# Informed Consent for Epidural Analgesia in Labour: A Survey of Irish Practice

***Abstract:***

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**Abstract**

Currently, we do not have a national standard regarding epidural consent in Ireland. The aim of this survey was to assess practice in obstetric units in Ireland with regard to obtaining informed consent prior to epidural insertion, and whether the risks discussed with women are being documented. A postal survey of anaesthetists in Irish obstetric units was performed in January 2012 to assess practice regarding obtaining informed consent prior to epidural insertion, and documentation of the risks discussed. The response rate was 16/18 (88%). There was major variation both in which risks are discussed with women in labour and what risks are quoted. The most frequently quoted risks were headache - 15/16 (93.8% of the respondents), partially/not working epidural - 15/16 (93.8%), drop in blood pressure -14/16 (87.5%) and temporary backache/local tenderness - 12/16 (75%). The more serious risks were not discussed as frequently: permanent nerve damage - 8/16 (50%), paralysis - 8/16 (50%), epidural abscess/haematoma - 6/16 (37.5%), meningitis - 3/16 (18.7%). The vast majority of respondents supported introduction of a national standardised information leaflet, detailing all the benefits and risks of epidural analgesia, to be shown to all women before consenting to epidural insertion.

**Introduction**

The role of the anaesthetist has been expanding over the last few decades and anaesthetists have become increasingly involved in procedures separate from other specialties, an example of which is providing epidural analgesia for labour, which may be the only medical intervention in the occurrence of natural delivery. Traditionally the complications and risks of anaesthesia were discussed as part of the surgical procedure. This has been always a matter of debate as anaesthesia has its own risks which are distinct from surgery, e.g. nerve injury from the epidural needle. This survey included all the obstetric units in Ireland. The aim of this survey was to assess practice in obstetric units with regard to obtaining informed consent prior to epidural insertion and whether the risks discussed with women are being documented.

**Methods**

A two-page questionnaire was sent to the lead anaesthetist in each obstetric unit in Ireland. Each anaesthetist was asked to report on his or her standard practice for obtaining consent for epidural analgesia in labour. This was taken as being representative of the standard practice in their unit. The aim of the questionnaire was to evaluate whether verbal or written consent is obtained, which risks are routinely discussed with patients and what risk is quoted. Each lead anaesthetist was also asked if they use an information leaflet and if they felt that there should be a standardised national Epidural Information Leaflet, detailing the benefits and risks of epidural analgesia, for use in all hospitals in Ireland.

**Results**

Of the 18 questionnaires sent out, 16 replies were received giving a response rate of 88%. In ten units (62.5%), written consent was obtained. In all other units, verbal consent was obtained prior to epidural insertion. Consent was documented in all units on either a specific consent form for epidural (75%) or in the patientsâ  notes (25%). Table 1 gives a summary of the risk information women are routinely given. It was not reported by any unit that they routinely informed women of all the risks associated with epidural analgesia.

Some units reported that patients were informed of risks, but an exact risk was not specified. Other units reported exact risks with the quoted incidence varying greatly from unit to unit. The most frequently quoted risks were headache (93.8%), partially/not working epidural (93.8%), drop in blood pressure (87.5%) and temporary backache/local tenderness (75%). The more serious risks were not discussed as frequently: permanent nerve damage (50%), paralysis (50%), epidural abscess/haematoma (37.5%), meningitis (18.7%) (see Figure 1). When obtaining consent from a woman with poor English, the majority of respondents (93.7%) reported that they either got a family member or friend to translate or used an official translator. Only one respondent reported that they would insert the epidural without consent if a translator was not available. No one reported that they would abandon the procedure.

Eleven units (68.7%) reported that they have a local Epidural Information Leaflet, which is shown to all women prior to epidural insertion. In four of these units, it is routinely documented that the information has been read and discussed with the patient prior to epidural insertion. Fourteen of the respondents (87.5%) felt that there should be a standardised national Epidural Information Leaflet, with the benefits and risks of epidural analgesia for labour stated, available for use in all obstetric hospitals in Ireland. All respondents felt that the Antenatal Clinic would be the most appropriate place to supply women with the information leaflet.

**Discussion**

This survey shows that there is major variation across Ireland both in which risks are discussed with women in labour and what risks are quoted. There is particularly low reported discussion of the serious risks of epidural analgesia. The lead anaesthetistâ  s practice was taken to be representative of the standard practice in their unit. While this may not be the case, there is still an unacceptably large variation in practice reported. The â  reasonable patient standard" asks what a reasonable patient would consider reasonable and material to the decision to consent to a procedure offered[1].

It is incumbent on the physician to ascertain what is reasonable and material for the patient. â  A risk is material when a reasonable person would be likely to attach significance to the risk in deciding whether or not to forgo the proposed therapyâ  [2]. The Supreme Court of Canada defines a material risk as follows: "even if a risk is a mere possibility, yet if it carries with it serious consequences, such as paralysis or death, it should be regarded as material and therefore requires disclosure"[3]. The recent guidelines from the AAGBI agreed with this standard and recommended that the decision to omit mentioning a risk should be rational and stand up to logical analysis[4]. It has been shown that women in labour would prefer to be informed of all risks associated with epidural analgesia and that non-disclosure of the risks is unacceptable to them[3,5]. We cannot morally refrain from discussing the more serious risks of epidural insertion with patients. It is difficult to quantify the incidence of these risks as they occur rarely.

The Obstetric Anaesthetists Association (OAA) has an Epidural Information Card with quoted risks derived from the literature, views from experts in the field and members of the OAA's Information for Mothers Subcommittee: persistent nerve damage, 1 in 13,000; epidural abscess, 1 in 50,000; meningitis, 1 in 100,000; epidural haematoma, 1 in 170,000; severe injury including paralysis, 1 in 250,000. These figures should be quoted to patients pre-epidural insertion. More frequent risks, such as hypotension, nausea and headache may vary from unit to unit depending on experience and training of the anaesthetists, adoption of full aseptic technique and drug regimes used. An individual unit may be

able to quote their own figures obtained from audit and data collection.

There is evidence that women in labour retain more information when provided with both verbal and written information, than verbal information alone[2]. We do not have a national Epidural Information Leaflet detailing the benefits and risks of epidural analgesia. The OAA Epidural Information Card is available in several languages (available from http://www.oaa-anaes.ac.uk)[6]. Our survey shows that there is overwhelming support for the use of a national standardised information card, such as the OAA's Epidural Information Card. Documentation in the notes that such a card had been read by the patient would also serve as medicolegal evidence for informed consent. Our respondents felt that the Antenatal Clinic would be the best environment in which to give women information about epidural analgesia. Women would prefer to be informed about epidural insertion prior to the onset of labour[3], therefore the Antenatal Clinic would be an ideal location for distribution of such a card.

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**References**

1. Hoehner PJ. Ethical Aspects of Informed Consent in Obstetric Anesthesiaâ  New Challenges and Solutions. Journal of Clinical Anesthesia 15:587â  600, 2003.

2. Canterbury v. Spence, 464 F. 2d 772 (D. C. Cir. 1972).

3. Pattee C, Ballantyne M, Milne B. Epidural analgesia for labour and delivery: informed consent issues. Canadian Journal of Anaesthesia 1997; 44: 918â  23.

4 . AAGBI. Consent for anaesthesia. Revised edition 2006.

www.aagbi.org/sites/default/files/consent06.pdf

5. Jackson A, Henry R, Avery N, Van Den Kerkhof E, Milne B. Informed consent for labour epidurals: what labouring women want to know. Canadian Journal of Anaesthesia 2000; 47: 1068â  73.

6. Obstetric Anaesthetists Association. http://www.oaa-anaes.ac.uk