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ORIGINAL ARTICLE

Informed consent for labor epidurals: a survey of Society for Obstetric Anesthesia and Perinatology anesthesiologists from the United States

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Background: Ethicists agree that informed consent is a process rather than just simply the signing of a form. It should provide the patient with needed information and understanding to authorize a procedure. Essential elements of informed consent for women requesting labor epidurals include a description of the procedure, the risks and benefits, and alternative treatments for analgesia including the associated risks and benefits. The purpose of this pilot study was to determine practices and opinions of obstetric anesthesiologists regarding informed consent for parturients.

Methods: Questionnaires were sent to 885 anesthesiologists who were members of the Society of Obstetric Anesthesia and Perinatology based in United States institutions in 2002.

Results: Of the 885 questionnaires sent, 448 (51%) were returned with 47% from academic and 47% from private practice institutions. Forty-six percent worked as part of an obstetric anesthesia team; 51% worked in centers where there were >3000 deliveries/year. Sixty-eight percent suggested that "parturients in active labor are able to give informed consent for labor epidural analgesia." Thirteen percent recommend antenatal anesthesia consults for parturients inquiring about labor epidurals and 41% participated in childbirth classes. Responses did not differ significantly between physicians in academic vs. private practice. More obstetric team practices than non-team practices participated in childbirth education (54% vs. 30%, $P < 0.0001$).

Conclusion: Despite the painful, stressful circumstances confronted by parturients, many respondents (76% in academic, 64% in private practice) thought that women in active labor are able to give informed consent.

Keywords: Informed consent; Labor analgesia; Epidural analgesia

INTRODUCTION

Obtaining informed consent in parturients in active labor is problematic because parturients must deal with the physical and psychological stresses of labor and manage pain during this exchange of information. There have been few studies concerning the practice of obtaining informed consent for labor analgesia in parturients.[1–3] Ethicists tend to agree that informed consent is a process rather than simply signing a form. According to Beauchamp and Childress,[4] in one model informed consent consists of three stages: threshold, information, and consent. Threshold requires adequate decision-making capacity (or competency), information considers disclosure and understanding, and consent consists of making a decision. The concept of informed consent supports the principles of beneficence and respect for autonomy. Beneficence promotes patient well-being (do no harm) and respect for autonomy honors individual views, choices and values resulting in the self-determination of patients. Informed consent provides opportunity and encouragement for patients to become more active in

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decision-making. In essence, it provides a patient with needed information and understanding to choose to authorize a procedure, free of coercion.

Essential elements that must be disclosed to women requesting labor epidurals include a description of the procedure, the attendant risks and benefits, alternative treatments for labor analgesia and their associated risks and benefits, and expected results with or without the labor epidural.[5] It is perhaps unrealistic to expect the anesthesiologist to be able to discuss completely and in detail all of these elements with a parturient in active labor. Parturients with a high level of pain may not even want to listen to or be able to focus on the discussion. The purpose of this study was to determine current practices and opinions regarding informed consent for parturients among active members of the Society for Obstetric Anesthesia and Perinatology (SOAP), to better define aspects of the informed consent process that warranted further investigation. Moreover, we wanted to test whether these practices and opinions depended on anesthesiology practice factors such as academic versus private practice.

MATERIALS AND METHODS

The study was approved by the Office of Research Compliance at the State University of New York at Stony Brook, University Hospital and Medical Center. We surveyed 885 anesthesiology members of SOAP based in the United States as of May 2002. The SOAP membership list was purchased from the organization. Members of SOAP no longer in clinical practice were excluded from the study. The questionnaire (Appendix) consisted of 13 questions, six about practice characteristics (type of practice, presence of an obstetric anesthesia team) and seven about informed consent practices and procedures (use of a separate anesthesia consent form, antenatal obstetric anesthesia consult capability, and opinions about obtaining informed consent in laboring parturients).

Statistics

The JMP v.5 software, SAS Institute, Inc. was used for data analysis. In order to obtain an overview of the results, simple χ^2 analysis was used to compare differences in informed consent practices and procedures among the various practice characteristics: practice type, obstetric anesthesia team presence, annual numbers of deliveries and continuing medical education (CME) credits. The data for each of the questions 7–13 were then examined in a four-parameter, nominal logistic model. This considers the effects of all four parameters simultaneously (which takes into account any possible correlations among practice parameters) and rates the model with a single P value (which takes into account the multiple analyses of a single set of data). If the P value for this whole model test was <0.05, those parameters with P values <0.05 in the Wald test were considered to be significant.

RESULTS

The response rate was 51% (448/885). The results are presented in Table 1. Of the respondents, the great majority were in either academic departments or private practice. Forty-six percent practiced as part of an obstetric anesthesia team and 51% worked in institutions where there were more than 3000 deliveries per year. Team practices were found with greater frequency in hospitals with higher annual deliveries (Fig. 1, $P < 0.001$) and were also more likely to be found in academic departments than in private practice (62%, vs. 31%, $P < 0.0001$). Most respondents participated in Continuing Medical Education programs. Participation was higher for academic than for private practice (81% vs. 67%, $P = 0.03$) and hospitals with higher annual deliveries (67% for ⩽3000 deliveries vs. 82% for >3000 deliveries, $P = 0.03$), but did not depend on the presence of a team practice. Few respondents answered the question about whether their practice consisted of at

Table 1. Practice characteristics

Question		Responses: n (%)
1. Practice type	Academic	210 (47%)
	Private	211 (47%)
	Other	26 (6%)
	Blank	1 (0%)
2. Deliveries per year	None	3 (1%)
	<1000	33 (7%)
	1000–3000	179 (40%)
	3001–5000	127 (28%)
	>5000	102 (23%)
	Blank	4 (1%)
3. ⩾20% Obstetric cases	Yes	74 (17%)
	No	25 (6%)
	Blank	349 (78%)
4. Obstetric anesthesia team practice	Yes	205 (46%)
	No	160 (36%)
	Blank	83 (19%)
5. SOAP member	Yes	430 (96%)
	No*	16 (4%)
	Blank	2 (0%)
6. Obstetric continuing medical education credits	Yes	332 (74%)
	No	115 (26%)
	Blank	1 (0%)

SOAP: Society for Obstetric Anesthesia and Perinatology.
The number of responses to each question (see Appendix 1 for the full question) is presented.
*16 respondents (4%) said they were not members of SOAP even though the questionnaire was sent to anesthesiologists on the SOAP membership roster. The responses of these individuals were included in all analyses reported here. Reanalysis of the data omitting responses from these individuals did not appreciably alter the significance of the comparisons reported in Table. 3.