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Editorial

Reconceptualising risk in childbirth ☆

Introduction

This special issue of *Midwifery* brings together a collection of papers which are at the forefront of understanding how concepts of risk affect or impact upon the organisation and provision of clinical maternity care. The call for papers arose from an identified gap in the evidence; a special issue in *Health, Risk and Society* (Volume 16, no 1) explored risk during pregnancy and childbirth from social science perspectives, and many of the papers looked at the lived experiences of women in relation to risk. The starting point for that collection was the observation that although birth in high income countries is safer than ever before, we face what Taylor-Gooby has termed the 'paradox of timid prosperity', where anxiety seems to be on the increase, in the face of overall safety (Taylor-Gooby, 2000, p.3). In pregnancy and birth, risk has expanded to become a complex and ever-present notion, associated with dangers, hazard and probabilistic reasoning. As Andrew Bisits notes in his commentary (Bisits, 2016), we benefit from a proliferation of research, giving ever more information about absolute and relative risks in pregnancy and birth, but whilst this knowledge is valuable, it can add to the sense that pregnancy is a problematic or dangerous time. Women and their partners or families then need to tease apart 'real', 'actual' and 'perceived' risks, take into consideration the context of their own lives, beliefs and values and work their way towards negotiating aspects of care that they felt comfortable with, in a context which seems to privilege the biomedical construct of clinical risk (Rothman, 2014).

The *Health, Risk and Society* special issue made a valuable contribution, but surprisingly few papers explored risk perspectives from maternity care professionals' perspectives. Given the widespread and generalised concern with rising costs of maternity care and increasing rates of intervention without clear evidence of benefit (Birthplace in England Collaborative Group, 2011; World Health Organisation, 2015; Benoit et al., 2015), it seemed important to address this gap and to understand better the impact of risk on clinicians' practice. Our call for papers (Coxon et al., 2015) particularly focused on the relationship between 'risk' and 'normality' and we invited papers that would add to our understanding of how midwives and others seek to 'square the circle' of promoting normality whilst managing risk.

That was over a year ago, and much has happened in that time. Our call predated the UK publication of the *Kirkup Report* (Kirkup, 2015) into failings of maternity care at Morecambe Bay NHS Foundation Trust in Cumbria, England, and this report has caused midwives and women using services to look again at the term 'normality' and consider its place in maternity care. One of the report's key findings was that attempts to 'uphold normality' and 'over-zealous pursuit of the natural childbirth approach' led to 'inappropriate and unsafe care' (p.13). Although the basis for this conclusion has been debated in the professional press and the media, it seems important to acknowledge that the term 'normality' has now developed into one with as many political charges and connotations as 'risk' already carries.

Risk-based practice in maternity care

The position of women, families and midwives in relation to birth is undoubtedly affected by the prevalence of 'risk' thinking in maternity care. Lee et al. (2010) have argued consistently over the past decade that parenting occurs in the context of 'risk society', particularly in high income nations, and one of the consequences of this is that parents need to demonstrate an ability to be effective 'risk managers' for themselves, and for their children. The papers collated here support this view, and also demonstrate how the same pressures are brought to bear on clinicians. This creates a circular scenario whereby organisations ensure clinicians' practice is oriented towards risk concerns; clinicians feel obliged to communicate information about risk to women and partners, and women and partners, already primed by cultural narratives of birth risk, experience pregnancy and birth through what Heyman et al. termed 'the lens of risk' (Heyman et al., 2010). The issue here is not that risks are discussed with women, (although as many of our contributors point out, the way risks are framed can limit the choices perceived to be available), but rather that such discussions are often unbalanced, focusing on unlikely but dramatic adverse outcomes without explaining the potential health gains for women and babies of careful and ongoing assessment, and considering options that are likely to incur fewer interventions overall. In this editorial, we identify thematic links between the special issue papers, and consider these in relation to risk theory and practice reflections. We note how individual papers address evidence gaps, and identify where these persist, and we finish by considering the contribution of the special issue as a whole to risk theory and the implications for ongoing service and practice development.

☆We would like to acknowledge that we have referenced the title of Barclay et al's paper within our Special Issue title; the phrase 'reconceptualising risk' neatly draws together the key themes within this issue.

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Maternity care and the culture of fear

A clear theme amongst papers in this issue is that maternity care clinicians describe work practices which take place within an organisational culture of fear. In her commentary for this Special Issue, Hannah Dahlen (2016) reminds us of the political value of fear, and suggests that fear serves the purpose of increasing anxiety about safety during birth, which justifies a range of actions and interventions, and inflames debate about the benefits and timing of interventions. For clinicians and service managers, concern to prevent a poor outcome for the woman or infant is always paramount, but there is also fear of litigation, and of consequences of 'risk' investigations for the individual's professional standing and continued employment. This may mean that clinicians take preventative actions to offset risks that *feel* real, but may be hypothetical in terms of calculable risk. In their discussion of US obstetric nurses' experiences, Striley and Field-Springer identify this category of risk as an 'identity' risk, or a 'threat to the sense of self' (Striley and Field-Springer, 2016), and their insight is borne out by the experiences of clinicians within the papers in our issue.

In our call for papers, we suggested that midwives and nurse-midwives practicing today have more rather than less autonomy than in the past, particularly in relation to supporting healthy women during normal or straightforward births. The papers in the special issue actively challenge this assertion, and argue instead that clinical autonomy is increasingly constrained, and that concerns about risk may eclipse or even 'overwhelm' notions of normality (Scamell, 2016, p. 14). In her paper, Mandie Scamell (2016, p. 14) explores how 'institutional concerns around risk and risk management impact upon the way midwives can legitimately imagine and manage labour and childbirth'. She argues that the 'risk' model and the 'normality' model constitute two separate, and in fact, divergent approaches, and explains with reference to historical policy guidance how this situation has developed over time. Scamell also provides a theoretical position which has its origins in Science and Technology Studies (STS). This consists of an argument that clinical governance practices seek to 'colonise the future' by altering clinical behaviours in the present, even though the 'imagined future event' is rare, the ability to avert problems through this approach is unknown, and the rate of new and unexpected complications which may have arisen as a result of taking a risk-based approach is rarely considered. Mandie Scamell's paper also shows that midwives are aware they need to be seen to behave in a particular (risk-averse) way, but feel conflicted when they are committed personally to supporting women to achieve a normal birth. In the end, argues Scamell, risk speaks much more loudly than normality.

Several of the papers explore the ways in which clinicians, despite being attuned to evidence-based practice, find themselves to be unwilling but effective participants in risk amplification exercises when they do 'risk talk' (e.g. see Van Wagner (2016), Plested and Kirkham (2016)). Vicki Wagner (REF) looks specifically at the practice of risk talk, whilst Joan Skinner and Robyn Maude (Skinner and Maude 2016) observe 'tensions of uncertainty' through exploring the implications of counselling women when the actual outcomes for the individual and her family are unknown and unknowable. Skinner and Maude (2016) make the case for expanding the field of interest beyond risk, and encompassing uncertainty as an important part of the experience of birth.

Focusing on the perspectives of women whose pregnancies are affected by risk issues, Suzanne Lee and colleagues provide two linked papers (Lee et al., 2016a, 2016b), one of which explores women's responses to information about clinical risk, (Lee et al., 2016a) whilst the other presents data about how women whose pregnancies are at increased risk perceive interactions with health care professionals, when they discuss planned place of birth (Lee et al., 2016b). Like Van Wagner (2016), Lee et al. note that strategies used by clinicians to communicate risk are under-developed, and argue that this topic needs far better understanding given that women's beliefs about risk are part of their individual personal philosophies, which form long before pregnancy.

In exploring the implications of 'risk talk', Van Wagner also shows that discussing risk signals the need for leaning towards technology, and argues that during risk discussions, clinicians are expected to present numerical data, explain or discuss complex statistical concepts to communicate 'evidence based medicine', even though the actual evidence available may be limited. As Andrew Bisits also makes clear in his commentary, explaining and contextualising low prevalence absolute risk data is a complex task, and a fuller appreciation of effective means of doing so is needed. It is also clear that clinicians feel they are asked to share information in a manner that selectively presents risks, because the emphasis is on being certain that all possible and potential risks are communicated. There is a clear need for further research on this issue, to understand better whether numerical information about 'probable' and 'possible' risk is valued by women, and if so, how this should be conveyed or presented effectively. This is particularly important because, as Lee et al.'s work argues, (Lee et al., 2016a) current approaches are likely to be ineffective. In this paper, which draws upon a psychological perspective, Lee et al. demonstrate how women selected or 'heard' information which aligned well with their prior beliefs. This suggests that 'confirmation bias' (or being more 'open' to congruent messages) contributes to the process of 'doing risk talk', and that discussions which may already be uneven or framed in a particular way are only partially heard.

Both Lee et al.'s papers arise from research of women who have known risk factors during pregnancy, some of whom planned home birth, whilst others planned to give birth in hospital obstetric units. Understanding decisions, preferences or choices which are at odds with clinical recommendations is an issue which has been historically under-researched, and it is valuable that several included papers have engaged with this issue. Lianne Holten and Esteriek de Miranda (Holten and de Miranda, 2016) summarise recent literature on 'unassisted birthing', and this is one of the first reviews to do so, whilst Miriamni Plested and Mavis Kirkham's paper (Plested and Kirkham, 2016) contains a phenomenological study of how women experience birth without a midwife. As Dahlen has previously argued (Dahlen et al., 2011), 'freebirth' is to some extent a logical, if unintended, consequence of women's alienation from mainstream maternity services, especially if they find their needs and concerns are not listened to by clinicians, or they are unable to secure access to services such as homebirth with a midwife. In their paper on service configuration and closures in remote and rural areas of Australia, Lesley Barclay et al. (Barclay and Kornelsen, 2016 [p. 10 of v1]) report consequences such as unplanned births without skilled staff present, birth 'on tarmac' awaiting airlift or avoidance of antenatal and intrapartum care as consequences of withdrawing services that are accessible to women. Through their detailed study, these authors make the case that over-reliance on biomedical risk perspectives as a basis for service decision-making has numerous implications for women and families, including separation, cost and lost opportunities to birth locally, even when the cultural and spiritual motivations for doing so are well known. They conclude that whilst clinical health considerations are clearly important, making decisions on the basis of these alone, or attempting to do so without the consent of the population served, may actually diminish the safety of women and babies, and argue that our understanding of risk in maternity care needs to be much broader, incorporating the social, emotional and cultural implications of maternity service provision.