2014-RV-15150R1: **Evidence, guidelines, and interpretations that count**

A commentary on Roome et al 2015: Why such differing stances? A review of professional colleges' position

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In their case study of recommendations about place of birth from professional bodies Roome and colleagues provide an important contribution to the general debate about guideline development, and, by implication, about how best practice in health care is determined. As they demonstrate, the interpretation of evidence is strongly influenced by the professional projects of those making decisions about it; in this case midwifery or obstetrics. This should not surprise us. More than fifty years ago, Festinger noted the sub-conscious desire to reduce cognitive dissonance (Festinger, Stanford University Press, 1957). In other words, we all try to make our experiences fit with our prior beliefs.

The qualitative research paradigm explicitly recognises that evidence is a co-production between the researcher, the researched, and the data. Good quality qualitative research includes techniques such as reflexivity and the search for disconfirming data to make interpretation more transparent and credible. As Roome notes, such approaches might also help those creating and using guidelines to recognise where and how specific beliefs and values inform decisions about what evidence counts (or doesn't count).

Indeed, some level of reflexivity is apparent in the review of planned hospital versus planned home birth that is a pivotal text for Roome. The authors state: '*The American College of Obstetricians and Gynecologists does not support home birth, citing safety concerns and lack of rigorous scientific study*' (Wax et al AJOG 2010;203:243.e1-8, p243). This sets the tone for how the review data were interpreted, including the assumption that higher rates of interventions, prematurity, low birth weight, maternal third degree tears, infection and haemorrhage found in the planned hospital birth group were justified by the lower risk of neonatal death. As Roome demonstrates, this value judgement seems to be disputed from the point of view of the professional project of midwifery. But who decides which interpretation is right?.

One vital perspective is only a small part of Roomes paper (probably because it is largely missing in guideline development); that of the women, families, and societies for whom maternity care is designed. It is very likely that most women do not conceptualise outcomes that matter to them as either-or (either reduced mortality or reduced morbidity/increased wellbeing), but rather as both-and. The recently published Lancet Quality Maternal and Newborn Care (QMNC) Framework is based on the views, experiences, and needs of maternity service users (Renfrew et al, The Lancet, 2014 384: 9948, 1129–1145). It demonstrates that childbearing women do indeed expect **both** maximum clinical health **and** maximum emotional and psychosocial wellbeing for themselves and their newborns. Putting the voices and priorities of women and families at the heart of decisions about what matters in maternity care is much more likely to lead to a balanced interpretation of the evidence than leaving it to one professional project or another. This requires more than a token service user involvement in outcomes development, guideline production, and interpretation of evidence into practice. The analysis of Roome et al should provide a spur for a global shift in this direction.

Disclosure of interest

I declare that, to the best of my knowledge, I have no interests to disclose in relation to the above mini commentary