EVIDENCE BASED RESEARCH IN MIDWIFERY

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ABSTRACT
‘Evidence based research in midwifery practice’ is an accessible and authoritative guide to implementing evidence-based care in midwifery practice. The importance of evidence in defining midwifery policy and practice is acknowledged and enduring. It identifies and explores recent evidence midwifery initiatives, reflects upon current evidence base to enhance their clinical practice. Evidence often guides practice by assessing the effectiveness of midwifery interventions. There are several ‘unscientific’ sources of evidence, which are valued highly by midwives – intuition, choice, experience, insight, common sense, philosophy, policy and practice. There is often a confidence management reaction to such documents but implementation varies when cost implications and change management are found to be difficult. However, their qualitative study into midwives decision-making strategies concluded that midwives do not appear to have the managerial freedom to engage with women in this way, and the decision-making remains dominated by medical and institutional authoritarianism. We would suggest that there is now clear place and time for acceptance of this wider body of research, which allows it to be valued and implemented if midwifery practice is going to resist further medicalization.

Key Words: midwifery, effectiveness of midwifery, evidence.

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INTRODUCTION:
Evidence based practice is now widely accepted as a fundamental tenet of midwifery. The importance of evidence in defining midwifery policy and practice is acknowledged and enduring. While the development and evaluation of research in midwifery is well charted, the question of how such evidence is incorporated into practice has, to date, received less attention and discussion in the midwifery profession. Answering this need, Evidence based Midwifery focuses on the dissemination and use of evidence for midwifery practice, and explores midwives’ experiences in using the evidence base to inform policy and enhance clinical practice.

Importance of EVRMP
‘Evidence based research in midwifery practice’ is an accessible and authoritative guide to implementing evidence-based care in midwifery practice. It identifies and explores recent evidence midwifery initiatives, reflects upon current evidence base to enhance their clinical practice.

STRATEGIES FOR EVRMP
- Conducting systematic reviews and analyses of the research literature;
- Collaborating with expert researchers and clinicians to facilitate the development of best practice information sheets based on the systematic review of the research;
- Promoting and delivering short courses in evidence based nursing and midwifery for nursing clinicians, nursing researchers, nursing managers and
- Contributing to cost effective health care through the promotion of evidence based nursing and nursing and midwifery practice.

Midwives were also becoming more active in research – undertaking studies that were to have clear clinical impact. Candlish et al.1998). However, some midwives have not been so enthusiastic. Bogdan - lovís and souse (2006), observing the professional conflict between an obstetric and midwifery model of care, comment on the fact that in the context of over-medicalisation of childbirth, high-profile evidence is usually measuring action rather than inaction, by focusing on when to intervene rather than whether to intervene at all.

Is there such a thing as widely acceptable evidence?
Evidence often guides practice by assessing the effectiveness of midwifery interventions. There are several ‘unscientific’ sources of evidence, which are valued highly by midwives – intuition, choice, experience, insight, common sense, philosophy, policy and practice (Wickham 1999). Wickham supports the concept of ‘evidence informed’ rather than ‘evidenced based’ midwifery and describes midwifery as being ‘far more than evidence’, with a need to move away from the ‘just dance’ paradigm, when recognising that only about 12% of midwifery and birth decisions can be supported by evidence (page 1996)

Hierarchies of evidence
Randomised controlled trials (RCTs) were classified as good (level 1) evidence; cohort and case control studies were classified as fair (Level 2) evidence and expert opinion was classified as poor (level 3) evidence. It was very simple and as such easy to understand and implement, but criticised for its simplicity that allowed for many implicit judgements.

Levels of evidence
1+ High-quality meta-analyses, systematic reviews of RCTs or RCTs with a very low risk of bias, 1+ well-conducted meta-analyses, systematic reviews of RCTs or RCTs, with a low risk of bias, 1- meta-analyses, systematic reviews of RCTs or RCTs with a risk of bias. 2+ high-quality systematic reviews of case-control or cohort studies. High quality case-control or cohort studies with a low risk of confounding, bias or chance and a high probability that the relationship is casual, 2+ well-conducted case-control or cohort studies with a low risk of confounding, bias or chance and a moderate probability that the relationship is casual, 2- case-control cohort studies with a high risk of confounding, bias or chance and a significant risk that the relationship is not casual
3 Non-analytic studies, e.g. case reports, case series
4 Expert opinions

What do midwives do when there is little evidence to guide practice?
There is often a confidence management reaction to such documents but implementation varies when cost implications and change management are found to be difficult. They used cues from their impression of the woman’s appearance and other physical markers such as uterine contractions and show, as well as level of distress ranked according to perceptions between of importance. Negotiation between professional and client, which clearly respects each other’s knowledge. However, their qualitative study into midwives decision-making strategies concluded that midwives do not appear to have the managerial freedom to engage with women in this way, and the decision-making remains dominated by medical and institutional authoritarianism.

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CONCLUSION:
We would suggest that there is now clear place and time for acceptance of this wider body of research, which allows it to be valued and implemented if midwifery practice is going to resist further medicalisation and to develop effectively in response to women’s aspirations and needs from their birth experiences. This will require clear collaboration between academics and practice based midwives working together to construct the body of knowledge. There will then need to be systems and professional leadership in place, which would be able to retain the distinctiveness of midwifery knowledge.

REFERENCE:
7. http://www.childlineindia.org.in