



Original Research Article

Psychological impact of Stillbirth on the Accoucheur

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ARTICLE INFO

Article history:

Received 02-02-2019

Accepted 08-10-2019

Available online 06-12-2019

Keywords:

Obstetricians psychology

Stillbirth

Traumatic impact

Accoucheur

ABSTRACT

This study was done to analyse traumatic impact of tragedy of stillbirth on obstetricians psychology and its effect on professional decisions. The tragedy of stillbirth is a reality in labour room despite of all measures taken to prevent or reduce its occurrence. The accoucheurs are often not able to deal with the psychological behavioural and practical aspects of Stillbirth. Despite taking all precautions and care some pregnancies do end up with babies who do not survive while the labour room staff is accustomed for welcoming and caring for live births. Hence tragedy of stillbirth is a trauma to them along with the parents and family. This study is particularly relevant in terms of increasing rate of depression suicides and retirement of many obstetric practitioners as they are unable to handle unpredictability and pressures and expectations of perfection of outcome in each pregnancy. It also looks into incidence, causes and management of stillbirths which are important aspects to prevent trauma of this tragic reality.

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1. Introduction

Aim of this study is to emphasise how obstetrician is affected personally and professionally after delivering a dead baby.

Stillbirth is defined as birth of a baby without any signs of life after 28 weeks of pregnancy. Stillbirth happening in third trimester of pregnancy is a big mishap. It traumatizes the mother as well as the family for ever creating depressing thoughts of sadness, guilt, isolation, anger, and imagining absent child for weeks, months, and even several years.

Due to improved antenatal care and prompt obstetric interventions the rate of late stillbirths at or after 7 months has reduced by 30%. On the other side the rate of early fetal loss around 5-6 months is the same for last 20 years. In research to recognise and reduce incidence of preventable stillbirths the impact on mother and family facing this misfortune has been extensively studied and published. However this misfortune also has an impact on the treating

doctor and staff in the labour room. Knowing the causes will help in preventing the incidence and recurrence of stillbirths.

1.1. Incidence and causes of stillbirth

Incidence of stillbirths in developed countries is only 2 % of total 2.6 billion world wide. A vast majority 98% are from developing and underdeveloped nations India ranks first as per WHO with highest incidence recording 22 Stillbirth for every 1000 total births. The government of India has developed an Indian Newborn action plan to reduce this to 10 per thousand by 2030 by better antenatal care, treatment of infections and medical complications in pregnancy, more institutional deliveries and improvements in socioeconomic status. Even a modest reduction in India's Still birth rate will mean thousands of life saved. Access to maternal healthcare depends on the socioeconomic, geographic and educational status of the population. The WHO every newborn action plan (ENAP) to end preventable deaths has a set stillbirth target of 12 per 1000 births or less by 2030.

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The most common preventable cause of stillbirth is placental insufficiency due to hypertension and diabetes. Lifestyle modification including proper nutrition and exercise, prenatal counselling and adequate treatment to control these medical disorders during pregnancy help to give successful outcome.

An interesting statistics show that although 50% of all stillbirths result from pregnancy disorders and conditions that affect the placenta, the causes of stillbirth are uncertain and intriguing in the rest half. Risk factors already known at the beginning of pregnancy (such as bad obstetric history, obesity, diabetes thyroid or hypertension) accounted for only a small proportion of the overall risk of stillbirth.

There is increasing evidence to show that placental pathology may be the cause of stillbirth. The placenta is a temporary organ developing specifically for each pregnancy. The examination of gross anatomy of placenta and its evaluation by sonography and by histopathology can provide a record of intra uterine events providing proof of the well-being of pregnancy as well as damages if any. Placenta function is to provide nutrition and give immunity and protective environment. Nutrition of the fetus depends on the placental vascularity developing throughout the pregnancy while the protective function is derived from autoimmune function against fetal antigen and control of infection.

Other factors associated with stillbirth include cord abnormalities (insertion site, coiling index) implantation site abnormalities (placenta previa, placenta accreta, increta and percreta), infectious disease processes (maternal or fetal) and compromise to the circulation (maternal or fetal). Thus It is important to study the placenta to recognise intrauterine events to help treat further Stillbirths.

1.2. Prevention of stillbirth

The chances of having another stillbirth are very low (1%). This may be due to better antenatal supervision in apprehension of the previous mishap and timely delivery after 38 weeks to avoid post maturity. The increased risk of stillbirth in post term pregnancies (>41 weeks gestation) may be attributable to placenta maturing at term causing diminishing blood supply to fetus. Placental dysfunction is the reason of fetal growth retardation and stillbirth in pregnancies of maternal age above 35 years. Hence study of stillborn infants by autopsy, study of placental anatomy and pathology and by karyotyping and stillbirth in pregnancies of maternal age above 35 years. Hence study of stillborn infants by autopsy, study of placental anatomy and pathology and by karyotyping would help to understand the causes of still birth. A large number of stillbirths occur after 37 weeks of pregnancy and can be reduced by changes in practice including.

1. Teaching mother how to recognise and report decrease in fetal movement and
2. A guideline for obstetrician what to do when the mother complains of decreased fetal movement.

This includes a kick chart and teaching how to count kicks and report if there is a decrease in fetal movement. She is advised not to wait but to report to the labour room whenever she thinks she has decrease in fetal movements

The clinical guideline recommends that all women who report to labour room with decreased fetal movement should have nonstress test (NST) immediately followed by sonography for fetal movement, amniotic fluid volume, and fetal growth and anatomy including colour Doppler study for perfusion.

By following these guidelines rate of fetal loss fell from 3 to 2 for every 1,000 births. However there was no increase in the number of women who came with complains of decreased fetal movements. Also ultrasonography helps to detect growth-restricted fetuses earlier for appropriate and timely action to prevent catastrophe of Stillbirth.

1.3. Psychological trauma of stillbirth

An obstetrician providing healthcare to a pregnancy always aims for the desirable outcome of a healthy baby and a healthy mother. The labour room is also geared towards delivering new lives and help bring happiness to the expecting mother and her family and typically is a place of celebrations. But stillbirths will occur as we go by *the statistics. 50% stillbirths occur when the women is in labour in advanced pregnancy* Our overburdened health systems often ignore the psychological needs of the patient as well as the doctor dealing with this traumatic experience. The mother's felt that medical health workers

1. Are insensitive to her loss.
2. Appear disinterested.
3. Their behaviour is non-compassionate and often defensive.
4. They also said that health worker would not.
5. Talk to the mother to let her know about what happened.
6. Try to minimise the event to mere statistics.
7. Do not show her the baby and discuss what had gone wrong.
8. Shift her to postnatal wards with nursing mothers adding to her grief guilt and depression.

Simultaneously the obstetrician also suffers from emotions of grief and guilt including apprehension of medico legal actions and even physical threat by relatives and misguided mobs. He finds himself inadequately equipped in terms of time, supporting staff, facilities and psychological training to deal with the tragedy. Such sour experiences often result in practising defensive obstetrics in future leading to more

caesarean deliveries and sometimes avoiding responsibility by referring the patient to other health centres or colleagues.

1.4. Emotions and apprehensions

1. Self reflection - Did I miss something
2. Guilt -Was it my fault
3. Feeling reclusive
4. Unable to discuss with colleagues -Due to
 - a) lack of time
 - b) Mistrust
 - c) Fear of loss of professional image
5. Avoiding talking to relatives
6. Depression
 - a) Eating disorder expressed as loss of appetite or binge eating
 - b) Loss of sleep
 - c) gloomy mood
 - d) Desire to retire from profession
7. Fear of medicolegal implication

The burden of trauma of stillbirth can be shared by the obstetrician with mother and family by

1. Reduce the woman's feeling of doom by empathetic dialogue to help her in acceptance of the mishap due to circumstances out of her control
2. Support an independent approach to her interaction with, and separation from, the stillborn according to the social and cultural practices and individual preference.
3. Support her grief and be aware of its critical stages of denial, isolation, anger, and depression.
4. Provide her with a comprehensible explanation for the stillbirth
5. Develop a well-organized care plan and treatment protocol from diagnosis of fetal demise to delivery or surgical termination and recovery.
6. Follow-up with her and her family in the postnatal period.

2. Review of Literature

Silver and Draper have identified that 'obstetricians... often feel awkward or uncomfortable spending time with grieving families'.

Gold et al., in a questionnaire study of US obstetricians in 2008, identified that 75% of respondents acknowledged that caring for women following stillbirth took a large emotional toll on the obstetrician.

Menezes et al. researched the 'toll' of working in maternal-fetal medicine for various healthcare professionals.

Samantha et al suggested that placental dysfunction underlies increased risk of fetal growth restriction and stillbirth in advanced maternal age women.

Thompson stated that the most common preventable cause of stillbirth is placental insufficiency. Another

two major causes of preventable stillbirths are maternal hypertension (high blood pressure) and diabetes — both of which are very treatable (or preventable) with things like diet, exercise, and medication.

Our study confirms that in addition to acknowledging the pain of stillbirth for bereaved parents, it is also time to acknowledge the human and professional impact of stillbirth on consultants. This study reveals a very human insight into the personal burden of stillbirths.

2.1. Design

Semistructured indepth qualitative interviews.

Sample of 50 obstetricians with more than 10 years of obstetrics practice and delivery rate of minimum 1000 annually both in private and government hospitals

2.2. Methods

Semi structured indepth interviews analysed by interpretative Phenomenological Analysis. IPA is a methodology for exploring human experience and its meaning for the individual.

It is an approach to qualitative analysis with a particularly psychological interest in how people make sense of their experience. IPA focus on examining how individuals make meaning of their life experiences

IPA requires the researcher to collect detailed, reflective, first-person accounts from research participants. It provides an established, dynamic phenomenologically focused approach to the interpretation. IPA study includes

1. Giving voice' (capturing and reflecting upon the concerns of the participants).
2. Making sense (interpretation).
3. Development and discussion conducted under supervision and peer support striking a right balance between these two components.

2.3. Outcome

The experiences, emotions and professional impact of stillbirth on obstetrician.

3. Results

Stillbirth was identified as amongst the most difficult experience for obstetrician. Two themes emerged:

1. Human response to stillbirth and
2. Weight of responsibilities resulting in the question what have I missed ??

This study would help to better understanding of the phenomenon of stillbirths which is unavoidable part of the obstetric practice. Understanding the psychology would help in creating more humane and compassionate understanding of the trauma.

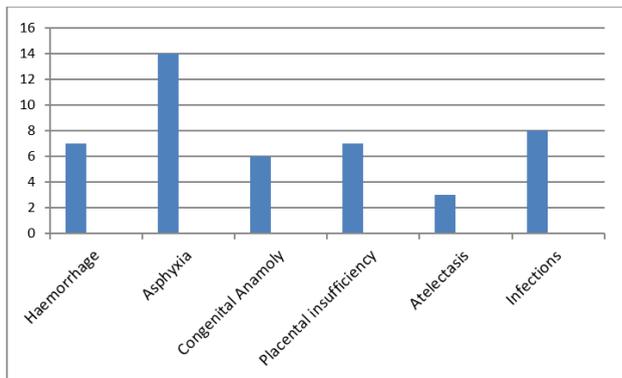


Fig. 1: Causes of still birth

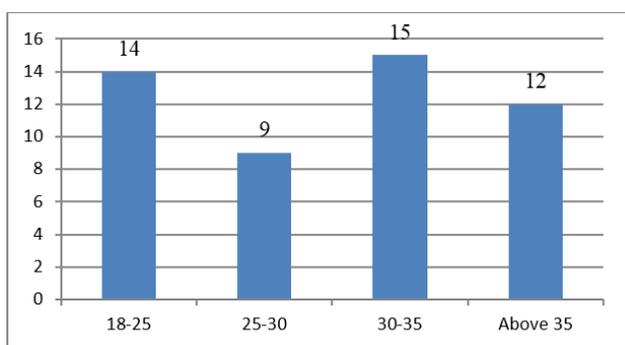


Fig. 2: Maternal age

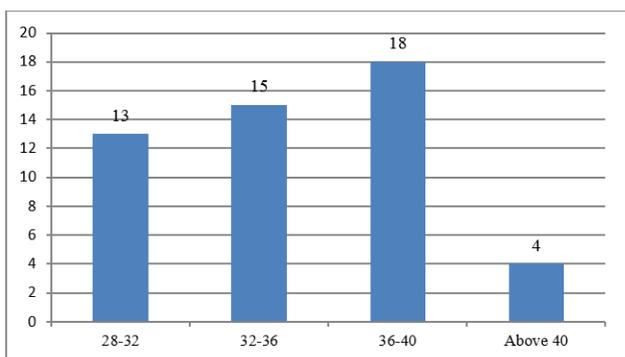


Fig. 3: Duration of pregnancy in weeks

4. Conclusion

Obstetrician enters the practice for providing safe delivery of healthy babies and face immense expectations of both the parents and society, yet each has to face the reality that not all babies survive. Despite the impact of stillbirth no obstetrician has received formal training in perinatal bereavement care. Any mishap or adverse outcome causes emotional distress to the patient and the doctor. This study highlights the significant impact of stillbirth on obstetrician including remorse and emotional trauma of the caregivers, medico legal concerns potentially impacting future obstetrics practice, counselling of the bereaved family and complexities of personal impact on the obstetrician. This study is particularly relevant in terms of increasing rate of depression suicides and retirement of many obstetric practitioners.

5. Source of funding

None.

6. Conflict of interest

None.

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Cite this article: Sharma P, Dheer R, Chaudhary A. Psychological impact of Stillbirth on the Accoucheur. *Indian J Obstet Gynecol Res* 2019;6(4):431-434.