Midwifery ∎ (∎∎∎∎) ∎∎∎–∎∎∎

Contents lists available at ScienceDirect

Midwifery

journal homepage: www.elsevier.com/midw

The fear factor of risk – Clinical governance and midwifery talk and practice in the UK☆

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ARTICLE INFO

Article history:
Received 15 July 2015
Received in revised form
18 January 2016
Accepted 2 February 2016

Keywords:
Risk
Midwifery
Childbirth
Labour
Clinical governance

ABSTRACT

Objective: Through the critical application of social theory, this paper will scrutinise how the operations of risk management help to constitute midwives' understandings of childbirth in a particular way.
Design and setting: Drawing from rich ethnographic data, collected in the southeast of England, the paper presents empirical evidence to critically explore how institutional concerns around risk and risk management impact upon the way midwives can legitimately imagine and manage labour and childbirth. Observational field notes, transcribed interviews with various midwives, along with material culture in the form of documentary evidence will be used to explore the unintended consequences of clinical governance and its risk management technologies.
Key conclusions: Through this analysis the fear factor of risk in midwifery talk and practice will be introduced to provide an insight into how risk management impacts midwifery practice in the UK.

Introduction

Contemporary midwifery practice in the UK, as is the case in several other high-income countries, converges upon an interface between two arguably divergent care objectives. On the one hand, midwives strive to inspire a sense of confidence and well-being in the women they care for to support them to give birth spontaneously, through a sensitive and individualised approach to maternity care provision. On the other, by contrast, midwives view their practice through a lens of risk where an urgency to pay attention to the potential risks involved in childbirth prevails. As Coxen et al. (2015) point out: 'It is not clear whether or to what extent individual practitioners can work in both models simultaneously, 'managing' risk whilst promoting 'normality'.'(p. 257). Being a good midwife in this setting involves balancing the demands of organisational risk management and governance structures with other professional priorities of normality and woman-centered care. Although these two objectives need not be in conflict, the empirical evidence presented in this paper shows how tensions can arise and how, when they do, there are inevitably emotional and professional costs.

Using primary data, taken from an ethnographic discourse analysis of midwifery talk and practice in the south-east of England, the paper will interrogate the consequences of this shift, portraying an empirically-based picture of the precarious world midwives practise in when simultaneously, *managing risk* whilst *promoting normality*. The paper's findings/analysis section will fall into two discrete parts: the first will present ethnographic, discourse analysis of both public and organisational texts (Gwyn, 2002; Atkinson and Coffey, 2004) along field note entries to describe how the technologies of organisational risk have been translated into action in the National Health Service (NHS) Trust in which this research was based during the period of investigation; the second will offer some lived experiences of how this translation operates in midwives day-to-day working lives. Preceding the findings/analysis section of the paper will be a brief introduction to the background and methods used in the study. Finally, the paper will close with a summary and discussion section.

Background to the study

In the UK the vast majority of intrapartum care is provided by midwives working within the, free at the point of childbirth, health service that is provided by the state – the NHS. The care these midwives provide can take place within different settings however the service is not uniform across the country. Depending upon the the individual NHS Trust midwifery care can be offered in high risk obstetric units located within the acute hospital

☆*Research sponsored by*: Centre for Health Service Research, School of Policy, Sociology and Social Research, Faculty of Social Sciences, Cornwallis North East, University of Kent, Canterbury, Kent CT2 7NF (Grant number ResGov 70). *Research funded by*: Economic and Social Research Council (Grant number ES/F020481/1).
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http://dx.doi.org/10.1016/j.midw.2016.02.010
0266-6138/

setting, low risk midwifery run units also located within the acute hospital setting, low risk midwifery units based within the community setting as well as in the woman's home. The NHS Trust described in this paper was selected because it offered intrapartum care in all four setting. Alongside the NHS maternity provision there was, at the time of data collection, a small, independent sector within the maternity services where independent midwives provided intrapartum services for a fee.

The purpose of the Economic and Social Research Council-funded study from which this paper draws was to investigate how midwives, working in a variety of intra-partum care settings, select from the possible ways of knowing about and managing risk, and how these selections translate into meaningful midwifery action. This research came out of an ever-increasing concern with risk within the health service generally, but within the maternity services particularly at a time when obstetrics accounted for the majority of the NHS litigation burden (National Health Service Litigation Authority, 2009). Given this context, surprising little had been carried out to investigate how midwives – the professional group responsible for the management of the majority of births in the UK – orientate themselves to this concept of risk. It was the extent of the potential influence midwives have upon how birth is performed which made the lack of research on the interpretative work midwives do when making sense of risk particularly remarkable.

The study was informed by the academic debate around the operations of risk in late modern society. From this perspective, risk perception is not simply an impartial probability of harm; rather, it is a socially embedded process, where some harms are amplified whereas others can be ignored (Douglas, 1992).

According to the social theory of risk, understandings of risk should never be considered to be neutral; rather, they can be understood in terms of the social and cultural context in which they are embedded. The work of Lupton and Tulloch (2002), for example, shows how the interests of the community can unsettle what otherwise might be taken-for-granted links between risk and harm. From this perspective, the way risk is perceived is not fixed, nor is it inevitable: individuals actively choose from an array of uncertainties about the future, deciding which ought be avoided, as well as which ones can legitimately be embraced (Douglas, 1992).

Although it is undisputed that there are real and potentially devastating physiological hazards associated with birth, it is the contention of this paper to posit that *which* hazards are problematised, which are chosen to be the target of risk technologies and services, is always socially mediated. The possibility of hazards during pregnancy and birth are unusual, even exceptional, but they are very real. The way in which these potential hazards are translated into meaningful action in the present, however, is, I suggest, helpfully understood as being socially constructed. Unlike some authors in maternity care literature, such as MacKenzie Bryers and van Teijlingen (Bryers's and van Teijlingen, 2010), who assume that the potential physiological hazards - first-order risks - can exist over and above the socially prescribed context from which they emerge, the study from which this paper draws took what can be described as a soft constructionist stance, whereby both kinds of risk, first-order and man-made – those risks arising out of the risk management structures themselves – are understood as only becoming fixed into meaningful action through discursive activities. Neither category of risk (first-order or man-made), therefore, is conceptualised as being free from the reaches of social and political negotiation and ramification.

From this theoretical standpoint, understandings of risk depend upon the social and cultural context in which these understandings are embedded. Given the privileging of the concept of *normality* in midwifery professional text books and academic journals in the UK – spontaneous physiological… birth without recourse to medical/technological intervention (Maternity Care Working Party, 2007) – it would seem reasonable to expect that midwives might have an understanding of birth that coalesces around respect for individual women's competency, as opposed to a faulty physiological body fraught with risk. As the findings section of this paper will demonstrate, understanding birth as a normal, spontaneous and essentially safe physiological process is not easy within the context of contemporary maternity care provision where sensitivity to the risks of birth are amplified.

Methods

The research project from which this paper draws followed an ethnographic discourse analysis design (Gwyn, 2002), providing rich data from a fluid and synthesised range of ethnographic data collection techniques. The multidimensional data – collection and analysis of clinical governance texts in both the public domain and those produced for the particular NHS Trust such as policy documents, protocols, meeting minutes and staff memos (Gwyn, 2002; Atkinson and Coffey, 2004), field notes (Atkinson, 1990; Armstrong, 1993; Coffey 1999) from participant observations (Spradley, 1980), ethnographic interview (Spradley, 1979) transcripts – were collected simultaneously.

The project was conceived upon a working hypothesis that the meaning of risk in midwifery talk and practice should not be taken as given, but instead it requires both investigation and explanation. The project aimed to elicit knowledge that functions at the tacit level, which exists as taken-for-granted common sense. The research design, therefore, had to be sensitive enough to look at the way midwives construct common-sense understanding of risk and how this manifests in their everyday clinical practice and talk. In order to facilitate the intimate observations of the meaning making of risk both through text, as a social interaction, and through midwifery talk and practice the principal data collection technique used in this research involved situating the researcher in various intra-partum care settings (a high-risk obstetric unit, an alongside midwifery-led unit, a freestanding midwifery-led unit and various homes) alongside participating midwives – both NHS and independent. This approach was supplemented with further shadowing of several of the Trust's midwifery management team members, for example during organisational meetings, etc. and multiple ethnographic interviews with all consenting participants. Triangulated approach that included direct observation of midwifery talk and practice in the different clinical settings revealed intricacies at work in the local socio-cultural dynamic, which those involved might not notice and might not think worth mentioning in an interview-type environment.

Analysis was integrated into the ethnographic data collection process (Gwyn, 2002) – the initial analysis of the clinical governance texts as a form of material culture (Bloch, 1999; Hodder, 2000; Gwyn, 2002), interview transcripts and observational field notes were produced while the researcher was in the field (Fetterman, 1998). Such embedding of analysis into data collection provided the opportunity to use emerging themes, such as *the fear factor of risk*, to direct purposeful sampling, interview schedule design and text collection (Denzin, 2002). This integrated approach provided rigour opportunities, whereby emerging analytical themes could be checked for the consistency and validity of interpretation with the participants during their involvement in the research. The embedding the data analysis within the data collection process (Gwyn, 2002) provides the opportunity to develop confidence in the authenticity of immerging analytical explanations. It should be stressed that this validity testing was not conducted with the aim of gaining participant consensus on the findings. For example, some of the most poignant data immerged out of the tensions that were identified between what

Please cite this article as: Scamell, M., The fear factor of risk – Clinical governance and midwifery talk and practice in the UK. Midwifery (2016), http://dx.doi.org/10.1016/j.midw.2016.02.010