Midwifery ∎ (∎∎∎∎) ∎∎∎–∎∎∎

Contents lists available at ScienceDirect

Midwifery

journal homepage: www.elsevier.com/midw

Risk talk: Using evidence without increasing fear

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ARTICLE INFO

Article history:
Received 11 May 2015
Received in revised form
3 April 2016
Accepted 15 April 2016

Keywords:
Risk
Risk communication
Evidence-based practice
Evidence-informed practice
Informed consent
Informed choice

ABSTRACT

Objective: this paper explores unexpected findings about how to "do risk talk" which emerged during a broader research project on of the application and misapplication of evidence-based practice in Canada.
Design: the study used qualitative methods such as semi-structured interviews and thematic analysis of inter-professional maternity care conference presentations.
Setting: Canada
Participants: fifty Canadian midwives, doctors and nurses involved in maternity care were interviewed to uncover the "how and whys" of differing interpretations and uneven application of evidence.
Results: care providers described a "lean to technology" as an unexpected result of using evidence in their discussions with pregnant women. They perceived risk talk as undermining low intervention approaches and reassurance about the safety of birth. Across professional groups, interviewees described how they attempted to mitigate this unwanted effect. Their strategies to put risk in perspective include finding comparable everyday risks, using words and pictures to describe numbers and using absolute risk and numbers needed to treat rather than relative risk. They warned about the need to balance a culture of fear combined with maternal altruism. Time, reassurance, awareness and humility were seen as key tools.
Key conclusions and implications for practice: midwives and other maternity care providers can use a variety of techniques to put risk into perspective. It is important to discuss evidence and risk with an awareness that the process itself can exaggerate risk. Care providers in all professional groups were motivated to avoid contributing to a culture of fear about childbirth and increasing rates of intervention.

Introduction

The research presented in this paper emerged unexpectedly during a broader research project conducted with health care providers in Canada, called “Reconsidering Evidence”. My PhD dissertation research explored the application and the misapplication of evidence-based practice (EBP) in maternity care. I used qualitative interviews with the health care providers involved in maternity care in Canada: midwives, nurses, family physicians and obstetricians. My goal was to uncover the “how and whys” of differing interpretations and uneven application of evidence. I explored the unexpected effect of EBP, or how “things bite back” (Tenner, 1996), and examined the social context and politics that produce particular “operations of evidence” in maternity care.

Although an exploration of how concepts of risk impact the application of EBP was part of my research, I did not set out to explore how care providers “do risk talk” and yet the subject repeatedly appeared in my interview data. Risk talk can be defined as the process of discussing pregnancy and childbirth care using estimations of risk based on numerical data from the best available evidence, often randomized controlled trials (RCTs). I use the term “talk” rather than “communication” to reflect how routine and ordinary the work of communicating risk has become in the day-to-day work of the care providers I interviewed. “Doing” risk talk is a reference to what Montelius and Nygren (2014) call the “performativity of risk”. Many informants experienced risk talk as a required performance.

During my interviews, informants consistently described a “lean to technology” as an unexpected result of using evidence in their discussions with pregnant women. Many had enthusiastically adopted EBP as an approach which they hoped would decrease the use of technology in childbirth. Despite this hope, they found introducing “risk talk” seemed to steer women's choices towards intervention. Providers from each of the professional groups volunteered that they used specific techniques to try to nurture a culture of risk tolerance rather than fear. This paper explores these themes and the strategies they described.

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http://dx.doi.org/10.1016/j.midw.2016.04.009
0266-6138/

The context of maternity care in Canada

The Canadian health care system provides universal access to health care for residents and is organized at a provincial/territorial level. Maternity care in Canada is challenged by geographic diversity with densely populated urban areas, decreasing populations in rural areas and very sparsely populated remote communities. Most Canadian births take place in large urban hospitals however births also occur in small rural hospitals, at home and in small birth centres. The majority of maternity care in Canada is provided by doctors who act as the primary care or "most responsible" provider for antenatal, intrapartum and post partum care. Nurses staff the labour floors and monitor and support those admitted under the care of doctors.

Although midwifery was an integral part of both aboriginal and immigrant societies in early Canadian history, midwifery was replaced by medical and nursing care by the mid-twentieth century in all but the most isolated parts of Canada. Public demand for alternatives to medicalized childbirth catalyzed a rebirth of the practice of midwifery outside the formal health care system in the 1970s and 1980s and activist movements called for recognition and funding of midwifery services (Allemang, 2013). Midwifery was established as a self-regulating profession and integrated into the health care system in many provinces during the 1990s, however the profession remains unregulated (and therefore alegal or illegal) in several of the country's health systems.

Canadian midwives work in continuity of care models and attend births at home, in birth centres and in hospitals. There is strong public demand for midwifery care and the profession is growing rapidly, however the increase in midwifery attended births has largely compensated for a decreasing numbers of family doctors involved in maternity care in urban communities. The majority of births in the country continue to be attended by the obstetrician and nurse team (CIHI, 2007; PHAC, 2012). Unlike most settings where midwifery is standard care for normal births and obstetricians act as consultants, most normal births in Canada are attended by high risk specialists working in large high risk centres (CIHI, 2007).

Methodology

Setting

Interviews were conducted in participants' workplaces. This included hospitals and midwifery and clinician practice offices. Participants came from across Canada. They worked in seven of the ten Canadian provinces and two of the three territories, with experience in rural, urban and remote settings. They worked in ten of 16 academic health science centres in the country. As part of my research, I attended professional conferences which took place in six of the 10 provinces in nine different cities.

Ethics

Ethics approval was obtained from the Research Ethics Committee of York University, Toronto, Canada in accord with the Tri-Council Policy Statement (CIHR, 1998). A consent form was provided to all participants in advance of the interview. Written consent was obtained from all participants.

Design

This study used qualitative research methodologies to understand how research evidence is used in clinical practice. Data was collected through key informant interviews and analysis of evidence-based practice tools, such as clinical practice guidelines and professional conference presentations. The research was designed as an inter-professional inquiry seeking to understand commonalities and differences between the professions. An interview guide was used to conduct semi-structured interviews with 50 care providers.

Recruitment

Care providers from across Canada with an identified interest in EBP were invited to participate with the goal of including approximately equal groups from the main maternity care provider professions: midwifery, nursing, family practice and obstetrics. My sampling was purposive, but also snowballed, with key informants letting me know about others who they thought should be interviewed. Some were identified through published literature, relevant conferences or participation in an inter-professional online chat group hosted by the College of Family Physicians of Canada called the Maternity Care Discussion Group (MCDG). I attempted to include both those who could be identified primarily either as advocates or as critics of EBP, and prioritized those who had published or spoken on the topic. I attempted to include a balance of those identified as front-line practitioners or as professional leaders. Some from each profession were selected because they were known as EBP researchers; others had never done research and focused on clinical practice. My sample cannot be seen to be representative of the professions, as informants expressed individual views and were selected for their interest in EBP.

Data analysis

Interviews were transcribed verbatim. Quotes were edited for readability only. A thematic coding guide was created based on themes that emerged from the literature, conference presentations and the interviews. This guide was used to conduct an analysis of the interviews and conference presentations. Transcripts were coded using NVIVO qualitative data analysis software. Interviewees consented to being named in my dissertation, however several asked to be anonymous in any subsequent publications and all are identified by profession only.

Findings

Care providers spoke about feeling compelled to use evidence in their conversations with the people they care for using terms that conveyed both pressure and regret. Some observed that EBP functioned less as a way of providing information and choice and more as a risk management approach. One obstetrician explained that "Discussing [evidence] with patients becomes something you better do or you're in trouble". For one midwife, concerns about the "heaviness" of discussions about risk and how much "space" risk talk takes in antenatal care, made her disillusioned with EBP:

> … it's a very heavy process and I feel that pressure. I feel that it has changed my practice. Of course it is informed choice but [I am concerned about] how much space it has taken in the whole time we spend with women about pregnancy. I'm just so fed up with that … weighing the relative risks of doing the screening, not doing the screening, doing the test, not doing [the test].

Some told me that in past practice they had recommended low intervention approaches such as a trial of labour after a previous caesarean section, expectant management of post-term pregnancy or vaginal birth for breech and twins. The obstetrician quoted

Please cite this article as: Van Wagner, V., Risk talk: Using evidence without increasing fear. Midwifery (2016), http://dx.doi.org/10.1016/j.midw.2016.04.009