Title page information

Title

The fear factor of risk – clinical governance and midwifery talk and practice in the UK.

Author names and affiliations

Mandie Scamell RM, PhD, MA, MRes, BA

School of Health Sciences, Northampton Square, City University London, EC1V 0HB

Corresponding author

Mandie Scamell, School of Health Sciences, Northampton Square, City University London, EC1V 0HB

Mandie.scamell.1@city.ac.uk

Present/permanent address

Research sponsored by: Centre for Health Service Research, School of Policy, Sociology and Social Research, Faculty of Social Sciences, Cornwallis North East, University of Kent, Canterbury, Kent CT2 7NF

Research funded by: Economic and Social Research Council

Abstract

Objective: Through the critical application of social theory, this paper will scrutinise how the operations of risk management help to constitute midwives' understandings of childbirth in a particular way.

Design and setting: Drawing from rich ethnographic data, collected in the southeast of England, the paper presents empirical evidence to critically explore how institutional concerns around risk and risk management impact upon the way midwives can legitimately imagine and manage labour and childbirth. Observational field notes, transcribed interviews with various midwives, along with material culture in the form of documentary evidence will be used to explore the unintended consequences of clinical governance and its risk management technologies.

Key conclusions: Through this analysis the fear factor of risk in midwifery talk and practice will be introduced to provide an insight into how risk management impacts midwifery practice in the UK.

Introduction

Contemporary midwifery practice in the UK, as is the case in several other high-income countries, converges upon an interface between two arguably divergent care objectives. On the one hand, midwives strive to inspire a sense of confidence and well-being in the women they care for to support them to give birth spontaneously, through a sensitive and individualised approach to maternity care provision. On the other, by contrast, midwives view their practice through a lens of risk where an urgency to pay attention to the potential risks involved in childbirth prevails. As Coxen, et al. (2014) point out: 'It is not clear whether or to what extent individual practitioners can work in both models simultaneously, "managing" risk whilst promoting "normality".'(p257) Being a good midwife in this setting involves balancing the demands of organisational risk management and governance structures with other professional priorities of normality and woman-centered care. While these two objectives need not be in conflict, the empirical evidence presented in this paper shows how tensions can arise and how, when they do, there are inevitably emotional and professional costs.

Using primary data, taken from an ethnographic discourse analysis of midwifery talk and practice in the south-east of England, the paper will interrogate the consequences of this shift, portraying an empirically-based picture of the precarious world midwives practise in when simultaneously, *managing risk* whilst *promoting normality*. The paper's findings/analysis section will fall into two discrete parts: the first will present ethnographic, discourse analysis of both public and organisational texts (Atkinson and Coffey, 2004; Gwyn, 2002) along field note entries to describe how the technologies of organisational risk have been translated into action in the National Health Service (NHS) Trust in which

this research was based during the period of investigation; the second will offer some lived experiences of how this translation operates in midwives day-to-day working lives. Preceding the findings/analysis section of the paper will be a brief introduction to the background and methods adopted in the study. Finally, the paper will close with a summary and discussion section.

Background to the study

In the UK the vast majority of intra partum care is provided by midwives working within the, free at the point of delivery, health service that is provided by the state – the NHS. The care these midwives provide can take place within different settings, however the service is not uniform across the country. Depending upon the individual NHS Trust midwifery care can be offered in high risk obstetric units located within the acute hospital setting, low risk midwifery run units also located within the acute hospital setting, low risk midwifery units based within the community setting as well as in the woman's home. The NHS Trust described in this paper was selected because it offered intra partum care in all four settings. Alongside the NHS maternity provision there was, at the time of data collection, a small, independent sector within the maternity services where independent midwives provided intra partum care for a fee.

The purpose of the Economic and Social Research Council-funded study from which this paper draws was to investigate how midwives, working in a variety of intra-partum care settings, select from the possible ways of knowing about and managing risk, and how these selections translate into meaningful midwifery action. This research came out of an ever-increasing concern with risk within the health service generally, but within the maternity services particularly at a

time when obstetrics accounted for the majority of the NHS litigation burden (National Health Service Litigation Authority 2009). Given this context, surprisingly little had been carried out to investigate how midwives – the professional group responsible for the management of the majority of births in the UK – orientate themselves to this concept of risk. It was the extent of the potential influence midwives have upon how birth is performed which made the lack of research on the interpretative work midwives do when making sense of risk particularly remarkable.

The study was informed by the academic debate around the operations of risk in late modern society. From this perspective, risk perception is not simply an impartial probability of harm; rather, it is a socially embedded process, where some harms are amplified while others can be ignored (Douglas, 1992).

According to the sociocultural, theory of risk understandings of risk should never be considered to be neutral; rather, they can be understood in terms of the social and cultural context in which they are embedded. The work of Lupton and Tullock (2002), for example, shows how the interests of the community can unsettle what otherwise might be taken-for-granted links between risk and harm. From this perspective, the way risk is perceived is not fixed, nor is it inevitable: individuals actively choose from an array of uncertainties about the future, deciding which ought be avoided, as well as which ones can legitimately be embraced (Douglas, 1992).

While it is undisputed that there are real and potentially devastating physiological hazards associated with birth, it is the contention of this paper to posit that *which* hazards are problematised, which are chosen to be the target of

risk technologies and services, is always socially mediated. The possibility of hazards during pregnancy and birth are unusual, even exceptional, but they are very real. The way in which these potential hazards are translated into meaningful action in the present, however, is, I suggest, helpfully understood as being socially constructed. Unlike some authors in the maternity care literature, such as MacKenzie Bryers and van Teijlingen (MacKenzie, Bryers and van Teijlingen 2010), who assume that the potential physiological hazards - first-order risks - can exist over and above the socially prescribed context from which they emerge, the study from which this paper draws took what can be described as a soft constructionist stance. This means that both kinds of risk, first-order and man-made – those risks arising out of the risk management structures themselves - are understood as only becoming fixed into meaningful action through discursive activities. Neither category of risk (first-order or man-made), therefore, is conceptualised as being free from the reaches of social and political negotiation and ramification.

From this theoretical standpoint, understandings of risk depend upon the social and cultural context in which these understandings are embedded. Given the privileging of the concept of *normality* in midwifery professional text books and academic journals in the UK – defined by Maternity Care Working Party (2007) Consensus Statement as birth "without induction, without the use of instruments, not by caesarean section and without general, spinal or epidural anaesthetic before or during delivery" (p1) – it would seem reasonable to expect that midwives might have an understanding of birth that coalesces around respect for individual women's physical competency, as opposed to a faulty birthing

body fraught with risk. As the findings section of this paper will demonstrate, understanding birth as a normal, spontaneous and essentially safe physiological process is not easy within the context of contemporary maternity care provision where sensitivity to the risks of birth are amplified.

Methods

The research project from which this paper draws followed an ethnographic discourse analysis design (Gwyn, 2002), providing rich data from a fluid and synthesised range of ethnographic data collection techniques. The multidimensional data – collection and analysis of clinical governance texts in both the public domain and those produced for the particular NHS Trust such as policy documents, protocols, meeting minutes and staff memos (Atkinson and Coffey, 2004; Gwyn, 2002), field notes (Armstrong, 1993; Atkinson, 1990; Coffey 1999) from participant observations (Spradley, 1980), ethnographic interview (Spradley, 1979) transcripts – were collected simultaneously.

The project was conceived upon a working hypothesis that the meaning of risk in midwifery talk and practice should not be taken as given, but instead it requires both investigation and explanation. The project aimed to elicit knowledge that functions at the tacit level, which exists as taken-for-granted common sense. The research design, therefore, had to be sensitive enough to look at the way midwives construct common-sense understanding of risk and how this manifests in their everyday clinical practice and talk. In order to facilitate the intimate observations of the meaning making of risk both through text, as a social interaction, and through midwifery talk and practice the principal data collection technique adopted in this research involved situating the researcher in various

intra-partum care settings (a high-risk obstetric unit, an alongside midwifery-led unit, a freestanding midwifery-led unit and various homes) alongside participating midwives – both NHS and independent. This approach was supplemented with further shadowing of several of the Trust's midwifery management team members, for example during organisational meetings, etc. and multiple ethnographic interviews with all consenting participants. Triangulated approach that included direct observation of midwifery talk and practice in the different clinical settings revealed intricacies at work in the local socio-cultural dynamic, which those involved might not notice and might not think worth mentioning in an interview-type environment.

Analysis was integrated into the ethnographic data collection process (Gwyn, 2002) – the initial analysis of the clinical governance texts as a form of material culture (Bloch, 1990; Gwyn, 2002; Hodder, 2000), interview transcripts and observational field notes were produced while the researcher was in the field (Fetterman, 1998). Such embedding of analysis into data collection provided the opportunity to use emerging themes, such as *the fear factor of risk*, to direct purposeful sampling, interview schedule design and text collection (Denzin, 2002). This integrated approach provided rigour opportunities, whereby emerging analytical themes could be checked for the consistency and validity of interpretation with the participants during their involvement in the research. The embedding the data analysis within the data collection process (Gwynn, 2002) provides the opportunity to develop confidence in the authenticity of emerging analytical explanations. It should be stressed that this validity testing was not conducted with the aim of gaining participant consensus on the findings.

For example, some of the most poignant data emerged out of the tensions that were identified between what participants did, to what they said they did in the interviews. By using an ethnographic research design, with its heavy emphasis on symbiotic analysis and observation in the field, it was possible to scrutinize the every day interpretative work midwives did when making sense of risk. The qualitative computer analysis programme of Atlas.ti was applied to the entire dataset in order to achieve an ongoing comparative method to check the relationship between concepts and to build common themes across the various data sources (Fielding and Lee, 1991), while more detailed social semiotic analysis using both Critical Discourse Analysis (Fairclough, 2003) and Conversational Analysis (Silverman, 1988) was carried out on selected ethnographic texts in order to scrutinise in more detail the emerging themes.

The Principal Investigator involved in this research took the position of what has been called an indigenous ethnographer (Cravez, 2008), that is to say a registered midwife carried out the bulk of the data collection and analysis involved in the project. Without question, capitalising on this insider identity provided certain methodological advantages in terms of access and acceptability, none of which should be underestimated (Bonner & Tolhurst ,2002). Being a midwife meant that it was relatively easy to develop trust and rapport with both the service users and providers. However, such practical advantages should never be accepted nebulously, such insider status is best thought of as being both a methodological advantage as well as a potential liability. Reflexivity on the impact of identity on the data collection, analysis and dissemination has been an essential part of the research process. Furthermore, the active involvement of

'lay' researchers on the project team offered invaluable professional impartiality ensuring that the insider positionality of the PI did not go unchecked and that over-identification or over-reliance on insider empathy did not obscure the goal of research.

Written consent and sequential verbal consent, more consistent with an ethnographic method (Parker, 2007), was gained from all those involved in the study (33 midwives, 3 independent and 30 NHS; 1 student midwife; 5 obstetricians; 19 service users). The NHS Research Governance Framework was followed and both the National Research Ethics Service and local Trust's Research and Development department granted ethical approval. Due to the sensitivity of the project, the research protocol was reviewed and approved prior to the commencement of data collection by the Head of Risk, Assurance and Legal Services and by the Head of Midwifery. Service user approval of the protocol was also sought and obtained from the local Maternity Liaison Committee prior to data collection. The researcher (a practising midwife) had a NHS licence to practise for the duration of the data collection. All data used in this article have been cleaned to remove identifying features, and all names have been changed.

Results/analysis

Although not necessarily well articulated in midwifery talk, there is an important demarcation in risk management that will determine the structure of this paper. This demarcation rests upon the object of focus within risk. *First-order* risk

management is about seeking out the physical risks inherent in pregnancy and childbirth. It is about anticipating potential harms in the reproduction process, the dangers that women's bodies pose to their infants and vice versa. These priorities have been at the heart of midwifery practice for the past one hundred years or so, with its applications of evolving technology and expertise to alleviate the hazards associated with childbirth and pregnancy. The inherent risks of pregnancy and birth, those risks that can be captured through morbidity and mortality statistics, are the risks around which maternity services and midwifery activity coalesce. A more recent addition to the risk technologies associated with childbirth has involved a shift in focus away from the woman's body. The object of focus for much of contemporary organisational risk technology is the very activities that are carried out by midwives in an effort to mitigate perceived physiological (first-order) risk in childbirth. Thus ,organisational risk regulation is concerned with another level of safety, where the reputation of and trust in the professionals themselves within the organisation, be it the NHS or the wider professional organisation and associate regulatory bodies, are at stake (Brown, 2008). As Scheytt, et al. (2006) argue:

> 'the relation between organizations and risk management moves beyond "first order" concerns with... health and safety... and becomes increasingly concerned with the by-products of the world of organizing itself.' (p.133).

The aim of this paper is to critically engage with the shift in the object focus of risk management in order to explore how this shift has impacted upon the way midwives can support women during labour in the UK. To provide ethnographic

authenticity to the findings section of the paper, ethnographic data will be presented in conjunction with analysis.

The organizational risk technologies

Starting with a description of the organisation's risk technologies –the potential man-made risks introduced through risk management in the maternity care provision – this section will go on to look at the unintended consequences these technologies had on the midwives involved in this study.

The organisation's risk technologies investigated in the study have their roots in clinical governance, which is described in *The New NHS: Modern and Dependable* policy document as being:

> 'A new initiative… to assure and improve clinical standards at the local level throughout the NHS. This includes action to ensure that risks are avoided, adverse events are rapidly detected, openly investigated and lessons learned, good practice is rapidly disseminated and systems are in place to ensure continuous improvements in clinical care'(Department of Health, 1997 p 88).

This policy marks the beginning of a chain of documents which arise out of: firstly, concerns that public confidence in health care providers was waning; and, secondly, an understanding that measures should be taken to ensure that performance and conduct within the NHS could be subject to careful scrutiny (Flynn, 2002). A swathe of new organisations and mechanisms was set up with the explicit goal of the standardisation and audit of health care provision, and, with the implementation of these organisational technologies, maternity services have become firmly entrenched in the clinical governance culture. In the UK context these have included the National Audit Office (NAO), National Service Framework (NSF) policy guidelines, Health Quality Commission (HCC) now the

Care Quality Commission (CQC), the Litigation Authority with its Clinical Negligence Scheme for Trusts (CNST)[1], the National Patient Safety Agency, and best practice standards of the National Institute of Clinical Excellence (NICE) to name a few.

In the NHS Trust where the research was conducted, this policy driver has been translated into a complex risk management strategy that, according to their 2009 declaration of intent document, aims to achieve four key objectives:

1. Achieving the standards or requirements set by external bodies as appropriate. These external regulations include:
    - Health Care Commission's (now CQC) Standards for Better Health
    - NHS Litigation Authority risk management general standards
    - National Patient Safety Agency directives
    - Health and Safety Executive risk management requirements and Health and Safety Policy statement.
2. Developing the Trust's links with these organisations.
3. Enhancing the Trust's internal risk management processes, which include: directorate integrated groups; quarterly executive performance reviews of directorates; a Trust risk management and governance group; a patient safety board; an online incident reporting system; rolling out the concept of failure mode effects analysis as a risk management tool; strengthening links between incidents, claims and complaints; provision of training; meeting annual staff appraisal targets; ensuring that health and safety committees meet regularly; and strengthening the use of risk information in the annual business cycle.
4. Ensuring that appropriate assurance is provided as to the efficacy of the risk management processes.

[1] This scheme was active in UK maternity services at the time of data collection

As these declarations suggest, clinical governance works in a very particular way. Much of the four objectives described above can be understood to be a response by the Trust, to realise the Government's demand for the NHS to become an 'organisation with a memory', where there is learning from clinical errors, whether they result in poor outcomes or near misses (Department of Health, 2000). Importantly, this learning is translated into robust accountability structures aimed at the standardisation of care through risk averse institutional procedures and protocols. This means that activities in the present and plans for the future are shaped by discrete, usually untoward, events that have happened in the past. With the benefit of hindsight – a hindsight which focuses on events in the past where things have gone wrong – mechanisms are put into place to ensure that such events will not repeated. Organisational risk technology is a device whereby attempts can be made to *colonise the future* (Giddens, 1991), where activity in the present is temporally sandwiched between, on the one hand, a preoccupation with adverse events from the past (regardless of how unusual these events are or whether they resulted in a harmful outcome) and, on the other hand, an anxiety to ensure that the possibility of an adverse incident occurring, or even worse, reoccurring, in the future be removed through structural planning. In this way, an aversion to risk becomes the lens through which future service provision can be imagined within the organisation (Heyman, et al., 2010) with its incident reporting systems, clinical audit trails, multidisciplinary training programmes and accountability structures.

The midwifery care described in this paper was suspended within the hindsight of risk management technologies a suspension where clinical practice in the

present becomes sandwiched between discrete, unforeseen (and frequently exceptional) adverse events from the past and risk management strategies that have been set up with the sole purpose to ensure that these unforeseen adverse events are avoided in the future. What is remarkable about the logic of this sandwich is that the likelihood of the adverse event reoccurring – the probability calculation – becomes relatively unimportant (Heyman, et al., 2010; Furedi, 2009).

The lived experience of risk technology

One of the most concerning problems with clinical governance in maternity care provision is the potential for unintended consequences that undermine midwives' commitment to normal and spontaneous birth. This is of concern because this commitment is born out of an effort to humanize birth (Misgaro et al, 2001) and to contain the iatrogenic harms associated with the routine medicalization of childbirth practices. In its attempt to reassure and guarantee a degree of certainty, ironically, clinical governance, risk technologies introduce further uncertainties, simply because the goal of *colonising the future* in this manner can never be fully realised, no matter how robust the governance mechanism is (Alaszewski, 2007). According to the data collected in the research project, this has two implications: the first is the tendency towards culpability where an individual midwife feels singled out and blamed; the second is the intensification of risk aversion or, put another way, the intensification of the scare factor of risk.

In the following part of the findings section of this paper, further ethnographic data will be presented to illustrate these two unintended, and little discussed,

consequences of organisational risk technologies. As part of the participant observation arm of the ethnography, it was possible to join the specially appointed full-time, risk midwives and experience part of the rigorous systems that have been put in place in order to 'learn from mistakes' (Department of Health, 2000). Through this observation, it was possible to witness the intensity of multi-disciplinary activity that went on 'behind the scenes' in the organisation's efforts to *colonise the future*. The observation data suggest that much clinical governance activity within the maternity services coalesced around what has been called a forensic approach to risk (Douglas, 1990). This is where out of the ordinary, recorded, untoward events, or near misses, are reviewed by multidisciplinary professional panels, made up of a midwife, an obstetric consultant and a clinical manager for risk, in order to assess the severity and culpability of that event. In other words, the aim of these meetings was to identify system or individual practitioner failures.

Incident investigation followed the risk meetings if discrete, untoward events were calculated to be serious enough. These investigations involved scrutinising the care given by those midwives directly involved in the event, and it is this aspect of the process that helps to illustrate the unforeseen implications of risk management strategy adopted. Although untoward events themselves and having to deal with those events were seen to be scary by most of the midwives involved in the study, this scare factor did not necessarily end at the point the event concluded. In fact, the scare factor could be protracted through the instigation of an internal investigation for several months after the event.

The culprit

To give an indication of how risk technologies of clinical governance impact upon midwifery talk and practice, I want to introduce Helen, a midwife I spent time working with at a free standing birth centre. When Helen initially participated in the study, she was a confident, bubbly person to observe. However, when I called her at her home to arrange further shadow shifts, after a break of a few months where I had been working at another unit, she seemed very hesitant. During this conversation, Helen explained that she wanted to work with me but that she had been having a hard time lately, and apologised for sounding so low. I explained to her that she did not have to agree to another shadow shift and that she could withdraw her consent to participate at any time, emphasising that I was not there to judge her practice in any way. When we did eventually work together again, there was a noticeable difference in her demeanour, as the following field note entry describes.

> 'Helen kept reiterating that she was nervous, explaining that, where she had felt clinically confident in the past, recent events had made her feel 'so s**t' that she was unable to make the simplest of decisions sometimes.
> The way she overcame her confidence crisis was to picture herself discussing the case with the consultant midwife: P.
> "I know this must be okay," she told me, "because this is what P would say. She would say she is not in labour, so I know it's okay to treat her like this,"
>
> By imagining what a senior midwife would advise her to do in a given situation, Helen could overcome the stresses that had been caused by the recent investigation into her practice and go about the business of being an autonomous practitioner...
>
> Helen and I left the room (where a mother was labouring) so that Helen could discuss her care plan with another midwife who had just arrived at the unit. She went through what had happened that morning, reiterating what she had told me earlier about what she thought P would say about the case. Through this actual, rather than imagined,

> conversation, Helen appeared to gain the confirmation she seemed to be seeking. During the conversation, Helen revealed more details about the incident that seemed to be haunting her practice so much. Helen explained that she was not traumatised by the event itself, stressing, with tears in her eyes, that:
>
> "I know I didn't do anything wrong. I know I am a good midwife."
>
> She told me very few details about the clinical scenario itself, which gave me the distinct impression that this was not the thing that was upsetting her.
>
> "I know we are told it is not a blame culture but this thing has been all about blame... It makes you feel like a bl**dy criminal! This job can be so s**t sometimes."
>
> This was followed by the declaration that, if she could leave the job, she definitely would. (Field- notes HJ 30).

The clinical incident under investigation, that was having such a devastating impact upon this midwife (and by implication the women she was caring for), had taken place *five months* before this observation took place. Although the midwife was confident in her own performance during this incident, the investigation itself seemed to have an ominous effect, casting a shadow over both her ability to practise and her self-identity as a competent midwife to support normal birth. As Heyman (1998) suggests:

> 'Once socially established, risks take on a life of their own, despite their indirect relationship to underlying causal processes, leaving behind their tenuous, debateable origins.'
>
> (p. 11).

Despite being conscious of the fact that the investigation procedure is not officially about allocating blame, Helen appeared to be acutely aware of the way the process operated to both amplify risk and identify failing. She was aware that

her reluctance to recognise personal responsibility was at odds with the assumptions entrenched in the risk management system. Once the uncertainties of birth are engulfed within organisational risk technologies, with its attempts to *colonise the future*, someone inevitably has to be held accountable if anything goes wrong (Alaszewski and Harvey, 2002; Downe and Dykes, 2009). Conceptualising untoward events in terms of culpability transforms these events into something that can be predicted and avoided. Through this translation, the possibility of bad luck, an unavoidable chance event for which no individual or system is directly responsible, becomes remote (Adams, 2003; Furedi, 2009). In other words, when bad luck from the past is used to predict the future, then the possibility for prospective bad luck vanishes and in its place is the notion of a culprit who, as soon as they have been identified, must be held accountable for negligence. This is important because, as Douglas (1992) noted, once a retrospective approach takes for granted that risks in the future are ascertainable:

> 'Anyone who insists that there is a high degree of uncertainty is taken to be opting out of accountability.' (p. 30).

Helen wanted to defend her position. She wanted to profess her innocence and, furthermore, she was clear that the uncertainties of birth are not always preventable. However, Helen also knew, at a deeply tacit level, that such an interpretation of childbirth as something that is both normal, and on some rare occasions unpredictable, was insupportable within the context of the organisation's clinical governance, risk technologies. Through the application of risk technologies, the uncertainties inherent in spontaneous birth (no matter

how infrequent they might be) are translated into risks. This is important because uncertainty denotes a future that cannot be predicted; an unknown. By contrast, thinking in terms of risk involves the active mitigation of unknowns; an attempt to minimise the unpredictability of the future in an effort to improve outcome. Within this context, childbirth cannot be trusted to occur spontaneously. Instead, childbirth is something that must be standardised and carefully managed through models built via the organisation's memory of past, adverse events.

The scare factor of risk

Although the internal investigation system into adverse events acts as a good illustration of unintended consequences in organisational risk technologies, it should be stressed that the impact of the logic of the technologies was not limited to those midwives directly involved in internal investigations. The connection between fear and risk seemed to be deeply embedded into the imaginations of the midwives involved in this study; even those who had no personal experience of the institutional mechanisms of accountability recurrently expressed it. A further extract of field notes taken from an observation episode that took place in a staff coffee room on a busy obstetric labour ward helps provide a sense of the ubiquitous nature of the fear associated with risk:

> 'A group of midwives began to ask me why I was here and what my research was about. When I gave them a brief description of the study, one midwife laughed and, rolling her eyes, candidly exclaimed: "Risk? Oh, that's easy. We just s**t ourselves."

> No one in the room thought that this description of risk justified any further clarification or demanded any explanation. There was neither protest of objection nor any indication of surprise; only mild amusement.' (Field notes).

One of the most persuasive elements of this observation was the reaction from the other midwives in the room at the time. The apparent homogenous acquiescence to the scariness of risk suggests that risk could only ever be understood as harm. As Naomi explained:

> "Risk is a potential hazard. Well potential, a risk is a potential hazard that could occur if you don't put into place mechanisms to eradicate or reduce it."

Similarly, Dianna described risk as:

> "Risk is… anything that makes the woman, if you are talking about labour and birth, it is anything that makes the woman or the baby unsafe."

In this second quote the precise nature of the harm is identified. A risk is a harm that operates to compromise the safety of the mother and/or baby. This linking of risk with harm was part of the taken-for-granted knowledge of midwifery by all the midwives asked to define risk, talked about it in this way. The consistency of opinion on how risk should be understood in midwifery practice cannot be underestimated and was expressed, regardless of whether the midwife was accustomed to working in a high-risk obstetric or midwifery led unit[2]. Further examples below offer an illustration of the uniformity of response when asked about risk. These examples, however, are by no means exhaustive, and the list could go on:

[2] One notable exception came from the data produced by my work with an independent midwife.

Andrea (senior midwife) 'Erm, I suppose it is something like to do with the likelihood of an adverse event. Something, oh, that is what I would think, the chance of something going wrong really that there is a risk of something might go wrong...So that is how we have to approach childbirth really."

Natalie (senior midwife) "risk is moving outside the realms of safe parameters I suppose. Erm, yer taking a risk is stepping into something that might cause harm or cause a problem depending on what you say."

Heather (midwife) "Risk must be, mmm, the chance of something going wrong I suppose."

Sharon (midwife) "Risk? Mmm. Well, it is not good is it? It is something that has gone wrong. I don't know. Something that is dangerous I suppose."

According to these data, an expectation to find midwives having a unique understanding of risk, an understanding that facilitates a professional privileging of birth as a normal physiological process, seems ill-founded and unjustified. Once defined as something dangerous and something that is always unsafe – something that is scary – then reactions to risk were inevitably avoidance focused. Unlike Lupton and Tullock's (2002) work, where they found that the active meaning making of some groups operated to unsettle the fear associated with risk and risk-taking, the midwives involved in this study saw childbirth as essentially risky and, moreover, they were scared by this risk. Within this ontological framework, the inevitable uncertainties in birth could not be tolerated, and good midwifery practice involved anticipating these uncertainties, avoiding them and, if possible, eliminating them completely.

Such negative loading of risk has been described in the literature as being peculiarly modern. Moreover, as Douglas (1992) argues, this approach to risk inevitably engenders a moral dimension where those who fail to demonstrate

suitable risk adverse behaviours are considered to be social outcasts. Given that the participants in this study talked about risk in this negative and heavily laden way, it is not surprising that midwifery responsibility in relation to risk involved putting into place robust and standardised mechanisms through which risks can be controlled. As Mary explains:

> "The midwife's role in relation to risk is highlighting potential risks to women or actually to colleagues. And probably minimising the risks."

When things do go wrong, therefore, when the uncertainties of childbirth are translated into negative outcomes, the logic of risk management is to assume that someone or something was responsible for allowing the event to happen. As Mary points out, risks belong to the future. Through an anticipation of a future inhabited by imagined risks, which have not (and indeed might never) yet occurred, demands are placed upon midwifery activity in the here and now. Conversely, the risk itself is something that does not overtly occupy the present, existing only as an imagined possibility. Instead, risk is a 'bad' that might happen at another time. Despite this elusive nature of risk in the present, concrete midwifery activity must take place in order to anticipate those harms that might, at some point, threaten the safety of the mother and/or baby. In other words, as Heyman (1998) observes:

> 'The current version of risk thinking requires anticipatory measures to have been systematically put in place across the entire society in order to anticipate the potentially unlimited class of what might happen.' (p. 214).

Discussion

According to the sociocultural theory of risk, understandings of risk depend upon the social and cultural context in which they are embedded (Douglas, 1992). Understandings of risk within the context of midwifery talk and practice in UK, therefore, might be expected to be balanced, even curtailed, by a professional privileging of a commitment to women's ability to give birth spontaneously, an 'emphasis is on the natural ability of women to experience birth with minimum intervention' (Sandall, et al., 2013). The data presented in this paper, however, indicates not only that this is not the case but also that it provides empirical evidence to demonstrate the process operating in the reverse direction. Rather than midwives' interest in the promotion of normality functioning to contain their aversion to risk, it appears to be their aversion to risk, through the application of organisational risk technologies, which unsettle midwives' ability to promote normality. The data presented here suggests that midwives manage to work within two dissentient models of care, 'managing' risk while promoting 'normality' because those models have a disproportionate coexistence. That is to say, one model overwhelms the other: the midwifery rhetoric of normal birth is devitalised by the hegemonic, prioritisation of risk management and risk aversion. Although the midwives involved in this study espoused to a commitment to women's ability to give birth spontaneously, this commitment was all too easily unsettled by the operations of the organisation's risk technologies. Importantly, the reverse cannot be said to be true: midwives' personal commitment to birth as a normal, spontaneous and essentially safe physiological process lacked the necessary vitality to curtail the social amplification of risk.

Conclusion

Building on the analytical framework of risk found in the broader risk literature, this paper presented empirical evidence on the interpretative work midwives do in their everyday talk and practice. Through the presentation of ethnographic data and analysis, it has been possible to show the work midwives do in the social construction of risk in the maternity care context. In particular, it was possible to explore the operations of risk technologies in relation to two mechanisms: the identification of the culprit, and the scare factor of risk. Through this ethnographic analysis, it is possible to observe how, through midwifery talk and practice, the uncertainties of childbirth are amplified and translated into risk. This ontological step confines the way midwifery practice and childbirth can legitimately be imagined. Importantly, by attending to the scary and ubiquitous nature of risk, midwives are in danger of obscuring opportunities where childbirth can be understand as an essentially safe and normal physiological process.

Acknowledgements

I would like to thank the Economic and Social Research Council for their financial support that made this study possible and the Centre for Health Service Research at University of Kent – particularly Prof Andy Alaszewski – for sponsoring my work and supporting me throughout.

References

Adams, John 2003. In Defence of Bad Luck. a Society which can'T Accept that Accidents Happen is Destined to be Governed by a Stifling Culture of Blame. Spiked-Essays Www.Spiked-Online.Com.

Alaszewski, Andy 2007. "Risk, Uncertainty and Knowledge." Health, Risk & Society 9 (1), 1-10.

Alaszewski, Andy and Harvey I., 2002. "Health Technology and Knowledge." In Health and Disease: A Reader, edited by Davey, B. and Grey, A. and Seale,C.,. 3rd ed., 302-307. Buckingham: Open University Press.

Armstrong, Gary 1993. "'Like that Desmond Morris?'." In Interpreting the Field. Accounts in Ethnography, edited by Dick Hobbs and Tim May, 3-44. Oxford: Claredon Press.

Atkinson, Paul 1990. The Ethnographic Imagination: Textual Constructions of Reality. London: Routledge.

Atkinson, Paul and Coffey, A., 2004 Analysing documentary realities. David Silverman (eds) Qualitative research. 2nd ed London: Sage, 56-75.

Bloch, Maurice 1999. Language, Anthropology and Cognitive Science. Man 26, 183-198

Bonner, Ann, & Tolhurst, G., 2002. Insider-outsider perspectives of participant observation. *Nurse researcher*, *9*(4), 7-19.

Brown, Patrick 2008. "Trusting in the New NHS: Instrumental Versus Communicative Action." Sociology of Health & Illness 30 (3), 349-363.

Coxen, Kirstie, Bisits, A, and Sandall, J., 2015 Call for special issue of midwifery on risk in childbirth. Midwifery 31(2), 257-8

Coffey, Amanda 1999. The Ethnographic Self: Fieldwork and the Representation of Identity. London: Sage Publications Inc.

Chavez, Christina 2008. Conceptualizing from the inside: Advantages, complications, and demands on insider positionality. *The Qualitative Report*, *13*(3), 474-494.

Denzin, Norman 2002. "Confronting Ethnography's Crisis of Representation." Journal of Contemporary Ethnography 31 (4), 482-490.

Department of Health. 1997. The New NHS Modern and Dependable. London: HMSO.

2000. An Organsiation with a Memory. Report of an Expert Group on Learning from Adverse Events in the NHS. London: Stationary Office.

Douglas, Mary ed. 1992. Risk and Blame: Essays in Cultural Theory. London: Routledge.

1990. "Risk as a Forensic Resource." Daedalus, Journal of the American Academy ofArts and Sciences 119 (4), 1-16.

Downe, Soo and Dykes, F., 2009. "Counting Time in Pregnancy and Labour." In Childbirth, Midwifery and Concepts of Time, edited by Christine McCourt, 61-83. United States: Berghahn Books.

Fairclough, Norman 2003. Analysing Discourse: Textual Analysis for Social Research. London: Routledge.

Fetterman, David 1998. Ethnography: Step by Step. California: Sage Publications Inc.

Fielding, Nigel and Raymond, L., 1991. Using Computers in Qualitative Research. London: Sage.

Flynn, Rob 2002. "Clinical Governance and Governmentality." Health, Risk & Society 4 (2), 155-173.

Furedi, Frank. 2009. "Precautionary Culture and the Rise of Possibilistic Risk Assessment." Erasmus Law Review 2 (2).

Giddens, Anthony 1991. Modernity and Self-Identity : Self and Society in the Late Modern Age. Cambridge: Polity.

Gwyn, Richard 2002. Communicating Health and Illness. London: Sage Pubns.

Heyman, Bob 1998 Risk, Health and Health Care: A qualitative approach. London: Arnold.

Heyman, Bob, Shaw, M., Alaszewski, A., and Titterton, M., eds. 2010. Risk, Safety, and Clinical Practice Health Care through the Lens of Risk. 1st ed. Oxford: Oxford University Press.

Hodder, Ian 2000. Interpretation of documents as material culture. John Goodwin (eds) Biographical Research. London: Sage Publications.

Lupton, Deborah and Tulloch, J., 2002. "'Life would be Pretty Dull without Risk': Voluntary Risk-Taking and its Pleasures." Health, Risk & Society 4 (2), 113-124.

MacKenzie Bryers, Helen and van Teijlingen, E., 2010. "Risk, Theory, Social and Medical Models: A Critical Analysis of the Concept of Risk in Maternity Care." Midwifery 25 (5), 488-496.

Maternity Care Working Party. 2007. Making Normal Birth a Reality.Consensus Statement from the Maternity Care Working Party our Shared Views about the Need to Recognise, Facilitate and Audit Normal Birth. London: NCT/RCM/RCOG.

Misago, C., Kendall, C., Freitas, P., Haneda, K., Silveira, D., Onuki, D., Mori, T., Sadamori T. and Umenai, T. 2001 From culture of dehumanization of childbirth to childbirth as a transformative experience: changes in five municipalities in

north-east Brazil. International Journal of Gynecology and Obstetrics, 75, Supplement 1, 67–72.

National Health Service Litigation Authority (NHSLA). 2009 Fact Sheet 3. Information on claims. London. NHSLA.

Parker, Michael. 2007. "Ethnography/Ethics." Social Science & Medicine (1982) 65 (11), 2248-2259.

Sandall, Jane, Gates, S., Shennan, A., Devane, D. 2013 Midwife led continuity models verses other models of care for childbearing women. Cochrane Database of Systematic Reviews, Issue 8.

Scheytt, Tobias, Soin, K., Sahlin-Andersson, K., and Power, M., 2006. "Introduction: Organizations, Risk and Regulation." Journal of Management Studies 43 (6), 1331-1337.

Silverman, David. 1988. Communication and Medical Practice: Social Relations in the Clinic. London: Sage Publications.

Spradley, James. 1979. The Ethnographic Interview. New York: Holt, Rinehart and Winston.

1980. Participant Observation. New York: Holt, Rinehart and Winston.