

# POSTNATAL 'DEBRIEFING'

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## INTRODUCTION

The postnatal period is critical for the mental wellbeing of the parturient woman who could be vulnerable to a spectrum of psychological disorders ranging from mild emotional instability to severe psychosis, yet apparently this critical period is not getting the desired attention.

Obstetric intervention and traumatic childbirth could have a negative impact on the woman's experience as a high level of obstetric intervention is associated with acute traumatic symptoms and fear of subsequent childbirth.<sup>(1)</sup> It seems that women who had an emergency caesarean section or an assisted vaginal delivery had more negative experiences of childbirth than those having a normal birth.<sup>(2)</sup> A study in 2004 found that fear of childbirth was a frequently reported reason for avoiding further pregnancy in 51% of cases after instrumental vaginal delivery and 42% after caesarean section,<sup>(3)</sup> and fear of vaginal birth was the most important reason for women who changed from preferring vaginal birth to elective caesarean section.<sup>(4)</sup>

The changes in medical staffing working patterns brought about by the European Working Time Directive (EWT) and the trend towards earlier discharge from hospital are possible contributing factors in the difficulty encountered by some middle-grade obstetricians in visiting the new mothers while they are still in hospital.

There are claims that postnatal support, counselling, understanding and explanation given to women do benefit their psychological wellbeing.<sup>(5,6)</sup> Conversely, failure of communication could lead to dissatisfaction. A 1996 study found that 7% of the medico-legal disputes in obstetric and gynaecology were due to failure of communication.<sup>(7)</sup> The current trend in the United Kingdom is that many maternity units routinely offer postnatal 'debriefing'.<sup>(8)</sup> Effective communication between the healthcare professionals and the woman and her family is essential and could prevent any potential misunderstanding or complaints. It is often difficult in an emergency situation to ensure full understanding; hence, planned, structured and standardised postnatal debriefing of women who had an operative delivery is imperative.

### AUDIT STANDARDS

1. Obstetricians should review the woman prior to hospital discharge and discuss the indication for operative delivery, management of any complication and the prognosis for future deliveries.<sup>(9)</sup>
2. Women who have had a caesarean section should be offered the opportunity to discuss with their healthcare providers the reasons for caesarean section and implications for the child and for future pregnancies.<sup>(10)</sup>

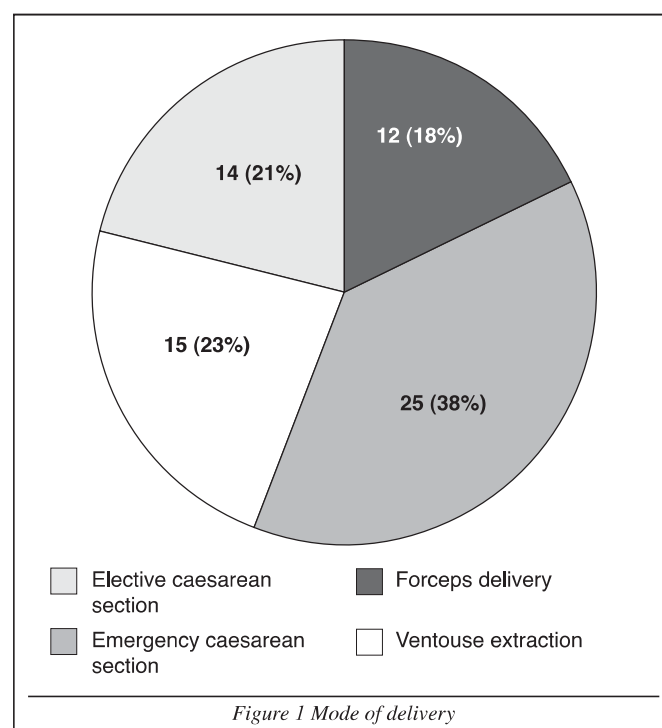
## METHOD

This is a prospective audit. Sixty-six women were interviewed on the postnatal ward on the day of discharge or prior to the day of discharge by the first author. Women included were those who had undergone operative delivery, either vaginally or by caesarean section. The delivery records of each woman were compared to the woman's replies to assess her understanding of the events. A designed proforma of five questions was completed by all the women. One woman was excluded because her proforma was not filled in completely, therefore only 65 women were included in the analysis.

The audit period was from the beginning of September to the end of November 2007.

## RESULTS

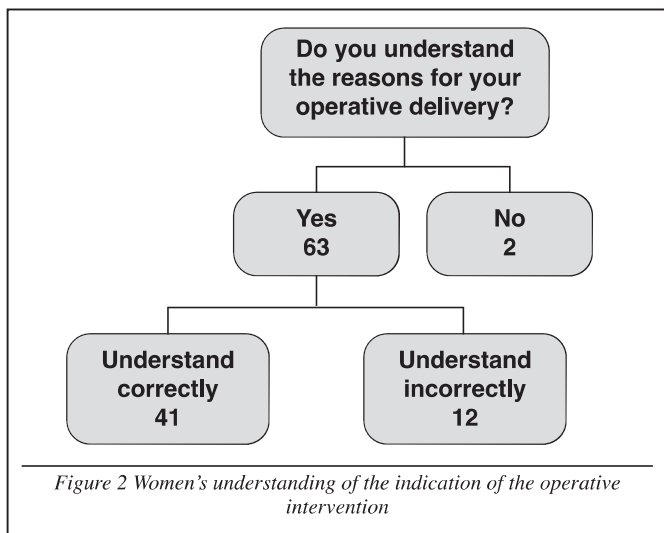
Twelve women (18%) were delivered by forceps, 15 (23%) were delivered by ventouse extraction, 14 (21%) had an elective caesarean section and 25 (38%) had an emergency caesarean section (see figure 1). Fourteen out of 63 of the women (22%) either did not know the reasons for the operative delivery or their understanding of the indication was incorrect (see figure 2). In ten out of 65 of cases (15%) doctors did not introduce themselves and four women (6%) were not sure, which means that 21% don't know the identity of their medical team (see figure 3). Forty-two women (65%) did see the team that delivered them who explained the circumstances of labour and delivery, while 23 women (35%)



did not see the team that delivered them; however, 16 (23%) were seen by another doctor and seven (11%) did not see any doctor. The birth experience of 25 out of 65 (38%) of the women was either very poor or poor (see figure 4). Nine women (14%) described their mood as either very low or low (see figure 5). There were 38 reported episodes of intervention or complications such as: episiotomy, third degree tear, postpartum haemorrhage, antepartum haemorrhage, wound infection or retained placenta (see table 1). Some women had more than one episode. There were 24 reported episodes of fetal complications and five newborns needed admission to the neonatal unit (see table 2).

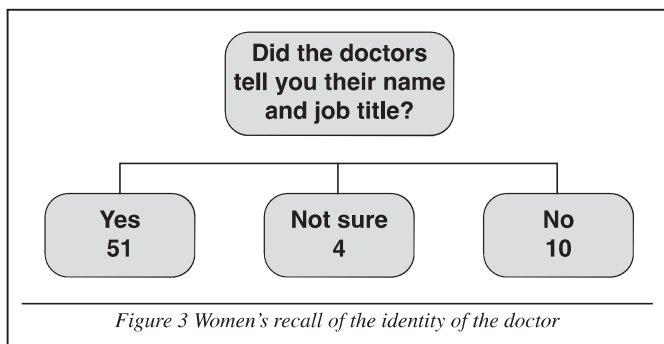
Complications	Number of reported episodes
Episiotomy	23
Third degree tear	4
Postpartum haemorrhage	6
Antepartum haemorrhage	1
Wound infection	3
Retained placenta	1

*Table 1 Maternal complications*



Complications	Number of reported episodes
Prematurity	4
Admission to neonatal unit	5
Small for gestational age	2
Fetal abnormality	1
Seizures	2
Jaundice	10

*Table 2 Fetal complications*



as to whether the maternal dissatisfaction was due to the care provided, the obstetrical intervention, the lack of fulfilment, the outcome, or perhaps other undisclosed factors. Nevertheless, there is no doubt that the maternal dissatisfaction would certainly strengthen the argument for structured postnatal debriefing.

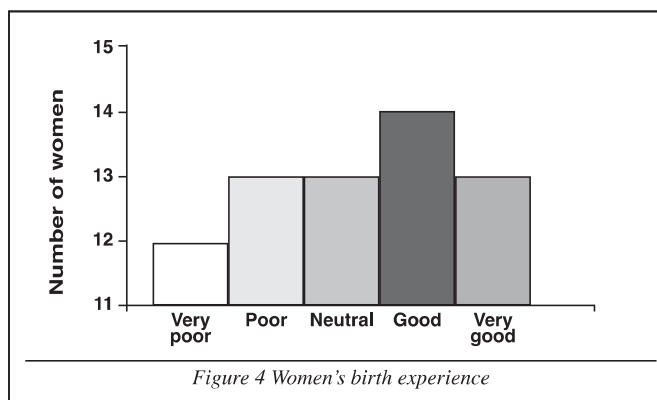
## DISCUSSION

The audit results are disappointing in that more than one in four of the women interviewed were either not informed or not well informed about the indication of their operative delivery or did not know the identity of their medical team. It is below expectation for more than one third of the women not to be reviewed in the postnatal period by the team that delivered them and for 11% of the women not to see any doctor in the postpartum period, which could mean that some women did not receive an explanation of the intervention or the care they received. Consequently, it was not a surprise that the birth experience of 38% of the women was unsatisfactory and 14% of them described their mood as either low or very low.

The audit findings raise the probability that the change in the working pattern as a result of the EWT to a shift system and the tendency for early discharge could have contributed to this gap in the care. This should not be an excuse, however, for not seeing the women during/prior to the end of the working shift or before discharge, and undoubtedly this is an opportunity for senior input into the care of these women. This objective of conducting a post-delivery visit by the caring team is achievable and is an excellent communication opportunity between the caring professionals and the women and their families that should not be missed.

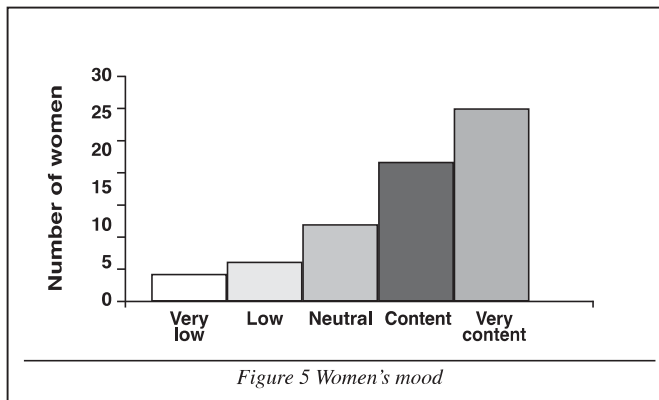
Is there any possibility of a correlation between the women's mood and the high incidence of obstetrical interventions and maternal and fetal complications in the sample? Although the number of the women surveyed is too small to draw conclusions, however, no one could be certain

Postnatal debriefing and other psychological interventions have become popular and they are widely introduced in different maternity settings, but their efficacy is yet to be objectively assessed. Several studies have looked at postnatal debriefing approaches to reduce psychological morbidity



following childbirth and many maternity units in the United Kingdom offer such a service, despite a lack of robust evidence.<sup>(8)</sup> There is a suggestion that women who received midwife debriefing were less likely to have high anxiety and depression scores after birth than women who did not.<sup>(6)</sup> However, the evidence is not sufficient enough to show that single postnatal debriefing session will reduce maternal psychological morbidity.<sup>(11,12,13,14)</sup>

The term debriefing could be confusing or misleading and many of the postnatal surveys and postnatal debriefings, including this audit, are not standardised and it is not clear what constitutes an effective debrief. Many workers commented that quite often the postpartum counselling and debriefing are opinionated, inconsistent, generalised, non-specific, lack details and difficult to reproduce.<sup>(15,16)</sup> Hence, it was suggested in 2002 that future research should be more specific, detailing the intervention and outcomes, the timing or place of the intervention and should acknowledge the complexity of the contributing factors to depression and trauma.<sup>(11)</sup>



## CONCLUSION

The postnatal care of these women could have been better and the experience of a significant number of the women was unsatisfactory. It seems that a golden opportunity for postnatal discussion and counselling was missed. The findings support the argument for a planned, structured and standardised postnatal care, including debriefing, especially for women who had obstetrical intervention or complications in labour.

Therefore, we suggest that:

- The team that delivered the woman should make every effort to see her post-operatively, particularly if there are complications. Where this is genuinely not possible, this may be a useful task for the team covering the labour ward.
- The professionals seeing women in the postnatal ward should routinely question them about their understanding and any negative feelings to ensure that they can be seen by the most senior member of the team prior to discharge.
- The practice of structured postnatal debriefing should be introduced in a consistent, systematic and standardised way and be subjected to regular assessment.

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