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The tensions of uncertainty: Midwives managing risk in and of their practice

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ABSTRACT

The tensions of uncertainty: midwives managing risk in and of their practice. There has been a fundamental shift in past decades in the way midwifery is enacted. The midwifery attributes of skilful practice and conscious alertness seem to have been replaced by the concept of risk with its connotations of control, surveillance and blame. How midwifery manages practice in this risk framework is of concern. Taking a critical realist approach this paper reports on a theoretically and empirically derived model of midwifery undertaken with New Zealand midwives. The model is a three legged birth stool for the midwife which describes how she makes sense of risk in practice. The seat of the stool is being with women and the legs are 'being a professional', 'working the system' and 'working with complexity'. The struts which hold the stool together are 'story telling'. Risk theory is reviewed in light of the empirical study and a theoretical gap of uncertainty and complexity are identified.

Introduction

There has been a fundamental shift in past decades in the way midwifery is enacted. The midwifery attributes of skilful practice and conscious alertness seem to have been replaced by the concept of risk with its connotations of control, surveillance and blame (Chadwick and Foster, 2013). The complexity of the task midwives face given the current dominance of the risk environment seems unacknowledged. Midwives face the complex task of brokering multiple paradigms of birth and risk, their own included, as they provide care to women and their families making the transition to parenthood; all within a context of uncertainty about what might eventuate. Current ideologies dichotomising birth into normal or abnormal, low risk or high risk, having a technocratic or social model, and being medically led or consumer focused, belie the reality of the complex set of shifting, competing and often unpredictable circumstances that the midwife must take into account as she supports women to birth. In some sense midwifery can be described as not only about'being with' women but is also a profession of 'being between'; brokering multiple paradigms of birth and of risk (Skinner, 2003).

Current constructions of risk have been widely theorised. Risk has been also investigated in maternity care (Lane, 2012; Smith et al., 2012; Coxon et al., 2013; Coxon, 2014), and there is now some empirical evidence exploring how risk is reflected in the actual practice world of midwives (Mead and Kornbrot, 2004; Lankshear et al., 2005; Scamell and Alaszewski, 2012; Scamell and Stewart, 2014). This paper adds to the body of knowledge in relation to risk and midwifery by describing a theoretically and empirically derived model which proposes how midwifery is constructed in the current risk driven environment and how midwifery manages to moderate or 'broker' competing discourses. It essentially seeks to answer the question of how midwives make sense of risk in the real world of their practice and how this then might inform current risk theory. The particular contribution of this work is that it has examined risk and midwifery in New Zealand, where the model of autonomous midwifery-led care is the norm, thus facilitating insight into decision making about risk, where it is less directly impacted on by institutional and medical constraints.

Theories of risk

There are two strands of risk theory that have been identified: techno-rational and sociocultural (Lupton, 1999; Zinn, 2008). Both are well described in the literature and emerged as theoretical proposals in the late 20th century. Techno-rational theory approaches risk as measurable and manageable. This approach sees risks as real and seeks to control or avoid them. It focuses on the mathematical calculations associated with the determination of the probability of an event occurring (Oakley, 2000). More importantly for midwifery, the techno-rational approach claims to define and measure what might be considered normal in a

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population (Hacking, 1990). Anything outside of normal and anything seen as potentially uncontrollable then becomes risky. Through the bio-medical gaze however, even the normal itself can become risky as a normal outcome cannot be seen or measured till after the event. Risks are therefore identified and controlled through the use technology, surveillance and intervention and are seen as objective and rational (De Vries, 1996; Cartwright and Thomas, 2001). For the midwife, any attempt to apply such epidemiologically based risk calculation to individual care planning in an attempt to manipulate outcome is subject to the ecological fallacy (Portnov et al., 2006) and is fraught with systematic error (Heyman, 1998). Despite all attempts of control, uncertainty remains.

Sociocultural risk theories go some way to expanding the understanding of risk. These too emerged in the late 20th century. Two key theorists, Beck and Douglas have made a significant impact on how we understand the current risk context in which we are immersed. Beck (1999) proposes that we now live in a 'risk society'. He states that our attitudes towards risk are in the process of undergoing fundamental change. Despite having never been safer, we are caught in a paradox; beginning to understand that technology is not able to control risk, yet at the same time still expecting it to do so. Thus our anxiety grows, as does our need for accountability or blame. Becks theory proposes that we are now seeing how complex the world really is yet have no framework or paradigm to deal with this. Our intensifying attempts at certainty and controllability paradoxically create even more risk (e.g. soaring caesarean section rates).

What Beck does not address to any great extent is the cultural variability in risk perspectives. These cultural perspectives concern the way societal forms affect the way individual and group decisions about risk are made. The most influential thinker in this field has been the anthropologist Mary Douglas (Douglas, 1994) who rejects both the objectivist approach and an individual rational choice approach She proposes instead that risks are decided upon according to the cultural meaning associated with them, values and uncertainties being integral to choices. Decisions are based on social rather than scientific knowledge with an underlying understanding that some knowledge is seen more authoritative. This cultural approach therefore helps us see risk decision-making as a result of community consensus, over rational choice. This can be seen in practice for example, in the decision making about place of birth.

One can see the potential relevance of these theoretical approaches to current forms of midwifery practice: a rise in anxiety, a focus on blame, and an overarching need for control and surveillance. There are many question to answer about how midwives manage to 'make sense' of practice in the 21st century. How does midwifery manage to support its basic relational nature and to claim expertise in 'normal'? How does it manage to maintain its watchful alertness in the face of uncertainty within the current risk context? What might it be able to offer as an alternative to a risk-driven, anxiety-inducing, intervention-racked, control-obsessed birth experience for new mothers?

The empirical approach

The research undertaken to explore the place of risk in midwifery practice took a critical realist approach which enabled the incorporation of diverse theoretical approaches and supported the idea of multiple risk paradigms. This philosophical basis proposes that knowledge should be explored through multiple lenses and that knowledge is both fallible and emancipatory (Bhasker, 1989; Danermark et al., 1997; Walsh and Evans, 2014). It provided the ontological and methodological support for the study. The research also needed to accept the complex nature of midwifery practice and be open enough to encompass the full range of midwifery responses, acknowledging that risk in the real world may be perceived as both real and as constructed. For the purposes of the research, risk was operationalised as the referral for obstetric consultation; the place where it is both identified and acted on. It was in this place that risk was more visible and more active.

The research was undertaken in New Zealand where midwives are the main providers of maternity care. The midwives in the study were all Lead Maternity Care providers, providing continuity of care, practicing autonomously, and being self-employed. They are able to continue to provide care in collaboration with obstetricians when risk factors are identified. Eighty percent of birthing women choose this type of care (Ministry of Health, 2015). Maternity care in New Zealand is fully state funded, can be provided in homes and/or hospitals. Partnership with women is the underlying philosophical approach which is embedded in regulation, standards for practice, and in how it is funded (Ministry of Health, 2007). New Zealand midwives have considerable decision making powers around risk, with systems in place to ensure women's involvement when collaboration with medicine is needed. Examining risk in this context, where midwives are less constrained by institutional demands and have much freer range of decision making enables a more open examination of how risk for midwives is perceived and managed.

In keeping with the critical realist methodology, the research took a mixed method approach. The first method was a national total population (649) postal survey of midwives' referral for obstetric consultation practices and their ongoing involvement in care. It also examined their attitudes towards the risk environment, including the medico-legal context, the referral guidelines and the degree of successful collaboration. There was a 52% response rate. The results of the survey are reported elsewhere (Skinner and Foureur, 2010).

The second method was the undertaking of six focus groups with midwives in a variety of sites across New Zealand. These were undertaken by the lead author, a practicing midwife and postgraduate midwifery teacher and researcher. The settings were chosen to reflect demographic sites with different characteristics (e.g. rural and urban) and also to represent a cross section of regionally analysed survey responses. The intention was to hear a wide variety of experiences and opinions. Once the sites were chosen, participants were either self-selected by identifying their wish to participate on the survey response form or volunteered during regional midwives' meetings. There were between 4 and 9 midwives in each group. Discussion began with how referral for obstetric consultation worked in their area and, using a semi-structured approach, the midwives were supported to explore other areas of risk such as risk screening, the medico-legal environment, shared decision making and what impact this had on how they practiced. Preliminary data analysis of the survey had been completed prior to the focus groups, so at the end of the discussion findings were presented to the group for comment.

These two data sets were initially analysed separately. The survey was analysed statistically. The focus group data were grouped and regrouped into themes and subthemes using first a content analytical approach and then a theoretically derived approach. Following this the key findings of the survey and the themes from the focus groups were analysed together in what critical realists refer to as retroduction, the creative leap, in which a model was created (Danermark et al., 1997). There were four theme areas from the focus groups. Once key findings from the survey were integrated alongside the focus group themes the model was created. This model has been presented in a midwifery text as an aid in the support and development of new midwives (Skinner and Dahlen, 2015). The final component of this piece of

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