

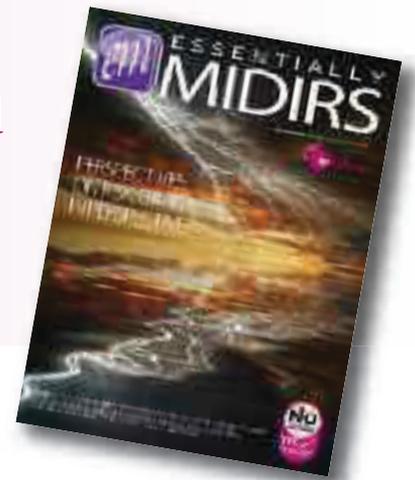
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Writes



Editorial comment on issues addressed in this month's Essentially MIDIRS...

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Comment by

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When less might be more...

Back in May, we published the abstract of a study that has given me a lot of food for thought ever since: the STORK study (Styles *et al* 2011), which looked at midwives' intrapartum decision making. The researchers gave midwives a series of scenarios and asked them whether they would refer the woman to obstetric care or 'keep' them. They then attempted to see if the midwives' answers correlated with factors such as the number of years' experience they had, whether they worked in a midwifery led unit or hospital setting and what their attitude towards risk was. Somewhat surprisingly, although the midwives exhibited a wide variety of responses in the circumstances under which they would 'refer' or 'keep' women, there was no correlation between their responses and any of these factors. The only significant

correlation was that the midwives who worked in a health board area which had recently had a series of high-profile adverse events were more likely to refer sooner than their counterparts in other areas.

I have just returned from a speaking tour where I have been discussing this study (among many others) with midwives, obstetricians and other people involved in the care of birthing women, and one of the discussion points that arose over and over again is the way in which what we do sometimes tends to be more hands on (in the broadest sense of the term) after something goes wrong. When horrid things happen, we tend to focus on what we should do about it. With the emphasis on the word **do**. In fact, so often, our immediate response to anything that happened that didn't happen in the way that we thought it ought to happen is to focus on what we can **do** to prevent a similar

situation in the future. I see this in many scenarios, and I'm not saying that this is inappropriate or unnatural. In fact, quite the reverse; it seems a completely natural, human response to adversity. "Oh no", we think, "this shouldn't have happened. It would be good if it didn't happen again, so let's try to figure out how and why it happened and **do** something which will prevent it happening again in the future".

I see this trend occurring in the literature as well, particularly where researchers have analysed situations where things have gone wrong. Often, they generate long lists of recommendations about what we should do differently. These lists often include more monitoring, screening and/or intervention than before, either universally or for women who fall into specific categories. However, even on a very simplistic level, I can immediately think of three reasons why this approach may be problematic:



- 1) It is generally very difficult to determine exactly why something happened. Untoward events that happen during pregnancy and childbirth are often very complex, as the literature which analyses adverse events highlights over and over again. There are often many varied and unrelated factors which have fed into a situation, and it is the rare situation where one simple error, omission or event directly led to the problem at hand.
- 2) Even if we can tease out one straightforward reason which explains why something happened, we can't necessarily be sure that doing something differently will prevent it happening again. We might postulate that taking a particular action might prevent problems occurring in the future, but even after very careful analysis such a postulation is more like a research hypothesis which we need to test rather than a finding upon which we all need to act. At least in theoretical terms.
- 3) The something different that we do may have other knock-on effects and actually create more problems in the long run. This is why researchers calculate statistics such as the number needed to treat. If someone suggests (for instance) that giving all factory workers a particular drug before they begin work will reduce the rate of work-related accidents, we not only need to see if this is true but also look at whether the routine administration of such a drug might have any unwanted effects as well as those that we are seeking to create. Would there be value in the drug if it reduced the rate of occurrence of some kinds of accidents while increasing the likelihood of others? Even screening tests can have unwanted consequences, not least of which are the false positive and false negative rates that are an inevitable consequence of any test that we use.

This list is only the tip of the iceberg; I haven't even begun to mention issues such as individual choice and consent, mainly because I want to keep the focus on the emphasis that we place on action, on the concept of **doing** something; often more than we did before. Report after guideline after study after consensus paper say we must **do** more. More monitoring, more checking, more screening, more form filling, more, more, more...

Sometimes we probably do need to **do** more. But maybe sometimes we need to **do** less. Or **do** nothing. Maybe sometimes we need to **think**, or even just **be**, rather than **do**. Yet the culture that has grown around modern birthing emphasises, promotes and supervalues doing. Doing has become what is expected of us, and it is very difficult to say (on almost every level) that maybe doing more isn't the answer.

“Often, they generate long lists of recommendations about what we should do differently”



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Nicky Leap wrote about her understanding of this:

'In life there is the potential to stumble across a phrase that pulls us up short, often a simple truth that will resonate through our core beliefs and values, heralding a profound impact on how we approach life thereafter. So it was for me when I was a newly qualified midwife and Independent midwife Hazel Smith said, in an almost throwaway aside, "You know, in midwifery, it's often true that, the less we do, the more we give." (Leap 2010:17-18)

While Nicky was writing about the midwife-mother relationship on this occasion, I think this phrase may have sister phrases that might be true in other aspects of maternity care. For instance, the less we do, the more likely we are to enable women to work with their body's natural ability to grow, birth and feed their babies. The less we do, the more likely we are to see women who don't experience side effects of drugs and interventions which can then create adverse events in themselves. If more is truly useful, then let's do more. But so often it feels like

more is a kneejerk reaction which isn't going to solve the problem, and maybe in some situations doing less might have prevented the problem in the first place.

Sometimes more is vital. Sometimes more is absolutely the answer. But maybe, at other times, less may be more, and when that is the case, it ought to be OK to say so.

References

Leap N (2010). The less we do, the more we give. In: Kirkham M ed. *The midwife-mother relationship*. 2nd ed. Basingstoke: Palgrave Macmillan.

Styles M, Cheyne H, O'Carroll R et al (2011). The Scottish Trial of Refer or Keep (the STORK study): midwives' intrapartum decision making. *Midwifery* 27(1):104-111.

