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ABSTRACT

Objective: to investigate the personal, social, cultural and institutional influences on women making decisions about using epidural analgesia in labour. In this article we discuss the findings that describe practices around the gaining of consent for an epidural in labour, which we juxtapose with similar processes relating to use of water for labour and/or birth.

Design: ethnography.

Setting: tertiary hospital in Australian city. **Participants:** sequential interviews were conducted with 16 women; hospital staff (primarily midwives and doctors) participated during six months of participatory observation fieldwork.

Findings: women were not given full disclosure of either practice and midwives tailored the information they gave according to the institutional policies rather than evidence.

Key conclusions: informed consent is an oft-cited human right in health care, yet in maternity care the micropolitics of how informed consent is gained is difficult to ascertain, leading to a situation whereby the concept of informed consent is more robust than the reality of practice; an illusion of informed consent exists, yet information is often biased towards medicalised birth practices.

Implications for practice: as primary maternity care-givers, midwives have a role in providing unbiased information to women; however it appears that hospital culture and policy affect the way that this information is presented. It is arguable whether women in such instances are giving true informed consent, and for this reason, the ethics of these hidden practices are questioned.

Keywords

Antenatal education; bioethics; epidural analgesia; informed consent; midwifery; water immersion

INTRODUCTION

There is ongoing debate in the literature about the purpose and benefit of antenatal education, as well as its effect on outcomes (Ferguson et al., 2013; Lothian, 2007). Although the information that women receive in antenatal education classes can vary widely, they are seen as a useful way to inform women about pregnancy, labour, birth and the postnatal period (Lothian, 2007). Education can be seen to contribute to women's ability to be informed about their decisions, and informed consent now embedded as a legal right in health care (Braun et al., 2010; Kotaska, 2017), yet the nuances and fallibilities of actually fulfilling true informed consent are rarely discussed. In this article, we offer some answers to, but also seek to question, current informed consent practices.

We do this by presenting findings from an ethnographic study which aimed to investigate the personal, social, cultural and institutional influences on women making decisions about using epidural analgesia in labour. The focus of this article is the way in which information about epidural analgesia was presented to women in three antenatal classes at an urban tertiary-level hospital, which is then contrasted with the way that the midwives talked about use of water in labour. We go on to explain how the women in the study perceived the information they received, before consolidating these points in a discussion of the informed consent process for both practices in which we question the notion of whether informed consent is attainable in such circumstances. The views of the women presented here are varied and include recollection of past pregnancies. They do not relate directly to the antenatal classes observed by Elizabeth Newnham (EN), which none of the participating women attended. Therefore the comparisons we make about information that women received and the information given by the midwives in the classes are of a generalised, rather than a specific nature.

Data for the study comprised of interviews, participant observation and state and local policies and guidelines. Sixteen women were recruited from the antenatal clinic from the participating hospital and were interviewed sequentially, with two antenatal and one postnatal interview. Women also had the option of EN's presence at their labour and birth, to which six women consented. Written consent was gained for the interviews and being present at the birth. For the purposes of anonymity, these participants chose (or—if they preferred—were allocated) pseudonyms. Participant observation was undertaken at an urban tertiary hospital that catered for approximately 3500 births a year. Field notes were hand written, then transcribed by EN soon afterwards, and analytic memos and thoughts were written in the margins as they occurred. Consent during the participant observation on labour ward was assumed, with well-disseminated information about the study and researcher disclosure. Staff could opt-out of the research by signing a written opt-out form but no-one availed of this (see Newnham et al., 2013). All midwives verbally consented to the

presence of the researcher in their antenatal class and the researcher was introduced as such to the class participants. Policy and practice guideline documents were also used as data. Data for this study were collected between 2011–2012. Ethics approval was gained from the university and the hospital involved in the study.

The research had Critical Medical Anthropology (CMA) as its theoretical framework and drew on Foucauldian and feminist theory. What Foucauldian analysis and CMA have in common is the identification of the difference between what is said (is done) and what is (actually) done (Lazarus, 1988). To draw on Foucault more specifically, the identification of dominant discourse is achieved by examining practice, particularly that which has become conventional or widely accepted (Foucault, 1991). Where this intersects with CMA, is in the identification of the influence of hegemonic discourse on the institution, and the ensuing influence of the institution on practice, including how practitioners interact with, and speak to clients (Newnham et al., 2015; Lazarus, 1988; Singer and Baer, 1995; Baer et al., 1986). Our intention here is to explain the ‘intermediate-social’ level of interaction (see Newnham et al., 2016b) between the midwives and women and show how this was influenced by hospital policy and practice expectations as well as how it affected women's experience.

FINDINGS

The antenatal classes In the three antenatal classes that EN attended, the midwives were not explicit about all of the effects of analgesia, and all worked within the ‘pain relief menu’ model (Leap and Anderson, 2008) as illustrated in the following field note excerpt from the first antenatal class.

[The midwife] goes on ‘So, we’ve tried distraction [squeezing stress balls, stamping feet] but for those women who choose other forms of pain relief, what can you have in the hospital?’ ‘Gas’ a woman calls out. ‘Epidural’ [calls another]. The midwife brings up pethidine. ‘Those are pretty much your options. Some will choose none of them, some will choose all of them, and it really doesn’t matter, you can have what you want.’ (Field notes 25/8/ 12).

In the first antenatal class the midwife goes on to describe the procedure of epidural insertion and some of the anaesthetic risks:

‘An epidural needs to be put in by an anaesthetist, in a sterile procedure.’ She explains how the woman needs to sit, with back curled, how the epidural is inserted, and the needle removed, that there is an initial test dose, then a full dose given. Ideally it ‘will make you extremely comfortable’. She goes on to tell them that it is not guaranteed to work 100%; that it can be more effective on one side than the other; that it may need to be re-sited; that the level of block should ideally be from the ‘belly button down’. She talks about the side effects: the possibility of a headache; that it might not work; risk of nerve damage; how the anaesthetist will explain the risks and get consent. An epidural means the end of active labour though...‘we don’t really do walking epidurals here’...You [will] have a bladder catheter, along with having to stay on the bed. Epidural and catheter nearly always go hand

in hand. The other thing that goes with an epidural is the little hand held Doppler, and you'll need to be connected to a monitor. Dads love these, and pushing buttons. It's a bit of a boy toy. You have a print out of your contractions and the baby's heart rate.' (Field notes 25/8/12).

There is no mention of the obstetric risks of epidural such as a longer labour, hypotension or pyrexia (Anim-Somuah et al., 2011). Although women who had informed themselves about the 'cascade of intervention' would recognise that some of these interventions would increase their risk of assisted birth, this is not explicitly referred to by the midwife. The use of continuous Electronic foetal monitoring (cEFM) is also downplayed; the midwife's description of the monitor as something that 'dads love' omits the fact that its use increases the risk of caesarean section (Alfirevic et al., 2017). The midwife is preparing the woman for the system requirements—keeping still for the epidural, monitoring the labour—rather than informing her of risks.

In the second antenatal class, the midwife reflects the institutional culture by articulating the easy availability of epidural analgesia:

'Women use epidurals quite regularly upstairs. They are placed by an anaesthetist.' She goes on to explain how a needle is placed into the back, which numbs the lower half of the body. There is still some feeling, she says, but the contractions are now like a pressure, not pain. It can lead to more intervention. Women usually end up with a catheter to drain urine, because the 'legs aren't working' and the [midwives] want the bladder to empty. 'Epidurals do work well with posterior babies and can give women time in a difficult labour for babies to move into the right position. Epidurals can affect pushing. Women don't feel that involuntary pushing. The midwife needs to examine you and may wait for the epidural to wear off in order to push in second stage. The positive side of an epidural is that if you do need to go to theatre, it can just be topped up' (Field notes 27/8/12).

At the third antenatal class, the midwife again gave technical details of epidural insertion, but no real information about the effects:

The midwife explains clearly about the catheter, how it is put in, and the needle withdrawn, which part is left inside the back, how it is taped and where the drug goes in, that there is a filter. 'Anaesthetics will talk to you about it at the time, but...you are unlikely to be in the space to talk to anybody at that stage, so do your research now and look at your pain relief options now.' (Field notes 12/9/12).

There was no information given in any of the classes about epidural analgesia increasing the risk of instrumental birth (Anim-Somuah et al., 2011) or decreasing breastfeeding rates (Kendall-Tackett et al., 2015; Jordan et al., 2009; Wiklund et al., 2009) and all midwives stated that there were no known effects on the newborn. While all of the midwives attempted to describe the pain of labour in encouraging terms, such as being 'positive' or 'good' or urging the women to 'trust their bodies', the rules of the institution were constantly being referred to: 'we don't like you to eat', 'you can only bring two support people', 'we expect you to progress one centimetre an hour', 'there is a time we

will need you to have your baby by'. The midwives were attempting to espouse the midwifery philosophy of normal birth, but this was moderated by a need to convey the fact that the institution does not tolerate any real trust in the birth process (Healy et al., 2016). The need to disclose institutional requirements—knowing that women are expected to comply—therefore undermined the positive language that the midwives used to try and promote women's empowerment ('it's your body').

Analysing this data—also drawing on our own experience of midwifery practice—led us to consider that downplaying the effects of interventions such as epidural analgesia is an attempt by midwives at protecting women from feeling guilt or regret after their birth. The lack of acknowledgement of obstetric risk with epidural acted as another protective effort, as midwives were attempting to give some information—the practicalities of having an epidural—while at the same time wanting to normalise the procedure for those women who would choose it. Midwives are all too aware of the sense of the failure that some women experience when their birth experiences do not go to plan and these midwives were trying to give permission for all of the options. This has also been observed in a study of childbirth educators in the United States (Morton and Hsu, 2007).

WOMEN'S VIEWS ON PHARMACOLOGICAL PAIN RELIEF FOR LABOUR

The women in the study generally did not have comprehensive understanding of the potential side-effects of epidural analgesia. In concert with medical and social views, it was broadly perceived as safe. One participant, Rose, who was having her first baby and was not planning on having an epidural, said:

I don't really know what the cons of having an epidural would be... there is a small possibility of something going wrong which probably isn't...worth worrying about (Rose, interview 2).

Kate, who had had an unplanned epidural after a long posterior labour with her first baby, and who was not necessarily planning on having one with this labour said:

I mean, they say there is a very slim chance anything can go wrong but there is always a chance, as with anything, particularly something going into your spine (Kate, interview 2).

Anna, having her third baby, was more aware of the obstetric risks, including instrumental birth:

I don't like the idea of forceps or ventouse and...the pain relief that you can probably get from an epidural I guess it's probably counteracted by the fact that you've had other interventions...what I've heard from a lot of people...is the fact that you can't move around...and that you need to be monitored (Anna, interview 2).

The women described the need for epidural analgesia if labour became intolerable, but fear of risks and being unable to move detracted from its appeal:

I think it's great if you are in pain and you can't tolerate your pain and if the labour has gone on too long...I have just heard horror stories as well...just about no feeling for couple of days in your legs and I had a friend who had a headaches for almost two years after because of the positioning of the needle (Bella, interview 2).

Then there were the women who had decided that they would opt for an epidural, and this too was expressed quite decisively and without much discussion of the pros and cons. Recent studies looking at women's experiences of epidural have found that women can feel ambivalent about their decision, even if they choose epidural analgesia (Hidaka and Callister, 2012; Jepsen and Keller, 2014). The women in this study were also ambivalent about epidural, whether or not they were choosing to use it.

I've had thoughts about it. Because when my mum had me, this is going back 29 years ago though, she lost control of her body from up here [chest]—right down...So that sort of freaks me out about it...I'm not a huge fan of pain, so I would take it, but I just don't want to lose control of my legs and stuff like that (Arkadia, interview 2).

I would say, the pros – that you can't feel it...you can't feel the pain. But the cons are that once you've had an epidural you can't move around, you're kind of limited as to how you can give birth... if you're in that much pain, an epidural is really, really beneficial but if you can manage the pain and keep moving around—that's what I hated about having an epidural...but the instant relief was just [laughs] amazing (Emma, interview 2).

The women described their attempts at finding out the right information as not always satisfactory, and they thought the effects of medication were often minimised.

It doesn't seem like it affects the baby at all and according to the midwives—I said 'You know, what about blocking the natural endorphins?' they said 'No it doesn't block it, it actually promotes it because when your body is relaxed you're promoting more of the endorphins' and I thought 'That doesn't sound right to me'...I ask questions like 'Will it affect my ability to be able to produce milk and the babies ability to be able to suckle?' and they are 'No, no, no that's all fine' and I thought 'Oh okay. I just can't imagine how it could possibly be absolutely fine but if that's what you are saying then that's what you're saying (Tessa, interview 2).

The women were more likely to want to 'start with the gas' because the side effects are fewer. The effects of pain relieving drugs on their unborn babies was a big concern for the women, and pethidine was not proposed by any of the women as an option because they had all heard that it 'goes through to the baby'. Some women also knew that it was an opiate and the stark contradiction between the ever-increasing need to monitor and restrict intake in pregnancy (eg. soft cheese, cured meats, coffee, alcohol) to then 'shoot yourself up with some pethidine' in labour seemed anomalous.

I was adamant I didn't want the pethidine and I never would have had it, you could have ripped me apart and I wouldn't have had it because it was all about the baby...I just said 'Oh does pethidine go to the baby?' and they were like 'Oh the epidural doesn't really' and I am like 'Give it to me. Give it to me right now' (Tessa, interview 3).

The hesitancy of women to have pethidine contrasted with the knowledge and practice of the midwives on labour ward who would often suggest pethidine as a way of avoiding epidural. The midwives saw pethidine as far less invasive, and without the attendant interventions (and therefore risks) of epidural analgesia.

As well as being considered less of a risk to the baby than pethidine, epidural analgesia was also demarcated as the better option because it allowed the women to be present mentally, unlike the gas or pethidine which they saw as being more likely to affect their thinking. The knowledge conveyed by the women in the study reflects the dominant medical discourse—of epidural as safe—from within which they made their choices about which kind of analgesia to use during their labour and birth. Although aware of some of the risks, the women were not fully informed of all of the potential effects of epidural analgesia. This was in part due to them not wanting too much information, but it was also perceived as a playing down of the risks in the information they received from midwives. Participants described feeling patronised by the way information was presented or that it was ‘sugar coated’, as if they needed to be protected from the truth.

Many of the women in the study discussed the usefulness of the idea (gained primarily from books) that pain in labour is physiological, akin to running a marathon. It put pain in perspective and framed it in a way they could relate to rather than fear. This has been found in another study where women received a prepared birth course designed to teach women about normal labour physiology and provide complementary therapy ‘tools’ for labour (Levett et al., 2016). Leap and Anderson (2008) argue that stepping through the ‘pain relief menu’ sends the message to women that they will be unable to cope with labour pain, it is just a matter of to what degree. They suggest a ‘working with pain’ approach that teaches women about the normal physiology of labour pain, addresses any fear and emphasises the duality of labour pain—that it can also bring joy and exhilaration—as described by women themselves (Leap and Anderson, 2008; Karlsdottir et al., 2014; Van der Gucht and Lewis, 2015). Van der Gucht and Lewis (2015) identify how the acceptance of labour pain is a crucial coping strategy for women. All authors suggest more research is needed in this area (see also Gagnon and Sandall, 2007), and our findings support this.

CONTRASTING PRACTICES: WATER USE

At the hospital in question, women had access to water for labour and birth, however there were restrictions to its use (Newnham et al., 2015). The midwives holding the antenatal classes echoed the institution's reticence at providing water for childbirth in the way they conveyed information about this practice, discussing the use of water with a sense of restriction and prohibition, even while simultaneously promoting its benefits—exposing yet another aspect of the paradox of the

institution, a finding we have described elsewhere (Newnham et al., 2017). For example, although one of the midwives mentioned waterbirth, it was in the context of being 'eligible' for a waterbirth and not a lot of detail was given:

'Whatever pain relief you choose to use, whether it is more natural or more physiological, if you're eligible for a waterbirth, that's great.'

Water was not brought up again until one of the pregnant women asked a question:

'Do all the rooms have baths in them?'

Midwife (MW): Three rooms have a bath...but you must have a signed consent form, have done all the paperwork before you come in, and not only do you need to meet all of the criteria, but there needs to be midwife on who is accredited, and there needs to be a bath free (Field notes 25/8/12).

The midwife is reiterating the lack of access that is the standard approach of the institution. In the second antenatal class, waterbirth was again not discussed seriously as an option until a class participant asked about it:

A woman asks: 'You don't do water births here?'

MW: 'Yes, we do. [Hospital] has quite a strict policy on waterbirth. You need to have signed the consent, and you need to have a midwife on who is accredited. You have to stay under the water. I think it's great...buoyancy, warm water...providing you have no complications and there is an accredited midwife. You need to be well informed'.

The woman asks: 'Can you get out if you want? If you've signed?'

MW: 'It's your birth. You can do what you like. For example, you don't need to get on the bed. But it is also good, if things don't go to plan, to say 'That's okay too'' (Field notes 27/8/12).

The hollow rhetoric of autonomy is evident here, as the midwife follows her explanation of the 'strict policy' on water use with the statement: 'It's your birth. You can do what you like'; an incongruity, as the latter assertion clearly contradicts the former.

Once again, in the third class, water use had to be raised by a participant of the class.

A man asks: If you don't have much of a birth plan, and you are in a room with a bath, can you have a waterbirth?

MW: If you even think you might have an inkling about a waterbirth, then you need to have a talk to your midwife next clinic visit, because there are all these restrictions and all this paperwork to do. In my clinic, I get most women to fill it out just in case they want to get in the bath. You need to have a room with a bath. (Field notes 12/9/12).

This midwife was obviously proactive in her clinic about getting the women to fill out the paperwork for waterbirth 'just in case'. That in none of the antenatal classes was water raised as a realistic option until it was asked about reflects institutional culture more than it does the individual

midwives thoughts on the use of water in labour. In a discourse analysis on waterbirth policies and guidelines, Cooper et al. (in press) have also shown how the existence of water birth policies has meant that the practice is only offered when requested rather than promoted as an effective tool for promoting normal birth (Cooper et al., in press; Cluett and Burns, 2009). The obvious conflict for midwives is this directly counters their professional requirement to promote normality in birth.

INFORMED CONSENT

Informed consent is based primarily on the biomedical principal of 'autonomy' (Braun et al., 2010; Beauchamp, 2007)—authority over the decision-making that happens about one's body and characterised by the threshold elements of competence and voluntariness, the information elements, including disclosure of factual information and explanation of alternative treatments, and consent elements, essentially the consent or refusal of the recommended plan (Braun et al., 2010, p. 814). However, in a society where intervention free birth is presented as 'risky', and medicalised birth as 'safe' (Newnham et al., 2015), it is difficult to identify what real choice women actually have, as the information given reflects biomedical discourse and a risk model of birth.

Discursive practices: The consent process

By the time the anaesthetist is called in labour at the woman's request it is unlikely that the woman will weigh up the options and decide against it. Although she may give only cursory informed consent—and at the site in question it was often verbal consent prior to the epidural being inserted—the request itself can be construed as part of the consent process, at the least reflecting a level of competence and voluntariness.

In the second antenatal class, the midwife told the women: 'You need to be well-informed' about birthing in water. The sense of needing to be well-informed was never given the same level of concern when it came to epidural use (see Newnham et al., 2015). The reality was two very different processes for the giving and receiving of information relating to consent with regard to the two practices. Below are some examples of the consent process for an epidural as experienced by the study participants, either in the current labour or their memory of previous labours.

EN: What do you remember last time of that consent form?

Lily: I think I signed something, I think I signed something! [laughs]

EN: So you don't remember what they said to you at that point, or...

Lily: There wasn't a lot said because I would remember if—he [anaesthetist] wasn't in the room for a long time so I would have remembered...I just remember he helped me breathe a bit better... yeah there is not a lot said (Lily, interview 2).

In this case, Lily highlights the lack of information given about epidural analgesia during the 'informed consent' process, observing 'maybe they presume that you've done some wider reading and understand the risk'.

Emma describes her previous experience with epidural analgesia as something she regrets, in part, because she was not aware of the risks:

At the time it didn't affect me, but looking back, I said to my midwife, I wish I that I could have tried it a little bit differently. But with a first-time baby you just don't know. When I had the epidural I was just in that much pain that I didn't even think about how it would affect the pushing and everything...I remember signing a form, and he was kind of talking to me but I don't really remember. I knew that it would make me go a bit numb though (Emma, interview 2).

Jade had had a failed epidural and several attempts at resiting it in her first labour, and although planning an epidural if she felt she needed pain relief for the coming labour, she describes being disconcerted at the lack of information she was given:

Even after you've had an epidural, if you have a catheter or if you need stitches or anything...I...never had any of that explained to me. I didn't even think they would do that and then I ended up with a whole heap of stitches and I was in pain for months and I wasn't prepared for it (Jade, interview 2).

Bella joked about the informed consent process in her labour, as she just wanted the pain relief:

He was blabbing on and I just went 'Yep, just put it in' and he did say something. Obviously there are risks, so he went through the risks...and I went 'I don't care, just put it in!' Kind of a joke but...at that time it was irrelevant (Bella, interview 3).

The following interview excerpts describe women's experiences with informed consent for using water in labour and birth.

EN: Have you gone through the water birth policy and signed it?

Nina: Yeah...I guess it's just the system covering itself which is fair enough but I don't think—they go on about risks of water birth and not the risk of epidurals and a lot of the other more medical interventions. I think it's a bit unbalanced, you kind of read between—because you know the midwives can't say explicitly 'It's fine, you have just got to sign it' but—you can read between the lines that it's kind of what they think (Nina, interview 2).

Rose had a similar sentiment about having to sign the consent forms for waterbirth.

EN: How did you find signing the waterbirth policy? Rose: I thought it was a bit—I thought it was a bit ridiculous, really, that you can give verbal consent to have drugs and yet you have to sign this huge form just to be in water. It makes it seem really dangerous and scary...I think if you didn't know much about it and they're like 'Here sign this form', you would be like 'Oh well, why? What is going to happen to me while I am in the water?' (Rose, interview 3).

Rose also noticed the reticence of midwives to offer this option:

I felt like there was a big lack of information about water birthing. Everyone just kept telling me 'Well you might not be able to do it because there might not be someone there or there might not be a room' (Rose, interview 3).

We suggest that epidural information is disparate because no-one claims ownership of the task of informing pregnant women specifically about epidural analgesia. Women are not usually exposed to anaesthetists in pregnancy, obstetricians might feel comfortable promoting epidural in labour and midwives may talk about epidural and other analgesic agents in classes or clinics, but not provide in-depth information about the risks. In addition, midwives might not consider providing comprehensive information specifically about epidural to be a primary objective of their role. In this study, the two women who had spoken to an anaesthetist during pregnancy had the most comprehensive knowledge about the pros and cons of epidural analgesia—and ironically both were actually put off the idea. The anaesthetists had no qualms (unlike the midwives) of telling women matter-of-factly exactly what an epidural does, its pharmacological and other possible side effects. This was a very small but interesting finding and may benefit from further research. However, regardless of how information is presented to women, contrasting the experiences of women giving consent for epidural and water in labour reveals a vast difference in the way informed consent was approached and gained, and highlights the institutional favour of medical procedures, even one as interventionist as epidural analgesia, over alternative or normalising birth practices. In fact it is arguable whether one could actually say in either case that a woman has given her informed consent in any real sense. Epidural information is scant and consent is brief, often verbal, with women not required to understand the a full list of side-effects or possible risks, and water use is fraught with risky language, is not offered freely as an option, and consent is written, rigorous, and psychologically arduous in its explications of risk.

DISCUSSION

From the point of view of medical anthropology, Lazarus (1988) has identified that analysis of the interactions within institutions provides a link between macro (political economy) and micro (cognitive or experiential) analysis and that taking a critical approach means to investigate social interactions between clinicians and clients, as well as discuss how the institution influences this relationship. Having previously articulated a macro-social level of analysis (see Newnham et al., 2016b), looking at the way that epidural analgesia is presented in medical discourse (Newnham et al., 2016a) and the intermediate- and micro-social analysis by looking at the influence of institutional culture and policy on midwifery practice (Newnham et al., 2015; Newnham et al., 2017), and now the information given to and received by women, we have been able to illustrate the way in which these discourses were operationalised at the micro-level of the informed consent process as well as

the influence of these discourses on the individual-level—how they affect women's experience of labour and birth.

Clinicians are in positions of power and can pass on ideological assumptions in their responses to clients. However they are also constrained by the institution to varying levels, which can result in a deferment of power to the institution itself (Lazarus, 1988). Although some of the midwives professed to support waterbirth, they also felt obliged to provide women with the reality of the hospital in which they were working, which served to reproduce medical ideology of the epidural as safe and accessible and the use of water as restrictive, therefore also sanctioning one practice—the medical one—over the other. The women noticed the effects of these discourses, and felt that they were not being given full disclosure on either practice. Women talked about their ease of access to epidural analgesia, finding the consent process even humorous at times, while women trying to access water described the solemnity with which the practice was approached. Others noticed the fact that midwives felt bound by the institutional policy, trying to 'read between the lines' of what the midwives were saying. Trying to promote normality while also needing to ensure hospital policies or medical guidelines are met creates conflict for midwives (Healy et al., 2016; Blaaka and Eri, 2008; Scamell and Stewart, 2014) and can belie not only the midwifery philosophy but also the best available evidence.

Foucault (1991, p. 75) identifies that power can be observed in 'regimes of practice'; daily interactions and occurrences are where dominant discourses are recreated. What this means is that at every interaction, individuals have the potential to contribute to or disrupt systems of power (Foucault, 2008). For example, in line with the need to provide information about alternative options within the informed consent framework, when discussing epidural analgesia it would fit well within their professional remit for midwives to not only inform women of the risks and benefits, but also mention that use of water in labour significantly reduces the need for epidural analgesia (Cluett and Burns, 2009) or that women who use epidural analgesia are more likely to remember the pain of labour prior to its insertion than women who use no pain relief due to its effect on oxytocin levels (Uvnäs Moberg, 2016). In other words, the alternative options need to have been presented for informed consent to have been gained.

If midwives are to uphold the midwifery philosophy of promoting and supporting normal birth practices, we suggest that such opportunities can be used to disrupt dominant biomedical discourse, particularly where it contradicts evidence. It might be more beneficial to women as well as more politically appropriate (see Walsh et al., 2015) if midwives were honest with women about the risks of epidural and the reasons why water is so inaccessible, and perhaps even—at a stretch—the fact

that the institution has a disciplining effect on women's labouring bodies that can diminish women's autonomy and control. We suggest that not to do so might actually constitute a breach of professional ethics in that it is otherwise upholding medicalised risk-focused philosophy of birth and may contribute to a lack of true informed consent for women. However, we are taking the position of devil's advocate here, and recognise that this is a complex area, with midwives balancing the need to follow policy, to fulfil women's expectations and not undermine their confidence in their chosen place of birth as well as uphold professional relationships. In addition, in order to do this, the midwife must be aware that s/he is upholding the dominant discourse in the first place.

CONCLUSION

In this article we have demonstrated how the dominant medical discourse was recreated at the antenatal education site; how antenatal classes, although purportedly being in the women's best interest, can have the effect of merely reproducing hospital policy or culture rather than providing unbiased and evidence-based information. This is despite the best intentions of midwives, who also appear to be constrained by the needs of the institution. The midwives were explicit in their identification of the barriers to accessing waterbirth but not in their delineation of the obstetric risk of epidural analgesia. It was presumed, because of the existence of the waterbirth policy, that women needed to be informed about the inaccessibility of this practice. Downplaying risk and emphasising choice also appeared to be a protective mechanism of midwives attempting to shield women from feelings of guilt or disappointment after their birth. Women in the study, while not always having a lot of information about epidural analgesia, identified that they would prefer straight talk when it came to risks and benefits of analgesia. They did not always feel as if they were being given enough (or the correct) information by midwives.

By outlining the practices of informed consent with regard to epidural and water use in labour, we have shown that not only were the two practices required to have two levels of informed consent – one very stringent and one very lax, but in addition, it is questionable as to whether these women had what can be considered as actual informed consent. In light of this we suggest that midwives acknowledge their disruptive potential, being at the nexus between women and medical discourse, and consider how they use their interactions with women to either uphold or resist dominant biomedical discourse.

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