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Editorial

Professor Kathleen Fahy, Editor in Chief

Evidence-Based Midwifery and Power/Knowledge

Being committed to evidence-based healthcare is essential for individual and professional credibility. According to the Cochrane Collaboration "Evidence-based health care is the conscientious use of current best evidence in making decisions about the care of individual patients or the delivery of health services"(1). This definition should really be limited to 'evidence-based medicine' as it doesn't match with my understanding of evidence based healthcare which will be further elaborated below.

What is meant by 'evidence-based healthcare' differs within and between professions and these differences represent a point of conflict. As a student of Foucault I am aware of the power/knowledge nexus. Put simply, Foucault argued that society confers power on those that it believes have knowledge; thus knowledge confers power. At the same time society also accepts that those who have social power are most likely to be the holders of truth and knowledge. Thus, it is axiomatic that those with social power are able to control what are accepted as knowledge. Foucault wrote 'power/knowledge' as a single concept because the nexus between power and knowledge is so close as to be indivisible (2-4). Evidence-based medicine is one way that supposedly 'irrefutable' knowledge can be used to exercise power.

Evidence-based medicine is based on putting experimental research design into practice. Evidence-based medicine is at its strongest when clinical trials are designed to answer a clear, well defined and simple question. The findings from clinical trials are most valid when there is also a defined and limited outcome that can be reliably measured. The findings of clinical trials are most valid if there has been relatively short timeframes between randomisation, intervention and outcome. For example a good question for evidence-based medicine would be one that asks; which of two, simple, specific treatments is more effective? Evidence to answer a question like this, can be reliably derived from a systematic review of multiple, well conducted, randomised controlled trials (RCTs)(1).

A well conducted trial is one that has a defined intervention that can be controlled during the experiment. This level of definition and control is most achievable in short-term drug trials where name, dose, time and route of administration can all be controlled. This degree of control is difficult, if not impossible, to achieve where the population to be studied is clinically diverse. Likewise, when the intervention has to be delivered by a large number of clinicians there are serious problems with definition and control. Clinicians have various, ill-defined levels of skill in delivering a particular intervention which undermines the controllability of the intervention. Thus, when an intervention that is entirely dependent on the knowledge, attitudes and skills of a range of clinicians then that intervention can't be defined and controlled in the way that it can in a drug trial. Regardless of this lack of scientific rigour, however, complex multifaceted clinical interventions are being studied as if there was the same degree of researcher control as there can be in a drug trial. For instance, in maternity care midwives and woman have criticised obstetricians for the use of such 'evidence' to limit and control women's choices for birth; e.g. length of labour, vaginal breech birth, physiological third stage and birth centre care.

Evidence-based medicine, as originally conceptualised, was not designed to eliminate or downgrade other factors that clinicians actually take into account when making clinical decisions. Clinicians really include not only external quantitative evidence they also consider evidence from their own experience, evidence from physiology, preferences and values held by clinician and patient and the particularities of the contextual of care. "The relative weight given to each of these areas is not predetermined, but varies from case to case" (5) Evidence-based medicine was first defined by Sackett et al in 1996 as "the contentious, explicit, and judicious use of current best evidence in making decisions about the care of individual patients. The practice of evidence-based medicine means integrating individual clinical expertise with the best available external clinical evidence from systematic research" (6).

The Sackett (1996) definition is acceptable to me as a midwife for a number of reasons. Firstly this definition includes the *judicious* use of current best evidence. Judiciousness, meaning 'careful judgement' has been interpreted by Pearson to mean decision-making that is inclusive of the patient's values, beliefs and preferences (7). Lesley Page and others also take this position to sources of evidence to inform decision-making in midwifery (8). Secondly this definition is acceptable because it limits itself to 'medicine' and does not try to encompass and subsume other health disciplines. Thirdly, I like this original definition because it incorporates the expertise of the clinician as part of

evidence-based decision-making. Indeed, Sackett et al go so far as to say that "without clinical expertise, practice risks becoming tyrannised by evidence" (6). It is this tyranny by evidence that is focus of my editorial. Evidence-based medicine can be seen as tyrannical, for example, when health insurance companies cite lack of evidence to deny insurance cover to people who may benefit from a specific intervention that does not have randomised controlled trial evidence (9). We see the tyranny of evidence in the use of power to impose medical protocols on the vast majority of maternity care practices. Further, women are equally tyrannised by 'evidence' which is conveyed to them in such as way as to cause them to feel fear and guilt and thus, to acquiesce.

Even within medicine, evidence-based medicine has been criticised for a number of reasons. One, that is important for midwifery, is that well designed RCTs are expensive. This means that the trials that get funded are more likely to meet capitalist interests to generate wealth (9, 10). Another limitation of evidence-based medicine is that the conduct of a clinical RCT requires support from all relevant clinicians and managers. This means that in maternity care, those with the funding and authority are able to conduct RCTs, whilst those with less power and funding are much more likely to be impeded by these barriers. This is a clear example of how knowledge and power are re-enforcing each other to support current power relations within maternity care.

It is reasonable to assert that definitive evidence for 80-90% of maternity care practices will never been able to be determined by RCT. We do, however, need evidence for practice so that we can assist women to make the best decisions for themselves by taking the best available evidence into account. We need a more expansive definition of evidence and evidence-based practice. The Joanna Briggs Institute (JBI), an international collaboration to generate and promote evidence-based health care, has a more inclusive definition:

> *Simply defined, evidence-based practice is the melding of individual clinical judgement and expertise with the best available external evidence to generate the kind of practice that is most likely to lead to a positive outcome for a client or patient. Evidence-based nursing is nursing practice that is characterised by these attributes. Evidence based clinical practice takes into account the context within which care takes place; the preferences of the client; and the clinical judgement of the health professional, as well as the best available evidence (11).*

Like the Cochrane Collaboration, JBI conducts systematic reviews; indeed a Systematic review of RCTs in either organisation uses the same format and software to conduct the review. What is different about JBI is that the definition of evidence goes beyond evidence of 'effectiveness' to also consider evidence of 'appropriateness', 'meaningfulness' and 'feasibility'. Thus, within JBI, a researcher can conduct a systematic review and meta-analysis of quantitative data. In a parallel fashion, a researcher can conduct a systematic review and metasysthesis of qualitative data. A metasysthesis can also be conducted of expert opinion and the so called 'grey literature' of government reports and other non-standard ways of publishing evidence that is relevant to decision-making in healthcare.

Whilst the conduct of Cochrane reviews of the effects of well defined interventions on equally well defined outcomes plays a role in evidence-based midwifery, it seems timely for us, as midwives, to become active in conducting JBI reviews of the effectiveness, feasibility, appropriateness and meaningfulness of the complex activities midwives and women collaborate in during childbearing. We need to do this because midwifery is far more than a constellation of interventions designed to achieve defined outcomes; it is about being with women in its fullest sense. In order to accelerate our aspirations to be evidence based profession I am interested in working with other midwives, with research qualifications, to forge a program of JBI-type reviews on a par with the already high involvement of midwives in the Cochrane Pregnancy and Childbirth Review Group. In this way we can build the knowledge base for the discipline of midwifery. Enhanced midwifery knowledge will be a counter to the tyrannical use of evidence-based medicine. Armed with evidence women and midwives will be more empowered to practise in the ways that they decide are the safest, most acceptable and most meaningful.

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