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

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Comment by

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Reflecting on risk assessment

I have spent some time over the past few weeks reflecting on the issues raised by the revised venous thromboembolism (VTE) guidelines which Julie Frohlich has reviewed in this issue. Because VTE is, as Julie writes, 'a killer' (2010: 27), we want and need to do everything we can to prevent it, yet it strikes me that the universal risk assessment suggested in these guidelines also has implications which will affect women and their families. Is it justifiable, I wondered, to carry out risk assessment — either generally or for a specific condition — without first seeking a woman's informed consent? Does it matter whether risk assessment is formal or informal? And how do we balance our desire to take all possible steps to prevent maternal death with the importance of ensuring that women consent to those actions which may impact on their choices and experiences?

The ramifications of risk assessment

My questions about whether women should need to explicitly consent to formal risk assessment are based on my understanding that this practice can and does have ramifications. Giving women information and advice about their risk status is an integral aspect of care, and this may seem innocuous to some, but being labelled as 'at risk' can lead to anxiety and affect the woman's perception of pregnancy as a normal, healthy state. I suspect that many of us focus more on the concept of choice as it relates to discussion around invasive interventions (such as the administration of anticoagulant therapy) than on the implications of risk assessment itself. Yet it is increasingly common that women are denied the right to birth in particular settings as a result of being deemed 'at risk', a label which may also lead to the recommendation of further screening and/or prophylactic measures, each of which may again have emotional and social as well as physical implications.

All of these issues may be considered minor compared to the potentially fatal nature of VTE, but setting has a direct effect on the amount of intervention experienced by women and interventions themselves carry risks which can also occasionally be fatal. In addition, it is good practice to measure the relative value of such recommendations, for instance by working out how sensitive and specific assessments are in identifying the women who may experience problems such as VTE. Currently, however, guidelines recommending that risk be assessed in relation to specific areas do not tend to discuss such measures, perhaps partly because our focus is drawn to the seriousness of one outcome rather than on assessment of the wider picture.

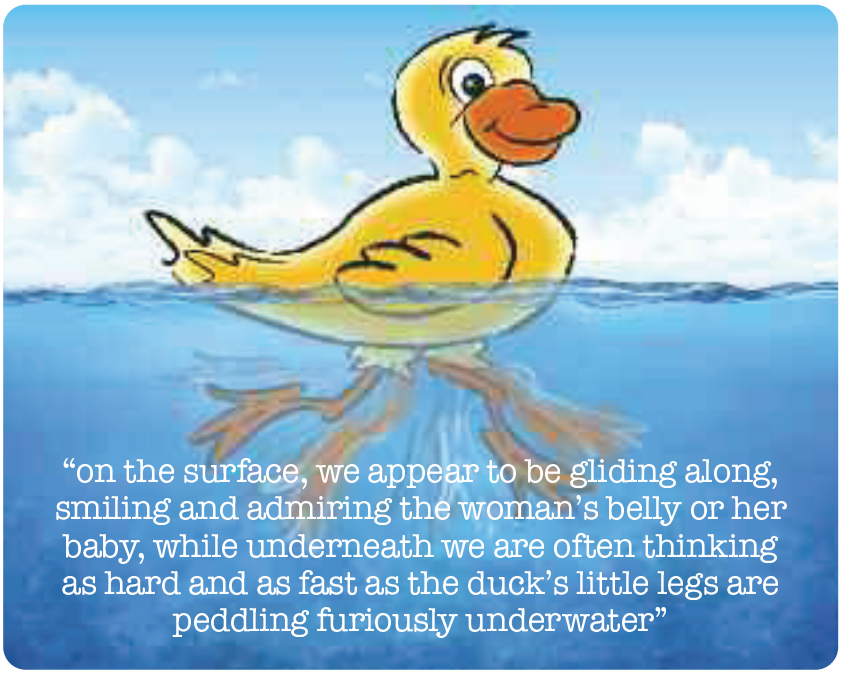
Particular care may be needed where some of the risk factors that we are assessing are common, and here I am thinking about obesity

and so-called advanced maternal age, both of which are increasingly prevalent. Because more women fall into the medical category of obesity than ever before, and because more women are choosing to have their families later, significant numbers of women will be deemed to be at risk for VTE. The actual risk that any given woman will experience this remains very low, however, and both obesity and advanced age are considered risk factors on the basis of expert opinion rather than research findings. Given the ramifications, should women be asked to consent to risk assessment?

Risk assessment as a continual process

If only it were as simple as that question makes it sound! Risk assessment is not limited to serious conditions such as VTE, and neither does it occur only on a formal basis. It happens continually, sometimes on a semi-formal or formal basis (such as where women who have had a previous caesarean section are denied access to birth centre care), and more often informally as a part of daily practice, without conscious thought. Midwives are constantly alert for signs that all is not well; while we focus on guarding and promoting normality, we understand that problems will occur and need to be aware of this possibility. If someone who knew nothing about birth saw me sat beside a family a few minutes after a baby has been born at home, they may well think that I am merely admiring the baby and congratulating his parents. Yet I would also (among other things) be monitoring the new baby's well-being, listening to his breathing, keeping an eye on the woman's general condition and blood loss, watching for signs of placental separation, paying attention to how the new family was interacting and recording all of this in the woman's notes.

Tricia Anderson used to describe midwives as being a bit like ducks: on the surface, we appear to be gliding along, smiling and admiring the woman's belly or her baby, while underneath we are often thinking as hard and as fast as the duck's little legs are peddling furiously underwater. I absolutely want women to perceive that I am gliding along in this manner (unless, of course, there really is a problem, in which case I would like to reserve the right to flap my metaphorical wings if I think this will help), because this will help them to relax, which in turn will promote the hormones that facilitate pregnancy, birth and breastfeeding. No matter whether we describe what we are doing as 'ensuring that all is normal' or 'assessing for potential risks', we cannot argue that ongoing risk assessment is not a constant focus for all of us involved in maternity care. It may not be something which is constantly obvious or under discussion, but this may be because there is a level of implied consent attached where a woman seeks maternity care, wherein she can expect that her caregivers will assess her status and inform her of any issues that may be relevant to her experience and/or decision making. Given that this is the case, how can we not justify formally undertaking assessment of a woman's risk status in relation to a condition that can be fatal? Surely this is even more justifiable than the less formal assessments that occur in everyday practice?



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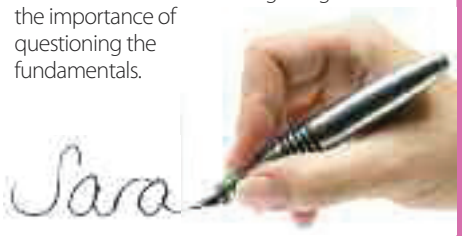
Evaluating risk assessment

When the first volumes of *Effective care in pregnancy and childbirth* were published, one of the chapters was entitled 'Formal risk scoring during pregnancy' (Alexander & Kierse 1989) and the authors described this area of care as a mixed blessing which carried significant implications and warranted further research. Perhaps some readers will disagree, but I feel that the focus has moved away from exploring and evaluating the concept of risk assessment in itself and towards adding more and more means of undertaking this. My reflection has made me think more about the nature of this concept, the kinds of risk assessment that I undertake as a midwife and how important it might be to look more closely at the way in which we think — and act and talk to women — about this in practice. While I remain concerned that we should be doing everything we can to prevent serious conditions like VTE from affecting as many women as possible, we surely also need to continue unpacking and researching concepts such as risk assessment in order to ensure that we are not forgetting the importance of questioning the fundamentals.



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