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Bad Habits - a poor basis for medical policy

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In this article, Marsden Wagner, formerly the Regional Officer for Women's and Children's Health at the European Regional Office of the World Health Organization, looks at the origins of and continuing problems caused by the widening gap between maternity practice based on sound evidence and practice which is based on peer approval.

Using the standard of practice of peers means that the individual practitioner is secure because the knowledge used. whether or not based on evidence, is approved by the leading practitioners.

To understand the conflict that exists between practice based on science or based on peers and between the recommendations of WHO and the recommendations of organisations of clinicians, we must go back to 1979, the International Year of the Child. In that year, the governments of Europe, concerned by rapidly increasing use of high tech interventions in obstetrics and rapidly rising costs, asked WHO to evaluate perinatal services. WHO organised the European Perinatal Study Group, containing all interested parties, including; obstetrics, neonatology, midwifery, nursing, perinatal epidemiology, health administration, economics, psychology, sociology and service users.

The emphasis of the WHO European Perinatal Study Group was not on how best to manage complications of pregnancy and birth but rather on what constitutes appropriate care for the 80% or more of women with normal pregnancy and birth. Although it was the beginning of the 1980's and the term "evidence based practice" did not yet have the widespread agreement it has today as the essential criterion for practice, the Perinatal Study Group looked at perinatal practices using scientific evidence as their criterion to determine what should and should not be part of routine practice.

The Perinatal Study group commissioned a study of the worlds literature which showed that only around 10% of all routine obstetrical interventions have a satisfactory evidence base (Fraser, 1985).

The Group conducted surveys which showed great variation in obstetrical practices with little or no relationship to perinatal outcome (Bergsio et al, 1983).

The variation was among countries, within countries, within districts, and between hospitals, demonstrating that much of perinatal practice is not necessarily lnrsed on the best scientific evidence but rather based on the opinions and beliefs of the local physicians, especially chief physicians. The result of this evidence based work of the Group was the WHO publication *Having a Baby in Europe* (WHO, 1985).

WHO then organised three international conferences on appropriate perinatal technology in Washington DC, Forteleza, Brazil and Trieste. Italy (Wagner, 1994). These consensus conferences, following a thorough review of the best scientific evidence and consensus from all interested parties, resulted in the WHO publications *Appropriate Tecbno1ogy for Birth* (WHO, 1985), and *Appropriate Technology Following Birth* (WHO, 1986). These WHO publications were often at odds with current standards of practice. In 1986 the President of the British Royal College of Obstetricians and Gynaecologists (RCOG) wrote in a letter to the Regional Director of the European Office of WHO *"The WHO guidelines used in The Lancet (WHO, 1985) are mostlv unacceptable and represent a very radical view which is not reflected in general British obstetric practice."*

Similar comments were made by obstetrical societies in other European countries as well. However, a more recent paper comparing these same WHO recommendations (guidelines) one by one with the concluding recommendations from a book (Chalmers I, Enkin & Kierse, 1989) that reviewed randomised controlled trials of perinatal practices concludes: *"The recommendations of WHO for appropriate technology at birth, devloped through survey research, discussions and debate are strongly endorsed by the findings of canfully controlled and critically evaluated randomised control trials"* (Chalmers B, 1992).

What is going on? Why is there a gap between evidence and practice - that is between the WHO recommendations proven to be evidence based and the obstetric practice endorsed by obstetrical organisations? Why did the RCOG so vigorously oppose the WHO effort?

The public health versus clinical approaches

The answer to these questions lies in a fundamental difference in perspective between what WHO recommends as routine practice and what is actually practised in European countries. Essentially the public health approach used by WHO to formulate recommendations is at loggerheads with the clinical approach used by practising physicians *(see table 1)*. Whereas the public health approach uses scientific evidence, as its base and then combines the best of the medical model with the best of the social model making recommendations for health policy, the clinical approach uses standards of practice as its base with the medical model as its sole perspective.

Table 1

Clinical Model	**Public Health Model**
Standards of practice	Scientific evidence
Medical model	Medical and social models

Individual patient	Community
Curing sickness	Promoting wellness
Health = medical care	Health = social and economic conditions
Doctors most important health care provider	Women most important health care provider
Doctors decide	Self determination based on human rights
Authoritarian hierarchy top down experts exclusive	Democratic bottom up (grass roots) all interested parties
Authoritarian hierarchy top down experts exclusive	Democratic bottom up (grass roots) all interested parties
knowledge	shared knowledge
Technology == science + progress	Appropriate use of technology
Goal: prevent pain & death	Goal: optimal benefit to individual & society

The origins of the standards of practice used by clinicians are multifactorial. Some of the standards of practice are indeed based on scientific evidence. If the evidence reveals a particular practice to have extreme risk (thalidomide, diethylstilbesterol) that practice is likely to be dropped as standard practice. If the evidence supports a practice which is doctor friendly (the electronic foetal monitor should be used with induction and epidural block) that practice is likely to become standard practice. If the evidence in favour of practice is incontrovertible but not doctor friendly (vertical birth positions preferable to lithotomy position) that practice is much less likely to become standard practice and there will remain a gap between evidence and standard practice.

Standards of practice is an important issue because several non-medical factors came into play*(see table 2)*. Whereas clinicians often give "experience" as the basis for a particular practice, the truth is probably closer to "habit"-the way it has always been done. This is illustrated by the way operative vaginal birth practices occur intemationally: in Britain and some former British colonies (Canada, Australia, New Zealand) forceps predominate while in Continental Europe vacuum extraction predominates.

Table 2

Non-Medical Determinants	**Examples of Practice**
Habit	Forceps versus vacuum extraction
Convenience	Induction, caesarean section
Fear of litigation	Routine EPM, cacsarean section
Money	Caesarean section
Commercial interests	Routine EPM

Convenience is another non-medical factor underlying standard practice. Since the advent of induction, scientific studies have shown birth to be more common on week days. (Macfarlane, 1978, 1984; Paocaud

et al, 1980 Other studies show emergency caesarean sections to be more commonly performed on week days (Phillips et al, 1962; Evans et al, 1984).

Because 85% of British obstetricians have been sued at least once, and 65% have been sued twice (Capstick & Edwards, 1990; Lancet editorial, 1991; British Medical journal editorial, 1991), British obstetricians themselves give fear of litigation or so called "defensive obstetrics" as their second most common reason for the unnecessarily high caesarean section rates. Thus we have another non-medical influence on standards of practice. Even the American College of Obstetricians and Gynaecologists now has written policy against routine use of the electronic foetal monitor on all women in labour (ACOG, 1995) but its routine use is still standard practice in many places because of the fear that a doctor who does not have an EFM tracing in the patient's record will be vulnerable in court.

In those countries, such as the US, where the income of the obstetrician and the hospital, at least in part, is determined by how many interventions are performed, scientific data show significantly higher hospital-specific rates of caesarean sections in private for profit hospitals than in public and private not for profit hospitals (Stephenson, 1992). Other studies from the US show that women with private health insurance have significantly higher rates of caesarean section than women without insurance and women with publicly provided health insurance (Stafford,l990; Haynes et al, 1986; Gould Cf 21, 1989). Such excessive caesarean section rates remain a concern because data suggests they carry higher mortality and morbidity rates than vagi- nal birth both for the woman and baby, even including elective repeat Caesarean section (Wagner, 1994).

What about the role of commercial interests? Their role in determining peri- natal standards of practice is subtle but pervasive. Universities, hospitals and physicians co-operate closely with industry. Industry gains access to patients and to highly skilled researchers (physicians).

Industry also gains by the communication of research- regarding use of a technology - in medical journals and at conferences. Hospitals and universities (sometimes physicians) may receive royalties and patent rights. More importantly, physicians and others may further their research careers through industry-funded research, which in turn, is the avenue to promotion and status.

As a less subtle example of how commercial interests can influence standards of practice, a meeting was organised by the International Federation of Gynaecology and Obstetrics (FIGOI to develop guidelines for the use of the electronic foetal monitor (EPM) during labour. The WHO participant discovered on arrival that most of the cost of the meeting., including bringing obstetricians from all over the world, was borne by the manufacturers of the monitors to be evaluated.

The participants had to pass through a manufacturers' display of monitors to get to the room in which the value of the monitors was to be discussed. Ultimately WHO could not endorse the report from the meeting because it recommended the global use of routine EFM on all women during labour, and the scientific evidence supporting this position was (and is) woefully inadequate.

Since a basic principle of medical practice is that whatever is done always must be for the benefit of the

patient and not the doctor, these non-medical factors - convenience, profit motive, fear of litigation and commercial interests - which are clearly for the benefit of the doctor, should never influence standards of practice. As a leading perinatal scientist wrote *"the increasing prominence (of legal influences) as determinants of clinical practice is not in the best interests of either present or future users of the maternity services"* (Chalmers I, 1985). But the reality is that the standard of practice in any given place is the compilation and legitimisation of what the influential doctors are doing.Unfortunately very often practices are not evidence based and are strongly influenced by non-medical factors.

Challenging authority

The power of the knowledge used by those in authority is not that it is correct but that it counts (Jordan, 1993). Because of the authority of WHO, if the orthodox standards of perinatal practice were to maintain their ascendancy, it was necessary for the WHO recommendations to be devalued, hence the previously cited letter from the RCOG to WHO. In other words,*"To legitimise one way of knowing as authoritative it is necessary to devalue or dismiss all other ways of knowing"*(jordan, 1993). A variety of strategies have been used to try to devalue or dismiss the WHO publications.

I know of no attempt to directly challenge the scientific validity or 'truth' of the WHO publications - no articles I've seen take on specific recommendations to show why they are not scientifically justified. Rather it is the relevance and authority which is challenged. For example, a professor of obstetrics in Austria declared publicly that the WHO recommendations on perinatal technology were for the third world (i.e. they may be valid but don't apply to us) although in fact, the recommendations were directed primarily to highly industrialised countries.

Another way to challenge the authority and dismiss the WHO publications is to discredit the individuals promoting the recommendations. *"Those who espouse alternative knowledge systems tend to be seen as backward, ignorant, or naive trouble makers. Whatever they might bare to say about the issues ago for negotiation is judged irrelevant, unfounded and not to the point"*(Jordan, 1993). In other words, if you don't like the message, shoot the messenger. (This also helps explain why attempts have been made over the years to separate me from WHO and claim that the recommendations are my idea). In this way the authority is removed and the publications can be dismissed.

Health policy for perinatal Service

From a public health perspective, today's modern perinatal practice includes extensive, intensive, often invasive, very costly, often unnecessary interventions. The list of obstetrical interventions with a gap between the evidence and what is practised is long including: routine ultrasound scanning during pregnancy, routine electronic foetal monitoring during birth, induction, lithotomy position during labour, operative vaginal birth, caesarean section, episiotomy (Wagner, 1994).

One might be forgiven for wondering what the efficacy of all this obstetrical intervention can be and why it continues when data on perinatal outcomes in industrialised countries show that the cerebral palsy

rate has not decreased in 50 years, the low birthweight rate has not decreased in 20 years, the matemal mortality rate has not decreased in 10 years and the commendable slight fall in the perinatal mortality rate in the past 10 years is due almost entirely to a slight fall in the neonatal mortality rate and not to a fall in the fetal death rate.

In addition, certain obstetric fads come along from time to time - every dogma has its day. Al the moment, active management of labour is the popular dogma, in spite of the fact that it has never had an adequate scientific basis (Thomtonj 8: Lilford R, 1994). Similarly an epidemic of epidural block for labour ain is occurring. in spite of a lack of adequate scientific assessment (Howell C, Chalmers I, 1992; Chalmers I, 1992), and serious risks for both woman and baby which are rarely mentioned when 'informed consent' is obtained (Thorp J et al, 1995; ACOG, 1995)

But there is also widespread reaction to such excesses in perinatal practices, brought on by four fundamental changes taking place today in health care policy. First the realisation that no country can any longer afford to pay for all possible health care interventions has resulted in an emphasis on cost effectiveness which is driving decisions about what to reimburse. Next, governments are realising that the best criterion in choosing which interventions to support is evidence based pradice. Thirdly, the understanding that choices about which health interven- tions to endorse are more social and ethical than medical is leading governments in the direction of placing health care decisions in the hands of people, not just doctors, and at a more local level.

The fourth and perhaps most important change taking place in perinatal health policy is that governments are realising that decisions about human reproduction are part of human rights. At the United Nations Conferences in Cairo and Beijing it was decided that women have "The right to make decisions concerning reproduction free of discrimination, coercion and violence as expressed in human rights documents. The promotion of the responsible exercise of these rights for all people should be the fundamental basis for government and community supported policies and programmes in the area of reproductive health' (United Nations, 1994).

In other words, governments must ensure that the woman and her family have the right to freedom in having the experience of their choice, free of coercion (even subtle coercion) and with full respect for the integrity of the person, during one of the most important events in their lives, pregnancy and birth. The nature of perinatal services must be such as to empower the woman and family to have the resources, ability and freedom to make such decisions. Unfortunately some clinicians are blind to the ways in which these political and social changes are impacting on health services, gradually forcing changes in health care delivery and shifts in control. It is happening more rapidly and more obviously in health services for birth and death where it is most clear that the issues are primarily social and not medical. This explains the struggle taking place in perinatal services. Public health agencies and public health professionals have a duty to bring the public health perspective to this struggle. Following the WHO international consensus conferences on appropriate perinatal technology, the consensus process demands a final step: presenting the recommendations to all relevant parties, including the public and governments, for

consideration and discussion so that a general community consensus can evolve. Such debate must take place at national and local levels and in public - not behind closed medical doors - to become part of the political process that detemiines health policy.

A final thought

Every sports team needs players (clinicians) and a coach or trainer (public health scientist such as a perinatal epidemiclogist) working together as we need a combination of both the clinical approach and the public health approach for optimal health care (Wagner, 1989).

Until now there has not been a healthy balance in the two approaches as the predominant role of the clinical approach and the attempts to disaedit the public health approach has steered us ol the right track. WHO has been working to correct the balance in the two approaches.

Still today in every industrialised country it is men who control birth and women who give birth. All the efforts at the WHO European Regional Office have been directed at using the public health approach to expand the body of knowl- edge in perinatology recognised as authoritative, and opening it up to include, in addition to the viewpoint of clinicians, the viewpoint of midwives, scientific re-searchers, public health professionals and women-at-large. These efforts are part of the global struggle for control of perinatal services, which, in turn, is part of the much larger struggles for control of women and control of all health services.

As part of this struggle, the WHO European Regional Office, as a public health agency, has been bringing to the attention of the public and govemments two serious problems brought about by the present hegemony of the clinical approach. The first problem is the reliance on standards of practice rather than scientific evidence leading to gaps between the evidence and the practices. While some clinicians still fear uncertainty and resist change, more and more clinicians are accepting evidence based practice and the standards of practice are gradually changing.

The second problem is having doctors decide health policy leading to the failure to honour the self determination of the individual and family and their basic human reproductive rights. The medical profession is used by society to control women's reproductive health (Stephenson & Wagner, 1995). There is no place in modern perinatal practice for doctors deciding such issues as where babies can be bom and who can be present at birth, or for using coercion such as court ordered caesarean section or, more subtly, trying to frighten a family out of choosing out-of hospital birth.

As someone with many years in clinical practice l understand that clinicians in general need to feel certain in what they are doing, even when that certainty is sometimes based on shared beliefs in a standard of care rather than evidence. But when I later trained as a perinatal scientist, I learned that science means uncertainty and scepticism and asking diiiicult questions. We in public health are like the little boy in the Hans Christian Andersen fairy tale who was the only one able to say *"The emperor has no clothes"* Not always a popular role but an absolutely essential one. Sadly, it must be added that there are

some scientists and public health professionals, including in WHO, who are afraid to publicly go against the power and authority of the medical profession.

By emphasising the public health approach to matemity services, WHO has created controversy and occasionally even conflict. While this may make some people uncomfortable, it is important to remember that progress does not occur without disagreement, controversy and debate. Perinatal services have progressed and clinicians can be given credit for working to close the gap between evidence and practice. But however far we have come, we can always go further. By holding this debate the European Association of Perinatal Medicine is helping to move things forward in matemity services through open, honest airing of differing points of view among clinicians, scientists and public health professionals. This will lead to better understanding on all sides to the benefit of women.

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