Epidural Analgesia for labour: Maternal Knowledge, Preferences and Informed Consent

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Abstract
Epidural analgesia has become increasingly popular as a form of labour analgesia in Ireland. However obtaining true informed consent has always been difficult. Our study recruited 100 parturients who had undergone epidural analgesia for labour, aimed to determine the information they received prior to regional analgesia, and to ascertain their preferences regarding informed consent. Only 65(65%) of patients planned to have an epidural. Knowledge of potential complications was variable and inaccurate, with less than 30(30%) of women aware of the most common complications. Most women 79(79%) believed that discomfort during labour affected their ability to provide informed consent, and believe consent should be taken prior to onset of labour (96, 96%). The results of this study helps define the standards of consent Irish patients expect for epidural analgesia during labour.

Introduction
In the past there has been a variation in the amount and type of information provided to women before regional analgesia for childbirth. However the medical profession are required to provide an increasing amount of information to patients prior to obtaining informed consent. Recent court judgements have altered the standard of informed consent applied in Ireland from what a “reasonable doctor” deems patients should know, to what a “reasonable patient” would want to know. This raises some difficulties with regard to the consent process for epidural analgesia in labour; an elective symptom relieving procedure carried out in an otherwise healthy population. Informed consent in relation to epidural analgesia is challenging because of the pain associated with the process, the lack of time available for consideration of the risks and the additional influence severe pain may place on a patient requesting epidurals. Prior investigations demonstrated parturients want knowledge of all risks prior to undergoing epidural analgesia, study aimed to assess the level of knowledge of Irish parturients with regard to epidural analgesia, and help establish a standard for informed consent for regional analgesia in labour in Ireland.

Methods
Following institutional Research Ethics Committee approval one hundred eligible patients were systematically sampled by one of two interviewers. Parturients who had undergone an epidural within the previous 24 hours for an uncomplicated vaginal delivery were included. All patients were interviewed by one of two obstetric anaesthetists within 24 hours of their delivery. Questions from the survey were either categorical, scored on a numerical basis or summarised using a descriptive scale. Descriptive statistics were used for analysis of the data.

Results
A total of 100 patients were surveyed over the three month study period. The majority of respondents were in the 20–35 year old age group (82, 82%) with just over half being primiparous. 39 (39%) of patients had previously had one or more epidurals. The majority of parturients (56, 56%) were Para 0 with only 8 (8%) Para 3 or greater. Over 80 (80%) of epidurals were performed at cervical dilation < 6cm. Only 65 (65%) of patients planned to have epidural analgesia prior to the onset of labour. 48 (48%) of patients were unaware an anaesthetic doctor performed the epidural insertion, with many believing epidurals to be carried out by midwives, technicians or obstetricians.

Knowledge of potential complications associated with epidural analgesia was widely variable (Figure 1). The majority of parturients relied on the midwife, family or friends as their most useful source of information regarding epidural analgesia (Table 1). In only 22(22%) of cases was the anaesthetist the main source of information. Despite this though, 96(96%) of parturients would like to receive information regarding epidural analgesia from the doctor performing the procedure. A large majority (87, 87 %) believed options for analgesia during labour should be discussed antenatally. Only 3 (3%) believed it was appropriate to consent to epidural analgesia all the time of insertion. The reason for this was that 79 (79%) of respondents felt the pain experienced during labour affected their ability to give informed consent. When asked whether the pain during labour would affect their ability to sign important financial documents a very similar number (81, 81%) believed their decision making would be compromised.

Knowledge of potential complications associated with epidural analgesia was widely variable (Figure 1). The most common complications respondents were aware of was back pain and the extremely rare risk of epidural haematoma resulting in paralysis. More common complications such as increased rate of instrumental delivery, slowing of labour and hypotension were mentioned by fewer than 30 (30%) of respondents. The majority of respondents wanted to be

Figure 1: Were you aware of the following complications of Epidural Analgesia? (Yes/No)
informed about all potential complications regarding epidural insertion (Table 2). In order of relevance though most parturients considered it more important to be informed about serious but rare risks, such as nerve damage than about less serious but more common risks such as slowing of labour, hypotension and motor blockade.

**Discussion**

Epidural analgesia for labour is widely available in Ireland and is an increasingly popular form of pain relief. Though rates vary significantly between hospitals a majority of primiparous women in this country receive epidural analgesia. Because women have information needs surrounding childbirth and value self determination full informed consent regarding epidural analgesia should be a priority in all patient care. However because of the timing and the clinical circumstances the consent process is frequently carried out in a superficial or abbreviated manner.

The major benefit of epidural analgesia is its superior analgesic effects. 85% of women receive an epidural during labour report significant pain relief within 30 minutes. However such a therapy carries with it an often underestimated and misunderstood risk of complications. These include prolonged first and second stages of labour, a higher chance of instrumental deliveries, hypotension, urinary retention and procedural failure. Post dural puncture headache is a well known and feared complication of epidural analgesia. The incidence of this complication is well documented, ranging from 1% to 23% of cases. It is well recognised that women who receive an epidural have an increased risk of developing post dural puncture headache. Post dural puncture headache is a common complication of epidural analgesia. The incidence of this complication is well documented, ranging from 1% to 23% of cases. It is well recognised that women who receive an epidural have an increased risk of developing post dural puncture headache. Post dural puncture headache is a well known and feared complication of epidural analgesia. The incidence of this complication is well documented, ranging from 1% to 23% of cases. It is well recognised that women who receive an epidural have an increased risk of developing post dural puncture headache.

Medical professionals face an increasing expectation to provide timely and accurate information, with an emphasis on providing true informed consent regarding epidural analgesia. Though it may be difficult to determine what the so-called “reasonable patient” wants to know. Our patient population wishes to be informed of all potential complications of epidural analgesia, and wants the consent process to begin prior to the onset of labour. These discussions are often disturbed by painful contractions and are met with multiple reactions including anguish, indifference, cursory acknowledgement and an eagerness to proceed with the epidural. In addition to the pain of labour this process may be handicapped by the emotional upheaval associated with childbirth, lack of sleep and a limited amount of time for the patient to think about what has been discussed. Real and successful participation in the informed consent process therefore is difficult. Our results demonstrate that 79% of women do feel that the pain associated with labour affected their ability to give informed consent. In a further corroboration of that figure 81% of patients felt that pain during labour would alter their capacity to sign important financial documents. Additionally it was previously reported that 40% of anaesthetists felt it was unreasonable to obtain consent at the time of epidural insertion. 6.7. It is clear that our patient population believe true informed consent cannot be provided during labour. There clearly exists a compelling argument for the consent process to begin prior to the onset of labour.

Medical professionals face an increasing expectation to provide timely and accurate information, with an emphasis on what the patient rather than doctors considers a material risk. Legal principles applying to the informed consent process have changed in recent years. Medical paternalism was previously widely accepted, as exemplified by the decision of Justice Kingsmill Moore in the case of Daniels versus Heskins as recently as 1953 to substitute a rule of law or even a rule of thumb or practice for the individual judgement of a qualified doctor, doing what he considers best for the particular patient would be disastrous. I cannot admit any abstract duty to tell patients what is the matter with them....all depends on the circumstances the character of the patient, her health, her social position.....

The legal basis for medical paternalism remained unchallenged until the year 2000, when Justice Kearns, in the case of Geoghegan v Harris held that a medical defendant was obliged to give a warning to the Plaintiff of any material risk according to what a “reasonable patient” would want disclosed and which is a known or foreseeable complication of an operation 2. In the case of Fitzpatrick v White (2007) 3 the Supreme Court reinforced the objective reasonable patient test, as well as cautioning against obtaining informed consent close to the time of the procedure, in that case on the morning of surgery. Such a recommendation could easily be translated in to avoiding obtaining consent for epidural analgesia during labour. The societal and medico legal aspects associated with the informed consent process are well documented in recent years. Providing true informed consent is becoming increasingly difficult at a time when patients and the law are demanding more. Our study demonstrates lack of informed consent for labour analgesia in women who have undergone epidural insertion. A step first in providing informed consent is to determine what the so-called reasonable patient wants to know. Our patient population wishes to be informed of all potential complications of epidural analgesia, and wants the consent process to begin prior to the onset of labour. Though this provides obstetric anaesthetists with a significant logistical problem our results help define the standard and timing of consent required in obstetric anaesthesia in Ireland.
Though ideally every woman should be informed of each possible complication prior to undergoing epidural analgesia for labour this is not always possible. What our study does demonstrate is that all reasonable attempts should be made to disseminate information to parturients prior to the onset of labour, include in this information all relevant risks, and take consent prior to arriving on the labour ward. This could be done by providing detailed written information regarding labour analgesia to each patient at one of their early visits, and taking of informed consent at a subsequent visit or at the time of hospital admission. This would improve the current situation significantly with limited resource requirements.

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References