Competing discourses of risk and woman-centred care: Challenges for midwives and women

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Pregnant women and their birth partners require detailed, evidence-based information from healthcare professionals throughout pregnancy and birth, in order to make informed decisions about their care choices and preferences. However, healthcare professionals – particularly midwives – operate within competing discourses of risk avoidance and woman-centred, personalised models of care, and bring their own perceptions of risk to the discussions they have with women. This article outlines the concept of risk and its relevance to contemporary maternity care, and using the example of birth plans, explores ways in which midwives and the women in their care might better negotiate competing discourses of risk and woman-centred care.
Keywords: risk, woman-centred care, birth plans, midwife identity

Risk is defined as the probability that a hazard will give rise to harm (Edwards & Elwyn, 2001). It has been suggested that there has been a move in modern society from considering risk an accepted part of life, to something that must be controlled or avoided (Healy et al., 2016).

Risk has been conceptualised in contrasting ways. Techno-rational theories of risk approach it as something measurable and manageable. From this perspective, the focus is on mathematical calculations that determine the probability of an event occurring (Skinner & Maude, 2016). In contrast, others have theorised risk as sociocultural in nature. Here, risks are seen as culturally situated, and individuals will make decisions according to interpretations relevant to them. This means that the language of statistics is perceived differently according to people's understandings of and assumptions about the relevance or importance of a particular risk (Edwards & Elwyn, 2001). Sociocultural understanding of risk suggests that, as a socially embedded process, some harms may be given greater significance while others can be disregarded, and further, perceptions of risk are neither fixed nor inevitable (Scamell, 2016). In this analysis, individuals will 'choose from an array of uncertainties' (Scamell, 2016), and make their own decisions about which risks should be avoided and which embraced.

RISK IN THE CONTEXT OF MATERNITY CARE

Although birth has become safer in recent years, particularly in the developed world, the risk discourse surrounding pregnancy and birth has intensified (Healy et al., 2017). Bisits (2016) suggests this may be due to a perception that 'risks abound everywhere in pregnancy', based on the vast number of risks that have been defined and articulated. Increasing levels of intervention and surveillance are associated with a risk-based model of maternity care, and it has been suggested that this may be happening in the face of a lack of supporting evidence (Dahlen, 2016) or where evidence actually suggests equal outcomes or even benefits to a low intervention approach (van Wagner, 2016).

The determination of risk in pregnancy, similar to that seen in wider society, is a complex process, rather than a simple mathematical calculation. Factors that influence women's perceptions of risk in pregnancy include family history, life experiences, cultural narratives, and experiences of healthcare more generally (Lee et al., 2016; Smith et al., 2012).

Given the dominant risk discourse in maternity care, it is unsurprising that midwives' own perceptions will be affected. Dahlen and Caplice (2014) suggest that working environments, models of care, and professional and organisational cultures will shape the way in which midwives work. This view is supported by Healy et al. (2016), who write that midwives working in obstetric-led settings are exposed to high rates of intervention, which potentially skews their perceptions of risk and impacts on the care of women, something Dahlen (2010) refers to as midwives 'learning the lessons of fear'.

Midwives themselves have referred to childbirth as risky, and in Scamell's (2016) study, described 'good midwifery practice' as a process of anticipating and, if possible, eliminating uncertainties in order to reduce risks. Page and Mander (2014) describe midwives

attempting to reduce harm and promote safety, but as a consequence, becoming increasingly risk averse and prone to defensive practice due to increased anxiety. Midwives in this context described 'doing things the way I always do them' as a means of reducing uncertainty, but this resulted in a narrow definition of normality and little tolerance for ambiguity before a labour was labelled 'abnormal'. Similarly, Jenkinson et al. (2017) found that midwives who had experienced negative clinical events were more likely to take a risk averse stance.

Midwives' fears and risk aversion impact on their role enactment. Healy et al. (2016) found that an 'assumption of abnormality' was impacting on practice in the form of increased interventions and surveillance of labour, even where unwarranted, while Dahlen and Caplice (2014) describe a rise in defensive practice resulting from healthcare professionals perceiving a need to protect themselves from liability and a fear of litigation. Jenkinson et al. (2017) report a sense of disempowerment among midwives in some organisational settings, finding they adopt a stance of acting 'with institution' rather than 'with woman'. Healy et al. (2017) believe this has an impact on the professional identity of midwives; while the profession is recognised as expert in normal birth, this role is diminishing in the face of obstetric dominance, and midwives in their study operated 'at a level of sub-optimal professional accountability and autonomy'.

The dominance of a risk discourse impacts on the care received by women, as a direct effect of healthcare professionals' risk averse and fearful approach to pregnancy and birth, and may impact negatively on birth outcomes (Dahlen & Caplice, 2014). Caregivers may be characterising women solely in relation to perceptions of their risks for various adverse outcomes (Bisits, 2016), and information-giving may be skewed towards the over-inflated perceptions of risk to which healthcare professionals are prone (Page & Mander, 2014). Further, women's choices may be limited, as caregivers offer only narrow definitions of normality. In this context, healthcare professionals are also fearful of putting trust in women's decision-making, due to their own feelings of vulnerability if women make decisions considered outside the norm, for example declining 'usual' interventions (Healy et al., 2016). The result is a threat to the relationship between professionals and women, as women may be demonised if they fail to demonstrate risk averse behaviours expected by healthcare professionals (Scamell, 2016).

THE RHETORIC AND REALITY OF CONTEMPORARY MATERNITY CARE POLICY

Woman-centred care is considered the 'gold standard' (Jenkinson et al., 2017), and is a widely recognised concept within the midwifery discourse (Healy et al., 2017) and in current maternity care policy in the UK. Encompassing a focus on women as individuals, and incorporating attention to physical, social, emotional, psychological, spiritual and cultural wellbeing (Jenkinson et al., 2017), this approach places women's needs ahead of institutional or professional priorities (Healy et al., 2017). This holistic, social model of pregnancy and birth is privileged within the midwifery profession, and suggests that midwives will base their care on an understanding of women's competency to birth their babies, rather than the body as 'a faulty entity fraught with risk' (Scamell, 2016).

While a social model of pregnancy anticipates normality, resulting in an approach where technology is servant rather than master, a technocratic approach 'extols technology and anticipation of pathology' (Healy et al., 2016). The technocratic model may represent an unexpected outcome of the introduction of evidence based practice. The ideal of evidence based practice is an expectation of flexibility, as evidence should be interpreted within the context of women's values, goals and individual circumstances, and reliant on strong relationships and good communication (Jenkinson et al., 2017). The reality of clinical practice, however, appears quite different. Van Wagner (2016) suggests this has resulted, ironically, from the generation of vast amounts of evidence; as evidence is generated, there is an increasing array of areas in which risks and benefits must be explored, in the context of pregnancy and birth. The result is the construction of 'risk talk', in which there is a tendency to offer women lists of options rather than deeper exploration of preferences and choices, and from which a culture of fear and risk aversion is likely to result.

In this conceptualisation, evidence based practice appears closely related to a techno-rational approach to risk; however, midwives are also expected to adopt a social model of care, which relates more closely to the sociocultural approach to risk. Skinner and Maude (2016) write that this results in midwives having to broker multiple paradigms, a state of 'being with' women, but also 'being between' competing paradigms of technocratic and social models of care. Healy et al. (2017) believe woman-centred care is difficult to achieve if midwives make decisions based on adherence to organisational policies and procedures rather than through collaboration with women, while Page and Mander (2014) describe problems faced by midwives where their practice philosophy is incongruent with the organisational imperatives with which they are expected to engage. Scamell (2016) supports this view, finding that midwives strive to inspire confidence and wellbeing in women through an individualised and sensitive approach to care, but are also viewing their practice through a lens of risk; here, being a 'good midwife' is a challenge, as midwives struggle to balance the demands of organisational risk management and governance structures with competing priorities of encouraging normality and supporting woman-centred care.

BIRTH PLANS IN COMPETING DISCOURSES

Birth plans offer a useful context in which to consider how competing discourses of risk and woman-centred, personalised care may play out in terms of healthcare professionals' practices, and the impact upon women's experiences of labour and birth.

Introduced in the 1980s, birth plans represented an attempt to help women avoid escalating interventions and gain some sense of control in labour and birth (Divall et al., 2016). Within contemporary maternity policy in the United Kingdom, birth plans have become part of usual maternity care, with templates and guidance for their completion appearing in women's handheld maternity notes and on a number of parenting websites, and explicit reference made to birth planning within policies promoting personalised care (e.g. Department of Health, 2003:43).

A number of benefits have been described in relation to the completion and use of birth plans, reported in a recent narrative review of global literature on the subject (Divall et al., 2016). From women's perspectives, birth plans are seen as an opportunity to become aware of and to explore available options for such things as pharmacological and non-pharmacological pain relief, birth settings and environment, and positions for labour and birth, as well as possible obstetric interventions. This exploration is expected to be facilitated through timely and detailed discussion with women's caregivers during the antenatal period; and in exploring and considering their individual preferences and wishes, women attain a sense of involvement in and control over decision making in labour and birth. Ideally, the process of shared decision making will help women feel confident and will reduce anxiety relating to childbirth. Similarly, studies of healthcare professionals' views have found some positive perceptions, centred on birth plans as an opportunity for parent education, enhanced communication and shared decision making, empowering women, and providing individualised care.

These positive views of birth plans echo contemporary social models of maternity care described earlier, where the emphasis is on women's involvement and sense of control over decisions and choices, and an individualised approach to care provision. In the UK, this has been articulated most recently in the National Maternity Review (2016), while on a global scale, the World Health Organisation has produced guidance stressing the importance of individualised education and monitoring of the physical, psychological, spiritual and social well-being of women and their families throughout the childbearing period (WHO, 2016).

However, a number of concerns have been raised that contradict the positive policy rhetoric around birth plans (Divall et al., 2016). Women have described a lack of opportunity or professional support to complete birth plans, and in some cases, a lack of awareness of what a birth plan actually is. Further, women have reported that healthcare professionals may not pay adequate attention to their birth plans in labour, impacting on their sense of control and experiences of childbirth. Malacrida and Boulton (2014) are critical of the rhetoric around ideas of choice, control and empowerment, writing that such concepts are in fact an illusion, as any sense of empowerment gained through writing a birth plan is lost due to the challenge women face in negotiating a highly medicalised childbirth environment and model of care.

Healthcare professionals have also described less positive experiences in the reality of supporting birth plans (Divall et al., 2016). In terms of writing birth plans, concerns have been raised about a lack of available time during antenatal appointments, and insufficient training to enable professionals to confidently support women to fully explore options, wishes and preferences. From the perspective of negotiating competing technocratic and social models of care, midwives have described difficulties in supporting women's choices and decisions while working within professional responsibilities and organisational structures.

Healthcare professionals' fears and concerns, described earlier in relation to working within risk averse organisational structures, may be influencing their attitudes and behaviours in the context of birth planning. A number of studies, particularly those relating to caregivers working in obstetrically-led settings, have described healthcare professionals' negative views of women presenting with birth plans in labour (Divall et al., 2016). This has resulted in a narrative among healthcare professionals suggesting that birth plans are associated with obstetric interventions and poor outcomes, particularly where birth plans have been considered inflexible or highly detailed, or where women are perceived to be making decisions about their care that are beyond usual safe care - according to the definitions within organisational policies and guidelines. These findings support ideas presented earlier: healthcare professionals fear a loss of control when working within a philosophy based on an 'assumption of abnormality' (Healy et al., 2016), and practise in ways that are less about working with women than 'with institution' (Jenkinson et al., 2017). Women's descriptions of a lack of support from healthcare professionals in writing and using birth plans echo Healy et al.'s (2016) reports of midwives exhibiting a fear of putting trust in women's decision making, based on their own sense of vulnerability.

NEGOTIATING COMPETING DISCOURSES

From the challenges described here, birth plans represent a clear example of the difficulties facing healthcare professionals and women in the negotiation of competing discourses of

technocratic and social models of maternity care, or techno-rational and sociocultural models of risk (Skinner & Maude, 2016). This final section offers some suggestions as to how midwives and other healthcare professionals might better approach this negotiation in order to properly support women's choices and decision making around labour and birth.

Midwives should reflect on their own fears, as doing so may in itself lessen the negative impact professionals' anxieties have on women's care (Dahlen & Caplice, 2014). It has been suggested that without self-reflection, healthcare professionals are more likely to give information based on personal biases (Lee et al., 2016).

The process of reflection may be helped by moving from a terminology of risk to one of 'uncertainty' (Page & Mander, 2016). While risk has been defined as 'the possibility of something bad happening', uncertainty refers to 'something that is not known or certain' (https://dictionary.cambridge.org/). Uncertainty can be seen as a core element of maternity care, given the unpredictable nature of labour and birth, but Page and Mander (2016) suggest midwives require organisational and policy support in order to tolerate ideas of uncertainty themselves. Healy et al. (2016) suggest a shift in focus away from risk and toward health and wellbeing, might positively impact on intervention rates. In the context of birth plans, communication based on ideas of uncertainty, rather than a focus on risk, serves two purposes: first, it enables women to take a more positive view of unpredictability in childbirth; and second, it supports a more holistic perspective when exploring options and choices for labour and birth, better aligned to the social model of care normally associated with midwifery. Healy et al. (2017) believe it is important for midwives to reclaim this core tenet of their professional identity, in order to move away from the dominance of obstetric practice.

Dahlen and Caplice (2014) believe midwives hold the power to reduce women's fears around childbirth, but this relies on them developing relationships of trust, and such development takes time (Royal College of Obstetricians and Gynaecologists (RCOG), 2010; Lothian, 2009). The benefits of strong relationships between midwives and women have been described. Jenkinson et al. (2017) write that gaining understanding of women's broader social worlds assists midwives in making sense of their decisions, and means midwives are better able to respect and support these decisions. Strong relationships are also associated with caregivers attaining greater understanding and tolerance of the potential for differences in definitions and perceptions of risk (Lee et al., 2016). These findings suggest a need for time and ongoing parent education in the context of birth planning, and may answer the criticisms women have made about midwives not taking time to fully explore what matters to them (Divall et al., 2017).

Bisits (2016) believes any discussion of labour and birth decision making should begin with an acknowledgement that childbirth has never been safer, and should use unambiguous language that emphasises absolute, rather than relative, risk. Discussion should reflect a balance of relevant biomedical risks and a woman's unique circumstances (Jenkinson et al., 2017). As described earlier, evidence based practice may result in a tendency to offer lists of options, rather than encourage open discussion that explores the meanings of decisions for individual women in the context of their personal values (van Wagner, 2016). Ensuring an individualised, contextualised exploration of wishes and preferences requires time, and access to a range of resources (RCOG, 2010). This suggests both advantages and challenges to the use of birth plan templates. While such templates may represent a useful starting point in the exploration and discussion of available options for labour and birth, they do not necessarily address the issue raised by women of healthcare professionals operating a 'tick box' approach to such discussions.

IMPLICATIONS FOR PRACTICE

This paper has demonstrated the importance of addressing risks and choices in a way more closely aligned to a sociocultural perspective, in order to support the ideals of woman-centred and personalised care espoused in a social model of maternity care. Improvements to the way in which risks, or uncertainties, are presented rely on effective communication and relationship building over time, which suggests a continued role for parent education throughout pregnancy. On a positive note, current UK policy emphasis on relational continuity would appear to support this (National Maternity Review, 2016). However, the continued focus on a techno-rational understanding of risk and the dominance of obstetric models of care mean that women face a challenge in fully exploring their wishes and preferences with healthcare professionals. Midwives hold the potential to act as advocates for women in this challenge, but must reflect on their own fears and aversion to risk in order to do so. Policy may appear to support ways of working that have the potential to reduce interventions in labour and birth, but at present, rhetoric appears far removed from the reality of maternity care systems.

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