



## Article

# Beliefs and values moderate evidence in guideline development

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1 2014-RV-15150R1: **Evidence, guidelines, and interpretations that count**

2 *A commentary on Roome et al 2015: Why such differing stances? A review of professional colleges'*  
3 *position*

4 Soo Downe July 22nd 2015

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5 In their case study of recommendations about place of birth from professional bodies Roome and  
6 colleagues provide an important contribution to the general debate about guideline development,  
7 and, by implication, about how best practice in health care is determined. As they demonstrate, the  
8 interpretation of evidence is strongly influenced by the professional projects of those making  
9 decisions about it; in this case midwifery or obstetrics. This should not surprise us. More than fifty  
10 years ago, Festinger noted the sub-conscious desire to reduce cognitive dissonance (Festinger,  
11 Stanford University Press, 1957). In other words, we all try to make our experiences fit with our prior  
12 beliefs.

13 The qualitative research paradigm explicitly recognises that evidence is a co-production between the  
14 researcher, the researched, and the data. Good quality qualitative research includes techniques such  
15 as reflexivity and the search for disconfirming data to make interpretation more transparent and  
16 credible. As Roome notes, such approaches might also help those creating and using guidelines to  
17 recognise where and how specific beliefs and values inform decisions about what evidence counts  
18 (or doesn't count).

19 Indeed, some level of reflexivity is apparent in the review of planned hospital versus planned home  
20 birth that is a pivotal text for Roome. The authors state: *'The American College of Obstetricians and*  
21 *Gynecologists does not support home birth, citing safety concerns and lack of rigorous scientific*  
22 *study'* (Wax et al AJOG 2010;203:243.e1-8, p243). This sets the tone for how the review data were  
23 interpreted, including the assumption that higher rates of interventions, prematurity, low birth  
24 weight, maternal third degree tears, infection and haemorrhage found in the planned hospital birth  
25 group were justified by the lower risk of neonatal death. As Roome demonstrates, this value  
26 judgement seems to be disputed from the point of view of the professional project of midwifery. But  
27 who decides which interpretation is right?.

28 One vital perspective is only a small part of Roomes paper (probably because it is largely missing in  
29 guideline development); that of the women, families, and societies for whom maternity care is  
30 designed. It is very likely that most women do not conceptualise outcomes that matter to them as  
31 either-or (either reduced mortality or reduced morbidity/increased wellbeing), but rather as both-  
32 and. The recently published Lancet Quality Maternal and Newborn Care (QMNC) Framework is  
33 based on the views, experiences, and needs of maternity service users (Renfrew et al, The Lancet,  
34 2014 384: 9948, 1129–1145). It demonstrates that childbearing women do indeed expect **both**  
35 maximum clinical health **and** maximum emotional and psychosocial wellbeing for themselves and  
36 their newborns. Putting the voices and priorities of women and families at the heart of decisions  
37 about what matters in maternity care is much more likely to lead to a balanced interpretation of the  
38 evidence than leaving it to one professional project or another. This requires more than a token  
39 service user involvement in outcomes development, guideline production, and interpretation of  
40 evidence into practice. The analysis of Roome et al should provide a spur for a global shift in this  
41 direction.

42 **Disclosure of interest**

43 I declare that, to the best of my knowledge, I have no interests to disclose in relation to the above  
44 mini commentary

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