A critical literature review of epidural analgesia

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Abstract

Background. Increasing intervention in birth continues to be a cause for concern and epidural analgesia is an ever more common intervention. A major influence on rising intervention rates is the complex relationship society has with technology. Influenced by various political and cultural narratives, there has been a tendency to view technological advance as both neutral and superior in the human quest for progress.

Aim. In this paper, the authors trace the dialectical relationship between culture and technology in order to investigate the way epidural analgesia is portrayed in the biomedical literature.

Method. A purposeful literature search was conducted, with databases including CINAHL, MEDLINE, Scopus, Google Scholar, Academic Search Premier and thesis repositories. Relevant literature was identified and analysed using the analytic framework of critical discourse analysis and drawing on critical medical anthropology and Foucault’s discourse analysis.

Findings. The biomedical literature on epidural analgesia concerned itself with particular outcomes, such as increases in CS and instrumental birth rates, and yet maintained its narrative of epidural as ‘safe and effective’.

Implications. By exposing the contextual nature of knowledge, another standpoint is offered from which evidence and practice can be reviewed. This critical literature review provides an alternate reading of epidural text and challenges some of the assumptions made about epidural analgesia, and the practices that stem from these beliefs.

Key words: Childbirth, epidural analgesia, technology, Foucault, critical medical anthropology, discourse analysis, evidence-based midwifery

Introduction

The epidural is considered a ‘routine’ analgesic choice for healthy women in labour, and its use is increasing in Australia and other high-income nations (Walsh, 2009; Lain et al, 2008). In Australia in 2012, 32.5% of women in labour used regional analgesia for labour (Hilder et al, 2014). While epidural analgesia has substantial analgesic properties it is also associated with increased risk of adverse outcomes. Significantly, the use of epidural analgesia during birth transfers a labouring women out of the category of ‘normal’ labour and increases her risk of intervention (Walsh, 2009; WHO, 1996).

This paper is a critical review of the epidural literature as it related to the doctoral research of one of the authors (EN). The research, an ethnography that examined influences on women in their decision to use epidural analgesia used critical medical anthropology as the primary theoretical framework and also drew on Foucauldian and feminist theory. These encourage examination and critique of the power relationships that serve to normalise particular behavioursthrough which medicine is identified as a dominant discourse (Newnham, 2014).

Foucault’s description of dominant discourses (termed ‘power/knowledge’) includes formations of practice that, given particular social and historical conditions of existence, come to define what is known and accepted and therefore what is played out in the social world. Discourses shape social understanding and practice by imposing boundaries on what can be articulated by who, by deciding which knowledge is to be kept, which excluded and by circulating certain statements and censoring others (Foucault, 1991).

Notions of context and contingency central to the Foucauldian argument are also present in critical theory,and are drawn on here in the examination of the ubiquity and the claim to authority of the medical model of birth. This critical review of the medical research into epidural analgesia highlights the contradictions and distinctions of current ideas, delineating the way that epidural is constituted as a safe intervention in the biomedical discourse. Fundamental to the location of frameworks of power in critical research is the reflexive positioning of the researcher (Singer and Baer, 1995; Thomas, 1993).

The authors of this paper were expressly looking for other ways to think about epidural use to add to the ‘epidural evidence’ of biomedicine. The declaration of the epistemological position held by the researcher works in two ways: by being honest in the declaration, potential bias is laid open to discussion and critique; the researcher then seeks to examine the data in a way that is framed by their position, but not held to it. There is a promise that by revealing their position, in being epistemologically transparent, data are not plied to say one thing or another.

Method

Literature relating to epidural analgesia, labour and childbirth, technology and relevant critical theory were accessed from databases including CINAHL, MEDLINE, Scopus, Google Scholar, Academic Search Premier and thesis repositories. Reference lists of relevant books, theses and articles were read and further literature identified. The critical literature review presented here forms the first part
of a broader critical discourse analysis of epidural analgesia, using Fairclough’s (1995) critical discourse analysis (CDA) methodology. In keeping with Foucauldian ideas of ‘power/knowledge’, CDA accepts that ‘hegemony is constituted in the discursive practices of institutions’ (Fairclough, 1995: 91). Outlining his theory of three-dimensional CDA, Fairclough identifies the importance of linking the macro-discourse of state and policy to the discursive practices identified at the micro-level through the use of three levels of analysis: wider social understanding, the properties of the texts themselves, and how the texts are produced and consumed (Fairclough, 1995). Working with these three levels of discourse, the first level – the broader medical and social understandings of epidural – is unpacked in this critical literature review. This provides the background for the two remaining levels of three-dimensional CDA. The discursive properties of the texts themselves were explored in an analysis of the language of risk and safety within hospital and policy documents (Newnham et al, 2015). The third level – the production and consumption of text and the effect of discourse on individual experience – is where discourse intersects with the lives of women, including the information they receive and the choices they are able to make. According to Fairclough (1995), the inclusion of all three aspects of discourse is necessary for comprehensive analysis. Without the broader context (in this case, medical constitution of epidural knowledge), the micro-experience cannot be made sense of, or is perhaps left unquestioned.

From this perspective, this paper first examines the influence of the ‘evidence-based medicine’ discourse and how it affects the way in which particular knowledge is produced. It then examines the significant epidural literature in the medical field, specifically primary research and systematic reviews. Employing the chosen theory, a critical ‘reading’ of this literature is provided identifying the role of technological rationalism and the impact of these dominant discourses on epidural and birth knowledge.

Findings

Questioning epidural analgesia
From an anaesthetic risk perspective, improvements in drug dosage and administration have made epidurals relatively safe and they are particularly useful in situations where caesarean section (CS) is necessary, enabling women to remain conscious and decreasing risk for mothers and babies by avoiding general anaesthetic. Yet intervention in labour, including the use of epidural, can dramatically change the birth outcome for otherwise low-risk women (Tracy et al, 2007). Despite this, biomedical research on epidural use in labour perpetuates a discourse of the ‘safety’ of the epidural, even while examining its negative consequences. This perpetuation of epidural safety in medical discourse, despite its effect on birth outcomes calls for a closer investigation of epidural knowledge and practice.

The prominence of medically-focused research perpetuates one particular kind of knowledge about epidural analgesia resulting in the acceptance of this technology as a ‘common sense’ option in Western birth culture (Downe and McCourt, 2008; Wendland, 2007). As a result other options for birth are marginalised by their absence in the literature and the resulting lack of alternatives. While judicious use of epidural analgesia may be beneficial in particular situations, its use as a common analgesic option requires closer examination.

Evidence based: biomedicine as a dominant discourse
One of the main claims by biomedicine over other knowledge disciplines is its unbiased truth and rationality. Although useful in providing measurable evidence, the claim by science to a lack of bias is contested as scientific knowledge is embedded within a historical context influenced by economic and social structures. Evidence-based medicine with the randomised controlled trial (RCT) at its pinnacle, is problematic because although evidence-based principles have their place and have been particularly useful in removing questionable practices in midwifery and obstetrics, they also pose a potential dilemma (Walsh, 2012; Johnson, 1997). Privileging the RCT over other research methods can flaw trial design by prompting researchers to fit projects into an RCT design, also affecting the kinds of questions being researched (Steen and Kingdon, 2008; Kotaska, 2004; Keirse, 2002). Murphy-Lawless (1998: 14) expresses this dilemma as ‘what is measured is often meaningless but without measurement there is no science’. Insofar as they mediate which questions are being asked, the RCT – and other scientific methods – are biased in that they derive from a worldview that privileges one kind of knowledge over other forms (Roome et al, 2015).

Much mainstream research – with its assumptions about knowledge, empiricism and medical authority – serves to embed particular worldviews, for example, of women’s bodies as uncertain, of technology as safe, or of the doctor as rescuer. With these ideas promulgated in the collective understanding comes a concomitant normalisation of the safety of intervention. Conversely, normal physiology labelled as unpredictable, becomes risky. As these ideas become entrenched into practice they circulate the power/knowledge of medical birth discourse (Newnham et al, 2015; Foucault, 1980), to which the authors now turn in the context of epidural research.

Epidural analgesia: exploring the evidence
The physiological problems associated with epidural use in labour that can lead to birth intervention include: altered uterine activity (either increased or decreased); labour dystocia (thought to be due to relaxation of pelvic floor and malrotation of the fetal presenting part) slower dilatation of the cervix; decreased oxytocin release by the pituitary gland and subsequent need for oxytocin augmentation; and decreased maternal bearing down efforts due to motor block (Gaiser, 2005; Jain et al, 2003; Finster and Santos, 1998).

However, research into epidural use has been conflicting, with early research showing high rates of instrumental and CS births associated with epidural use. One extensive review of epidural research identified how the relationship
between epidurals and CS found in previous decades has since been attributed to the denser motor block of those early epidurals (Gaiser, 2005). Research looking at the effects of newer, low-dose epidurals has found a strong causal relationship between epidural and instrumental deliveries, and motor weakness remains considerable, even with low-dose techniques (Jain et al, 2003). Additionally, studies are still identifying a relationship between epidural analgesia and CS (Ros et al, 2007; Tracy et al, 2007; Kotaska et al, 2006). However, as no causal link has been isolated, it is possible that epidural use and CS are outcomes from an as yet unknown common cause. One of the difficulties with epidural research is distinguishing the reverse causality between the need for epidural and the presence of a pre-existing labour dystocia (Gaiser, 2005). The most recent Cochrane systematic review, which compared epidural to non-epidural or no analgesia in labour, noted the conflicting findings of previous research about whether or not epidural analgesia increased the risk of CS and concluded that while epidural use does not increase the overall risk of CS, it does increase the risk of instrumental birth by 40% (Anim-Somuah et al, 2011).

Identification of any causal relationship is challenging because epidural analgesia is not a sole intervention but brings with it numerous other interventions such as intravenous fluid administration, electronic fetal monitoring (EFM) and labour augmentation, making it difficult to extrapolate any particular influence. For instance, two studies looking at the difference in birth outcomes when inserting epidural analgesia early or late in labour showed no difference in instrumental delivery rates. What they did identify was a positive correlation between intravenous oxytocin and the CS rate (Wang et al, 2009; Chestnut et al, 1998). If epidural analgesia necessitates exogenous oxytocin use and oxytocin use increases the risk of CS then epidural analgesia is going to influence, if not directly cause, this outcome. Similarly, EFM has been shown to increase CS rates (Alfirevic et al, 2013; Devane et al, 2012). Also confusing attempts at correctly ascertaining the effects of epidural analgesia have been ‘natural experiment’ studies whereby changes in policy or accessibility that either increase or reduce epidural rates have not resulted in a corresponding relationship in numbers of instrumental birth (Gaiser, 2005). Gaiser (2005) stated that with the new research demonstrating the effectiveness (or at least diminishing the connection between epidural and CS) of new epidural techniques, obstetricians declared that epidural analgesia should be accessible to all women unless medically contraindicated.

Despite this optimism, more recent studies have confounded the existing evidence. The Comparative Obstetric Mobile Epidural Trial (COMET) (Cooper et al, 2010) compared two types of low-dose with traditional (high-dose) epidural. A no-epidural comparison control group was matched for mode of delivery. The authors stated: ‘The mode of delivery and numbers recruited to each group illustrate the previously reported findings of an increase in spontaneous vaginal delivery with both mobile techniques and the expected higher number of spontaneous vaginal deliveries and fewer operative deliveries, especially by CS, in the comparison group’ (Cooper et al, 2010: 32). So, while some researchers are declaring an impasse in relation to epidural research and a green light for routine epidural use, these authors were expecting higher rates of instrumental and CS delivery in their epidural groups. The figures demonstrate this with the spontaneous vaginal birth (SVB) rate in the no-epidural group (approximately 75%) double that of the SVB rate in the high-dose epidural group (approximately 35%) and still much higher than in both of the low-dose groups (both approximately 43%). Conversely, all three epidural groups had rates of CS nearing 30%, while the no-epidural group had a 9% rate. Instrumental births were around 40% in the high-dose group, 30% in the low-dose groups and 15% in the no-epidural group. An Australian population-based descriptive study also showed a three-fold increase in CS rates with epidural alone, as well as when used in combination with oxytocin (Tracy et al, 2007). A survey conducted in the US found that of 750 first-time mothers with term pregnancies, 47% were induced and of those having an induction, 78% had an epidural and of mothers who had both attempted induction and an epidural, the unplanned CS rate was 31%. Those who experienced either labour induction or an epidural but not both, had CS rates of 19% to 20%. For those first-time mothers who neither experienced attempted induction nor epidural, the unplanned CS section rate was 5% (Declercq et al, 2013). While one cannot infer causality in this study, these practices contribute to the ‘cascade of intervention’ that can lead to CS.

A small number of studies call for caution with regard to epidural analgesia, and suggest solutions, such as restricting use (Hemminki and Gissler, 1996), the need for further research (Nystedt et al, 2004), and the provision of comprehensive informed consent about the risks (Kotaska et al, 2006). It is concerning that there is only minimal reference in the literature to the fact that maternal oxytocin production is inhibited by epidural use (Gaiser, 2005; Rahm et al, 2002). As well as contributing to the need for exogenous oxytocin, reduced endogenous oxytocin may be the causative factor in reduced breast-seeking behaviour in the newborn and reduced breastfeeding rates in women who have had an epidural (Wiklund et al, 2009). Although it is now recognised there is a lack of robust research in this area (Buckley, 2015; Foureur, 2008; Uvnäs Moberg, 2003). Although there were efforts to decrease problems that are associated with epidural use such as: ceasing the epidural when the woman is 8cm dilated, decreasing the amount of local anaesthetic used in order to decrease motor block while still maintaining sensory block, allowing a longer second stage for women using epidural analgesia and waiting for descent of the presenting part before beginning active pushing (Gaiser, 2005; Finster and Santos, 1998), the early findings of increased CS and instrumental birth rates did not lead to a concerted effort by the medical community to avoid
epidural analgesia altogether. The increasing popularity of epidural analgesia, despite unfavourable research results, can be explained in part by the continuing discourse of ‘safe and efficacious pain relief’ (Drysdale and Muir, 2002: 99). Clearly the high CS and instrumental birth rates were cause for concern. But rather than discontinuing epidural use – as happened so rapidly, for example, with the discontinuation of vaginal breech birth after the term breech trial (Downe and McCourt, 2008; Steen and Kingdon, 2008) – research continued for some decades. Not simply because epidural is an effective analgesic agent, but, this paper proposes, because epidural use, instrumental birth and CS fit within a medical discourse that favours control, technology and intervention (Walsh, 2009).

Moreover, it appears that the consequences of epidural analgesia were also ignored because they affected women’s experience, rather than measurable medical outcomes. Therefore, while instrumental delivery appears as a consequence of epidural analgesia in the biomedical literature, the consequences of instrumental birth for women, and their future health and wellbeing are not discussed (Sharma et al, 2004). With the exception of one study (Cooper et al, 2010) which looks at satisfaction rates, instrumental birth as an outcome is largely dismissed and there is a tacit assumption that increased obstetric intervention is an acceptable risk factor. However, for women, instrumental birth may not be an acceptable risk factor. Both instrumental birth and coached pushing, rates of which are increased with epidural analgesia, increase the likelihood of third- and fourth-degree tears. The sequelae of this severe perineal trauma can include pain, fear of birth, incontinence, sexual dysfunction, post-traumatic stress disorder and depression (Rådestad et al, 2008; Hayman, 2005; Creedy, 1999). These outcomes, and their corollaries, indicate that instrumental birth rates need to be a serious consideration in the epidural analgesia debate.

After 40 years of medical research into the risks of epidural analgesia, there are still no definitive findings about its effect on childbirth (Toledo et al, 2009; Gaiser, 2003; Jain et al, 2003), although it is likely that it does increase instrumental birth rates (Anim-Somuah et al, 2011). The only outcome that is clearly upheld throughout current research is that, despite the still unproven effects of epidural analgesia on labour, it provides the most effective analgesia (Cooper et al, 2010; Wang et al, 2009; Jain et al, 2003). A discussion of the safety and effectiveness of epidural analgesia prefaces the majority of the research articles and epidural analgesia is cited as the ‘gold standard for analgesia in labour’ (Norman, 2002: 28). This emphasis on the relief of pain at any cost is indicative of what is important to biomedical culture, which both influences and reflects wider cultural norms.

A critical reading of the evidence

‘The influence of the ideology of technology becomes most clear when medicine is on the scene... things that can be quantified are made real; those that cannot be quantified come to seem unreal. Infection rates are an observable measure for childbirth; joy is not’ (Rothman, 1989: 86).

Biomedicine continues to implement practices based on technology and intervention by upholding a fairly circumscribed research agenda. In disseminating particular kinds of data in specific ways there are things that are not identified; that are left silent. These include maternal subjectivity, consequences for the mother-newborn dyad, and long-term health outcomes (Wendland, 2007). In effect, by their lack of representation in the data, biomedical research reproduces underlying Western cultural values by minimising the importance of women’s experiences and implementing simplistic, mechanistic answers to complex problems. Ramin et al (1995: 788) comment that ‘pain relief during labour is of paramount importance and in most circumstances the two-to-four-fold increased risk of CS delivery associated with epidural analgesia is a secondary consideration’. This illustrates the medical perspective of the ‘abnormality’ of labour pain and the priority to alleviate it and normalises technological intervention such as CS, while ignoring its significant risks. It also focuses on the pain of the physiological event, while ignoring the pain caused by the intervention. It is unlikely that CS is a secondary consideration for women. Pain in labour is complex and when women have been asked, labour pain (and its relief) is not necessarily of paramount importance (Karlsvåg et al, 2014; Leap and Anderson, 2008), so from many women’s perspective the opposite is the case. In rejecting women’s experiences as important data, research in this field can fail to include interventions that seem insignificant to medicine, but may be highly significant to women (Baker et al, 2005).

Compared to biomedical research, there are fewer studies concerned with women’s experiences of birth, although research of this nature is increasing. Not discounting the importance of medical research, comparing the two does generate a clear picture of what is seen as important (van der Gucht and Lewis, 2015), and this appears to be the advancement of technology and medicine rather than the experience of women and protecting birth from unnecessary technological intervention. Indeed, evidence that supports non-technological practices is not easily implemented, while technologically-focused evidence is often taken up instantaneously (Romano and Lothian, 2008). What this shows is that although ‘evidence-based’ medicine can have a positive impact, it is not a paragon of unbiased universal answers, but is subject to, and replicates, powerful social discourses such as scientific and technological rationalism.

Rationalising technology

There is a common point of view that holds technology to be politically neutral, ahistorical and autonomous with little human control or direction except in the luck or genius of those who can discover its secrets (Hill, 1988). Termed ‘technological determinism’, this viewpoint has been criticised for failing to acknowledge the social, historical and economic influences on the construction of scientific knowledge. Critics of the technological determinist position call for scrutiny of the underlying assumptions of technology use. Some decades ago, Marcuse observed that
‘in the contemporary period, the technological controls appear to be the very embodiment of reason for the benefit of all social groups and interests – to such an extent that all contradiction seems irrational and all counteraction impossible’ (Marcuse, 1972: 22).

Technological determinism depends on the perpetuation of ideas that suggest all progress is the embodiment of reason, a position of techno-rationalism. Progress is positioned as a moral good within society. Arguments that critique progress are therefore defined, by their juxtaposition to the ‘rationality’ of advancement, as unreasonable and irrational (Blackwell and Seabrook, 1993). This argument is reflected in the ‘pain relief as progress’ theme in the epidural literature. Crowhurst and Plaat (2000) say labour analgesia is a part of the modern Western lifestyle, along with ‘air travel, the mobile phone and the personal computer’, implying that any other choice is irrational and archaic. They state: ‘The greatest advances in analgesia and anesthesia for labour and childbirth in the 20th century have been (1) the discovery and development of today’s safe and efficacious analgesic techniques; (2) the social acceptance that it is unnecessary for parturients “to bring forth children in pain and sorrow”’ (Crowhurst and Plaat, 2000: 164).

The reverse of this argument is that anyone who wants to argue the merits of pain is relegated to a regressive paradigm of anti-progress. The implicit assumption of the ‘pain relief as progress’ theme is that not wanting to relieve the pain of childbirth must be absurd. However, as Leap and Anderson (2008) suggest, there are positive and purposeful aspects to labour pain: it summons support, heightens joy, reinforces triumph and triggers neurohormonal cascades. Pain in labour is not a simple or reducible medical problem. However, the relief of pain in labour is an ongoing concern of biomedicine, particularly within anaesthesics and has even been described as a ‘human right’ (Cohen, 1999: 224).

Problematically – and noted by midwives from the time of their introduction – medical technologies can interfere with the process of being present at labour; that commitment to women’s embodied experience that midwifery philosophy upholds (Leap, 2000). Low-tech interventions, such as continuous support during labour, can decrease women’s need for analgesia, as well as operative birth rates (Hodnett et al, 2013). This more traditional midwifery practice of providing physical and emotional labour support contributes to a shared embodied experience. Some women and midwives expect and put their faith in the use of technology (Sinclair, 2011; Sinclair and Gardner, 2001) and, in some cases, it is both useful and necessary. However, reliance on technologies establishes the indirect surveillance of disembodied processes that neglects the historic embodied relationship between the woman and midwife (Sandelowski, 2002; 1998; Barger-Lux and Heaney, 1986). Knowledge and practice that support the normal process of birth and women’s embodied experiences are typically not supported in medical birth settings. The positioning of obstetrics with ‘technology’ provides access to dominant techno-rational norms of science and safety, and allows the perpetuation of technologically-oriented practices that are not clearly evidence based over simpler, low-tech midwifery practices that can reduce childbirth intervention rates.

Despite the lack of conclusive evidence, the salient assertions in the biomedical epidural literature are that epidural analgesia is essentially safe, should be available for all women and is a ‘human right’. Underlying this is the unease about epidural outcomes and there are constant recommendations that research needs to focus on improving these by varying the doses and/or drugs used.

**Challenging paradigms**

The ‘pain relief as progress’ discourse in the epidural literature forms part of what Leap and Anderson (2008: 38) have termed the ‘pain relief paradigm’, whereby midwives who have internalised the techno-rational assumptions outlined above perpetuate a belief that women cannot endure the pain of birth. These authors recommend that midwives examine their own beliefs about pain and if possible adopt a ‘working with pain’ approach, which accepts pain as a normal part of the birth process (Leap and Anderson, 2008), and this support can actually reduce women’s desire for analgesia (Romano and Lothian, 2008; Walsh et al, 2008). Pain is also viewed positively by some women as a rite of passage that brings a sense of pride and accomplishment (van der Gucht and Lewis, 2015; Karlsdottir et al, 2014; Lundgren and Dahlberg, 1998).

Satisfaction with the birth experience is not necessarily related to pain relief, and is complex and multi-faceted (Hodnett, 2002; Kannan et al, 2001; Lundgren and Dahlberg, 1998), illustrated by the fact that some women who have had an epidural express less satisfaction with the birth process than those who have not had one (Waldenström et al, 2004). It has been suggested that the need for an epidural in labour may not be related to actual levels of pain, but to a woman’s pre-existing ‘birth ideology’ (Heinze and Sleigh, 2003: 330). It has also been proposed that increasing uptake of epidural analgesia could be due more to unsupportive and fragmented maternity care than actual pain relief requirements (Walsh, 2009). From this perspective, epidural analgesia is not so much a ‘human right’ and ‘rescuer of women in pain’ as a potentially unnecessary intervention: one that is not well-explained, does not always alleviate women’s ‘suffering’ in labour, and might actually decrease women’s joy in the birth process.

**Conclusion**

Epidural analgesia has been promoted as safe, efficacious and necessary, by the biomedical literature, while demarcating its potential negative side-effects. The problem with wholesale acceptance of ‘evidence-based’ scientific research is the lack of transparency of its own philosophical premises. Dominant ideologies, such as technological rationalism, are renegotiated and perpetuated as if they represent a universalised reality. Most women will have been exposed to these social discourses of pain and epidural use and may not have been exposed to knowledge that
challenges this paradigm. However, in light of the ongoing uncertainty about research findings, there needs to be a robust and informed debate about the appropriate use of epidural analgesia in low-risk labour.

This critical analysis of the discourse surrounding epidural analgesia has explored some of the ways in which medical, scientific and technological discourses have influenced Western birth practices in relation to the production of information about epidural analgesia. It adds to the growing knowledge base about social contexts of birth, and delineates the way in which dominant ideas about pain/relief are perpetuated. Childbearing women have to negotiate increasing amounts of information from various sources, are faced with obstetric practices that may not be evidence based, or be denied midwifery practices which are. Midwives and others interested in the wellbeing of birthing women need to have an understanding of how various discourses – such as the biomedical epidural discourse – are sustained, as well as an awareness of alternate perspectives in order to fulfil the midwifery responsibility to provide advocacy, information sharing, and to work in partnership with women.

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