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REVIEW ARTICLE

Midwives' and obstetricians' perceptions of risk and its impact on clinical practice and decision-making in labour: An integrative review

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ABSTRACT

Background: Risk and risk assessment are increasingly affecting how maternity services are governed with rates of intervention continuing to rise in obstetric-led services for low-risk women.
Aim: This review synthesises original research that examines how perceptions of risk impact on midwives' and obstetricians' facilitation of care for low-risk women in labour.
Methods: A five stage process for conducting integrative reviews was employed. A robust search strategy incorporated electronic searches in The Cochrane Database of Systematic Reviews, EBSCO, EMBASE and Scopus from 2009 to 2014. The initial search resulted in the retrieval of 2429 articles which were reduced to 14 through a systematic process.
Findings: The results of this review revealed an over-arching theme of an assumption of abnormality in the birthing process leading to unnecessary intervention and surveillance. Three sub-themes are presented under this central theme – (1) external influences on risk perception that include practice guidelines and professional responsibility; (2) influence of personal fears and values on risk perception focusing on differing attitudes to physiological birth; (3) impact of professionals' perceptions of risk on women's decision-making in labour.
Conclusion: Practice is influenced by an assumption of birth as abnormal and is compounded by issues such as institutional risk management, lack of midwifery responsibility, fear of involvement in adverse outcomes and personal values regarding physiological birth. These findings suggest that a shift in focus away from risk and towards health and wellbeing in the planning of maternity care may go some way towards providing a solution to the increasing intervention rates for low-risk women.

1. Introduction

The concept of risk has largely altered from an accepted part of life to something that must be avoided or controlled.[1] Risk and risk assessment are continually affecting how maternity services are governed.[2] The perception that birth can only be considered safe in retrospect is creating a system where interventions are practiced in order to avoid the occurrence of prospective negative incidents.[3] This technocratic model of birth extols technology and anticipation of pathology. This is in contrast to the social model that anticipates normality with technology seen as a servant and not a master.[4]

In the United Kingdom (UK) the normal birth rate stands at 42% which is a significant decrease since the 1990s.[5] This figure accounts for women who birth without induction, pharmaceutical anaesthesia, forceps, ventouse, caesarean or episiotomy. Similar patterns are reflected in figures from Ireland and Australia.[6,7] This is despite encouragement for all women to have as normal a pregnancy and birth as possible which has been highlighted as crucial in the on-going focus of improving maternity care.[8] Regardless of guidelines[9] that urge professionals to foster the view that birth is safe for low-risk women and their babies, women's confidence in their ability to have a normal birth is increasingly diminished. This is often as a result of an increased focus on risk assessment and risk management with high-tech maternity units often viewed as the safest place to birth.[2] Research exists to support the safety of out-of-hospital birth and a large prospective cohort study in the UK[10] revealed that 30% of low-risk multiparous women are likely to have intervention if they birth in

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an obstetric-led unit compared to between 5% and 9% in a midwifery-led unit with equivalent perinatal outcomes.

Interventions are largely considered to be the domain of obstetricians. However, midwives are increasingly accepting these as normal within the hospital environment.[10] Midwives working in obstetric-led settings are exposed to increasing amounts of intervention resulting in higher perceptions of risk regarding women who are in fact low-risk.[12] This is equated to 'learning the lessons of fear'[11] and it is suggested that healthcare professionals are increasingly being obliged to work in this model of care, both willingly and reluctantly, in the interest of safety.[12]

Risk management policy and its associated operations within hospital institutions very often do not account for the underlying philosophy and assumptions of risk discourse that are present and have a bearing upon practice.[4] Salutogenesis has been suggested as a theory to deliver changes to the planning and delivery of hospital-based maternity services.[13,15] This would incorporate a focus on what factors contribute to positive as opposed to negative outcomes and could make a contribution to tackling the high levels of intervention that appear to be elusive at present.[13]

The aim of this integrative literature review is to synthesise evidence of midwives' and obstetricians' perceptions of risk about birth when facilitating care for low-risk women in labour ward, hospital settings. It examines how these perceptions affect the use of interventions and technology in labour. Obstetricians are included in this review as they are involved in the planning of care for low-risk women in obstetric-led settings and in the delivery of care for their low-risk private patients.[14] Although reviews exist that investigate midwives experiences of working in hospital labour wards[10] and professionals' views of fetal monitoring[15] to our knowledge there are no existing literature reviews particularly pertaining to this topic. Due to the significant rates of intervention for low-risk women in obstetrical settings it is important that risk perceptions of both midwives and obstetricians working in this setting are examined to understand how they may be contributing to the rising intervention rates. *This review asks the following two questions:*

(1) What factors affect midwives' and obstetricians' perceptions of risk when facilitating care for low-risk women in labour?

(2) How do perceptions of risk impact on midwives' and obstetricians' clinical practice and decision-making when facilitating care for low-risk women in labour?

2. Methods

This review followed the systematic approach to integrative reviews devised by Cooper[16] incorporating an up-dated methodology of this framework by Whittemore and Knafl.[17] Particular attention was paid to the design and conduct of the search strategies, appraisal of study quality and methods for synthesis as these have been highlighted as areas of challenge by the Cochrane Qualitative Research Methods Group.[18] This is a particularly appropriate review method for the nursing/midwifery disciplines to inform evidence-based practice as traditional systematic reviews, which place an emphasis on randomised clinical-based trials, often fail to answer complex decisions that practitioners are faced with in reality.[19] The methods of this review are reported in a five stage process that includes stages similar to primary research. This method is also consistent with the PRISMA (2009) guidelines for reporting systematic reviews.[20]

2.1. Stage 1: problem identification

Search strategy tools have been developed to help researchers define key elements of a review question. Most focus on reviews of quantitative studies such as PICO (Population, Intervention, Comparison, Outcome). It has been suggested that using the SPIDER tool (Sample. Phenomenon of Interest, Design, Evaluation, Research type), which was adapted from PICO, may be more appropriate for reviews of qualitative/mixed method studies.[21] The SPIDER tool was employed for this integrative review as it was felt that the terminology used in the research questions were suited to qualitative methods of inquiry and thus more suited to SPIDER. The search terms developed from this tool are shown in Table 1.

Table 1
Search strategy from Scopus database.

(1) Birth (2) Childbirth (3) Parturition
(4) 1 or 2 or 3
(5) Midwi* (6)"Nurse midwi*" OR nurse-midwi* (7) Obstetrician*
(8) 5 or 6 or 7
(9) Risk* (10)"Risk assessment*" (11) Safe*
(12) 9 or 10 or 11
(13) Attitude* (14) Opinion* (15) Perspective* (16) Perception* (17) View*
(18) Insight* (19) Experience*
(20) 13 or 14 or 15 or 16 or 17 or 18 or 19
(21) "decision making" OR decision-making OR decision* (22) Approach*
(23) Practice*
(24) 21 or 22 or 23
(25) 20 or 24
(26) 4 and 8 and 12 and 25
Limit 26 to (pubyear > **2008**) and (limit-to (doctype, "**ar**") or limit-to (doctype, "**re**")) and (limit-to (subjarea, "**MEDI**") or limit-to (subjarea, "**NURS**")

All search terms were inputted using restriction of 'TITLE-ABS-KEY' field except for rows 9, 10 and 11 which were restricted using 'All' field. Limited to English language.

The search included peer-reviewed studies originating in Western Europe, Australasia and the North American continent from January 2009 until June 2014 (5.5 years). This timescale was chosen in order to present up-to-date and contemporary findings in a rapidly changing practice and social context where interventions such as caesarean section continue to rise.[6] Only studies that include midwives who have experience of working in hospital settings are included as this is the area that has been highlighted in which midwives have increased perceptions of risk.[22]

2.2. Stage 2: literature search

The search strategy incorporated electronic searches in The Cochrane Database of Systematic Reviews, EBSCO (Academic Search Complete, Cinahl, Medline, Social Sciences Full Text), EMBASE and Scopus as these were deemed appropriate for research pertaining to midwives and obstetricians. This was followed by ancestry searching of the reference lists of both relevant theoretical articles and of the included studies.[16] An example of the search used in the Scopus database is outlined in Table 1. The search strategy in other databases was very similar with only minor variations.

The results of the complete search are presented in PRISMA[20] format in Fig. 1. The final number of studies included was reduced using explicit methods based on inclusion/exclusion criteria (see Table 2) to 13 studies providing 14 papers. These include: one quantitative study and 12 qualitative studies. No systematic reviews met the criteria for inclusion in this literature review. The literature predominantly revealed studies pertaining to midwives with only three studies taking into account the views of obstetricians. Literature emerged from six countries which included five articles from Australia, five from the United Kingdom and one each from Canada, the USA, New Zealand and Belgium. A variety of methodologies were utilised in the 13 studies and these are identified in Table 3 which summarises the 14 papers.