

midirs Writes



Editorial comment on issues addressed
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Comment by
Sara Wickham Editor

Exploring expert opinion

In the ReView article of the updated RCOG Green-top Guideline on obstetric cholestasis that is featured in this issue (Wickham 2011), I noted that, mainly because of the limitations that exist around the knowledge we have of this area, many of the recommendations in the guideline are based on expert opinion rather than evidence. But what issues does this raise? Is it a problem, or should we be placing as much value on expert opinion as on any other kind of evidence?

Any consideration of the concept of expert opinion must really include a brief look at how this is linked with the movement towards evidence-based practice. In fact, epidemiologist Ken Johnson (1997) described the shift towards evidence-based practice as 'a welcome movement away from belief- and

tradition-based' current medical opinion' (1997:350). Similarly, when Friedland *et al* (1998) analysed the key differences between the so-called 'traditional' and evidence-based paradigms, they described the 'old' paradigm as one in which '*individual clinical experience provides the foundation for diagnosis, treatment, and prognosis. The measure of authority is proportional to the weight of individual experience*' (1998:2). By contrast, the new approach instead focused on the use of evidence '*derived from systematic, reproducible, and unbiased studies to increase their confidence in the true prognosis, efficacy of therapy and usefulness of diagnostic tests*' (Friedland *et al* 1998:2)

The idea was – and, for many people, continues to be – that, while personal opinion and experience can be biased, research findings are somehow more objective. However, it doesn't take that much experience of reading research and research

commentaries to realise that bias also plays a significant part in research, not least because existing beliefs and experience tend to be a strong influence on the kinds of questions that people seek to research as well as on the ways in which they research them and the way in which findings are interpreted and discussed. Both Jo Murphy-Lawless (1998) and Ann Oakley (2000) have argued that traditional obstetric culture and ideology may influence current thinking (and thus practice) more than is generally acknowledged, and that influences on medical thinking may not always include (or be limited to) the ways of knowing that are seen as important within evidence-based practice.

'Medical practitioners very often decide what to do on the basis of educated guesswork, preference, tradition, material resources or fear of litigation, rather than because this or that procedure has been shown to be safe and effective.' (Oakley 2000:17)

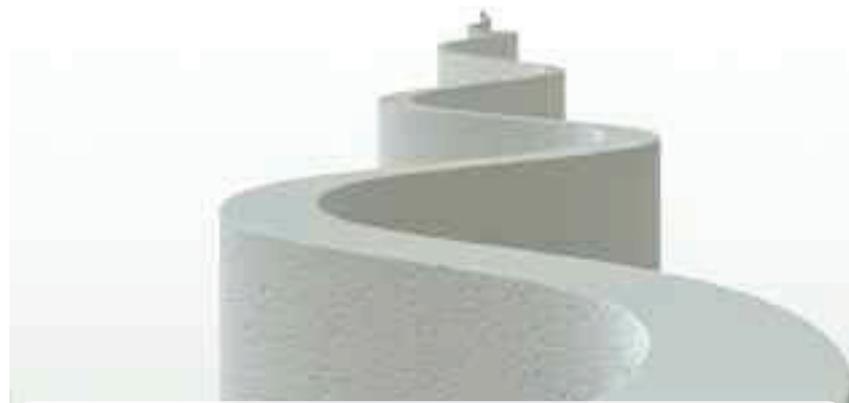


But another significant problem – as can be seen from the ReView article in this issue (p27) – is that there are huge gaps in the knowledge that we can gain from research. If research studies haven't been carried out in a particular area, then we have little to go on other than our own experience and opinion, and this is perhaps why the authors of the RCOG guideline (Kenyon & Girling 2011) have included these points: it is better to offer something rather than nothing.

The philosophical debates about how clinical expertise and expert opinion can, should, or might, fit with evidence and into practice are vast, but there is a general agreement that these kinds of knowledge are important, particularly when it comes to the application of research findings to individuals in practice. In reality, and on a day to day basis, all practitioners will use their experience as well as their understanding of evidence and a multitude of other kinds of knowledge in order to care for women and babies, and this was always acknowledged by the 'founding fathers' of evidence-based medicine, whether or not it is valued to the same degree in practice:

'External clinical evidence can inform, but can never replace, individual clinical expertise, and it is this expertise that decides whether the external evidence applies to the individual patient [sic] at all and, if so, how it should be integrated into a clinical decision.' (Sackett et al 1996:72)

However, there is a key difference between this and the questions I raised above, which concern the stage at which clinical experience and/or expert opinion are used, and also raises questions about whose opinion counts. It is one thing for individual practitioners to use their experience in practice: indeed, this is something that we all do every day. But it is something rather different when the expert opinion of a small number of people becomes part of a guideline that (whether they intend it to be so or not) may then be adopted as the basis for informing decisions about the care of many hundreds or thousands of women or babies. Sometimes, several people are involved, and the recommendations that result might be described by the use of the word consensus, yet this consensus tends to reflect the views of the group who hold the most power within the mainstream hierarchy. It may not reflect the totality of the experience of every group or individual who might have been consulted and, so often, it is women, midwives (particularly those with the most experience of physiological birth) and people such as doulas, childbirth educators and breastfeeding counsellors who are not consulted. Or, if they are invited along, it is a token invitation and their words are not taken into account.



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For the record, I am not necessarily disagreeing with any of the points that Kenyon & Girling (2011) make from their expert opinion. I have only looked after a small number of women with obstetric cholestasis and I wouldn't claim to have greater or different knowledge of this area, so the fact that I have picked up on this issue is a reflection of the way in which it made me think about the wider problem rather than because I see elements of this guideline as problematic *per se*. But I do think it behoves us to pay attention to the way in which guidelines are developed and the issues that are raised when we consider the question of who is interpreting research and/or sharing their expert opinion. Otherwise, we may find that the guidelines that many people are having to follow in practice become an increasingly narrow path which curves away from the knowledge, experience and opinions that are held by women and their midwives.

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