3 Pain relief in labour in Great Britain and Ireland

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Introduction

The newly diagnosed pregnant mother is usually filled with curiosity about both the physical changes that will occur over the forthcoming months and the process of actually delivering her baby. Childbirth education is a major industry in both Great Britain and Ireland. Bookshops offer a large variety of pregnancy and childcare manuals and the National Childbirth Trust is a very successful enterprise offering antenatal and postnatal care and support to mothers. In the past many articles and book chapters on pain relief in labour failed to inform the mother in simple language about what she might expect to experience in her first and subsequent labours. Articles that place the same emphasis on the value of aromatherapy and homeopathy as on pharmacological analgesia during labour serve more to mislead than to educate. A more honest and open appraisal of pain in labour combined with statistics on the uptake of the various methods of pain relief would be of greater benefit to a woman than the carefully selected anecdotes of an author whose ideas have been polarised by her own experiences of childbirth. Whilst some excellent and informative lay publications are now available, relevant and up-to-date medical statistics on all aspects of labour are often inaccessible.

Use of labour analgesia

The National Birthday Trust, a charity concerned with the peripartum care of women, was founded in 1928. The promotion of analgesia in labour was one of
the original aims of the Trust. During one week in June 1990, the Trust surveyed all hospital and home deliveries in the United Kingdom. The survey was prospective and aimed to collect data from the mother, her partner and the professionals (predominantly midwives) responsible for her delivery. It assessed pain in labour and the availability and use of different types of pain relief. The survey was in two stages with some mothers being assessed six weeks after delivery, thereby enabling an evaluation of the changing perception of pain with the passage of time. The results form one of the most important publications on the subject of pain relief in labour in the UK in the past decade.

Three hundred and thirty maternity units were identified as being suitable for participation in the survey (table 3.1). It had been estimated that between 13,000–15,000 might deliver during the surveyed week, and while data were provided by the professionals on 10,353 mothers, only 6,459 women completed their part of the questionnaire and of these only 6,093 recorded the method of pain relief. Six weeks after delivery 1,400 mothers were followed up of whom 1,149 (82%) responded. Seventy-nine percent of the surveyed women had spontaneous vaginal deliveries, 10% had instrumental vaginal delivery and the caesarean section rate was 11.4%. Of the non-pharmacological analgesic techniques transcutaneous nerve stimulation (TENS) and relaxation were the most widely available and used. Entonox and pethidine were easily available in most units whereas epidural analgesia was not universally available (table 3.1). It was found that the great majority of mothers used Entonox at some time during labour, 37% used pethidine, 18% epidural analgesia and 5.5% TENS. Acupuncture, hypnosis and homeopathy were used by less than 1% of mothers. The main factors influencing the method of analgesia used were the original planned method, the duration of labour, parity and the mode of onset, spontaneous or induced. The effect of the duration of labour on the principal method of analgesia used by nulliparous is shown in figure 3.1. Entonox was used by approximately 75% of mothers, irrespective of the duration of labour, whilst there is a decline in the use of pethidine as the principal method after 8 hours. The uptake of epidural analgesia increases four-fold throughout labour. The survey also showed, not surprisingly, that nulliparous were twice as likely as multiparous to use epidural analgesia, as were those whose labours were induced. In those units where an epidural service was available, 17% of mothers planned to use epidurals, 24% actually did, and 33.5% planned to use epidural analgesia next time. Comments by the mothers were also reported, several complaining that they had not been adequately warned of the severity of labour pain and the consequent need for epidural analgesia, and that epidural analgesia had been delayed or withheld.

Inevitably, a mother’s choice will be influenced by the attitude of the midwife caring for her and the local availability of the various forms of analgesia. Surveys conducted in the old South East Thames region of England between 1988 and 1992 highlighted some local variations. Figure 3.2 shows epidural rates in 11 obstetric units in four geographical groups. In the first group, epidural rates relate to unit size, but in the next, the rate in Tunbridge Wells is more than double that in Maidstone, though both serve similarly wealthy country towns and rural communities. Two adjacent London suburbs, Sidcup and Bromley, show a similar disparity as do the hospitals in the fourth group, all teaching hospitals serving deprived inner city communities. There is little change over time, except in Gravesend where two units had combined to improve services. Thus the proportion of women using epidural analgesia in different units varies widely, the