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Original Research - Qualitative

A qualitative exploration of how midwives' and obstetricians' perception of risk affects care practices for low-risk women and normal birth☆

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ABSTRACT

Background: Maternity care is facing increasing intervention and iatrogenic morbidity rates. This can be attributed, in part, to higher-risk maternity populations, but also to a risk culture in which birth is increasingly seen as abnormal. Technology and intervention are used to prevent perceived implication in adverse outcomes and litigation.
Question: Does midwives' and obstetricians' perception of risk affect care practices for normal birth and low-risk women in labour, taking into account different settings?
Methods: The research methods are developed within a qualitative framework. Data were collected using semi-structured interviews and analysed thematically. A purposive sample of 25 midwives and obstetricians were recruited from three maternity settings in Ireland. This included obstetric-led hospitals, an alongside midwifery-led unit and the community.
Findings: Midwifery is assuming a peripheral position with regard to normal birth as a progressive culture of risk and medicalisation affects the provision of maternity care. This is revealed in four themes; (1) professional autonomy and hierarchy in maternity care; (2) midwifery-led care as an undervalued and unsupported aspiration; (3) a shift in focus from striving for normality to risk management; and (4) viewing pregnancy through a 'risk-lens'.
Discussion: Factors connected to the increased medicalisation of birth contribute to the lack of midwifery responsibility for low-risk women and normal birth. Midwives are resigned to the current situation and as a profession are reluctant to take action.
Conclusion: Improved models of care, distinct from medical jurisdiction, are required. Midwives must take responsibility for leading change as their professional identity is in jeopardy.

Statement of significance

Problem or issue

Unwarranted intervention in birth, particularly for low-risk women, is leading to unnecessary morbidity. The majority of women in both Ireland and the United Kingdom give birth in obstetric-led hospitals despite policy change to reflect the appropriateness of midwifery-led care for many.

What is already known

Midwives and obstetricians are using intervention and detailed surveillance to protect themselves from perceived implication in adverse outcomes and litigation.
Midwifery-led care results in lower rates of intervention and increased satisfaction for women.

What this paper adds

Midwives are resigned to the current medicalised, interventionist model of care and as a profession are reluctant to take action. Midwifery professional identity is in jeopardy if

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the current technocratic model of care continues to dominate.

Definition of risk: 'Uncertainty denotes a future that cannot be predicted, an unknown. By contrast, thinking in terms of risk is a process of mitigating those unknowns, minimising the unpredictability of the future in an attempt to improve outcome'.[1]

1. Introduction

Risk theory suggests that we live in a 'risk society' where the notion of risk has become more pervasive in modern times.[2] This is particularly noticeable in pregnancy and childbirth. While birth has become safer in many developed countries the risk discourse has intensified as emphasised by Chadwick and Foster.[3] As birth becomes reconceptualised in terms such as 'blame', 'harm', 'hazard' and 'safety'[4] there is little tolerance for mistakes and accountability for adverse events can fall on individuals including healthcare professionals and pregnant women.[5] Contributing to the intensification of the risk discourse is the rise in organisational risk regulation that is concerned with mitigating risk through clinical governance as a form of shared self-regulation.[6] Scamell[5] suggests that clinical governance undermines midwives' commitment to normal birth by escalating the 'scare factor of risk'.

Infant perinatal mortality rates currently stand at 4.7/1000 births in Ireland (when corrected for congenital abnormalities), representing a decrease of 13.9% since 2005.[7] Direct maternal mortality rates in Ireland and the United Kingdom (UK) are as low as 3.25/100,000 maternities (Knight et al.).[8] While this is reassuring, maternity care in Ireland is facing increasing intervention and iatrogenic morbidity rates.[9] This may be partly attributed to, for example, increasing maternal age and obesity but these changes in the maternity population do not fully explain the rise in interventions related to pregnancy and birth. Although technology and interventions have contributed to the decline of both infant and maternal mortality these are 'double-edged swords' when used without clinical indication.[10] An Australian study suggests that interventions can be performed to prevent perceived adverse outcomes and litigation, despite a lack of research to indicate their effectiveness.[11] Dahlen warns that unmanaged fear and deeply held beliefs, without scientific evidence, can cause untold damage and lead to increased levels of intervention and surveillance for all women.[12]

A recent review of Irish maternity services, which included review of international experiences from other developed countries, identifies how consultant-led services work well for complex pregnancies and emergency management but are over-medicalised for low-risk women.[13] This review partly stemmed from a lack of care options available to pregnant women in Ireland. In total, there are 19 hospital units offering maternity services with over 99% of women birthing in one of these units under the care of a lead obstetrician.[13] Approximately one third of these women have booked privately with a consultant obstetrician.[14] Two co-located midwifery-led birth-centres are in operation and some hospital units offer limited midwifery-led antenatal care and limited homebirth services.[13] Approximately 20 self-employed community midwives offer a homebirth service throughout Ireland so consequently only 0.2% of women birth at home with 0.6% birthing in midwifery-led centres.[13] Two Irish studies[15,16] suggest that women want more choice, particularly midwifery-led birth-centres, but are constrained by the services on offer in their areas.

UK government policy and international guidelines identify midwives as the most appropriate profession to care for women with healthy pregnancies and have been promoting the benefits of midwifery-led care for over 20 years.[17–20] Research demonstrates that intervention rates decrease and satisfaction rates increase when women are cared for by a named lead midwife or team of midwives in a continuity model of care.[21] It is suggested that despite the high level of policy support for alternative birth settings there continues to be limited opportunity for women to avail of them and this may be a result of contemporary discourse that emphasises risk, blame and responsibility, ultimately constraining women's decisions and choice.[3]

Although policy supports midwives to lead care for low-risk women, findings from a systematic review indicate that midwives increasingly view birth as abnormal with normality now defined by the absence of abnormality.[22] Australian and UK studies found that midwives may be increasingly risk averse, relying on technology and surveillance to rule out abnormalities.[23,24] Several qualitative studies from Ireland, Australia and Sweden reveal that a focus on clinical risk management, and an underlying risk discourse, is affecting the role of midwifery advocacy and autonomy. One study suggests that the threat of litigation has resulted in difficulties for midwives supporting low-intervention birth and over-reliance on technology to prevent perceived adverse outcomes.[11] Midwives working in the hospital setting in Australia believe they have become institutionalised and increasingly risk adverse such that they perform interventions when requested by obstetricians despite disagreeing with them.[25] Irish midwives believe that the ability to manage birth in a medical manner is prioritised as a skill in obstetric-led settings.[26] Similarly, a Swedish study proposes that midwifery skills are often looked upon with disdain or as competing directly with safety.[27]

The perception of birth as risky and requiring medical surveillance is contributing to a service that relies on technology, intervention and surveillance to achieve 'safe' outcomes. Risk management is no longer fulfilling its role of protecting women and babies from harm but is linked to intense surveillance of birth. While professionals and organisations see this as protecting themselves it does not always serve the women in their care.[22,28]

2. Aim of study

The aim of this study was to understand midwives' and obstetricians' perceptions of risk regarding low-intervention birth and investigate how this affects decision-making. This study adds to the limited literature directly concerned with the effect of risk perception on decision-making in labour. To our knowledge this topic has not been researched in the Irish maternity setting and, as such, the findings will add to the evidence currently available. This is timely in the Irish context, linked to the publication of the new Irish maternity strategy[13] which addresses issues including midwifery-led care, choice and woman-centred care as key principles. This paper sets out findings related to how risk perceptions affect the role of midwifery in the current maternity services. A further paper will explore other aspects of risk.

3. Study methodology

3.1. Design

The underlying epistemology for this study is based on the theory of social constructivism and is reflected in the research design. This theory argues that situations are not inevitable but are based on jointly constructed understandings, created through social interaction and influenced by factors including culture and social context.[29] A qualitative research design was chosen for this