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Risk and boundary work in contemporary maternity care: tensions and consequences

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While the organisation of work in maternity care has historically witnessed boundary work between midwives and obstetricians, modern service provision has posed many challenges to professional boundary work, with increasing litigation and risk management practices fuelling the social construction of a ‘risk discourse’ within maternity care. Drawing upon observational and interview data of an ethnographic study conducted in a UK obstetric-led maternity unit during 2013, this article explores the professional experiences of contemporary ‘risk work’ and the impact of such ‘risk work’ upon the professional role boundaries of obstetricians and midwives. Midwives and obstetricians expressed concern regarding risk in childbirth. Obstetricians and midwives perceived control over the childbirth process as a means of promoting risk minimisation, so that risk management was central to the perceived rational management of uncertainty in maternity care. Anxiety over uncertainty, error and blame was associated with dominance of the biomedical model of care in translating and managing risk and a perceived increase in the medicalisation of childbirth. Such ‘risk discourse’ had consequently provoked boundary work tension, with the perceived shifting of professional role boundaries of obstetricians and midwives within maternity care. As a consequence of contemporary risk work and reconfiguration of role boundaries, the role of the midwife in the twenty-first century was perceived to be in a state of flux. I note that contemporary risk work and the reconfiguration of professional boundaries in maternity services potentially places the midwifery profession ‘at risk’ of deprofessionalisation, raising concerns for the future role and professional status of midwives.

Keywords: risk; risk work; risk minimisation; role boundaries; boundary disputes

Introduction

There is a recognised dearth of research exploring the nature of contemporary ‘risk work’ in healthcare (Horlick-Jones, 2005). The daily experience of professionals in how working practices are framed by the concept of risk (Gale, Thomas, Thwaites, Greenfield, & Brown, 2016) and the impact of such risk work on professional role boundaries, are particularly neglected areas of study. In this article I address this gap in knowledge by exploring the professional experiences of contemporary risk work in maternity service provision and the impact of such risk work upon the professional role boundaries of obstetricians and midwives. The impact of risk work in maternity services is of particular interest as whilst the organisation of work in maternity care has historically witnessed role boundary work between midwives and obstetricians, modern service provision has posed

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many challenges to professional boundary work. Clinical governance, increasing litigation and risk management practices have fuelled the social construction of a ‘risk discourse’ within maternity care, provoking tensions and consequences with risk and role boundary work. In this article I draw upon existing literature to explore the nature and impact of risk upon maternity care and the role of risk in demarcating professional boundary work between obstetricians and midwives over time. Presenting ethnographic observational and interview data, I then explore the tensions of risk work in contemporary maternity care, discussing the consequences of the discourse of risk upon the professional role boundaries of obstetricians and midwives.

**Risk work in maternity care**

**Risk, health and maternity care**

There is ongoing debate as to whether modern society is a ‘risk society’ (Beck, 1992; Burgess, 2016), being more aware and less tolerant of risk (Harrison & McDonald, 2008) and possibly even risk averse (MacKenzie Bryers & van Teijlingen, 2010). In healthcare in particular, the concept of risk has become synonymous with an event or action potentially causing harm (Burgess, 2016). Aven and Renn (2010) discuss the multi-dimensionality of risk and that whilst there is no agreed definition of risk, risk is interconnected with the concept of uncertainty. Uncertainty is associated with ‘not knowing for sure’ and ‘events for which it is not possible to specify numerical probabilities’ (Pettersen, 2016, p. 40). The concepts of risk and uncertainty in healthcare have subsequently become negatively associated with healthcare when considering the potential of healthcare events, and the actions of healthcare professionals, in causing harm. Alongside this, in response to numerous high profile healthcare scandals and subsequent public inquiries since the 1990s, there has been a shift from professional self-regulation of clinical practice to external scrutiny and regulation through clinical and research governance (Alaszewski & Brown, 2012). The concepts of risk and uncertainty in contemporary healthcare now permeate all aspects of healthcare regulation, instigating a broad range of risk management and regulatory practices in an attempt to manage risk and uncertainty in healthcare (Alemanno, 2016; Hutter, 2008; Professional Standards Authority, 2015a, 2015b, 2016).

Governance within the National Health Service (NHS) aims to manage risk in healthcare practices and thereby reduce the likelihood of harm, by assuring high standards of care and the fitness to practise of healthcare professionals in the current risk conscious society. The concept of risk therefore plays political and moral functions in healthcare and the use of such ‘risk discourse’ in modern society prevents risk being viewed as a neutral term (Coxon, 2014). The risk discourse presented within contemporary healthcare has heightened professional concerns of risk as a concept, provoking tensions, anxiety and accountability issues about healthcare risks and in managing such risks within their everyday work (Beddoe, 2010; Gale et al., 2016). In maternity care, perceptions of risk and risk management have played an integral part in the transition from a social model to a medical model of care over the course of the twentieth century (MacKenzie Bryers & van Teijlingen, 2010), whereby labour and birth have become viewed as conditions to be treated rather than as natural processes in themselves (Davis-Floyd & Sargent, 1997). Consequently, working practices have become framed by the concept of risk and attempts to manage such risk in maternity service provision, with the discourse of risk continuing to play a significant part in the reshaping of current service provision within maternity
services in the twenty-first century (Arulkumaran, 2010). Aligned with the cultural theory of risk (Douglas, 1992), in that understanding of risk depends upon the social and cultural context in which they are embedded, maternity service professionals have ‘socially constructed’ pregnancy and childbirth as potential sources of danger, fraught with risk of adverse outcomes (Healy, Humphreys, & Kennedy, 2016; Scamell & Alaszewski, 2012).

In attempting to manage such perceived risk in childbirth, the escalation of scientific evidence framed within the biomedical model of care and the routinised hospitalisation of childbirth, have radically changed the nature of childbirth (Scamell, 2014; Scamell & Alaszewski, 2012). The discourse of risk permeates the biomedical model of care and managing risk has arguably become central to legitimising intervention during pregnancy and childbirth (Lankshear, Ettorre, & Mason, 2005). In the field of childbirth in particular the development of scientific evidence and its ability to impact upon decision-making and the birthing process, has therefore altered the status of childbirth as well as the professional roles and responsibilities within maternity services (Alaszewski, 2016; Scamell & Alaszewski, 2012).

The discourse of vulnerability of the female body and foetus, and the need for medical supervision and protection, underpins the medicalisation of pregnancy and childbirth (Alaszewski, 2016; Rothman, 2014). Additionally, as maternity service providers, both obstetricians and midwives are viewed as ‘high risk’ professionals due to potential harmful events resulting as a product of human agency, in itself instigating a ‘blame culture’ within the discourse of risk (Douglas, 1990, 1992). Douglas (1992) describes blaming as a ‘way of manning the gates through which all information must pass’ (p. 19). In keeping with such observation, the contemporary childbirth ‘blame culture’ can be interpreted as a reaction to error during pregnancy and childbirth and finding responsible culprits to blame. Hofmann and Stetzer (1998) suggest that as a result of holding individuals accountable and placing blame, past and future errors may be viewed with fear and less open communication, directly influencing professional interpretation of, and reaction to error and blame. Undoubtedly, errors resulting in harm during pregnancy and childbirth can be exceptionally costly and long run, thus an error that results in the birth of a child who has suffered harm can result in the care provider being liable for the lifetime care costs of the child. Due to the significant proportion of NHS litigation claims resting with UK maternity services, services and professionals are increasingly regulated by ‘risk management’ standards in attempting to avoid harm to childbearing women and unborn babies and avoid the associated costs of litigation claims due to harmful outcomes (NHS Litigation Authority, 2014). Such standards, aimed at improving the safety of maternity care and reducing litigation, inevitably associate pregnancy and childbirth with risk, and the control of professional behaviour in managing risk. As such, the concept of managing risk is now central to the ‘rational’ management of uncertainty in maternity care (Coxon, Scamell, & Alaszewski, 2012), and scientific knowledge continues to be integral to managing uncertainty in pregnancy and childbirth (Scamell & Alaszewski, 2012). Uncertainty, error and blame are therefore central to professional interpretation of, and reaction to risk.

The concept of risk in contemporary maternity services is arguably integral to the dominance of the biomedical model of care (MacKenzie Bryers & van Teijlingen, 2010), driven by an increasing ‘blame and claim culture’ consequently fuelling the medicalisation of childbirth (Bogdan-Lovis & Sousa, 2006). Whilst it can be argued that the risk agenda in the twenty-first century continues to play a significant part in the shaping of current maternity service provision, there is a dearth of research exploring the impact of
the contemporary risk discourse on the role of professional groups and their ability to defend their professional role boundaries (MacKenzie Bryers & van Teijlingen, 2010).

**Risk and boundary work in maternity care**

Sociologists have long debated the concept of ‘boundary work’ in how professional groups seek to carve out occupational jurisdiction, based upon knowledge and expertise, and establish a privileged position for themselves achieving ‘social closure’ from the remainder of society (Abbott, 1988; Hughes, 1971/1984; Larson, 1977). Such social closure however is not absolute, and can be a politically contested process (Martin, Currie, & Finn, 2009; Nancarrow & Borthwick, 2005; Witz, 1992). Whilst regulation and legislation can influence where occupational role boundaries may fall, the demarcation of occupation boundaries is not fixed by either the profession or the state, but remain largely socially-constructed (Allen, 2001a, 2001b; Timmons & Tanner, 2004). Arguably, professions themselves are in fact social constructions, based upon epistemological foundations, conveyed to the public through rhetoric and manipulation of knowledge to which it exclusively claims. A profession in itself is therefore not a status, but a discursive claim, which is more or less successful in differing social contexts (Abbott, 1988). Professional role boundaries are therefore subject to dispute (Allen, 2001a, 2001b; Timmons & Tanner, 2004), and as such, relationships between professions are adapted, resisted and transformed according to socially constructed divisions of work (Shirley & Padgett, 2006).

Historically, maternity service provision has witnessed role boundary work between midwives and obstetricians, aligned with the scope of professional practices and articulated in the language of risk. At the point of midwifery professionalization in the UK in 1902, childbirth became divided by the very process of labour informed by a discursive strategy of power and the female gendered construct of nursing (Rothman, 2014). Articulated in the language of ‘risk’, female midwives, within the concept of ‘routinised nursing care’, were granted licence to attend the ‘low risk’, uncomplicated process of ‘normal labour’. ‘Medical men’ were therefore granted licence to attend ‘high risk’, abnormal labour, being labour which required intervention and thus became medicalised (Donnison, 1988). As autonomous professional groups however, midwives and obstetricians display a comparatively high ‘indetermination/technicality ratio’ within their professional role boundary, in that the individuals of the profession practiced judgement within their work more frequently, rather than a set of structured actions (Jamous & Peloille, 1970).

In keeping with their historically gained non-interventionist mandate (Hughes, 1958; Munro & Spiby, 2010), midwives in the UK are registered autonomous professionals licensed to undertake boundary work within the realms of normal pregnancy and childbirth events (Midwifery 2020, 2010; Nursing & Midwifery Council, 2012; Sandall, Morton, & Bick, 2010). The contemporary risk discourse however has influenced the categorisation of risk in maternity services, which has shaped the organisation of risk work between obstetricians and midwives (MacKenzie Bryers & van Teijlingen, 2010). Increasing litigation and risk management practices have provoked an increasing number of childbearing women being classified as requiring ‘high risk’ obstetric-led care, inevitably impacting upon the perception of risk and the professional role boundaries within maternity services. Lankshear et al. (2005) suggest that perceptions of risk and uncertainty influence clinical decision-making and care management and with the power of decision-making usually residing with the medical profession, the biomedical model of care is ultimately legitimised. This is proposed to overpower the embodied normality paradigm of midwifery presenting medical knowledge as authoritative (Rothman, 2014), resulting in
midwives having limited power and skill to ‘police’ their professional role boundary of normality (Scamell, 2011, 2016; Scamell & Alaszewski, 2012; Scamell & Stewart, 2014). Consequently, normality is described as an ever-narrowing window within childbirth (Scamell & Alaszewski, 2012), whereby midwives themselves are preoccupied with the discourses of medical risk and the dangers of childbirth (Lankshear et al., 2005; Scamell, 2011; Scamell & Alaszewski, 2012; Seibold, Licquirish, Rolls, & Hopkins, 2010). Moreover, Scamell (2016) reported that midwives’ commitment to preserving the normal, physiological process of birth ‘lacked the necessary vitality to curtail the social amplification of risk’ (p. 19).

Whilst authors have explored the discourse of risk and the everyday work of midwives (Lankshear et al., 2005; Scamell, 2011, 2016; Scamell & Alaszewski, 2012, 2016; Seibold et al., 2010), there is a dearth of research exploring the implications of such risk discourse on the boundaries of risk work across professionals groups (Gale et al., 2016), particularly obstetricians and midwives. In this article, I address this gap in knowledge by exploring the experiences of contemporary risk work for obstetricians and midwives in modern maternity service provision, particularly the tensions, and the impact, of managing contemporary risk work on the professional role boundaries of obstetricians and midwives.

Methodology
In order to explore the experiences of contemporary risk work for obstetricians and midwives, in particular the tensions, and the impact, of contemporary risk work on professional role boundaries, I decided to use an ethnographic approach. Ethnography is recognised as a social practice concerned with the study and representation of culture. Ethnography allows for thick detailed description of actual behaviour (Geertz, 1973), and is therefore one of the most informative approaches in learning ‘how things work’ within that culture (Van Maanen, 2011a; Watson, 2011). Van Maanen (2011b) describes ethnography as an interpretive methodology and ‘the practice of representing the social reality of others through the analysis of one’s own experience in the world of these others’ (2011b, p. xiii). In assuming that reality is socially constructed within the healthcare setting, as previously discussed, I took an interpretive ethnographic approach to the study design in this study (Denzin, 1996). As an independent researcher (and qualified midwife), I deemed an interpretive ethnographic approach the most effective way of gaining an in-depth understanding of how contemporary risk work was impacting upon the role boundaries of midwives and obstetricians due to my ability to observe, and interview, professionals during their everyday working life.

I adopted an interpretive ethnographic approach to allow my identity as a midwife and researcher to be reflexively incorporated into the process of data collection and analysis. An interpretive ethnographic approach allowed for the simultaneous collection of data through participant observation and field note generation and in-depth interviews (O’Reilly, 2012), methods deemed appropriate for gaining an in-depth understanding of the tensions and impact of contemporary risk work on the professional role boundaries of obstetricians and midwives. Ethnographic fieldwork typically involves the development of close relationships between the researcher and those being researched (Hammersley & Atkinson, 2007) in order to fully understand the culture from their perspective (Van Maanen, 2011a). In essence, ethnography seeks to make the strange familiar, however due to my professional role as a midwife I recognised that I would need to ‘make the familiar strange’ (Van Maanen, 1995, p. 20). As a researcher within my own culture, strangeness was not a given but an achievement (Ybema & Kamsteeg, 2009). I addressed
this by self-reflection and ‘deconstructing my taken-for-granted understandings’ (Ybema & Kamsteeg, 2009, p. 111) of everyday working life. I had an NHS contract of employment throughout the research process which allowed for ease of access, but I had not practised for 11 months prior to data collection. The 11 month break from midwifery practice was a factor which enabled me to reflexively ‘make the familiar strange’ (Van Maanen, 1995, p. 20) and ‘deconstruct my taken-for-granted understandings’ (Ybema & Kamsteeg, 2009, p. 111) within the maternity department.

The study was conducted within a single site NHS obstetric-led maternity services department in the middle of England during 2013. In total I engaged in approximately 300 h of participant observation and conducted 37 semi-structured interviews. Participant observation provided the opportunity to undertake research in a familiar social environment, being immersed in the lived, human experience whilst focusing on local interpretation (Geertz, 1973). I was able to observe day-to-day working activity and interactions between midwives and obstetricians of various levels of seniority within all areas of the maternity department. For in-depth interviews (Kvale & Brinkmann, 2009), I took a purposive approach to sampling as I felt this method was fit for purpose in selecting obstetricians and midwives with a mixed level of skill and experience (Low, 2013; May, 2011). 21 midwives and 16 obstetricians self-selected for interview following a recruitment and information campaign within the maternity services department, targeting all midwives and obstetricians working in the selected site. As this number provided a range of skill and experience across both midwives and obstetricians all 37 self-selecting participants were interviewed. Verbal consent was obtained daily for researcher participant observation and written consent was obtained prior to all interviews. For their own comfort and convenience, I encouraged the interview participants to choose their preferred location for interview, which was predominantly a private office space within the research setting. Interview recordings ranged from 35 min to 91 min in length.

I took an iterative, inductive and constant comparative approach to data generation and analysis (Charmaz, 2006), whereby data analysis was embedded within the data collection process. All interviews were electronically recorded and transcribed verbatim, and together with typed observational field notes, I used the computer software NVivo 10 to assist me in organising and coding the data. All data was anonymised and at the point of transcription interview recordings were allocated a unique identification code. Triangulation of data, and an iterative process of coding and grouping of themes, informed subsequent sampling and observational activity. This process provided a framework for the coding and analysis of data and identification of emerging key concepts. Data presented in this article are extracts from interview transcripts and field notes addressing the focus of this article.

Throughout the research process the NHS Research Governance Framework (Department of Health, 2005) was followed and ethical approval for the research was acquired from the Local Research Ethics Committee in August 2012 (Health Research Authority, 2016). Research approval and site access was granted from the Trust Research and Development department prior to commencement.

Findings
In this section I draw upon thematic analysis of interview and observational data with midwives and obstetricians, exploring the professional experiences of contemporary risk
work and the consequences of such risk work upon professional role boundaries. Pseudonyms have been used to protect the anonymity of participants.

**Anxiety over uncertainty, error and subsequent blame provoking defensive practice**

Midwives and obstetricians discussed the concept of risk and how their daily work was increasingly influenced by ‘risk management’ practices. Both midwives and obstetricians recognised that risk management practices, aimed at improving the safety of maternity care, inevitably associated childbirth with risk, and thereby aimed to control professional behaviour in managing such risk. Both midwives and obstetricians were unanimous in recognising the need to manage risk and promote the safety of childbearing women. Whilst obstetricians and midwives acknowledged their professional responsibility in translating risk for childbearing women and providing safe care, the changing relationship between professionals and society and the increasing ‘blame culture’ was expressed as having an impact upon the way that both midwives and obstetricians perceived risk as Sara, an experienced midwife of 12 years, explained:

> We’re in that society, that culture at the moment where somebody is always looking to blame...there’s always a scapegoat... and it’s sad that it’s like that...risk is dictating everything we do in maternity.

The changing relationship between professionals and society was also believed to be influencing the relationship between colleagues and managers in the workplace. Both obstetricians and midwives reflected on the perceived ‘blame culture’ and how they felt scared and unsupported in their daily clinical role. Dr White, a doctor of 37 years, reflected:

> I’ve been practicing medicine for 37 years and things have changed a lot now. If something went wrong 37 years ago, the patient would say well thank you very much for trying your best, and your colleagues would say to you, well I know you did what you could, now, if you make a mistake the patient says, how come that went wrong, and should I go to a solicitor and see if I can sue you, and your colleagues are looking at you thinking, really?! Was that a problem, do we need to look at that?

Natalie, an experienced midwife of 15 years, also explained how the ‘blame culture’ fuelled anxiety and a feeling of isolation:

> I think because of the blame culture, we’re frightened to do our own job, because if you don’t do it perfectly and something happens, you’re going to be sued and...your name’s going to be dragged through the mud...Sometimes you feel a little bit isolated, so you don’t trust the people that are there allegedly to support you.

This perceived lack of support within daily practice was embodied within a wider risk discourse of anxiety and uncertainty within the workplace. Informed by past experiences of blame, fear of uncertainty in childbirth, potential future error and subsequent blame, informed professional interpretation of risk. Midwives reported that all maternity service professionals were increasingly requested to read and sign departmental guidelines and policies to provide documentary evidence that all staff had knowledge of the contents of such documents, as Louise, a junior midwife of 2 years explained:
We’ve got to that point now where individuals are asked to sign to say we’ve read guidelines and policies... so they’ve read the protocol, they’ve read the guideline. They’ve signed to say they’ve understood it... and if they’re still involved in an incident... they’re going to be disciplined for it, because they’ve signed to say they’ve read it [policy]...and they’re going to adhere to it word for word, and if they haven’t for whatever reason, well there’ll be trouble. So people are frightened... We’re really frightened about that.

Anxiety over future error and subsequent blame was therefore highlighted as a significant problem in maternity services. Whilst both obstetricians and midwives recognised the role of guidelines and policies in facilitating safe care, the anxiety of not conforming to such documents ‘word for word’ seemingly provoked professional concern about care management and the personal implications of unintentional non-conformance.

Fuelled by the discourse of risk, both midwives and obstetricians talked about that due to anxiety over uncertainty in pregnancy and childbirth, professionals were more likely to manage care of childbearing women differently. Jane, a midwife of 8 years, talked about how midwives and doctors were practising more defensively, with doctors in particular underestimating the extent of cervical dilatation to justify medical intervention.

There are obstetricians and midwives that are having complaints put in about them... there are situations where it’s gone before a court, and they’ll always be twisted... So people have not necessarily got the confidence or the conviction to carry out the care that they want to give because they’re always thinking of, what if something goes wrong, and I think that’s where people are behaving defensively really. We’ve seen it where somebody’s [labouring woman] not progressing, they [obstetricians] will underestimate at the [vaginal] assessment to justify what their management is going to be, so you’ve got the medical team essentially medicalising women to try and make sure that nothing goes wrong on their watch.

Dr Brown, an experienced doctor of 32 years, also talked about how doctors were practising more defensively in contemporary maternity care provision:

If you look realistically on the ground, you see the obstetricians are scared and taking a more defensive role, which I personally don’t like, because I trained... based on clinical examination and your sort of approach, as a whole about a patient, rather than to practise defensive medicine.

As a consequence of anxiety over uncertainty, midwives and obstetricians therefore described a rise in defensive practices within maternity services. Defensive practices were interpreted as clinical management decisions based upon fear, uncertainty and attempts to minimise risk, rather than based upon clinical assessment alone. Many midwives felt they lacked the confidence to challenge such defensive practices. This lack of confidence was associated with midwives feeling fearful of future error and subsequent blame, as well as experiencing uncertainty themselves. Midwives talked about seeking refuge from such uncertainty and fear of future blame by also engaging in defensive practices, subsequently fuelling the dominance of the biomedical model of care. Maria, a midwife of 25 years, talked about how midwives were engaging in defensive practice due to fear:

We [midwives] are also more defensive practitioners, there’s more medicalisation in the way that we practice because we are afraid too. Any deviation from the norm, we don’t kind of think laterally any more, and think, well it could be because of this, so we’re straight in there [medicalising care] as well because we’re afraid that if something happens, they’ll say, well you should have done this... you should have done that... so we change the way we practice...
I look how we worked when I qualified to how we work now, normality in midwifery seems to have disappeared...It’s such a shame.

Both midwives and obstetricians therefore highlighted that anxiety and uncertainty were integral to the translation of risk in daily practice. This suggests that whilst obstetricians and midwives recognised the requirement for risk management practices to improve the safety of maternity care, professional perceptions of risk were framed negatively around the implications of risk translation and management for the professional. This was also evident through observation of a discussion in practice between Lisa, a senior midwife in charge of the labour ward, and Dr Howard an obstetric consultant, following the morning ward round.

The medical ward round, involving all doctors on duty and Lisa, the labour ward coordinator, had just finished. Dr Howard, the obstetric consultant, and Lisa walked towards the midwives station. Dr Howard said to Lisa ‘ok, so you’re happy about the plan for each room?, and room 4 [low-risk woman in labour], can you just keep an eye in there and get her reviewed [by a doctor] if she hasn’t delivered soon, as she’s been pushing for nearly 1 hour now’. Lisa said ‘yes I’m starting ‘my round’ in there so I’ll let you know’. I asked Lisa about ‘her round’ and she explained that the labour ward coordinator was expected to conduct their own ward round, following the medical ward round, to document a plan of care for each woman on the labour ward, ensuring organisational guidelines are followed. I questioned Lisa about making plans for midwives and Lisa said ‘I suppose you could say that the midwives on shift are autonomous practitioners and I don’t need to make plans of care for them, but as a result of a few incidents this is what we have to do now’. (Extract from field notes 190613)

Professional perceptions of the organisational and social context of risk were therefore integral to risk translation in practice. Professional concern regarding risk had provoked socialisation amongst obstetricians and midwives that control over the childbirth process promotes risk minimisation. Both midwives and obstetricians were conscious of how anxiety of uncertainty, future error and subsequent blame were influencing defensive practices in attempting to manage the uncertainty of risk in childbirth. Dominance of the biomedical model of care in managing the uncertainty of risk was talked about as having a negative effect on the medicalisation of pregnancy childbirth, namely medically-led intervention, instigated by both obstetricians and midwives.

**Tension of risk work: risk minimisation versus risk causation**

When considering the implications of risk management practices, both obstetricians and midwives reflected on the tensions of translating and managing risk in practice, and the unintended consequences on childbearing women. Strategies adopted in practice to minimise calculated risks were ironically perceived as potentially placing childbearing women ‘at risk’. Midwives reflected openly about the frustrations they experienced during daily practice, where increasing documentary requirements associated with risk identification and minimisation were affecting their ability to be ‘with woman’ as Robina, a midwife of 8 years explained:

> Being a midwife, it actually means to be ‘with woman’...But you’re not with women when you’re trying to meet all the regulations and all the standards and fill in all this risk paperwork, you’re ‘with paperwork’ not ‘with woman’.

Helen, a semi-retired midwife of 27 years concurred:
If you’ve not ticked that box and you’ve not ticked this box we’re in trouble, you know it [risk] stifles midwives practising as midwives…there’s so many things that are pulling us into a range of places that makes being with women and caring for women so hard! I mean I look back…27 years ago when I first entered into midwifery and I look at what you would’ve done as records then to what you do now, and you think, well where’s the time to actually look after the women?

Increasing paperwork, associated with identifying and minimising risk, was felt to not only affect the time midwives are able to spend caring for women, but also their ability to utilise their embodied knowledge and expertise in providing basic midwifery care as midwives Natalie and Sue explained:

Dare I say, ticks in all of the risk boxes just helps insurance for the hospital, government targets and all that, it’s something we just have to do, but sometimes I think they lose a little bit of focus of what’s actually on the front line, taking you away from providing basic care to women to perform these pointless tasks. (Natalie, midwife for 15 years)

Risk management is actually stopping us caring. You know, I’ve seen it first-hand where a newly qualified midwife was concentrating so much on filling her paperwork in that she forgot there’s a woman there she needs to care for. (Sue, midwife for 10 years)

The impact of ‘paper work’ upon care practices was also visually evident in practise.

I observed numerous midwives sat at the midwives station completing the required paperwork following the delivery of a baby and I heard a man suddenly shout for help. The labour ward coordinator quickly entered the room. I was later told that a woman who had delivered just 30 minutes previous was experiencing a life threatening vaginal bleed and the labour ward coordinator explained that the midwife caring for her was not in the room at the time of the incident. The midwife was sat in an office completing the required paperwork associated with the delivery. (Extract from field notes 090713)

Reflecting upon interview and observational data, it is evident that midwives perceived risk minimisation practices, associated with increasing paperwork, as a constraining factor on their professional role as a midwife. Midwives expressed concerns that such practices were impeding rather than facilitating safe care, potentially placing childbearing women ‘at risk’, due to midwives spending more time completing documentation than providing basic care. Midwives, however, appeared reluctant to challenge the risk management processes in place describing them as ‘something we just have to do’.

Whilst midwives discussed the negative implications of risk management in practice, obstetricians were ambivalent regarding the tensions they experienced during daily practice in translating risk and the impact of care management upon childbearing women. Dr Black, a doctor of 29 years, reflected on ‘cautious’ practice, justifying such practice as a means of safeguarding childbearing women.

Every potential case is a medico-legal case, so you’ve got to make your own safeguards and put your own safety measure in place, so what’s the harm in being cautious as long as the woman is cared for and the baby is delivered safely?

Whilst some obstetricians appeared uncritical of practising ‘cautiously’ in order to minimise risk, other obstetricians, such as Dr Smith, a doctor of 34 years, were more critical in their reflections of balancing risk and safe care. ‘Cautious’ practice was perceived to be deskilling obstetricians and midwives and therefore placing childbearing women ‘at risk’.
People think caesarean sections are an easy way out of an uncertain situation, but the more caesarean sections you do, the less skilled people are at doing vaginal delivery, and the less skilled you are at vaginal delivery, the more you’ll do caesarean sections. It’s a vicious circle fed by fear I think…it’s set to get worse as well, there’s no doubt about it.

The differing views and experiences of obstetricians and midwives evidences the tension of translating and managing risk in contemporary childbirth, and whether risk management, in attempting to minimise risk, inadvertently places childbearing women at risk due to defensive intervention or loss of professional skill.

**Shifting of professional role boundaries**

Anxiety, uncertainty and rising defensive practices, fuelling the medicalisation of childbirth, were talked about as having a consequential effect of shifting the professional role boundary between midwives and obstetricians. Midwives talked about experiencing reducing levels of professional autonomy, and no longer practising within the role boundary of their historic professional mandate of normality as Jenny, a midwife of 18 years explained:

> We’ve been sucked into a biomedical model of care, we’re frightened to practice any other way. Autonomy has gone…we are fed by CNST [Clinical Negligence Scheme for Trusts]… We’re fed by Trust policies. We are like a conveyor belt of semi-professionals…we’re just like clockwork toys. We have to just do as we’re told really. And we’re scared to go against that, just in case it [care] goes wrong. As then they’re going to say, well, the guideline says… you should’ve done this and you didn’t do that.

Midwives felt that the translation and management of risk in childbirth had a direct impact upon their professional status as midwives. Midwives felt unable to use their embodied midwifery knowledge to inform clinical care and professional judgement. Midwives therefore talked about practising as ‘clockwork toys’ rather than autonomous practitioners. This provoked feelings of midwives being subject to risk management processes which had negatively impacted upon their professional role and status, suggesting a professional inability to maintain social closure (Larson, 1977) and preserve their professional role boundary. Consequently, midwives talked about obstetricians benefitting from increasing medicalisation of childbirth, whereby care management was not challenging the role boundary of obstetricians as Louise, a midwife for 4 years explained:

> Unless they’re really passionate…midwives find it very difficult to challenge, because once they’re [women] on that path and the obstetricians are involved, that’s it…the obstetricians want to manage care the only way they know how, to get that syntocinon up [artificial hormone infusion to induce labour], get them on that monitor [electronic device to monitor the foetal heart beat] and get them delivered as soon as possible.

Talk of increasing medicalisation of childbirth and lack of challenge to the role boundary of obstetricians was also noted during informal conversations between midwives, regarding the changing care ‘risk’ status of childbearing women present on the labour ward:

> Following the morning ward round the labour ward coordinator changed the last name written in black [low risk care classification] on the inpatient board to red [high risk care classification] and jokingly said to the two band 5 midwives stood at the midwives station ‘well that
didn’t last long did it, we have a full house of red again [all women classified as requiring high risk, obstetric led, care]. (Extract from field notes 100413)

The familiarity of this scenario highlighted that the midwives were accustomed to a higher number of women requiring high risk, obstetric-led care than those requiring low risk, midwifery-led care. Obstetricians also acknowledged the increasing medicalisation of childbirth within maternity services, suggesting that childbearing women were in receipt of obstetric-led care, despite those women being suitable for midwifery-led care. Obstetricians felt that anxiety was driving unintended consequences on healthcare in provoking defensive practices. Obstetricians such as Dr Jones, a doctor for 30 years, alluded to the incidence of unnecessary care intervention that mainly serves to protect obstetricians from medico-legal issues in practice.

I think many patients of mine could be looked after by the midwife safely, but no, I have to see them and have this test and that test, just because I have to be safe. It’s very easy to criticise anybody in hindsight…anybody can do that! but, the lawyers, they do it, so we have to learn, and in learning from those experiences, we become defensive, it’s unfortunate… being defensive is not just writing a letter to be defensive, it changes care and that costs money…to some extent we all practice defensive medicine.

Increasing medicalisation of childbirth has therefore challenged the professional role boundary and professional mandate of midwives, whilst appearing to strengthen the biomedical model of care, and the medical mandate of obstetrics as a specialty. Robina, a midwife for 8 years, talked about how this situation has ultimately overpowered the embodied normality paradigm of midwifery, presenting medical knowledge as authoritative:

Defensive practice is strangulating midwifery…and it’s demoralising really, making you feel like actually, what am I here for? You know, obstetricians are always saying ‘why don’t you do this, do that, let me come and do the VE [vaginal examination], let me do that, don’t put her in that position’ well I’ll tell you what, why don’t you look after her yourself then, Mr. Obstetrician? I’ll go and do something else. That’s how it feels, they just take over.

The disempowerment of the embodied normality paradigm of midwifery, and the authoritative position of medical knowledge is evident within the medicalisation of childbirth. Obstetricians such as Dr Black, a doctor for 29 years, presented medical knowledge and obstetric-led care as authoritative, suggesting that if midwives were able to adequately justify that medical intervention was not required, obstetricians would ‘back off’.

If midwives can prove that medical input is not needed, then maybe we [obstetricians] would back off… I think, with defensive medicine, it has to go that way, because otherwise midwives are going to be getting sued as well, and they don’t want that. You know, you have to be more defensive these days because of the way patients are, and women are. You know, people now think it’s their absolute right to have everything… that’s just the way it is.

With the changing nature of contemporary midwifery practice, the impact upon the shifting of professional role boundaries between obstetricians and midwives was also recognised by obstetricians. Dr Brown, a doctor for 32 years, talked about how risk in childbirth, and the medico-legal challenges that accompany such risk are the main causes of such role boundary shift.
Well I do wonder if it [risk] will affect professional roles more, as changing roles is going on already now. We’re already in litigation ages, we are so aware of litigation and the risks in childbirth…and we are becoming more defensive because of it…it [risk] is bound to affect role boundaries in some way.

Despite obstetricians recognising that professional role boundaries had shifted between obstetricians and midwives, obstetricians appeared unconcerned, arguably due to the fact that the role boundary of obstetricians in contemporary maternity care was not experiencing negative consequences. Midwives however expressed concern in relation to such role boundary shift that extended further than anxiety, uncertainty, future error and subsequent blame in practice. Midwives such as Joanne and Helen were fearful that the professional status of midwives in the future may be lost due to the changing role of the midwife, and the impact of risk in driving defensive practices and further medicalisation of childbirth.

I think it [risk management] makes care more medicalised…We’ve seen it happen slowly but surely with all that’s been introduced, and I think the obstetricians have now claimed it [maternity care] as their area…I think they’ll reclaim even the low risk stuff in time. (Joanne, midwife for 16 years)

I think we could lose professionalisation. I think we could lose the role of the midwife and that frightens me, you know, we could become obstetric nurses and ultimately lose our professional status. I think as a bunch of women, we’ve lost the sisterhood. We don’t support our sisters in moving the profession forward. (Helen, midwife for 27 years)

Midwives’ accounts can therefore be interpreted as midwives having real concerns over shifting professional role boundaries and the potential loss of professional status. Midwives felt at risk of deprofessionalisation due to the impact of the risk discourse in influencing the changing role of the midwife in contemporary maternity care. Midwives talked about how they had ‘lost the sisterhood’, in that the profession as a whole had lost its vision, and lacked united support in working together as a profession in maintaining professionalization.

Discussion
In this article I have explored how obstetricians and midwives in an obstetric-led maternity services department talk about, and experience contemporary risk, in how working practices, and role boundaries, are influenced by the concept of risk. Whilst obstetricians and midwives recognised the requirement for risk management practices to improve the safety of maternity care, professional perceptions of risk were framed negatively around the implications of risk translation and management for professionals. Due to anxiety over clinical error and subsequent blame, the biomedical model of care was perceived as dominant in managing the uncertainty of risk amongst both midwives and obstetricians. Midwives and obstetricians talked about a subsequent increase in defensive practices in managing contemporary risk work, with scientific knowledge remaining integral to managing the uncertainty of risk in pregnancy and childbirth (Scamell & Alaszewski, 2012).

Both obstetricians and midwives were unanimous in suggesting that translating and managing risk in contemporary maternity care was influenced by anxiety and uncertainty, inadvertently affecting the management and delivery of care provided. This was largely informed by the organisational and social context of risk translation in practice. Professional concern regarding risk, and the dominance of the biomedical model of
care, had provoked socialisation amongst obstetricians and midwives that control over the childbirth process promotes risk minimisation. Tensions, however, were noted with the assumption that risk management practices and defensive care were effective in minimising risk and promoting safety of women, a central tenet of risk management. Midwives talked about how risk management, as a means of minimising risk, was a contradiction in terms in that risk management processes currently in place to manage and minimise risk were potentially placing childbearing women at risk. This was due to the requirement of the midwife to complete risk management documentation, which was inadvertently reducing the time available to the midwife to safely care for women in her care. Despite the noted tension in attempting to minimise risk, midwives appeared reluctant to challenge, appearing powerless in describing the risk management documentation as ‘something we just have to do’.

There was also ambivalence amongst obstetricians that defensive care was effective in promoting safety of women. Defensive practices were described as a source of risk causation, in that continued reliance on defensive practices could ultimately result in the deskilling of professionals. This highlights a contradiction with the knowledge base upon which risk management is inferred, in terms of risk minimisation, and the everyday experiences of risk workers in attempting to minimise risk in practice. Despite these tensions the biomedical model remained the prominent paradigm in managing maternity care, fuelling control, intervention and the medicalisation of childbirth. Arguably this could be explained by medical risk translation and care management residing within the biomedical model of care, and the historical interventionist mandate of the medical profession. Translation and management of risk was therefore socially constructed (Larkin, 1983), with the biomedical model of care appearing to control the parameters of risk work for both obstetricians and midwives.

Both obstetricians and midwives were consciously aware of the growing risk culture, increasing litigation and its impact upon maternity care. Obstetricians, in particular, acknowledged the presence of defensive practices within maternity services. Many childbearing women were believed to be in receipt of obstetric-led care, despite the women being suitable for midwifery-led care, as obstetricians ‘have to be safe’. Rising defensive practices, of the medical profession in particular, appeared to reinforce scientific knowledge and its ability in the field of childbirth to impact upon care management and the birthing process (Scamell & Alaszewski, 2012). Overpowering of the embodied normality paradigm (Rothman, 2014) left midwives feeling unable to use their embodied knowledge and professional judgement to inform clinical care. In fact, midwives themselves talked about co-opting defensive practices as a refuge from anxiety over uncertainty, error and subsequent blame in practice, reinforcing the dominance of the biomedical model of care. With midwives talking of practising as ‘clockwork toys’, as opposed to autonomous practitioners with the ability to utilise embodied knowledge, the variance in ‘indetermination/technicality ratio’ (Jamous & Peloille, 1970) between the obstetricians and midwives was noted to have a consequence on the relative autonomy of both professional groups (Johnson, 1972). Perceived increasing medicalisation of childbirth, whereby defensive care management was largely within the realms of the biomedical model of care, appeared to strengthen social closure (Larson, 1977) and preserved the role boundary of the obstetricians. Professionals talked about a reconfiguration of existing professional role boundaries whereby the role domain of the midwife was decreasing, whilst the role domain of the obstetrician increased. This appeared to provide the opportunity for obstetric knowledge, with the authority of the biomedical model in contemporary maternity care, to gain relative dominance over midwifery knowledge (Jamous & Peloille,
1970; Larkin, 1983) in defining and managing risk in maternity care. This was evidenced by obstetricians themselves presenting medical knowledge and obstetric-led care as authoritative, suggesting that if midwives were able to adequately justify that medical intervention was not required, obstetricians would ‘back off’. Ultimately, this provoked midwives to feel subject to contradictory risk management processes which had negatively impacted upon their professional role boundary and status.

As a result of shifting professional role boundaries, the role of the midwife in the twenty-first century was perceived to be in a state of flux, raising concerns for the professional status of midwives within future childbirth provision. Midwives’ accounts suggest that midwives had real concerns over their ability to ‘police’ their professional role boundary of normality (Scamell, 2011, 2016; Scamell & Alaszewski, 2012; Scamell & Stewart, 2014). As a result, midwives felt at risk of depoliticisation due to the changing role of the midwife in contemporary maternity care and the general loss of authority in their embodied knowledge of normality in translating and managing risk in maternity care. Midwives and obstetricians talked about anxiety over clinical error and subsequent blame leading to an increase in defensive practices in contemporary risk work (Douglas, 1992; Hofmann & Stetzer, 1998), with scientific knowledge becoming integral to managing the uncertainty of risk in childbirth (Scamell & Alaszewski, 2012). The ever narrowing window of normality in contemporary childbirth (Scamell & Alaszewski, 2012) provoked midwives to reflect on their ever decreasing role as being ‘clockwork toys’, suggesting that obstetricians would ‘reclaim even the low risk stuff in time’.

In this article I have provided new evidence that as a consequence of contemporary risk work, role boundaries between existing professions are being reconfigured due to the inability of professional groups to defend their professional role boundary. Frontline practitioners who are required to interpret and manage risk within their everyday work are experiencing tensions and consequences in managing ‘risk work’ due to the conflicting knowledge bases upon which the ‘risks’ that inform their professional role boundary work are inferred (Gale, Greenfield, Gill, Guttridge, & Marshall, 2011). This evidence is significant in developing our understanding of the impact of contemporary risk work upon the professional role boundaries of professionals undertaking risk work.

**Conclusion**

In this article I have demonstrated that contemporary risk work poses boundary work tensions for risk workers such as obstetricians and midwives, tensions which have ultimately provoked the shifting of professional role boundaries within modern care provision. Increasing incidence of defensive practices by both midwives and obstetricians, fuelled by professional anxiety of risk, have resulted in midwives expressing an inability to defend their professional role boundary, subsequently providing the opportunity for obstetric knowledge to claim relative dominance over midwifery knowledge in translating and managing risk. Findings presented in this article therefore illuminate how contemporary risk work is potentially eroding the professional role boundary of an autonomous professional group, whilst strengthening the professional role boundary of another professional group. This is a significant finding in developing our understanding of the impact of contemporary risk work upon the professional role boundaries of professional groups undertaking risk work. Contemporary risk work is potentially placing established professional groups at risk of depoliticisation, particularly within services where conflicting knowledge bases upon which the ‘risks’ that inform role boundary work are inferred.
(Gale et al., 2011), and where reconfiguration of role boundaries is likely to escalate as a consequence of risk work interpretation.

In this study I have shown that midwives and obstetricians perceived there to be, and talked about, an erosion of midwifery practice and this provided the context for their talk about boundaries. If midwives are not able to defend their role boundary in promoting normality in childbirth, and thereby continue to co-opt in defensive practices themselves as a refuge from uncertainty of risk in practice, the contemporary nature of risk work is potentially placing the midwifery profession ‘at risk’ of deprofessionalisation. For the sake of promoting the health and wellbeing of future pregnant women, let us hope this in not the destined future of the midwifery profession in the UK.

Disclosure statement
No potential conflict of interest was reported by the author.

References


