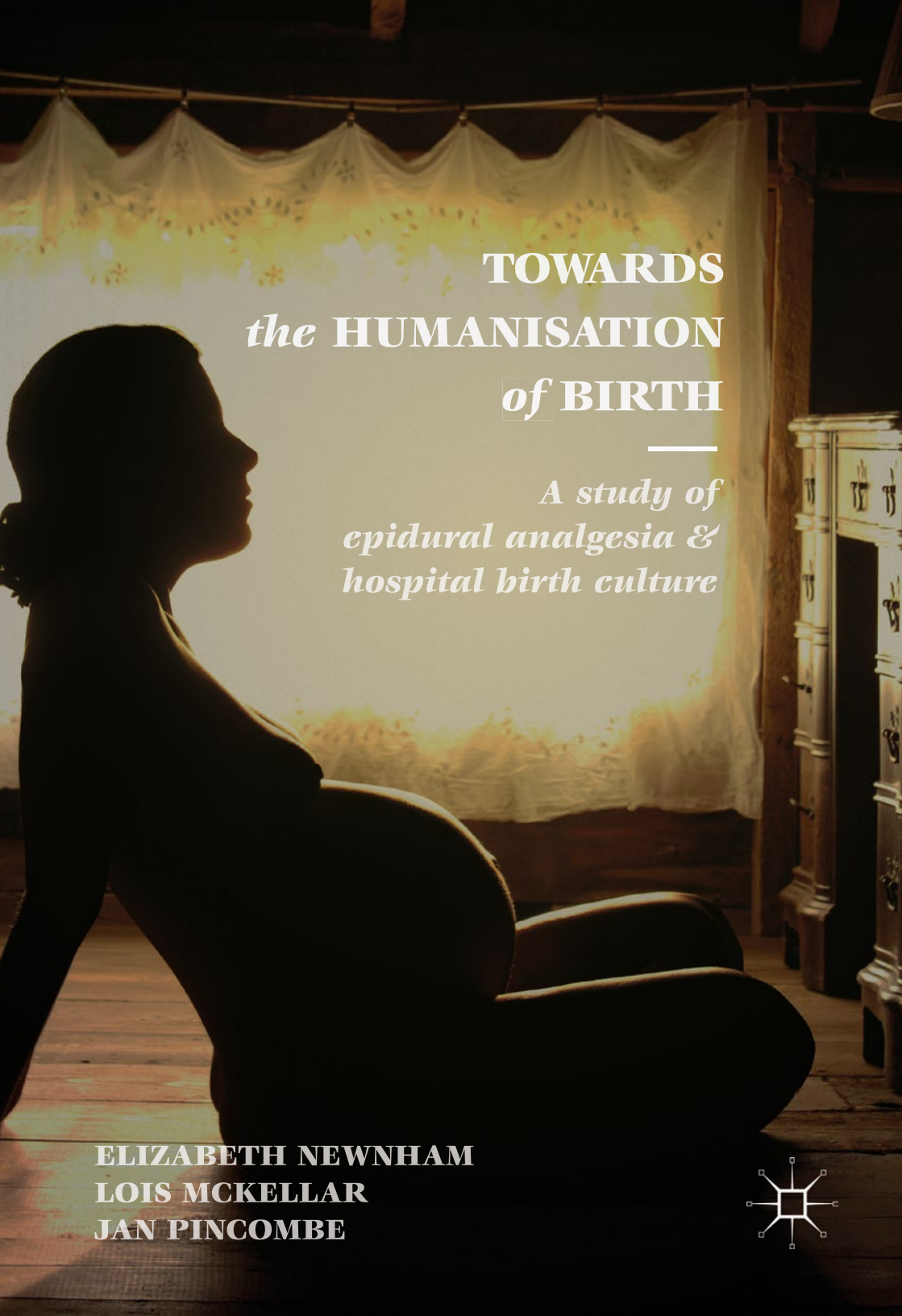

TOWARDS *the* HUMANISATION *of* BIRTH

A study of epidural analgesia & hospital birth culture

ELIZABETH NEWNHAM
LOIS MCKELLAR
JAN PINCOMBE

Towards the Humanisation of Birth

'This careful comparative ethnography will be most welcome to all scholars interested in birth, midwifery, and obstetric practice, as well as midwifery researchers. Its concepts of the institutional paradox and midwifery technology are extremely useful and original contributions. The introductory poems are also wonderful, bringing a sense of high art to the text. The very highest quality of scholarship is evident in this book.'

—Dr Robbie Davis-Floyd

Elizabeth Newnham • Lois McKellar
Jan Pincombe

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Foreword

This book is a timely and relevant addition to the movement towards humanising birth, questioning the regular use of epidural analgesia in normal labour by providing an incisive cultural analysis of hospital birth culture. The evidence is indisputable that epidurals undermine childbirth physiology and lead to increased intervention rates. As identified in this book, the attitudes of maternity care practitioners towards pain in labour will affect the way this information is presented in policy documents, in practice guidelines, and in the information that is shared with women. This results in a maternity service culture throughout the Western world that privileges the use of epidurals over evidence-based forms of care that are known to lower epidural rates and promote positive experiences for women. As discussed here, the implications for women who enter large obstetric units anticipating a normal labour and birth are profound.

In spite of ongoing resistance by women, midwives, and others who wish to promote physiological birth, the epidural is framed as the modern way of giving women control over their bodies. We see research projects in low-income countries asking women if they would like the same access to epidurals for pain-free labour as that enjoyed by their sisters in high-income countries, and concluding that this is a human rights issue. Thus, in practice settings across the world, the question is being asked: 'Why would you not have an epidural in this day and age?' Midwives who critique this approach are accused of practising 'medieval midwifery'

and making women feel guilty if they choose to have an epidural. Worse still, there are suggestions, enhanced by media frenzies, that midwives are putting the lives of babies at risk in their attempts to promote normal birth, creating a moral panic about childbirth, and placing the blame with midwives rather than looking more deeply into the system of Western birth culture.

Concerns to avoid making women feel guilty and a lack of faith in women's ability to manage pain in labour are perhaps understandable if you practise in an environment where it is rare to see women giving birth completely 'under their own steam', assisted only by encouragement from others. We read of student midwives entering their third year of education who have rarely witnessed women having drug-free labours. They are being taught about the evidence that, overall, positive birth experiences are not related to the level of pain experienced and that many women view pain as part of a sense of triumph and transition to motherhood—but they are rarely seeing this in practice.

The potential for women to emerge from their childbirth experiences feeling empowered with an increased sense of self-efficacy has been widely identified in qualitative research projects and media accounts by women themselves. Sadly, the converse is also true, particularly where women feel they were not supported or listened to and where they felt overwhelmed and frightened by a cascade of events leading to post-traumatic stress, depression, and disrupted parenting. With suicide now the leading indirect cause of maternal death in many Western countries, addressing the humanisation of birth is an imperative. This book shows how a core component of this process is addressing the complexities of attitudes to pain in labour. This is a starting point for changing the culture of birth in institutions where epidurals are seen as the most appropriate way to manage pain even where labour is straightforward.

Interfering with birth in the absence of medical necessity has serious consequences in terms of the potential increased risk of complications for women and their babies. Furthermore, there is strong evidence to support practices that promote physiological birth and a positive experience for women. These include providing continuous one-to-one support in labour, immersion in water for pain relief,

a home-like environment for labour, and avoiding routine interventions and restrictions on the woman's freedom to move around and adopt positions of her choice.

Where there is patchy provision of one-to-one support in hospital environments, it is perhaps no surprise that women end up opting for epidurals. We should not assume, though, that this system failure is associated with women's preference. Women are embracing drug-free labour at home, in birth centres, and in midwifery-led units with many more unable to access these options. Stories arising from these settings and, indeed, positive stories of drug-free births in large hospital institutions should be much more widely circulated and discussed. This applies particularly where practitioners tend only to hear stories about complications and emergencies in case reviews.

This book identifies how the biomedical research on epidural use encourages the concept of the 'safety' of the epidural, even when discussing its possible side-effects. This perpetuates an acceptance of epidurals as a modern, 'common sense' option. Research identifying the physiological and emotional effect of the environment for birth and the disturbance of hormonal processes in labour are rarely discussed with women.

As suggested in this book, robust discussion is needed about the wider effects of epidurals on women's experiences of birth and an alternative framing of supporting women through a 'working with pain' approach. Such discussions need to be informed by descriptions from women about empowering birth experiences and widespread dissemination of the importance of hormonal responses during childbirth as described in Sarah Buckley's important text: *Hormonal Physiology of Childbearing: Evidence and Implications for Women, Babies and Maternity Care.*[1]

The authors of this book propose that, rather than the fraught polarising of 'normal birth' and 'medicalised birth' (midwifery/obstetrics), we should think about 'the notion of a continuum, with intervention-free birth at one end and medicalised birth at the other, with women, midwives and obstetricians in the middle, maintaining a dialogue about what is best for women as individuals'. They suggest that this would require a shift by the medical profession to understand birth as a normal process

until proved otherwise, rather than conceptualising birth as 'only normal in retrospect'. It would also require complex understandings of power dynamics and how these influence the culture and practices within contemporary maternity services.

This text makes compelling reading. It articulates complex concepts and ideas with clarity, drawing on rich data in a stimulating and courageous challenge to the notion that epidural analgesia is safe and should be universally available to women. A critical examination of how birthing ideologies inform hospital practices is linked to the effect this has on the choices women make about epidural use. A thoughtful analysis of the effects of the global rise in interventions in childbirth is offered in order to articulate the need to humanise birth, identify the potential dangers of the technocratic birth paradigm, and promote physiological birth. Complex issues associated with the role of epidural use within this conundrum are introduced, including the contested meanings of pain in labour.

The potential role of midwives in engaging with individual women in relationships based on mutual trust while also engaging with uncertainty is articulated with reference to discussions on how the social and cultural construction of 'normality' can be problematic in the way midwifery is viewed and enacted within contemporary maternity care systems.

Each chapter in this book starts with a participant's poem, drawn from the research data in order to provide 'verisimilitude'. These poems are very powerful; they bring to life the data and experiences of women in a way that adds authenticity and credibility to the arguments that are posed in each chapter.

An ethnographic study undertaken in the labour ward and interviews with women are critically analysed drawing on an impressive blend of theoretical perspectives and literature to identify the socio-cultural implications that need to be considered if practice is to be woman centred and emancipatory. The spotlight is placed on a culture riddled with values that perpetuate surveillance and contested notions of risk. The discourse of pain in labour is thoroughly explored in relation to technocratic attitudes and practices and powerful arguments are presented for how women are placed at risk in institutionalised birth settings.

A critical review of literature related to labour analgesia includes an analysis of how historical, social, political, economic, and cultural factors

influence the way in which women's bodies are viewed by science and the philosophical thinking that has underpinned medicine and midwifery. This contributes to an analysis of the epidural within contextual belief systems and the biomedical discourse of risk and safety that excludes the social, physical, and emotional meaning of childbirth for women.

It might be easy for midwives working in institutions to feel paralysed about the effect the dominant culture has on their efforts to promote normal birth; however, the lead author's analysis of interviews with women offer an alternative framework for working with women around managing pain in labour. As they grappled with the uncertainty of facing the unknown, the majority of women interviewed wanted to trust their bodies to know how to manage pain in labour; they also wanted midwives they could trust to guide, advise, and support them in 'going with the flow'. Women were practical in their approaches to labour pain, drawing strength in the idea that women have been giving birth since the beginning of time. They also saw pain as potentially transformative and associated with the joy of bringing their baby into the world. The trust women placed in the midwife's role of guiding them through labour was at odds with many of the midwives' ideas that women had already decided what they wanted before coming into hospital and that the woman's partner should be the person providing them with support.

The conclusion is compelling; that midwives should focus on supporting women fully through labour in the understanding that most women will have a sense of trust in their bodies and that this needs to be reflected back by the midwife. Unless women specifically ask for an epidural in their birth plan, midwives should assume that women want to be supported through the process of giving birth.

This is a stimulating and thought-provoking book that will no doubt promote interdisciplinary discussion and be of significant interest in the international arena. What is so impressive about the work is the broader lens the authors bring to a quite specific topic, reminding us that multiple domains impact on something that seems like a straightforward clinical decision from the midwives' or obstetricians' perspective and a straightforward choice by a labouring woman. Institutional, neoliberal, gendered, medicalised, technocratic, and professional project discourses have real influences and help construct the space where decisions around pain

management in labour are made. In addition, drawing on her research, the lead author brings a critical lens to how these discourses operate, challenging taken-for-granted assumptions, for example, an elective epidural service, and making visible how these discourses diminish women's agency and body autonomy. All of this opens the space up for alternative choices and, arguably, more authentic, embodied experiences for women. This challenging text is essential reading for all who are committed to humanising birth and promoting positive experiences for women.

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Ultimo, NSW, Australia — Nicky Leap
Nottingham, UK — Denis Walsh

Note

1. Available online: www.ChildbirthConnection.org/HormonalPhysiology.

Preface

Around the world, more and more women are using epidural analgesia in labour. Epidural analgesia provides adequate pain relief, but is also associated with detrimental side-effects, including increased risk of instrumental birth and decreased oxytocin production. Epidural analgesia also requires additional measures such as continuous electronic foetal monitoring and intravenous therapy, thus moving women out of a 'low-risk' labour category. Importantly, epidural use does not necessarily increase women's satisfaction with birth, which is not inevitably related to levels of pain. Women's attitudes to labour pain are complex and multifaceted and, contrary to the broader medical view, pain is not necessarily the primary concern of women anticipating labour.

In this book, we contribute to the growing movement of humanising birth by providing an ethnographic critique of institutional birth, using epidural analgesia as the point of entry into hospital birth culture. The idea of looking at hospital birth culture through the medium of epidural analgesia came to our attention through our experience as midwives: watching epidural rates increase, noticing how it was portrayed to women, and trying to ascertain women's understanding of it. Early on in the research process, we came across a paper by midwife academic Denis Walsh, who articulated very clearly the complexities that epidural analgesia brings to birth as well as introducing the idea that epidural rates may be increasing due to social and cultural factors, such as increasingly

alienating birthing practices, rather than because women are less able to cope with pain. We therefore examine here concepts of birth pain and its relief, with a particular focus on the institution as an arbiter between the macro-culture of socio-political norms and the micro-culture of individual experience and interactions.

We begin the book by critically examining epidural use, looking at the various influences on women, as well as the way birth ideologies inform hospital birthing practice, and the resulting effect on the choices pregnant and birthing women are able to make about their bodies. We use a Critical Medical Anthropology (CMA) approach, which considers the interplay of structural power relationships, and how these power relationships are played out in the social world. CMA analysis begins with identification of the problem; in this case the increasing uptake of epidural analgesia by labouring women, with questions as to the amount of information accessed by women, the role of midwives in this process, and the role of pain in labour. Ultimately, what we provide is a study of hospital birth culture which can inform and direct current and future birth practice.

In the case of critical ethnography, objectivity does not rely on absence of bias. It identifies, rather, that biases are always present in the outlining of the research problem: the choice of question being asked and the theoretical framework used. It is in the laying open of these biases that intellectual rigour stands (and in this way is perhaps more honest than more 'objective' research that fails to question its implicit assumptions). We locate ourselves, and our premise that the indiscriminate use of epidural analgesia is a problem, not a solution, at the centre of this research. Thus, this ethnography is not presenting 'the' version, it cannot. It is presenting 'our' version, and throughout we take the reader back to the data and weave the theory around this, forming a piece of research that is, we feel, both credible and necessary.

The preparation of this book has been, of course, a large piece of work. We are grateful to the Australian government and the University of South Australia for awarding the Australian postgraduate award which funded this research. We especially thank the participants of the study, without whom the book could not have been written. We have been pleasantly surprised by the feedback: the women we interviewed were pleased to have been able to speak about their experiences; those midwife clinicians from

the study who attended presentations of our research have also affirmed aspects of the findings. Other midwifery colleagues and experts in the field have responded to this research at both national and international conference presentations, including Australian College of Midwives' National conferences, the Normal Labour and Birth conference in the United Kingdom, and at International Confederation of Midwives' congresses, in Prague and Toronto. There has been a high level of substantiation from those midwives we have spoken to about similar issues occurring around the world. We thank all of these midwives for their feedback.

Thanks also to others who have read early versions of chapters and provided constructive criticism as well as anonymous reviewers of journal articles and the final manuscript of this book. We would particularly like to acknowledge Robbie Davis-Floyd who gave valuable suggestions and generously provided us with a chapter of her forthcoming book. Thanks are also due to Palgrave and the wonderful editors there. In addition, we are indebted to Nicky Leap and Denis Walsh, who enthusiastically suggested the publication of this research and who have kindly written the foreword to the book.

Finally, we would like to thank our families, those people who know us best and keep us going. This book is for you.

Dublin, Ireland — Elizabeth Newnham
Adelaide, SA, Australia — Lois McKellar
Adelaide, SA, Australia — Jan Pincombe

Sections of this book were originally published in journal articles; we list these below underneath the relevant chapters, which may contain additions and amendments.

Chapter 1

Newnham, E., Pincombe, J., & McKellar, L. (2013). Access or egress? Questioning the "ethics" of ethics review for an ethnographic doctoral research study in a childbirth setting. *International Journal of Doctoral Studies, 8*, 121–136. Copyright permission obtained from the Informing Science Institute Board of Governors and allowed under Creative Commons licence.

Newnham, E., McKellar, L., & Pincombe, J. (2016). Critical medical anthropology in midwifery research: A Framework for ethnographic analysis. *Global Qualitative Nursing Research, 3*, 1–6. https://doi.org/10.1177/2333393616675029. Copyright permission obtained from SAGE Publications and allowed under Creative Commons licence.

Chapter 2

Newnham, E., McKellar, L., & Pincombe, J. (2016). A critical literature review of epidural analgesia. *Evidence Based Midwifery, 14*(1), 22–28. Copyright permission obtained from the Royal College of Midwives.

Chapter 4

Newnham, E., McKellar, L., & Pincombe, J. (2017). Paradox of the institution: Findings from a hospital labour ward ethnography. *BMC Pregnancy and Childbirth, 17*(1), 2–11. Copyright retained by authors under the BioMed Central licence agreement.

Chapter 5

Newnham, E., McKellar, L., & Pincombe, J. (2017). It's your body, but…' Mixed messages in childbirth education: Findings from a hospital ethnography. *Midwifery, 55*, 53–59. Copyright permission obtained from Elsevier under pre-existing licence terms.

Newnham, E., McKellar, L., & Pincombe, J. (2015). Documenting risk: A comparison of policy and information pamphlets for using epidural or water in labour. *Women & Birth, 28*(3), 221–227. Copyright permission obtained from Elsevier under pre-existing licence terms.

Contents

List of Abbreviations

3:10/4:10	Stands for 3 contractions (or 4 contractions) in the space of 10 minutes.
ARM	Artificial rupture of membranes
cCTG	Continuous CTG monitoring throughout labour (rather than an intermittent trace)
CMA	Critical medical anthropology
CTG	Cardiotocograph
Cx	Cervix
EBM	Evidence-based medicine
EFM	Electronic foetal monitoring (used in the literature to refer to CTG monitoring in labour)
EN	Elizabeth Newnham (Field notes and interviews)
GBS	Group B Streptococcus bacteria
GD	Gestational diabetes
ID	Identification
IOL	Induction of labour
IV	Intravenous
LSCS	Lower segment caesarean section
MET	Medical Emergency Team
$MgSO_4$	Magnesium sulphate
MW	Midwife (Field notes)

$N_2O\&O_2$	Nitrous oxide and oxygen ('gas and air')
OP	Occiput Posterior
PPH	Post-partum haemorrhage
REG	Registrar (Field notes)
SOL	Spontaneous onset of labour
SRM	Spontaneous rupture of membranes
T/L	Team leader

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1

Introduction

Background: Models of Care, Philosophies of Birth

There is an ongoing debate regarding the provision of maternity care, situated in the midwifery/medical dichotomy, which has permeated birth discussion since the advent of medical involvement in birth in the seventeenth century (Donnison 1988; Ehrenreich and English 1973; Murphy-Lawless 1998; Roome et al. 2015; Towler and Bramall 1986; Willis 1989). Since then, midwifery as a profession has become increasingly concerned with 'guarding normal birth' (Crabtree 2008, p. 100; Fahy and Hastie 2008, p. 22; Kent 2000, p. 28). Broadly speaking, the midwifery model of birth is one that promotes the process of birth as a normal physiological process and a significant life event for a woman, which impacts on her spiritual, sexual, and psychological development (Fahy et al. 2008). The linguistic origin of the English word midwife, *midwyf* (meaning 'with-woman'), is foundational to midwifery philosophy, evident in contemporary terminology such as 'woman-centred' care. This term describes the concept of the woman and midwife in partnership, one based on mutual trust and respect, and to provide care during this

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life event which is unique to each woman (Hunter et al. 2008; Leap 2000). Within the midwifery model, practitioners value women's embodied knowledge as well as the importance of clinical knowledge and skills. They acknowledge the uncertainty of birth, while being equipped for emergency scenarios. This model also identifies the emotional qualities that can affect a woman's labour, the subtleties of hormonal influences and the effect of the environment (Fahy et al. 2008; Lepori et al. 2008).

However, there are challenges to the midwifery concept of 'normal'.[1] This includes changes in the definition of normal as increasingly, routinised, medicalised birth is being described as normal if it does not result in an instrumental or a caesarean birth.[2] Thus, augmented labour, the use of analgesics and oxytoxics for the third stage of labour may all be defined in some places as normal birth. Indeed, Davis-Floyd (2018) takes this a step further as she discusses the way that medicalised birth practices are normalised through a technocratic lens even as normal labour and birth processes are framed as risky and therefore 'abnormal' (see also Wendland 2007; Kennedy 2010). As such, midwives may be at risk of losing non-medical definitions of normal birth, especially as many midwives are socialised, through their education and employment, into hospitalised/medicalised birth (Crabtree 2008, p. 99; Wagner 2001).

Although it refers primarily to the normalcy of birth as a physiological event, the symbolism of 'normal' birth can also alienate women who have an instrumental or caesarean birth; it can signify that their experience was somehow abnormal and therefore different or lacking (Kennedy 2010). This has led to proposed terminology such as optimal birth—supporting women to have the optimal birth experience within their unique circumstances, and salutogenic birth—focusing on factors that optimise health and wellbeing rather than those that contribute to disease (Downe and McCourt 2008; Kennedy 2010).

Another difficulty with midwifery's focus on the 'normal' is the potential failure to notice 'the ways in which "normality" is historically, socially and culturally produced' (Kent 2000, p. 30). Discussion on the construction of 'normal' is present in contemporary midwifery literature (Downe 2008; Walsh 2012), identifying a need for midwives to delineate *midwifery* definitions of normal, rather than relying on the obstetric

view that birth can be normal 'only in retrospect' (Flint 1988, p. 35; Williams 1997, p. 235), whereby '[a] birth cannot be judged as normal until after it has concluded, when doctors are in a position to say that there has been no pathology present throughout the entire birth process' (Murphy-Lawless 1998, p. 198). However, there is also a danger in the idealisation of a 'sentimentalised' view of birth and blanket condemnation of medical birthing practices which can provide timely intervention in emergency situations (Dahlen 2010). In a model of exemplary midwifery practice, Kennedy (2000) outlines the 'art of doing "nothing" well', where midwives achieve a seemingly effortless act of being present to the woman and supporting normal processing that actually involves an intense vigilance and attentiveness. There is also a genuine risk to women in furthering the dichotomy between the medical and midwifery professions (MacColl 2009, pp. 7–20; Wendland 2007).

The medical profession has provided life-saving procedures for both women and babies. Nevertheless, expanding the use of medical techniques to all areas of birth without critical examination is imprudent and potentially iatrogenic. As Mead (2008, p. 90) notes,

> The situation we are experiencing today is primarily the result of good intentions, namely the desire to reduce maternal and perinatal mortality and morbidity. However, in the absence of sound programmes of research, these good intentions have contributed to an increase in maternal morbidity, particularly an increase in intervention in pregnancy and childbirth, and a disproportionate rise in caesarean sections, without a corresponding improvement in neonatal outcome.

The birth paradigm dichotomy was elucidated by journalist Mary-Rose MacColl (2009) in *Birth Wars*, the book she wrote after participating in the Queensland maternity review process. MacColl describes the turf war between 'organics' (those dedicated to working with the uncertainty of birth, with minimal disturbance of the process of birth—often, but not always, midwives and homebirth advocates) and 'mechanics' (those who intervene in the birth process, who see control as better than uncertainty—usually, but not always, obstetricians). MacColl's observation is not new; she is describing the historical and continuing dialectic

between medical and midwifery discourse. However, the contribution that MacColl brings to the debate is her recognition of the negative impact of this divide on women themselves.

Having professional power inequities in the birth environment introduces the possibility of danger from either perspective. Medical dominance limits women's choices, mechanises an intricate psychophysiological process and may cause intervention-based harm. However, the case of midwives delaying transfer or ignoring a potential complication in a naïve kind of sentimentalised birth ideology (MacColl 2009, pp. 7–20) is also damaging (see Dahlen 2010). While the cases MacColl cites may be extreme, and in many cases midwives and medical practitioners work well together, the difficulty for women is to distinguish between issues of *medical control* and real issues of *safety*; between the unnecessary or the life-saving intervention. Many women do not know, and may not be told, the risks associated with intervention in childbirth (MacColl 2009, p. 120). Wagner (1994, p. 6) declares that 'conflict over birth technologies is a major battle in a contemporary health revolution' because of the disagreement between midwifery and medical models of health. He notes that the 'conflict is sharpest in the areas of birth and death where the social model seems to offer an important contribution to the orthodox medical model' (Wagner 1994, p. 6). In other words, in areas where biomedicine is most contested, it pushes back the hardest. However, if, as has been suggested, the most significant factor affecting women's decision to have an epidural in labour is not pain during labour, but her beliefs about childbirth (Heinze and Sleigh 2003), then it is all the more necessary to somehow bridge this divide. It is likely that social, medical and midwifery perspectives on childbirth influence a woman's decision to have an epidural. In light of this, challenging and changing social perspectives on birth will effectively have an impact of women's birth experiences.

Although we are working with the notion of medicalised childbirth, we do not intend to further dichotomise the two models. Rather, we propose the notion of a continuum, with intervention-free birth at one end and medicalised birth at the other, with women, midwives and obstetricians in the middle, maintaining a dialogue about what is best for individual women. For this to occur there would need to be a shift by the medical profession to understand birth as a normal process until

proven otherwise, rather than as an inherently pathological process. The biomedical model has essentially been the dominant model in the birthing practices of most Western countries, particularly since the move to hospitals, and the medical system, in Australia at least, remains actively opposed to attempts at increasing midwifery models of care (see Newnham 2014). The resulting imbalance of medicalised versus 'normal' birthing practices needs redressing, in the hope that a combined and congruent maternity service can ensue.[3] Evidence of this is occurring throughout the world (Davis-Floyd et al. 2009). In a recent article in the *Wall Street Journal*, two obstetricians who succeeded in reducing caesarean section rates in their hospital refer to the importance of birth unit design, the frequent need to do 'nothing' to support birth, the contradiction this causes with the medical desire to do 'something', the need to develop 'tolerance for uncertainty', judicious evidence-based use of technology, rather than technology for its own sake, and the influence of culture on making and keeping these changes (Marcus 2017). That these ideas are entering mainstream obstetric discourse inspires hope for safe, integrated and humanised maternity services globally.

Humanised Birth

Humanised birth as a perspective has been gathering momentum for some time (see Davis-Floyd 2001; Page 2001; Umenai et al. 2001; Wagner 2001). It originated in Brazil and other Latin American countries, where the concept of humanised birth has been clearly demarcated (see Rattner 2009) to the point where humanised birth practices have been encoded into legislation. In Brazil, ReHuNa—Network for the Humanization of Childbirth was founded in 1993 to counter obstetric violence using the more positively framed language of humanised birth. Following the inaugural International Conference on the Humanization of Childbirth in Fortaleza, Ceará, Brazil, in 2000, Marden Wagner (2001, p. S25) wrote:

> Humanized birth puts the woman in the center and in control, focuses on community based primary maternity care with midwives, nurses and doctors working together in harmony as equals, and has evidence based services.

However, as Davis-Floyd (2018) points out, it is easier to acknowledge overtly dehumanising birthing practices; in most Western countries, the technocratic system of birth provides clean and safe venues, provision of privacy, and respect for autonomy (to an extent), showing that although it may still maintain a separation of mind and body, it does for the most part hold on to a sense of integrity. However, the process of medicalisation itself can be dehumanising, in its mechanistic view of the human body and the way this translates to the treatment of birthing women (Wagner 2001). Women in all settings are describing incidences of dehumanised birth: practices occurring without consent, being treated with disrespect and without compassion.

The Research

This book is based on a piece of critical ethnographic research conducted in an Australian metropolitan hospital. We chose a major hospital as our study site, because a high percentage of women in Australia give birth in hospital labour wards (this number was 98% in 2014) and our focus was mainstream birthing environments (AIHW 2016, p. 16). During an intensive six-month period of fieldwork, hospital culture was observed, as we talked to hospital staff, examined hospital documents and recorded these observations as field notes. The observations and conversations formed the field notes proper, to which analytic memos were added. Consistent with this kind of research, a journal was kept throughout as a way of organising thoughts and maintaining reflexivity.

In addition, 16 pregnant women participated in a series of three interviews—two in the antenatal period and one postnatal—and were asked for consent for a researcher to be present at the birth. Interviews were recorded and transcribed verbatim and the transcripts analysed for themes. All data were analysed through the lens of a three-pronged theoretical framework—CMA, Foucault, and Feminism—using continuous analysis and 'thick description' (Geertz 1973). We also adapted and used the Health care arena model (Baer et al. 1986; Newnham et al. 2016). We provide a more in-depth understanding of CMA and ethnography in the following pages.

Critical Medical Anthropology

Critical Medical Anthropology (CMA), a term coined by anthropologists Merrill Singer and Hans Baer, who were integral in its development, emerged in the 1980s as a critique of traditional medical anthropology (Singer and Baer 1995, p. 5). As a branch of anthropology, traditional medical anthropology tended to take Western medicine (biomedicine) at face value, acting as a cultural translator for medicine in order to understand miscommunication in medical encounters, to provide a layperson's perspective, or to increase medically recommended behaviours, such as taking medication (Singer and Baer 1995). Medical anthropology, though potentially useful, was not necessarily reflexive or critical in its understanding of medicine, and worked within the auspices of medical authoritative knowledge. However, there was increasing concern in anthropology to examine biomedicine as closely as other cultural systems, and to culturally situate its belief systems, rituals and values in the same way as other cultural domains. CMA therefore takes a critical stance in the study of biomedical culture, rather than working as its cultural mediator, and it questions medicine's portrayal of itself as objective, as working only with 'truth' and 'fact', removed from cultural influences (Singer and Baer 1995, p. 5). Further to this, there was a push in CMA for understanding the way in which power relationships in medicine interacted with the global capitalist economy, and to ensure that medical anthropology did not become 'an instrument for the medicalization of social life and culture, but also, like biomedicine, an unintended agent of capitalist hegemony and a tag-along handmaiden of global imperialism' (Singer and Baer 1995, p. 5).

As stated above, CMA uses a structural, political economy (Marxist or neo-Marxist) approach,[4] examining the historical development of the economic, social, and political circumstances leading to the situation in question. This 'wide-lens' view of historical and cultural influences prior to focusing on the ethnographic minutiae of the everyday allows for the dissection and critique of behaviours, practices, and beliefs that are otherwise accepted or taken for granted as the status quo.

Ethnography as a Critical Method

Ethnography essentially means the study of culture, and ethnography with a critical stance explores power relationships within culture (Thomas 1993).[5] Cultural beliefs and practices that surround birth have a significant impact on the way birth is both understood and managed; by women, midwives, and broader health systems (Jordan, B 1993). To answer our questions about the use of epidural analgesia for labour, we have undertaken a critical study of the culture of birth.

Critical research methodologies typically highlight social justice issues and seek social emancipation (Crotty 1998, pp. 118, 157).[6] Critical ethnography, therefore, seeks to change the status quo, rather than just to describe occurrences. It invokes 'a call to action that may range from modest rethinking of comfortable thoughts to more direct engagement that includes political activism' (Thomas 1993, p. 17). By examining how knowledge about birth has been constructed, and the way in which epidural analgesia fits into particular belief systems about birth, a critical analysis of its increasing use can ensue. This provides an alternative starting point for talking about epidural analgesia and the use of this method of analgesia for otherwise healthy birthing women. As Thomas (1993, p. 3) identifies, '[w]e create meanings and choose courses of action within the confines of generally accepted existing choices, but these choices often reflect hidden meanings and unrecognized consequences'. Focusing the research spotlight on epidural use illuminated cultural birth norms that were not necessarily anticipated, for while ethnographic research commonly sets out to examine a culture (or what is perceived as a problem or inequity within that culture) more generally (Thomas 1993, p. 35),

> it is frequently only over the course of the research that one discovers what the research is really 'about', and it is not uncommon for it to turn out to be about something quite remote from the initial foreshadowed problems. (Hammersley and Atkinson 1983, p. 175)

Ethnographic research has a specific and important role in identifying cultural influences on childbirth and highlighting change requirements in health care institutions, including:

> creating a more efficient, more effective, more equitable and more humane health care system, particularly in illuminating the organizational and interactional processes through which health care is delivered. They offer important information, to policy makers and practitioners, about factors that compromise or promote high quality care, particularly the ways in which well-intentioned actions may have unanticipated negative consequences. (Murphy and Dingwall 2007, p. 2224)

Given that humane birth practices within maternity systems are now seen as a priority by those at the forefront of the profession, and by those who have witnessed the inhumane practices that are occurring daily around the world (see Human Rights in Childbirth), ethnography provides a fitting approach to explore the 'unanticipated negative consequences' of otherwise ordinary, well-intentioned maternity care provision.

Ethnography in Midwifery

Ethnography, previously concerned with examining cultural practices of 'the other', non-Western societies, has in recent decades turned to aspects of Western culture, including cultural analysis of medical and health care settings (Liamputtong and Ezzy 2005). With respect to midwifery specifically, ethnographic research has been useful in demarcating the juxtaposition of power relationships and cultural norms: those of women, of midwives, of medical staff, and of the institution. Ethnographers peer underneath the discourses of practice and philosophy, exposing their influence on what is said and done. Over the last two decades, midwifery ethnographies have unearthed a deep sense of disempowerment in midwifery culture, which appears to contradict the role of midwives as facilitating empowerment in the women they work with.

Hunt and Symonds' (1995) ethnography of English labour ward culture provided insight into the assembly-line, industrial nature of labour in the hospital system, within which midwives pursued ways of increasing control of their environment, including attempts to 'slow down the production line' (Hunt and Symonds 1995, p. 144). The masculinised medical system as well as the industrial environment led to a lack of

autonomy for midwives—although this was offset somewhat by their status as skilled professionals. The birthing women in the study possessed the least amount of power and had very little control over their birth experience. Later, Machin and Scamell (1997, p. 83) described how medical interpretations of birth led to a self-fulfilling situation whereby birth intervention was perceived by women as safe and reassuring. Such findings would indicate a culture that perpetuates a self-fulfilling philosophy of medicalised birth.

Kirkham's (1999) ethnography of midwifery practice in the United Kingdom identified a divergence in cultural norms whereby midwives supported women through their pregnancy and birth process, encouraging autonomy and control, but had little access to similar support, autonomy and control themselves. Equally, while promoting trusting relationships between midwives and women, there was a decided lack of trust within institutionalised midwifery, with midwives identifying a culture that emphasises self-sacrifice, guilt, and blame, leading to a lack of solidarity between colleagues and a resulting horizontal violence. Midwives wanting to enact change felt they had to do so secretly for fear of being targeted as a misfit or deviant. Kirkham (1999) noted that this kind of behaviour, associated with feelings of powerlessness, is symptomatic of oppressed groups, therefore any attempt to make changes in the maternity system, she argued, needs to first address culture. However, cultural change can be hard to implement for various reasons; one of which, as suggested in another ethnographic study, is how the endemic and embedded nature of an oppressed midwifery culture can lead to inaction and apathy towards change (Hughes et al. 2002).

Dykes (2005, 2009), also using CMA in a critical ethnography on interactions between breastfeeding women and midwives in English postnatal wards, found that organisational temporal restrictions inhibited midwifery practice, causing care to be technical rather than relational. Dykes (2005) argues that this time pressure constitutes a form of oppression and calls for re-evaluation of the midwife-mother relationship, and the suitability of the hospital environment for the initiation of breastfeeding. A more recent study by Scamell (2011) identified how midwives reproduce medicalised risk culture in their language and use of surveillance techniques in labour, even as they profess to operate from a