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COUNSELING PREFERENCES OF PARTURIENTS RECENTLY DELIVERED BY CAESAREAN SECTION

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ABSTRACT
Counseling for caesarean section is an essential aspect of the pre-operative preparation. This consists of information on diagnosis, indication, safety, complications, pain management and addressing other concerns of the patient. This counseling leads to improved uptake of the procedure and increases patient satisfaction. This study has been designed to assess the counseling received and to document the counseling desires of parturients undergoing caesarean section at the University of Benin Teaching Hospital, Benin City. It was a cross-sectional descriptive survey of 248 consecutive consenting parturients who were between 3 and 4 days post caesarean section. An interviewer administered questionnaire was used to seek information on the subjects of this study. A total of 56.6% of respondents reported having no health talk whatsoever about caesarean section during the antenatal care. While over 90% had counseling on the indication, there was less emphasis on safety, complication and pain relief following the procedure. Over two thirds of the respondents will like to have information on the possible complications and the effect on future reproduction of the caesarean delivery. Notable important concepts that these respondents will like discussed include likelihood of subsequent vaginal delivery, family planning options, interval before sexual intercourse and timing of subsequent pregnancy. The majority of women undergoing caesarean delivery desire to have relevant information necessary for them to give consent including those on safety, complication and other relevant reproductive health concerns due to the caesarean section.

Introduction

Counseling for caesarean section is an essential aspect of the pre-operative preparation. It is expected to be a 2-way discussion between the patient, spouse and close relatives on the one hand and the care provider – usually the doctor, on the other hand. Essential aspects of such counseling include information on the indication, description of the procedure, its safety, analgesia, and the side effects/complication of the surgery, associated procedures, including anaesthesia, and the drugs used[1,2].

Elective/planned caesareans present ample opportunity for counseling. However, the emergency caesarean section is unique in that, in many instances, decision and need for the procedure is urgent either to save the mother's or baby's life. In these cases, ample time may not be available for shared decision making. In these

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instances, information is passed on the patient who is expected to give consent based on this. Though the counseling is usually incomplete, consent is legally presumed in such emergencies [2].

Counseling for surgery including caesarean section has been shown to improve uptake of the procedure, increase post caesarean satisfaction, reduce stress and improve uptake of repeat caesarean section [3,4]. In addition, it also enables the patient know the diagnosis which is usually an important part of the past obstetric history in subsequent pregnancies. It becomes even more important in areas like low income countries where aversion for caesarean section remains significant [5].

Search of the literature revealed a paucity of studies on counseling for caesarean section which is the commonest major obstetric surgery with increasing incidence worldwide[6]. The only related study in this environment reported poor record of counseling[1]. None of the studies have assessed the patient's counseling needs. This study is aimed at assessing the extent of counseling received by parturients recently delivered by caesarean section. It also assesses the counseling desires of the parturients. We believe this will help expand the scope of counseling and tailor such to the patients' desires.

Methodology

This cross-sectional descriptive study was conducted using an interviewer administered questionnaire. It was done at the lying-in wards of the University of Benin Teaching Hospital, Benin City, Nigeria. The study population included parturients who had caesarean delivery between the months of April and july, 2013. Those who had altered sensorium, were considered unfit for counseling or consent as at caesarean section or refused participation in the study were excluded. The women were interviewed either on the 3rd or 4th day post caesarean when it was adjudged that they were fully conscious and alert, the pain of surgery was less and they were more co-operative. The study was approved by the Ethics committee of the University of Benin.

The questionnaire first sought information on the parturients' socio-demographic data and if they had any talk during the antenatal care on caesarean section. Next, information on the issues she will prefer to be discussed during counseling for the surgery was obtained. She was then asked if she received information on specific aspects of routine counseling. The issues include indication, safety, complications, pain relief during surgery and also pain relief after surgery. Following this, her desire for specific information on complications of the procedure and the effect on family size was obtained.

The information obtained was then coded into the computer and relevant descriptive analysis carried out using SPSS version 16.

Results

A total of 248 parturients met the inclusion criteria. The average age of the respondents was 30.9 ± 5.3 years and the median parity was 2. Caesarean section was elective in 27.8% and emergency in 72.2%. There were 89(35.9%) of women in this study with at least one previous caesarean delivery.

A total of 141 (56.6%) respondents reported having had no talk whatsoever on caesarean section during antenatal care.

Figure 1: Chart showing the distribution of relevant issues of counseling received by respondents who had delivery by caesarean section

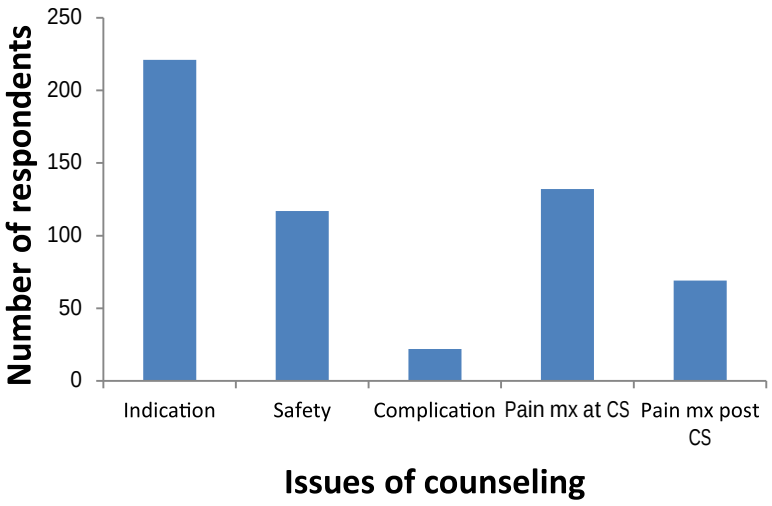

Figure 1 shows the distribution of relevant issues of counseling received by the respondents. It shows that while almost 90% of respondents reported having had counseling on indication, there was much less emphasis on other aspects of counseling – worst on issues bordering on complications with only 9% of parturients reporting having been counseled on complications.

Specific counseling desires of the respondents include the effect of the caesarean section on subsequent vaginal delivery, the total number of caesarean sections she could have in her reproductive life, the interval before she commences sexual intercourse, interval before the next delivery and contraceptive options after caesarean section. More specifically, 72% of respondents will like to know the complications associated with the intended caesarean section as part of counseling while 84% will like to know about effect on future reproduction including interval before the next pregnancy, family planning options and the mode of future deliveries.

Discussion

This study has shown that important information necessary for shared decision making is conspicuously absent during counseling of women undergoing caesarean section in the studied centre. It also shows that women have important counseling needs preparatory to surgery – in this case, caesarean section. Majority of women reported not having received any health talk on caesarean section during the period of antenatal care. A large percentage also missed out on being informed of essential counseling needs during the preparatory counseling for informed consent for the surgery. These all raise questions on how informed the women really are to give informed consent.

Informed consent is an important step in medical decision taking. It is an indication of the patient's individual autonomy that gives the authorization to the physician for a medical procedure. While it is a legal requirement, it is expected to be the result of a conversation between the physician and patient about the proposed treatment, available alternatives, options of non

treatment and the risk/benefit of the procedure[7,8]. The involvement of the patient in the decision making has been shown to improve patients' compliance with planned procedures and reduce the incidence of regret[2,9,10].

It is surprising that only a minority of patients reported having a talk on caesarean section during the antenatal care. This may not be unconnected with the reported aversion for caesarean delivery in our environment as previously reported[5]. With this as background, it seems possible that talks during the antenatal clinic on caesarean section may be wrongly conceived as offensive[10]. However, this notion obviously gets dispelled when antenatal clients are made to see such counseling as routine procedure and not personal. In addition, considering that majority of decisions for caesarean sections are taken as emergencies, since the indicating complications may occur during labour, it behoves on the care giver to introduce this topic in the antenatal care. Giving such information, nevertheless, will require tactful means. Moreover, it has been reported that majority of women report satisfaction following a caesarean delivery[11].

As expected, almost all patients reported having been counseled on the indication for the caesarean section. This agrees with the finding of Adisa et al who reported that over 90% of respondents who had elective major surgery in Ile-Ife, Nigeria had knowledge of the diagnosis[1]. However, the situation was different for complications, pain relief and safety about which only a minority of patients received information also similar to the finding by Adisa and colleagues. The indication is often necessary for the patient to give consent hence the information on diagnosis/indication for surgery is almost always given to the conscious patient who will need to be convinced that she cannot continue with her quest for a 'normal' vaginal delivery. The others seem to be glossed over as it may be assumed that signing the consent form is the required instrument to proceed with the surgery hence the patient may just have no choice anyway over these other factors. They may only be referred to during counseling if the patient expresses worry over them or seems to require more assurance concerning the surgery.

Almost ninety percent of women reported their need for information on reproductive issues following caesarean delivery. This is very similar to the finding of Verkyul et al who found in a slightly related study that 87% of women undergoing caesarean delivery in the Netherlands will love to have routine counseling on combined caesarean section-tubal ligation in the course of the pregnancy[9]. They also showed that these women were more satisfied with the decisions they had taken irrespective of the content of such decision.

It is often assumed that patients should not be informed of possible complications of the intended surgery as they could get alarmed. That may explain the finding in this study that less than 10% of respondents were informed of possible complications of the surgery. Adisa et al in their paper also reported that less than 40% of respondents had knowledge of possible complications of their surgery. The response of the respondents in this study of their counseling preferences negates such assumption – overwhelming majority want to be informed of possible complications. This practice is in line

with best practice on patient counseling for informed consent[2,7,8,12]. Going further, while Wood and Blackburn believe that though information on severe but rare complications could be alarming, they opined in their paper that such information is still mandatory in these days of increasing litigation activity. They question the rationale since such information contributes to patients' stress and hardly dissuades them from going ahead with the surgery. They however suggest offering the patients the choice of a simple consent as an alternative to full consent as such could relieve physicians of the fear of litigation[13,14].

This work is one of the first in the available literature in this environment that addressed the issue of counseling as it affects caesarean section. It therefore creates baseline data for comparison in subsequent works. It also had as respondents, a cross-section of clients who had caesarean section just before they were discharged from the hospital hence recall was not much affected. On the other hand, though this study found that majority of the respondents were willing to have a wide range of information during counseling, it did not assess when they will prefer to be given the information as different information may be more appropriate at different times in the peri-operative period.

In summary, counseling is an important pre-operative requirement. Women undergoing caesarean section unfortunately do not have as part of pre-operative counseling, discussions on safety, complications and some other pertinent reproductive health issues. Women will like to know how soon after a caesarean section they can commence sexual intercourse, what type of family planning method to use, when they can get pregnant again and options of delivery mode following the index caesarean section. Counseling on these issues will reduce post-operative stress[15]. While conceding that the issue of counseling, patient's choice and informed consent in pregnancy is not straight forward[16], expanding the scope of counseling given before carrying out a caesarean section or at least at the next opportune time is an invaluable aspect of medical/surgical best practice.

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