vulnerability' and 'safety' (MacKenzie Bryers and van Teijlingen, 2010). As birth becomes reconceptualised in these terms, there is little tolerance for accidents where individuals - including midwives, obstetricians and women - are held accountable for adverse events (Scamell and Alaszewski, 2015).

Risk management was originally meant to protect, but in healthcare today, risk management may be exposing people to more intervention than is necessary (Pilleary Edwards and Murphy-lawless, 2006). This develops from heightened, and sometimes irrational, perceptions of risk. Such perceptions mean healthcare professionals are reluctant to accept even a minimal possibility of risk (Scamell and Alaszewski, 2012), demonstrated by existing maternity practice where intervention and surveillance are employed even in the absence of risk factors (Rattray et al., 2011; Scamell, 2011).

The purpose of this paper is to analyse what factors affect both women's and midwives' perceptions of risk regarding birth, and how this in turn affects the care women are experiencing. The wider sociocultural factors that affect risk perceptions surrounding childbirth are considered prior to a discussion of how both the structural and operational processes of maternity services are impacting on risk perceptions and care regarding birth. This paper will argue that skewed perceptions of risk have produced a maternity service that focuses solely on safe outcomes, as opposed to optimal outcomes, and will discuss how this is having a negative impact on maternity care and the profession of midwifery.

This discussion paper is based on findings from an integrative literature review of midwives' and obstetricians' perceptions of risk regarding birth (Healy et al., 2015) and on reflections of the first stage of analysis from primary research currently underway on this topic (Healy et al., unpublished data). While the research is being undertaken in an Irish maternity care context, the issues discussed in this paper have wider relevance for the provision of maternity care in other countries. This paper is aimed particularly at the midwifery profession but has relevance for obstetricians, policy makers and maternity service users.

## Background

Advancements in maternity care and health in general mean that maternal and infant mortality rates are continuing to decline in developed countries. Infant perinatal mortality rates currently stand at 5.9/1,000 births in Ireland, representing a decrease of 31% since 2003 (Economic and Social Research Institute (ESRI), 2013). Direct maternal mortality rates in Ireland and the United Kingdom (UK) are as low as 3.25/100,000 maternities (Knight et al., 2014). Although these figures are extremely reassuring for both healthcare professionals and women, current practices do not reflect this. Caesarean section rates are rapidly increasing, with rates of normal birth in decline (ESRI, 2013). Routine use of technologies that are not necessary is contributing to this. Electronic fetal monitoring, for example, was originally introduced to the labour ward setting to reduce perinatal mortality and morbidity. Not only did it fail to reduce these incidences but it dramatically increased the rate of caesarean section, resulting in increased maternal morbidity (Walsh, 2006). Intervention in the form of continuous electronic fetal monitoring continues to be used unnecessarily in obstetric-led units for low-risk women despite best evidence (Smith et al., 2012). This is often the result of fear of litigation and decision-making that errs on the side of caution (Hood et al., 2010).

These are worrying trends and it has been identified that women with healthy pregnancies who birth in midwifery-led models of care have similar perinatal outcomes to their hospital counterparts, but

are far less likely to have intervention for their birth (Brocklehurst et al., 2011). Given the reported discrepancy in outcomes between models of care, consideration should be given to how health-care providers' perceptions of risk regarding birth, and the culture of risk within hospital institutions, affect care.

## **Sociocultural perceptions of risk that impact maternity care**

We currently live in a culture of risk amplification, with significance placed on the likelihood of adverse outcomes (Dahlen, 2010). The judgement of risk is often relative, with an acceptance of certain risks while other less likely, less serious risks are found unacceptable (Symon, 2006). The right to healthcare, increasingly, is seen as the right to health - leading to a lack of tolerance for unsatisfactory outcomes and a demand that professionals always 'get it right' (Wilson and Symon, 2002; MacKenzie Bryers and van Teijlingen, 2010). This has repercussions for maternity care, where unsatisfactory outcomes in child or maternal health are resulting in a thriving environment of blame, complaints and litigation (Symon, 2002; MacLennan et al., 2005; Hood et al., 2010).

As society becomes increasingly risk averse, women are exposed to a continual speculation of risk regarding pregnancy and birth (Possamai-Inesedy, 2006). Many view birth within the context of risk and have become hypersensitive to it (Scamell, 2014). Scamell (2014) suggests that this is based on a fear of possible risk rather than the probability of it or from any substantial experience. For risk to have a benefit it must be intelligently balanced, weighed and contextualised (Rothman, 2014). It is contended that the mass media contribute to the intensification of risk by reporting on it emotionally as opposed to intellectually, resulting in the severity of outcomes outweighing the probability of them in women's perceptions (Pilley Edwards and Murphy-lawless, 2006). Stories of harmed babies are particularly newsworthy and add to the already heightened sense of risk and fear surrounding birth (Symon, 2002). The media are rapid in their allocation of blame, perpetuating the notion that childbirth is not a natural occurrence but an event that warrants detailed surveillance and intervention

(Coxon et al., 2012). Subsequently, women are reluctant to take what are deemed 'unacceptable' risks for fear of being labelled as 'bad mothers' (Wilson and Symon, 2002; Scamell and Alaszewski, 2015). This was demonstrated in a large qualitative study (Cheyney, 2008) where women described being labelled as selfish and irresponsible by friends, family and the medical profession for making the decision to have a homebirth. This social construction of childbirth as a medical event makes it almost impossible to avoid notions of risk that surround it (Possamai-Inesedy, 2006), perpetuating a negative cycle of risk, resulting in increased interventions and surveillance (MacKenzie Bryers and van Teijlingen, 2010).

In summary, women are subjected to a litany of risks regarding birth, resulting in perceptions of risk that are not always rational. The expectation of perfect outcomes for birth has skewed perceptions of risk for women and wider society. The mass media contribute to this by sensationalising negative incidents. This, in turn, is contributing to the culture of intervention and litigation. Operating in this culture, both midwives and obstetricians are under huge pressure to 'get it right' all the time.

### **Structural factors of maternity care affecting risk**

Perceptions of risk regarding childbirth are prevalent in wider society, and are also embedded in the structure of the maternity service. Structural factors relate to the way the system is organised and includes the availability, acceptability and accessibility of appropriate care at an individual, organisational or environmental level (Blankenship et al., 2000). These factors are deeply embedded in the way systems are organised; they develop over a long period of time and do not change in the absence of policy intervention. This section discusses how structural factors of maternity care, including models of care and risk stratification, have an impact on how risk is perceived; and how this, in turn, influences the care women experience.

Although midwifery-led care is thriving in some organisations and independently in certain areas the majority of births in Ireland (>99% (Cuidiu, 2011)) and England (>92% (Brocklehurst et al., 2011)) still

take place in large, centralised, high-tech units under the care of an obstetrician, which has been a growing trend since the 1970's (Kennedy, 2010). This is despite numerous reports including Changing Childbirth (Department of Health (DH), 1993), Maternity Matters (DH, 2007) and Midwifery 2020 (Chief Nursing Officers of England, Northern Ireland, Scotland and Wales, 2010) that advocate choice of care models for women (MacKenzie Bryers and van Teijlingen, 2010). Updated guidelines by the National Institute for Health and Care Excellence (NICE, 2015) also advocate that professionals promote home or midwifery-led units as the safest birthplace for all low-risk women. England has considerably higher out-of-obstetric unit births than Ireland: 2.8% homebirths, 3% in alongside midwifery units and fewer than 2% in freestanding midwifery units (Brocklehurst et al., 2011) compared with 0.2% homebirths and less than 0.5% in alongside midwifery units. Ireland has no freestanding midwifery units (NPEC, 2013; Cuidiu, 2011). Despite higher figures of women receiving midwifery-led care in England, a significant deficit persists as potentially 45% of women giving birth in the NHS in England are low-risk and therefore could avail of this option (Sandall et al., 2014).

The NICE (2015) guidelines advocate that women should be supported to birth wherever they feel safe, including hospital, but should be aware of what to expect from each model of care. Within obstetric-led models, a woman may rarely meet her lead obstetrician. Antenatal care in this technocratic, medical model tends to be fragmented with minimal midwifery input and a focus on diagnostic tests and surveillance rather than relationships. This system-based care as opposed to relationship-based care can result in women being deprived of opportunities to explore their fears in relation to childbirth and to understand how they shape risk in a social context (Dahlen and Gutteridge, 2015). Alternatively, women who have experienced midwifery-led care and homebirth describe high levels of satisfaction with this model (Sandall et al., 2013). An American qualitative study that interviewed 50 women (Cheyney, 2008) details how a relationship with a midwife allowed women to reject the medical model of birth in favour of a social model that provided opportunities for educated and informed decision-making.

The low figures for midwifery-led care may reflect a lack of choice available, as an Irish study shows that women express interest in midwifery-led care where it is unavailable (Byrne et al., 2011). Despite this, many women actively choose obstetric-led care. This may be attributed to a widespread assumption that birth is medically risky and that a high-tech hospital environment can provide a higher level of safety, but with little consideration or understanding of how this can expose them and their babies to greater levels of intervention and, therefore risk (MacKenzie Bryers and van Teijlingen, 2010; Coxon, 2014).

Women are exposed to the concept of risk from an early stage in their pregnancy when they are processed through the hospital system. They will be stratified by risk status at their first antenatal visit, with their best hope being a low-risk categorisation (Rothman, 2014). Although risk assessment has improved outcomes in certain situations, when applied to all pregnant women this can result in unintended but harmful consequences (Jordan and Murphy, 2009). Possamai-Inesedy (2006) points out that introducing a term that holds negative connotations, i.e. risk, into the reproduction setting may have undesirable consequences for women. In fulfilling the role of guardians of normal birth, there is a call for midwives to advocate for cautious and evidence-based risk assessment that is both holistic and tailored to the individual (Jordan and Murphy, 2009).

As the majority of midwives now work in tertiary level care, their experiences of midwifery practice are such that exposure to normal birth as the 'norm' is diluted. Normal birth is defined as birth without induction, pharmaceutical anaesthesia, continuous electronic fetal monitoring, forceps, ventouse, caesarean or episiotomy (Maternity Care Worker Party, 2007). Two studies using web-based surveys (Liva et al., 2012; Wiklund et al., 2012) identified that perinatal nurses and midwives working in standard obstetric-led labour wards are less likely to see normal birth as safe or important than midwives working in midwifery-led settings. Although midwives are professionally recognised as the experts in normal birth, this role is becoming eroded in obstetric-led units as an increased culture of risk and fear is leading to a veneration of obstetric decision-making for all women (Hood et al., 2010;



Healy et al., 2015). A qualitative study of 18 perinatal nurses (Carlton et al., 2009) reveals that many have lost their confidence in facilitating physiological birth, excelling in care for women with epidurals but struggling to cope when faced with a woman experiencing labour pains. Though the structure of mainstream maternity services can deprive midwives of opportunities to develop facilitation skills for normal birth, many midwives are happy to work in the obstetric-led model as it suits their life or they personally subscribe to the medical approach (MacKenzie Bryers and van Teijlingen, 2010).

The current structure of maternity services is depriving women of opportunities to experience midwifery-led care; an obstetrically managed birth in a hospital environment is the only choice for most. This is creating a technocratic, medical-focused experience that is depriving women of the opportunity to develop knowledge and awareness of birth in their relationship with a midwife. This is so that they understand risk and can make informed decisions. Midwives operating in this system have developed skewed perceptions of risk (Page and Mander, 2014; Liva et al., 2012), resulting in a loss of midwifery skills in facilitating normal birth (Larsson et al., 2009; Carlton et al., 2009). Midwives must engage in re-creating a culture of normality and trust in birth that places the woman at the centre of compassionate, relationship-based models of care (Cooper, 2015).

## **Operational factors of maternity care affecting risk**

As a culture of risk is increasingly embedded in both wider society and our health-care structure, it is not surprising that it has manifested in the day-to-day operations of our maternity services. Operational factors that include strategies for care and risk management will tend to reflect the philosophy of care in a unit. This section discusses how risk-based care, including interventions to mitigate potential risks, is developing in maternity care. It then moves on to how this is affecting midwifery efficacy.

## A focus on risk management

In the drive to provide safer maternity care there has been a dramatic rise in risk management (MacKenzie Bryers and van Teijlingen, 2010) but managing risk is not necessarily the same as facilitating safety (Dahlen, 2014). It may not improve outcomes and can potentially create negative consequences (Jordan and Murphy, 2009). With the intensification of risk management, there has been an increased focus on preventing adverse physical outcomes while omitting psychological, cultural and spiritual well-being. These are not considered to be of equal importance, which is highlighted by the lack of statistics on respectful and compassionate care (Byrom and Downe, 2015).

Alongside greater emphasis on risk management is a growing fear culture within maternity care. There is an increased assumption by professionals that birth is an 'abnormal' process and 'normality' can only be attributed in retrospect (Scamell and Alaszewski, 2012; Healy et al., 2015). A qualitative ethnographic study of midwives in the UK (Scamell, 2011) demonstrates that this assumption is resulting in undertaking detailed surveillance to rule out abnormalities. Fear of litigation is used to justify intervention, augmenting beliefs that trusting the birth process in a litigious, fear-based environment is unrealistic (Hood et al., 2010). A Canadian study that interviewed 56 health professionals (Hall et al., 2012) reports that professionals may knowingly undermine women's confidence and responsibility by embracing intervention and surveillance techniques, and continue to do so to protect themselves from the effects of being involved in adverse outcomes. In this study, professionals defend the practice of making decisions in the 'best' interest of the mother or baby as they feel personally responsible for the outcome. This external control can be destructive, as the woman's desire for a healthy baby may lead to an abuse of power where professionals provide information in an emotionally laden way to gain compliance, which goes against the ethos of informed consent (Munro, 2015).

Midwives, in an effort to protect themselves from involvement in adverse outcomes, may deprive women of emotional safety in the name of risk management. To counteract the culture of risk and

fear that is currently dominating maternity care, midwives must become acutely aware of their contribution to unnecessary interventions and the lack of holistic, women-centred care. Studies of care pathways for normal birth demonstrate that these pathways can assist midwives in using evidence-based care to legitimise less intervention for low-risk women (Cheyne et al., 2013; Hunter and Segrott, 2014). Ultimately, there must be a refocusing of attitudes to birth, at the heart of which lies not only kindness but appropriate evidence-based care and not a 'tick-box' culture (Downe and Byrom, 2015).

### **The impact of a risk culture on midwifery efficacy**

Despite the claim that there has been an over-emphasis on the midwifery vs obstetrics debate (Coxon et al., 2012) a hierarchical structure exists within maternity services which can be directly attributed to risk management. Within obstetric-led models, midwives see obstetrical hierarchy as preventing them from fulfilling their role (Keating and Fleming, 2009; Cheyne et al., 2013). They report being overruled by obstetricians on decisions of care despite best evidence to support their practice (Surtees, 2010). Midwifery 2020 (Chief Nursing Officers of England, Northern Ireland, Scotland and Wales, 2010) proposes that midwives become the lead carers for all healthy women with straightforward pregnancies. However, in a qualitative study of 10 midwives (Everly, 2012) participants reported how they are acknowledged and respected as the experts of normal birth in midwifery-led settings but that this does not apply in the hospital setting, where they are pressured by obstetricians to perform unwarranted interventions on low-risk women. Preliminary findings from one-to-one interviews for primary qualitative research currently underway reveal that obstetricians believe midwives do not want the responsibility of being lead carer as it exposes them to greater levels of professional risk in terms of accountability (Healy et al., unpublished data). These preliminary findings also disclose that midwives feel obliged to involve obstetricians at an earlier stage than previously to protect themselves against implication in adverse outcomes. This is supported by

research revealing that midwives who have recently experienced high-profile adverse outcomes are more likely to refer care to an obstetrician at an earlier stage than their counterparts (Styles, 2011).

Adding to diminishing midwifery efficacy is the diminishing of normal birth itself, as the current climate of care narrowly focusses on medical outcomes, disregarding the larger picture (Hyde and Roche-Reid, 2004). This is resulting in a de-emphasis on midwifery skills and holistic care (Keating and Fleming, 2009), considered a cornerstone of midwifery philosophy (Nursing and midwifery Board of Ireland, 2015). Midwives have a duty to be experts and leaders for normal birth or there will continue to be a deepening fear of childbirth. If midwives do not fulfil this role, normal birth will become a thing of the past.

## **Conclusion**

Despite obstetric and midwifery discourse appearing to be focussed on safety, in reality the focus is on risk management. It is questionable whether this focus is directed towards providing safer care for women and babies or towards protecting the healthcare professionals who work in the system. With a blame culture apparent in many services, it is not surprising that risk-based care takes precedent over considerate, individual care. The fear of being implicated in an adverse outcome can have devastating effects, both professionally and personally, on healthcare professionals. There is a perception that engaging in risk management will have a protective effect, even at the cost of less-than-optimal care for women and babies.

Although risk management can minimise adverse clinical outcomes, there can be unintended consequences that increase morbidities for women and babies, particularly those linked to caesarean section. Therefore, midwives must engage in decision-making and care that is based on evidence, not fear. This entails seeking out opportunities to increase facilitation skills for normal birth so that these skills are not lost to the midwifery profession, and to ensure women experience quality individualised care.

Creating a culture of relationship-based care that is woman-centred and individualised, rather than service-centred, can provide opportunities for women to understand their perceptions of risk. This will contribute to them becoming actively involved in informed decision-making regarding their care. For low-risk women, having access to midwifery-led care is a necessity to counteract rising intervention rates, but before this can happen midwives must resume and embrace the role as experts of normal birth in all settings. Downe and Byrom (2015) urge midwives to have the courage to apply the solutions so that we can bring joy and passion back to maternity care.

It is important to keep pushing this agenda forward in the research arena to deepen understanding of attitudes to risk and appreciate how they have an impact on the care provided. While this paper is based on findings from a recent literature review and primary research currently underway, there is a strong resonance between the issues that emerged and recurrent discourse across a range of policy, research and media sources.

## Key points

- Birth is increasingly seen as risky by women, health professionals and wider society
- A culture of risk management is resulting in maternity services that are medical-focused rather than women-centred
- There is a growing perception that birth requires obstetric involvement and intervention; this is prevalent in the midwifery profession as well as obstetrics
- Maternity professionals, in an attempt to protect themselves from involvement in adverse outcomes, are depriving women of psychosocial safety in the birth process
- Lack of relationship-based care diminishes opportunities for women to properly explore their attitudes to risk

- Midwifery, as a profession focused on promoting trust in normal birth, is threatened by the dominant medical model of maternity care and highly interventionist practices in birth. Midwives must act to reclaim this role, balancing considerations of risk with the principle of women-centred holistic maternity care.

## Ethical Statement

As this is a discussion paper, no human or animal subjects were involved in this research. For this reason, ethical approval was not sought from any institution.

## Conflict of Interest

The main author of this paper is a PhD student with the Department of Nursing of Midwifery in the University of Limerick. She is in receipt of a grant, in the form of a monthly stipend, from this university to pursue a PhD, but there is no conflict of interest in the reporting of data. The co-authors are supervisors of this PhD.

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