WHAT DO WE TELL WOMEN ABOUT OPTIONS FOR PAIN RELIEF IN LABOUR?

The pain, the pain, oh the terrible pain. The vast majority of pregnant women spend some part of their pregnancy worrying about the pain of labour. How bad will get? Will I be able to cope? How soon before I can get an epidural? Is it really as terrible as they say it will be? As each woman travels through her maternity care, does she receive consistent support, advice and information in relation to her pain relief options? It can certainly be argued that she does not. Information is slanted by the views of the person providing it – swaying from one extreme; there is no need to suffer unnecessarily, through to the other; pain is a normal part of the experience of birth; and everything in between. For a woman and her whanau, they have to navigate their way through these varying philosophies, attempting to place themselves and their own world views into the philosophy of the person seated across from them.

In an ideal world all those involved in the maternity sector would sing from the same song sheet. Advocates, Childbirth Educators, Midwives regardless of the setting, Obstetricians, Anesthetists, GP's and community organisation, would have an agreed set of principles that information was based on. They would be both evidence based and woman friendly and they would above all else be consistent.

So in this mythical "ideal world" what would be the key messages on the song sheet?

1. **Childbirth is a normal physiological process**
   Shocking perhaps, but true. All those working at the coalface need to be aware of their own tendency to become risk averse and lose sight of the fact that for many, birth is not an illness and women are not patients.
2. **Pain is a normal part of this process**
   Pain in labour is not abnormal. It serves a multitude of purposes, its primary one being to provide essential feedback to the woman and her support team. Throughout labour there are a number of interdependent hormonal players whose sole job is to bring about a safe and healthy outcome. Pain is a vital aspect of this process.
3. **A woman's body is beautifully designed to cope with labour and birth**
   Is the blueprint so flawed that it requires medical assistance every time? Those suffering diabetes or heart disease have a glitch in their blueprint but does that mean medicine should treat everyone as though they have diabetes or a cardiovascular disease? Trust in the process of birth is essential.
4. **For some women more medical forms of pain relief can be a necessary part of her experience, however these interventions may not be without risk**
   In spite of the normality of birth, it would be unreasonable to suggest that for some women more assistance may not be necessary; however it is also unreasonable to suggest that this assistance is without risk.
5. **Epidural medications may significantly interfere with the normal and finely tuned balance of labour, birth and breastfeeding.**
   We ignore the role of the key birthing hormones – prostaglandin, oxytocin, beta-endorphins and catecholamines – at our peril.

6. **While medical forms of pain relief may be requested, a woman needs to make a fully informed decision which includes being made aware of the risks.**

   The Code of Rights talks about providing a level of information that a "reasonable person" would expect to receive. This includes the good, the bad and the ugly – women are capable of balancing the information to reach decisions that are right for her and her right to do so must be respected.

It is well accepted that there is actually little in the way of solid evidence supporting much of maternity care and many clinicians are guided by a "knowing" littered with ever growing pockets of evidence-based practice. The gold standard however is to utilise evidence to support both the information given and the care recommended. The difficulty lies in finding a body of evidence that can be accepted and utilised by all those working within the maternity sector.

The NICE guidelines for Intrapartum Care of healthy women and their babies, 2007 (updated June 2008), is perhaps the only current document that comes close to meeting the needs of both women and practitioners. There is a significant body of evidence supporting the recommendations with a large multi-disciplinary team involved in the development of the guidelines. There are a number of recommendations contained with the guideline with regards to pain relief options in labour and these can be utilised to ensure that women are receiving consistent, evidence-based information:

- Healthcare professionals should consider how their own values and beliefs inform their attitude to coping with pain in labour and ensure their care supports the woman's choice.
- Women who choose to use breathing and relaxation techniques in labour should be supported in their choice.
- Women who choose to use massage techniques in labour that have been taught to birth partners should be supported in their choice.
- The opportunity to labour in water is recommended in labour.
- Accupuncture, acupressure and hypnosis should not be provided, but women who wish to use these techniques should not be prevented from doing so.
- The playing of music of the woman's choice in the labour ward should be supported.
- TENS should not be offered to women in established labour.
- Ethonox should be available in all birth settings as it may reduce pain in labour, but women should be informed it may make them feel nauseous and light-headed.
- Opiods should be available in all birth settings. Women should be informed that these will provide limited pain relief during labour and may have significant side effects for both the woman (drowsiness, nausea and vomiting) and her baby (short-term respiratory depression and drowsiness which may last several days.)
- Women should be informed that opiods may interfere with breastfeeding.
- Before choosing epidural analgesia, women should be informed about the risks and benefits, and the implications for labour:
    - it provides more effective pain relief than opiods
    - it is associated with longer second stage of labour and an increased chance of vaginal instrumental birth
    - it is not associated with long-term backache
    - it is not associated with a longer first stage of labour or an increased chance of caesarean birth

    - it will be accompanied by a more intensive level of monitoring and intravenous access
    - modern epidural solutions contain opiods and, whatever the route of administration, all opiods cross the placenta and in larger doses may cause short-term respiratory depression in the baby and make the baby drowsy
- Women in labour who desire regional analgesia should not be denied it, including women in severe pain in the latent first stage of labour
- Women with regional analgesia should be encouraged to move and adopt whatever upright positions they find comfortable throughout labour
- Once established, regional analgesia should be continued until after completion of the third stage and any necessary perineal repair
- At full dilatation, pushing should be delayed for at least one hour and longer if the woman wishes unless the woman has the urge to push or the baby's head is visible

Until all those working with women during the childbearing year get onto the same page, what women are told about pain relief is subjective and heavily influenced by personal values and beliefs leaving women are in the middle, questioning who to believe.

Perhaps the focus instead needs to be on empowering women to believe enough in themselves and their own bodies so they can make a decision that is right for them.

The NICE guideline of Intrapartum Care can be download from:
http://www.nice.org.uk/CG55

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