1 Information for mothers

Pregnant women, their friends and their relatives may seek information about epidural analgesia from a variety of sources and this may lead to an incomplete and distorted view of pain relief in labour and in particular epidural analgesia. It is important that health care professionals are able to give sound answers to the many questions that they may be asked. Women need to be given accurate information in order to make an informed choice for their care during labour and delivery. It is to be recommended that a woman is well educated in the antenatal period so that she is able to give informed consent to an anaesthetic intervention even when she is in pain and distressed or has had opioid analgesia.

Why should the information be given?

The main reasons for giving information are to ensure that each woman is able to make informed choices about her labour and delivery and that she is able to give informed consent to an epidural if that is required. Normally verbal consent is obtained for epidural analgesia though it is much debated whether written consent is required. The medical notes should record the facts of the discussion and what information about risks and benefits was part of that conversation.

The best prelude to informed verbal consent is that the woman is knowledgeable about epidural analgesia before she arrives on the labour ward. The information must be understandable and take into account the language, intelligence and level of education of the woman. When epidural analgesia is discussed, all options of pain relief, with the risks and benefits of each should also be included. It is essential that this is a two-way process and that the woman is able to voice her concerns and have her questions answered. If the consultation was difficult because the woman was very distressed with pain then this should be recorded.

The main problems that relate to consent for epidural analgesia are that a large number of women may not intend to have an epidural and therefore do not feel it necessary to gain information about epidurals in the antenatal period. The problems arise when these women then cry out for an epidural.
when they are in pain and have had entonox and pethidine administered to them. It is exceedingly difficult to have a sensible discussion about pain relief and the risks and benefits of epidural analgesia in this situation though it could be said that consent in this case is implied as the woman needs to position herself for the procedure and to lie still. This situation is compounded if the woman does not speak English and though tempting to use the partner this is no substitute for a professional interpreter.

Birth plans or advance directives also cause problems and it could be argued that as the directive was written before the woman was aware how painful the labour would be, she should be able to change her mind in labour. A degree of common sense is needed in these situations. If the woman is almost fully dilated and is progressing well in a normal labour it is possibly wise to support her without an epidural, but if the labour is progressing abnormally and slowly then an epidural is possibly good practice to help the woman be in control.

The public has access to many sources of information and these include the internet, books, leaflets and magazines. Though a significant number are able to access good information easily there are still a significant number of women who are ill informed or denied access to information and the report of the Confidential Enquiry into Maternal Deaths highlights the problems of these disadvantaged women and in particular the problems of language and culture. Health care professionals must ensure that good lines of communication are in place at all levels of consultation throughout the antenatal period. Advice should be consistent and anaesthetists have a responsibility to ensure that our colleagues are well educated and know what information is recommended for the women.

Midwives have a responsibility to ensure that women with particular anxieties about epidural analgesia or medical problems have an anaesthetic consultation. Appropriate consultation can take place to discuss for example obesity, previous back surgery, cardiac disease, previous anaesthetic experience or particular fears. This consultation will allow a plan for analgesia and anaesthesia for labour and delivery to be set out and in the event of anaesthetic intervention being necessary the consent issue should be much easier.

**How and when should the information be given?**

Information should be readily available throughout the antenatal period using verbal, written and video material. The most important aspect is that all the health care professionals give accurate and consistent advice and are available to discuss questions about pain relief and in particular epidural analgesia. Midwives have a key role in helping women make informed choices about their place of delivery and decisions about the mode of delivery and pain relief.
The ideal time and place for talks and discussions about epidural analgesia is in the antenatal period and especially during parentcraft meetings when all aspects of pain relief in labour are covered. This type of group teaching is the most important way of reaching the majority of pregnant women, although at times it can be difficult to pitch information at a level that will be understood by all. For this reason the presence of an obstetric anaesthetist at selected parentcraft meetings allows questions to be asked and promotes discussion and better understanding of the issues.

Leaflets and videos provide an important source of additional information about epidural analgesia and they are usually on display at antenatal clinics and parentcraft meetings.

The Obstetric Anaesthetists Association (OAA) has worked hard to achieve these objectives in their pain relief booklet *Pain Relief in Labour* that has now sold over 250 000 copies and is available on the OAA website in over 17 languages. It is of great credit to the OAA that this booklet has been scored highly by the Centre for Health Information Quality. With the permission of the OAA the booklet is reproduced in Appendix C as an ideal for written information.

Although most pregnant women should have received all the information they need about epidural analgesia from parentcraft classes, there will be some women who ask specific questions arising from their personal circumstances at routine antenatal visits or during antenatal hospital admission. Medical and nursing staff should be able to answer such questions, and an obstetric anaesthetist should be available for consultation when the need arises. Planned analgesia should be the aim for women who have particular anxieties or medical problems.

By the time a pregnant woman reaches the delivery suite it is to her advantage that she already has a background of information about epidural analgesia, as this will allow an informed rational decision to be made early in labour should she request an epidural or should an epidural be recommended by a member of the delivery-suite team.

When this is not the case it can be difficult to explain the procedure of an epidural and the reasons why it is recommended to a distressed labouring woman. Explanations that can be given calmly and in full to a woman ‘in control’ may need to be modified or even directed to the partner of a woman who is ‘out of control’.

The aim of informing all pregnant women about epidural analgesia in the antenatal period is that they arrive on the labour ward fully aware of what degree of pain relief an epidural can offer and how it will affect them and their labour. In many instances this information may lead to a planned epidural.

Information about the anaesthesia required for Caesarean section should also be available for all women in the antenatal period and is essential for those women who are to have a planned Caesarean delivery. This is recommended by the National Institute for Health and Clinical Excellence (NICE)
in Clinical Guideline 13 – Caesarean section. The OAA has produced an information document, which is available on their website.

What information should be given?

Information should be made available to allow the pregnant woman and her partner to make informed choices about her labour and delivery. It is helpful to divide this information into four areas:

Anaesthetic service
Anaesthetist
Pain relief in labour
Anaesthesia.

Anaesthetic service

To make an informed choice about the place of delivery the woman should know what anaesthetic service is available. Some maternity units only have a limited obstetric anaesthetic service and may only run an on demand epidural service between certain hours. Others will have a dedicated obstetric anaesthetic consultant during those hours and outside those a dedicated resident anaesthetist for the delivery suite. To help make an informed choice, the woman may wish to ask the following questions: the epidural rate, Caesarean section rate, how long she can expect to wait to have an epidural sited, what the accidental dural puncture rate is, whether the women are followed up in the immediate postnatal period, and also whether there is the facility for postnatal follow-up at a later date for problems. Many obstetric anaesthetic services include the availability of an antenatal consultation with a consultant anaesthetist and these consultations are especially useful when the mother has particular anxieties or inter-current medical problems.

Anaesthetist

The general public is often unsure about the role of an anaesthetist within the maternity service and the following information may be useful. This information has been produced in a leaflet and it has been used on occasions where obstetric anaesthetists have run an open forum with the public.

Your anaesthetist in childbirth

An anaesthetist is part of the team that cares for you in pregnancy and childbirth. Your anaesthetist has a wide range of skills to help you when you have your baby and though everyone knows that anaesthetists give anaesthetics many people are unaware of the full role of the obstetric anaesthetist.
Most maternity units provide an epidural service. Ideally this is provided 24 hours a day, 365 days a year and run by obstetric anaesthetic consultants. A team of anaesthetists are available to administer epidural analgesia to women in labour. Also the anaesthetic team will be there to look after you if you need a Caesarean section and will encourage you to have a regional anaesthetic so that you can be awake for the delivery of your baby. A Caesarean delivery can therefore be a pleasurable birth experience with your partner present to support you and witness the birth.

Anaesthetists are highly trained in resuscitation and intensive care so if you are unfortunate enough to develop a serious complication of pregnancy then the obstetric anaesthetist is available to care for you. If you suffer from a medical condition an obstetric anaesthetist is often involved in planning your labour and delivery with the obstetric and midwifery staff and you may be asked to meet the anaesthetist in the antenatal period. Usually this is to advise on analgesia as we have a broad range of techniques to provide help with the pain of labour or the choice of anaesthesia if your delivery is to be by Caesarean section.

**Pain relief in labour**

Information about pain relief in labour should not focus on pain but rather the management of labour with dignity and control. It must be recognized that every labour is different and not all women want the same experience. Some women want to experience pain though others wish to have a pain-free labour and our role is to help women make the right choice. It is also vitally important that the woman remains flexible in her outlook to avoid disappointment and that those women who have a medical reason for epidural analgesia are appropriately managed. The OAA has made information to mothers a priority and the *Pain Relief in Labour* leaflet is appended at the end of this book (see Appendix C). Information should be available about all methods of pain relief and include an unbiased discussion of the risks and benefits of each technique. It is important that the language is appropriate for the level of understanding and education of the woman and translations and interpreters are widely available.

**Frequently asked questions**

**Does it work?**

Yes, it is the best pain relief available. It may take a little time to produce complete pain relief (i.e. a perfect block) in all women. The aim is a pain-free labour. Failure to achieve this may be due to the epidural’s being put in place too late, in which case the anaesthetic effect has insufficient time to work
before delivery. Recent developments have shown that epidural analgesia can be used to modify pain and allow the woman to remain ambulant.

**How does it work?**

Epidural analgesia works by blocking the transmission of impulses in the nerves that carry the sensation of pain from the uterus and birth canal to the brain. The local anaesthetic is placed around the nerves in the epidural space – a space outside the spinal cord.

**Is it safe?**

Yes, but like all procedures it carries a small risk of complications that can be explained to you. (This question may first be approached by emphasizing the general safety of the obstetric unit with particular reference to staff available – ideally 24-hour resident-designated cover.)

Specific questions about safety are usually related to minor complications such as a headache or residual areas of numbness, or to the possibility of serious complications such as paralysis, coma or even death. (These topics are dealt with later.)

**Minor complications**

*Headache:* A headache can be caused by accidental puncture of the dura – the membrane surrounding the spinal cord – this is not life-threatening and can be regarded as a nuisance. If this complication occurs, you should be told immediately and a full explanation of the best way to treat it will be given.

There is a risk of dural puncture associated with epidural analgesia and the overall incidence is around 0.5–1.0%. (Only half of these will go on to develop a headache if treated appropriately, that is the overall incidence of dural-puncture headache is about 0.25–0.50%.)

*Areas of numbness:* Areas of numbness are most commonly due to a circumstance of the birth, for example a forceps delivery or the pressure on your legs from the apparatus that supports them during delivery rather than the epidural itself. You should report any such areas of numbness to the anaesthetist or midwife. However, occasionally areas of numbness in the legs can remain for some time after the epidural – anything from a day to several weeks. They resolve in due course.

**Serious complications**

Serious complications from an epidural are extremely rare. Specific worries about the risk of serious complications such as paralysis, coma or even death resulting from an epidural are occasionally voiced. Quantification of these risks may be helpful – one study suggests 1 in 100 000 epidurals. The general
Information for mothers

Safety of the unit and the immediate availability of an anaesthetist can again be emphasized.

Will it hurt?

Inserting an epidural is sometimes uncomfortable but not usually painful. However, you will feel some sensations and these can be fully explained to you by describing the various stages of the procedure.

Position

You will either be curled up on your side or bent forward in the sitting position. You must remain still as the epidural space is small and the procedure is delicate.

Timing

It is easier to insert the epidural before you are in too much pain, but it is never too late to ask for an epidural; although in some circumstances an epidural may not be appropriate.

Preparation

Your back is cleaned and draped and a small amount of local anaesthetic is injected into the skin overlying the area where the epidural will be inserted, that is between the bony bumps (spinous processes) at about waist level. This may sting a little but it makes the rest of the procedure more comfortable.

Insertion of the epidural needle

The needle used to detect the epidural space will be inserted between the spinous processes. The only sensation that you will feel here is pressure on your back. Once the epidural space is found, the catheter – a fine polythene tube – is inserted through the needle; this may produce a strange sensation or a feeling of ‘pins and needles’. The needle is removed and the catheter is left in place and firmly attached to your skin with sticky tape.

Administering the epidural anaesthetic

First, a test dose of anaesthetic is injected through the catheter to ensure that you do not react adversely to it. Once this is established the next dose is given, which may take up to 20 minutes to have its full effect. When the anaesthetic has taken full effect you should be pain free, but you will still be aware of your contractions. You should also be aware of the presence of the baby’s head during delivery.

Top-up doses of anaesthetic

Top-up doses are usually necessary every 30–60 minutes. Each dose is given through the catheter by the midwife or anaesthetist and the administration
Chapter 1

of each dose is painless. A stronger top-up of an epidural already in place can give sufficient anaesthesia for a forceps delivery or a Caesarean section if either becomes necessary during your labour.

Will it damage or affect my baby?

No, only a minute amount of the local anaesthetic may reach your baby via your blood stream. The effect of this is practically zero and is very much less than the effect of pethidine or other pain-killing drugs that you may be given for a painful labour without an epidural. Epidural analgesia will not affect your ability to breastfeed and may enhance it.

Will I be able to push?

Yes, but your second stage of labour will be managed differently if an epidural is in place. Without an epidural, pushing usually begins as soon as the cervix is fully dilated, that is at the beginning of the second stage of labour. With an epidural in place, you may not experience the urge to push at this stage. Instead, the baby’s head will naturally continue its passage through the birth canal aided by the normal contractions of your womb. You should feel the urge to push when the baby’s head is near delivery, and you will then be encouraged to push actively to enjoy a normal childbirth.

Will I need an instrumental delivery if I have an epidural?

Not necessarily. However, an epidural may have been recommended to you in the first place because there are circumstances connected with the birth of your baby that may in themselves make a forceps delivery more likely.

Will it damage my back?

No, minor back problems are common after childbirth with or without an epidural. Epidurals are themselves used to treat many chronic back conditions.

If you happen to suffer from any back complaint, for example a previous operation on your spine, a slipped disc (disc prolapse), or a twisted or bent spine (scoliosis), you should tell the anaesthetist or midwife. Back problems such as these can make the giving of an epidural technically more difficult, but they are not a contraindication.

Will I be able to move my legs?

While the epidural is working, you may experience temporary difficulty in moving your legs. The dose of local anaesthetic can be adjusted to minimize
this effect, and recent developments may allow you to walk about with the epidural in place.

**Do I really need an epidural?**

You may choose to have an epidural simply to enjoy a pain-free labour. However, an epidural may be recommended to you, by a doctor or midwife, if you have or develop a particular problem in pregnancy or during childbirth. If this is the case the need for an epidural will be explained to you.

**What if it is suggested that I have an epidural?**

The obstetricians, midwives and anaesthetists looking after you may suggest that an epidural would be helpful for a variety of good reasons and they will explain these fully to you. If you require a Caesarean section epidurals are encouraged in preference to general anaesthesia enabling you to see your baby at the moment of birth and allowing you to participate in the birth.

**Anaesthesia**

Most women do not believe that they will need an anaesthetic during childbirth. However with a Caesarean section rate of around 20% and rising, a significant number of women will have an anaesthetic either for a Caesarean section or for other medical reasons. All women should know the risks and benefits of general and regional anaesthesia and know what percentage of women are delivered under regional anaesthesia in the unit they are booked in. Information leaflets should be available in all units. The OAA has recently produced a leaflet on Caesarean section called *Caesarean section: your choice of anaesthesia* (which is reproduced in Appendix D) and also a video and DVD.

Regional anaesthesia can be achieved by an epidural top-up, a spinal or combined spinal epidural. These techniques are described in Chapter 12. Whichever technique is used the woman should be informed of the risks of headache, failure, pruritis, nausea and vomiting, and hypotension. She should understand that during the procedure she will feel a degree of pushing and pulling and if at any stage she is uncomfortable then the anaesthetist will be with her to support her and administer medication to her. The woman should also be informed about the administration of syntocinon to help the placenta separate and the uterus contract, the need for prophylactic antibiotics, thromboprophylaxis and the provision of post-operative pain relief.

Even in the emergency situation the delivery of the baby by Caesarean section with regional anaesthesia should be a pleasurable birth experience,
with the woman and her partner able to see the delivery of their baby and to have close contact with the baby as soon as possible after delivery.

Despite all our efforts, however, some women go into labour with prejudiced opinions about epidurals and regional anaesthesia based on information, which is often biased and anecdotal, gleaned from the popular press and women's magazines, or the internet. When the aim of comprehensive, balanced information available to all is achieved, women will at last have a full choice of pain relief in labour and be well informed about regional anaesthesia if they need a Caesarean section.

The OAA (www.oaa-anaes.ac.uk) has made providing information to mothers a priority and continues to help women make informed choices about their management of analgesia and anaesthesia in childbirth.