No doubt about it. Epidurals are aptly named the “Cadillac of analgesia.” Epidurals allow women to be awake and aware yet free from pain during labor and birth. They permit an exhausted woman to rest or sleep. And while their usual effect is to slow labor, the profound relaxation they offer can sometimes put a stalled labor back on track. Despite these benefits, you would do well to look under the hood before you decide to drive this “Cadillac” off the lot. Like all medical interventions, epidurals have potential harms. The wise woman will want to weigh them against her other options. Unfortunately, many care providers don’t supply complete information. To give you a more balanced picture, here are the disadvantages of epidurals according to the research:

• A minimum of 5 more women per 100 will have a vacuum extraction or forceps delivery: Consequences of these types of delivery include increased probability of a tear into the anal sphincter muscle and injury to the baby.

• Seventeen more women per 100 will experience a drop in blood pressure which can pose a risk to the baby.

• The narcotics included in epidurals greatly increase likelihood of nausea and can cause itching.

• Epidurals interfere with establishing breastfeeding. Studies specifically link fentanyl, a common narcotic component, to early problems and higher probability of switching to bottle feeding. Associated interventions such as instrumental vaginal delivery may also affect early breastfeeding.

• Somewhere between 1 in 1,400 and 1 in 4,400 women will experience a life-threatening complication.

• Combined spinal-epidurals, sometimes called “walking epidurals,” increase complications. Compared with standard epidurals, more women will experience itching, some will have breathing problems or difficulty swallowing, and some babies will experience a prolonged episode of abnormally slow fetal heart rate.

Epidural side effects can also have negative psychological consequences. Fetal heart rate disturbances, a drop in blood pressure, or difficulty breathing or swallowing may cause intense alarm and distress. Itching or nausea can make a woman miserable.

While complete pain relief may make for a more positive labor experience, epidurals’ interfere with the natural interplay of hormones, which has its downside. During unmedicated labor, beta-endorphin levels rise in response to pain, producing a “high”
that enables women to transcend labor pain and experience that “top of the world” feeling after giving birth. An adrenalin surge in late labor dispels exhaustion, gives a woman extra oomph to push out the baby, and ensures that she is excited and alert to greet her baby. Oxytocin is the hormone of love, not just contractions, and unmedicated women have higher levels after childbirth than any other time in their lives.

Still, labor is unpredictable. You don’t want to cross an epidural off your dance card. Just be sure that you make your decision freely, not because you feel pressure or lack an alternative. Here are some ways to do that as well as minimize potential harms:

• Choose a care provider with a cesarean surgery rate of 15% or less. Studies show that in the hands of care providers with low rates, epidurals do not increase cesarean odds. Practitioners who have vaginal birth as a goal will have more patience and manage labor and epidurals differently than others.

• Choose a mother-friendly birth environment. In most hospitals, confinement to bed, continuous fetal monitoring, and restricting labor support companions such as doulas, along with lack of amenities such as showers, deep tubs, and birth balls make epidurals the only viable option for coping with pain. Where epidurals are the norm, nurses may not know how to support a laboring woman without one, and staff may actively promote their use.

• Delay an epidural until active, progressive labor. This will help prevent two problems: running a fever, which becomes more likely the longer the epidural is in place, and the baby persisting in the occiput posterior position (head down, facing the mother’s belly). These complications increase the likelihood of cesarean or instrumental vaginal delivery. And because epidural-related fever cannot be distinguished from fevers caused by infection, babies are more likely to be kept in the nursery for observation, undergo blood tests and possibly a spinal tap, and be given precautionary I.V. antibiotics.

• Choose a standard epidural of the lightest intensity that keeps you reasonably comfortable over a spinal or “walking” epidural.

Finally, whether an epidural is Plan A or B, take classes that prepare you for coping with labor without one and consider hiring a doula. You will want a variety of comfort measures and coping strategies at your
finger tips. For one thing, you may need them if you are delaying an epidural until active labor. For another, the anesthesiologist may not be available when you want your epidural, or you may be among the 1 in 10 women for whom it does not work. It is also possible that labor will turn out to be easier than you thought and you decide you don’t need one after all.

Henci Goer is the author of *The Thinking Woman’s Guide to a Better Birth* and *Obstetric Myths Versus Research Realities*, a new edition of which is in press. Goer moderates the “Ask Henci” forum on Lamaze International’s website and appears as a regular guest blogger on Science and Sensibility. She was a doula for over 20 years and a Lamaze educator for ten.