Women and Birth 28 (2015) 221–227

Contents lists available at ScienceDirect

Women and Birth

journal homepage: www.elsevier.com/locate/wombi

ORIGINAL RESEARCH – QUALITATIVE

Documenting risk: A comparison of policy and information pamphlets for using epidural or water in labour

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ARTICLE INFO

Article history:
Received 14 November 2014
Received in revised form 29 January 2015
Accepted 31 January 2015

Keywords:
Risk
Choice
Epidural
Waterbirth
Childbirth

ABSTRACT

Background: Approximately 30% of Australian women use epidural analgesia for pain relief in labour, and its use is increasing. While epidural analgesia is considered a safe option from an anaesthetic point of view, its use transfers a labouring woman out of the category of 'normal' labour and increases her risk of intervention. Judicious use of epidural may be beneficial in particular situations, but its current common use needs to be assessed more closely. This has not yet been explored in the Australian context.
Aim: To examine personal, social, institutional and cultural influences on women in their decision to use epidural analgesia in labour. Examining this one event in depth illuminates other birth practices, which can also be analysed according to how they fit within prevailing cultural beliefs about birth.
Methods: Ethnography, underpinned by a critical medical anthropology methodology.
Results: These findings describe the influence of risk culture on labour ward practice; specifically, the policies and practices surrounding the use of epidural analgesia are contrasted with those on the use of water. Engaging with current risk theory, we identify the role of power in conceptualisations of risk, which are commonly perpetuated by authority rather than evidence.
Conclusions: As we move towards a risk-driven society, it is vital to identify both the conception and the consequences of promulgations of risk. The construction of waterbirth as a 'risky' practice had the effect of limiting midwifery practice and women's choices, despite evidence that points to the epidural as the more 'dangerous' option.

'At the simplest level, we may conclude that 'risk is in the eye of the beholder'.[1]

1. Introduction

This article draws from the doctoral research of author EN, an ethnographic project which aims to examine the way personal, social, cultural and institutional influences inform women's choices regarding the use of epidural analgesia in labour. As midwifery researchers, we were concerned with rising epidural rates and how women were informed about epidural analgesia. The focus of this paper is primarily on the stark contrast that we noticed concerning the information and use of epidural analgesia, compared with the information and use of water in labour, which stood out from other pain relief options because it was so contested, restricted and controlled. First we discuss the evidence that lies behind our concern, as we identify the 'problem' of epidural use, and present some of the evidence regarding the use of water in labour and birth. We then outline the use of critical medical anthropology as the methodology for this study, and as the framework for analysis, before moving into the 'emergent concepts' of the ethnographic research findings. The central tenet—that the use of water in labour and birth was constructed as a risky practice and that this affected midwifery practice and women's choice—is then made, demonstrated through a comparison of hospital and policy documents and with reference to wider theoretical literature on risk. The findings are discussed as they relate to, and further, current debates on the position of risk in childbirth.

2. Background

Most Australian women (97%) give birth in hospital labour wards,[2] which are primarily obstetric-led units. These units are

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http://dx.doi.org/10.1016/j.wombi.2015.01.012
1871-5192/

well equipped to manage emergencies and care for women considered high risk, but do not always offer diversity of care practices for low risk women. The availability, choice and provision of pain relief in labour offer a good example of this. A common intervention offered in obstetric-led units for healthy women during labour is epidural analgesia, which although provides substantial analgesic properties, is also associated with an increased risk of instrumental delivery, higher rates of electronic foetal monitoring (EFM), exogenous oxytocin use, intrapartum fever, hypotension, and decreased breastfeeding rates.[3–11] Some of these associated consequences, such as EFM and oxytocin use, each carry their own risk of further intervention,[12–14] leading to a 'cascade of intervention' that disrupts the normal physiological process of birth. Despite the risks that accompany epidural analgesia in labour, it is referred to consistently throughout the medical and consumer-directed literature as a safe option for women. There is little doubt that epidural analgesia can be useful in some situations of complicated labour and birth, however, the WHO state:

> if epidural analgesia is administered to a low-risk pregnant woman, it is questionable whether the resulting procedure can still be called "normal labour"...epidural analgesia is one of the most striking examples of the medicalization of normal birth, transforming a physiological event into a medical procedure.[15]

Despite this, epidural analgesia is considered a 'routine' analgesic choice for healthy women in labour, and its use is increasing, both in Australia and other high-income nations.[9,16]

Conversely, water in labour and birth is an increasingly common, though still marginal, practice that offers benefits such as increased relaxation and satisfaction, reduced length of labour and intervention, and increased rates of spontaneous vaginal birth.[17] Labour and birth in water is a safe practice, with no significant adverse effects noted in current research.[18–20] Significantly, and perhaps paradoxically in terms of our findings, water immersion decreases the use of epidural analgesia in labour[21] and therefore avoids the risks associated its use.

3. Methodology

The aim of this doctoral research was to examine the way personal, social, cultural and institutional influences inform women's choices regarding the use of epidural analgesia in labour. We used a critical medical anthropology (CMA) framework to inform the research. CMA primarily uses a political economy approach—though dominant social forces other than class are relevant, in this case, the authority of the medical model—and considers the economic, social and political circumstances that influence the situation in question, encouraging the examination and critique of the power relationships that influence normalised behaviours.[22] By examining how knowledge about birth has been constructed, and the way in which epidural analgesia fits into particular hegemonic belief systems about birth, a critical analysis of cultural meanings of Western birth practices and their impact on birthing women can ensue. This provides an alternative starting point for talking about epidural and the use of this method of analgesia for otherwise healthy birthing women.

Using an ethnographic method, EN conducted participant observation in a metropolitan, tertiary hospital labour ward and antenatal classes over a period of six months, including conducting informal interviews with staff members and taking detailed field notes of observations, conversations and interactions. Sixteen women were recruited for a series of three interviews—two antenatally and one postnatally—and participants were also asked to consider my presence at the birth, to which six of the women consented. A third aspect of the ethnography was comprised of document analysis, including information handouts designed for pregnant women, hospital policy documents, and state health department policies. Ethics approval was gained from both the University and the Hospital Ethics Committees. National guidelines for the conduct of ethical research were followed, and data was de-identified to preserve confidentiality.

This paper focuses on some of the 'emergent concepts'[23] from the field notes and document analysis for this research. Using the CMA framework, and engaging with wider theoretical perspectives on risk, we reflect on how institutional beliefs and policies, as well as broader societal notions of risk, can impact on women's choices at the level of practice. The following sections firstly outline the context of risk culture, then go on to describe the machinations of policy on choice as negotiated and maintained within this culture, by examining the documents pertaining to the practices of waterbirth and epidural analgesia.

4. A culture of risk

The centralisation of birthing services in risk-averse acute-care hospitals, within the context of a social milieu increasingly preoccupied with risk, and compounded by an overarching risk discourse specific to childbirth[24] ensures that the overarching focus of birth is one of risk, rather than one of normality. The problem in Australia, where hospital birth is still the norm, is that women often have to fit within this risk model, even if they are classified as having a 'low-risk' pregnancy. Evidence suggests that midwives caring for low-risk women 'adapt their practices according to the context'.[25] That is, in large, all-risk labour wards, midwives are more likely to adapt their thinking to cater for high-risk even if the women they are attending are not.[26] As our meaning systems[29] of birth become increasingly fragmented and medicalised, the incorporation of risk discourse into the consciousness of women and midwives is likely, not only affecting the way that women birth[25,27,28], but making it all the more important to tease out the nuances of language and practice that perpetuate it.

4.1. Risk culture and choice—water restriction

The culture of the field-site was manifestly risk-focused. The meanings ascribed to particular practices as described by hospital policies tended to normalise intervention, and marginalise non-medical practices. This influenced the behaviour and individual practices of the midwives, affecting the culture of the site as a whole. As one midwife put it: '*The thing is here, is that there aren't that many options. There's pethidine or there's epidural. They don't use TENS here, which is really good for early labour. And they don't really use the baths*'. *(MW19)*

There was a lot of discussion by the midwives about the restrictions around labour and birth in water. Women were not supposed to *even get into the bath* unless the midwife who was caring for her was accredited to provide waterbirth. The accreditation process itself was seen by the midwives as barrier, and it was difficult to get supervising midwives to facilitate the accreditation process. Another barrier to the use of water was the increased paperwork involved. One midwife, discussing this difficulty, said: '*they are good pain relief. I think they should have more [water birth].*'

EN: 'Do many women ask for it?'

MW13: *'No, and we don't volunteer the information, even down in clinic. Just like today, [we] could use water therapy for her, but it's a bit late in labour to talk about water therapy. There's so much [paperwork] involved now, whereas in the old days [women used to just get in the bath, it was simple].*'