# NZCOM CONSENSUS STATEMENT

# *Prescribing and administration of Narcotic Analgesia in Labour*

***This Consensus Statement was ratified at the NZCOM Annual General Meeting on 29 July 2011***

The New Zealand College of Midwives (Inc) acknowledges that pain is a normal part of giving birth for the vast majority of women. In a normal labour and birth, pain is protective in that it enables the woman to prepare for, and give birth to her baby. It tells her to move to a place where she feels safe, focus on herself and call the people she trusts to be close by.[1]

One to one midwifery support in labour is known to make a significant difference to the way in which women interpret and manage the pain they have in labour.

There is strong evidence that the presence of supporters caring for women at home in their own environment during the latent phase of labour is associated with a reduction in the requirement for analgesia.[2] Furthermore a safe, calm, caring and drug free environment also positively influences the outcomes of labour for both mother and baby.

Every woman will respond to the pain of labour differently depending on her physiological, social, emotional and cultural experience and environment.

There are many non pharmaceutical ways of supporting women to cope with labour pain when labour is building normally towards the birth. Therefore the routine use of any pharmacological analgesic medicines in normal labour is not supported.

The attitudes and behaviours of midwives have been shown to be more powerful than any other influences in helping women to cope with pain in labour[3].

Systematic reviews demonstrate <u>four</u> factors that are relevant to women's satisfaction with pain management in labour. They are:

- Personal expectations
- Support from caregivers
- Quality of relationships between caregivers
- Women's involvement with decision making processes

These factors override influences such as maternal age, childbirth preparation, birth environment, pain scores, immobility, medical intervention and continuity of care.

**Narcotics**

Narcotic drugs have been used commonly for many years as an analgesic agent when pain is abnormal or overwhelming during labour. Pethidine is the only narcotic drug that a midwife can prescribe on her own account (Misuse of Drugs Act 1975). The evidence for Pethidine as an effective analgesic in labour is weak and the adverse effects on the neonate are well documented in relation to respiratory and breastfeeding initiation and maintenance.

Other narcotics may only be administered under the direction of a medical practitioner.

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[1] Labour Pains? Making Choices, New Zealand College of Midwives, 2010

[2] Leap N, Anderson T. The role of pain in normal birth and the empowerment of women. In: Downe S, editor. Normal childbirth: evidence and debate. 2nd edition. Edinburgh:Churchill Livingstone; 2008. pp. 29-46

[3] Leap, N., Newburn, M. Working with pain in labour: an overview of evidence. Perspective: The NCT publication for parent- centred midwifery 2010;6:pp.9-12

**Recommendation**
The College does not recommend the use of the narcotic pethidine. If pethidine is used it should be used judiciously and with caution during labour.

Midwives should be aware that the interval between the administration of a narcotic drug to the time of birth is important. The shorter the interval the more significant is the adverse impacts on the newborn. (The half life of norpethidine in the neonate is 30-60 hours)

Giving multiple doses of a narcotic will compound the impact on the newborn and is not recommended.

The College recommends midwives discuss the following points with women if they are considering using a narcotic for pain relief in labour:

- The benefits and side effects of pharmacological and non- pharmacological analgesia should be discussed antenatally, including whether the woman has any allergy or sensitivity to opiates. If this is not possible then discussion and consent for analgesic use should be gained before administration to the woman in labour.
- The narcotic pethidine affects the memory of pain rather than acting specifically on the pain a woman experiences when in labour. It is increasingly viewed as an inferior drug for the purpose of pain relief
- Narcotics cross the placenta to the baby and have a depressive effect on the baby's respirations. This can be reversed in the short term by the administration of Naloxone. However the reversal action of Naloxone may be of a shorter duration than the depressant effect of the narcotic. This may lead to delayed respiratory depression for the baby after birth.
- The baby receives maternal metabolites if the mother has been given narcotic pain relief and begins to produce its own metabolites. Findings suggest it is particularly unsafe to administer narcotics in early labour because of the metabolite effect. Other measures to assist the woman manage pain in early labour should be provided.
- Studies have demonstrated unequivocally that breastfeeding is affected by exposure to narcotics and the baby's ability to initiate and sustain breastfeeding.
- If narcotics are administered in labour both the woman and the baby require extra monitoring following birth to assess for potential respiratory depression.

**References:**


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Source: International Journal of Obstetric Anaethesia. Vol 20. Issue 1. Pages 38-50. Jan 2011

The purpose of New Zealand College of Midwives Consensus Statements is to provide women, midwives and the maternity services with the profession's position on any given situation. The guidelines are designed to educate and support best practice.

All position statements are regularly reviewed and updated in line with evidence-based practice.