AIMS For a better birth...

Risk and contingency

AIMS Journal, 2016, Vol 28 No 2

Jo Murphy-Lawless talks about the politics of birth and risk

When I see news headlines or hear media reports about the latest research on pregnancy and birth, I find myself growing tense as I wait for the near inevitable use of the word 'risk'.

I do so knowing that the very notion of 'risk', its history, and why it has come to dominate our thinking in these last three decades, is largely hidden from those who must use it. Yet its use has become an imperative of the work of clinicians in interpreting individuals' needs and circumstances and supporting them as an active, skilled clinical presence. Equally, it is an imperative for me as a sociologist to make sense of the changed conditions surrounding birth, which themselves reflect broader disquieting shifts in our society that have actually brought to the fore why we focus on 'risk' in the way we now do.

In June, 2014 the Guardian reported on an American study, which found an 'increased risk' for women who gave birth within 18 months of their first baby; the risks were of the very premature birth of the second and a 'high' risk of that second baby having a '*birth defect*' and '*childhood behavioural problems*'.1 The RCOG, when asked about the research, said that women should leave a year's space (ibid.). There is no question that premature birth may carry significant complications with long-term impacts and consequences, hence a clinician's view might be that we need a risk assessment approach to forestall as many factors as possible leading to prematurity. So this stream of research becomes what Anthony Giddens2 terms '*colonising the future*', that is taking the abstract systems of science and attempting to apply them in such a way as to bring about a '*reduction in life-threatening risks*'. Typically, this is done by instituting larger research programmes, but also in stating increasingly tightly configured guidelines and protocols to capture these new 'risks' in order to pin them down in a clinical setting.

However, these are not neutral actions. This is a dual movement of creating more scientific 'knowledge' and then writing guidelines to match the new evidence. It is the same conventional workbench science with all its capacities, allied to new technologies, which has promised us for well over half a century to bring about vast improvements for all. And in one sense this has been so: the elimination of dangerous communicable diseases and many other forms of life-threatening ill-health, ensuring safe water and sanitation and so on.

However, the devil is in the detail, and working within this frame of reference, there is detail in relation to this current research that lies beyond individual clinicians' line of vision to bring about effective change. The report on prematurity3 and the RCOG response recommended birth spacing to counter the

associated risks. This is a rational (and therefore correct) programmatic approach which can be translated into a guideline. However, the very women who might need to hear that message about birth spacing are probably the least able to listen, with least control over broad areas of their lives.

The study[3] focused on women who gave birth to a single baby in Ohio. The demographics for Ohio put the lives of at least some of those 450,000 in context:

'*a child poverty rate of 24 percent, poverty impacting particularly on single parents and African American and Hispanic children, and high levels of teenage pregnancies.*'[3]

In other words, there are significant numbers of women in deeply vulnerable circumstances. Knowing this, how might we refocus on the risks of premature birth?

The data from Sandra Lane's[4] Why Are Our Babies Dying? are insightful in this regard. Lane painstakingly examines birth patterns from Syracuse, NY, a city which has had the highest perinatal death rates in America for several decades of African American infants. Lane presents the complex picture that lies behind such figures: institutionalised racism, poverty, unemployment, poor housing, drugs, and a lack of state support have all contributed to 'excess perinatal mortality'.

Sandra Lane terms this excess of mortality experienced by the poorest women in the United States as a form of 'structural violence' located in a profoundly unequal society, one which is accelerating in its impacts on the poor and the excluded. Poverty kills, and this constitutes a structural risk that has never been distributed equally across the population. As individuals, of course many clinicians, be they midwives or doctors, know this and attempt to work with it as best they can.

But what results, in a complex and overlapping scenario, is that pinning down 'risk' in the narrower sense, armed with the algorithmic pathways of 'risk assessment' approaches, and then proceeding to make recommendations on '*optimal birth spacing of 18 months*'[1] may be entirely the wrong thing to do. Wrong because we are facing much deeper 'risks' for many vulnerable women that escape the logic of the risk management strategies which have come to be favoured.

Another example of the problematic pinning-down of risk can be read through the discussion of recent research in The Lancet.[5] The research comments on prematurity in the course of examining cause-specific mortality and the extent to which deaths in the first 28 days following birth make up an increasing proportion of deaths in the under-5s. This is an international study of a number of countries, but it cites the UK as having one of the higher rates of death in the first 28 days. When interviewed about this, one of the researchers, Professor Joy Lawn, cited a number of risk factors leading to premature birth, amongst which two caught my attention:

- Increasing rates of obesity.
- Increasing rates of caesareans, the rate now topping 30 percent.

Michael Marmot[6] and Richard Wilkinson and Kate Pickett[7] have pointed out that rates of obesity are

accelerating in the most unequal societies and that more equal societies have far lower rates. Tim Lang from the Centre for Food Policy in City University London has shown[8] that the poorer you are, the more likely you are to have to rely on the mass-produced dense-energy foods sold most cheaply through the supermarkets. So a worsening crisis of food poverty can be said to be contributing to higher rates of obesity in women, again generating concrete risk factors that in many respects lie beyond the power of the clinician in how she or he must currently work. There is a connection here between deepening social inequalities and the increasingly narrow approaches to risk calculations. It is as if we sense the immense damage we have done to our social fabric. However, the extent of the damage invokes a panic which doubles back to seek out yet more calculations about risk rather than searching elsewhere to bring about far sounder approaches to how we care that acknowledge the depth of inequality.

A third brief example perhaps will show how we do not, indeed cannot, see that individual woman. The very welcome Maternal Mental Health Alliance report on the cost of not attending to perinatal mental health both for women and their children[9] looks at the problem of nondisclosure for women and relates this to both the lack of information and lack of trust, quoting the 2013 RCM research which stated that 40 percent of women see a different midwife at each antenatal appointment. That 40 percent and the realities it points to of completely fragmented antenatal care sound like a risk to me.

All these examples reflect a radically changed climate from the 1980s when we hoped for and worked towards the equal presence of voice, agency and evidence in working with every pregnant woman; when Marsden Wagner hoped that the consensus conferences on appropriate birth technologies would move to a 'scientific evaluation'[10] in the widest possible sense (remember, he involved sociologists and birth activists in those conferences); when the first edition came out of Effective Care in Pregnancy and Childbirth, with a similar focus on evidence and the hope that it would make sense to everyone involved in birth and welfare and best care - women, midwives, obstetricians, policymakers.

We could not really see then the straws in the wind, like the 1979 Conservative Party election manifesto [11] with the promise to introduce private beds into the NHS as the first move towards turning the NHS into a marketplace.

What has happened? Is there a connection between how gaps have opened up between how the major health institutions, providers and researchers see health and the experiences of ordinary people? How have so many protocols and guidelines which emphasise certain approaches to risk become more important than seeing all the other risks of living, those structural risks for poorer people? Is it not urgent for us to ask how our society, which prizes scientific and technological advances, has permitted these devastating gaps and inequalities to take root? And crucially, why they are accelerating?

These last three decades mark a turning point in which we can see that we have become less and less confident about how we are to make progress, or even what we might count as progress. In an era of what sociologists like myself term late modernity or *'liquid modernity*', our everyday realities most frequently point to far more precarious lives and, by implication, they show us how our systems are less able and less willing than ever to support people, all of us, as part of a wider community.

There is a strong sense now that anything, however improbable, can be a 'risk' and this is coloured by the belief that we have no intrinsic skills to deal with the unexpected. The monumental growth of 'risk thinking' has run alongside the often ruthless intentions of our public bodies to set limits on their wider social responsibilities and to deny the work of building collective security with all of us, for all of us.

The use of risk assessment tools, which form a core component of contemporary clinical services, prevents us from being clear-sighted about this late modern society which, in Wendy Brown's summary, is 'over-regulated and under-resourced'.12 Placed in this light, how much weight can be given by clinicians to these risk assessment tools, given all the pressures to conform to increasing constraints from policies that target cuts in funding?13

Our technocratic society, which constantly assures us that still more progress is in the offing, is seriously open to question and to its ethical regulation by all of us.

The scandal at the heart of the Francis Report on Mid- Staffordshire was that lack of ethical regulation. There were risk assessment schedules by the dozen, yet these could not capture the real risks people were confronting in a hospital that was dangerously understaffed and dangerously demoralised. These issues were not picked up by so-called regulatory bodies who could only read risk assessments set by limited terms of reference. These bodies sent in reports which asked as few questions as possible, not least to protect their own continued existence.

Since that 1979 straw in the wind about the NHS, risk has come to be defined as narrowly as possible, while there is a real and growing sense of concrete risks which overwhelm the poorer and more vulnerable on a daily basis. Within what Nicolas Rose,14 another sociologist calls the 'neoliberal logic', risk management and risk reduction have 'come to replace other forms of professional action and judgement'.

What is to be done? We need to get skilled-up about the weaknesses of these risk discourses that inevitably support institutions over the individual midwife working with women in need of the best possible care.

We need to strengthen local actions to bring together once more voice, agency and evidence on the part of women, midwives and obstetricians in our communities, to make space politically. Above all, we need not to be afraid of being political in order to secure better practices that reflect our principles about birth. We must do this collectively and very quickly.

References

1. Campbell D (2014) Women 'risk premature birth if they have second child too quickly'. Guardian, 4 June 2014. http://www.theguardian.com/society/2014/jun/04/women-premature-birth-second-child-quickly
2. Giddens A (1991) Modernity and Self-Identity: Self and Society in the Late Modern Age. London. Polity.
3. Spotlight on Poverty (2014) Ohio: Poverty by Demographic.spotlightonpoverty.org/states/ohio/
4. Lane S (2008) Why Are Our Babies Dying?: Pregnancy, Birth and Death in America. Boulder, CO. Paradigm Publishers.
5. Liu L et al (2014) Global, regional, and national causes of child mortality in 2000-13, with projections to inform post-2015 priorities: an updated systematic analysis. The Lancet. doi: dx.doi.org/10.1016/S0140-6736(14)61698-6.
6. Strategic Review of Health Inequalities (2010) Fair Society, Healthy Lives (The Marmot Review): Strategic Review of Health Inequalities in England post-2010. http://www.instituteofhealthequity.org/resources-reports/the-marmot-review-implications-for-spacial-planning
7. Wilkinson R and Pickett K (2010) The Spirit Level: Why Equality is Better for Everyone. London. Penguin.
8. Lang T and Heasman M (2004) Food Wars: The Global Battle for Mouths, Minds and Markets. London. Routledge.
9. Maternal Mental Health Alliance (2014) Everyone's Business.everyonesbusiness.org.uk/.
10. Wagner M (1994) Pursuing the Birth Machine: The search for appropriate birth technology. Camperdown, NSW. Ace Graphics.
11. Conservative Party (1979) Election Manifesto, 1979. www.politicsresources.net/area/uk/man/con79.htm
12. Brown W (2001) Politics out of History. Princeton. Princeton University Press.
13. Liebenberg L et al (2013) Neo-Liberalism and Responsibilisation in the Discourse of Social Service Workers. British Journal of Social Work. doi: 10.1093/bjsw/bct172
14. Rose N (1996) Psychiatry as a political science: advanced liberalism and the administration of risk. History of the Human Sciences, Vol. 9 No. 2, pp1-23.