Revista Colombiana de Obstetricia y Ginecología
ISSN: 0034-7434
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Federación Colombiana de Asociaciones de Obstetricia y Ginecología
Colombia

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¿ES JUSTIFICABLE LA ALTA PROPORCIÓN DE CESÁREAS? Cómo aproximarnos a esta tendencia de carácter mundial

Revista Colombiana de Obstetricia y Ginecología, vol. 65, núm. 2, abril-junio, 2014, pp. 104-107
Federación Colombiana de Asociaciones de Obstetricia y Ginecología
Bogotá, Colombia

Editorial

IS THE HIGH PROPORTION OF CAESAREAN SECTIONS JUSTIFIED?

Approaching this world trend

From our vantage point in the front lines, we have witnessed the speed at which our specialty has been moving towards the future. Several years ago, as we started our training in obstetrics, we came to Instituto Materno Infantil, an institution with a long history, long-standing experience and a path that offered hope for a professional career faced with rapid transformations driven by technological breakthroughs. The practice at the time was that of great obstetrical manoeuvres, semiological examination, and difficult case discussions. Maternal mortality back then was close to 222 deaths for every 100,000 live births (1), as a result of a high frequency of eclampsia and associated neurological morbidity, and also complications of abortions performed in unsafe conditions. However, we had dreams of saving lives and we were there to see the birth of perinatology, a door opener to the foetus and neonate as patients in their own right. Perinatology looked into foetal wellbeing and moved steadily towards foetal surgery. Thus, perinatal medicine joined genetic engineering in its quest to arrive at the perfect human clone.

These advances have led to inevitable consequences.

1. Medicalization of prenatal control.
2. Institutionalized deliveries, making home birth a rare occurrence and dealing a mortal blow to midwives (2).
3. Emergence of a new branch of medicine: obstetric anaesthesia. On this point, suspicious doubt is legitimate as stated by Bartolomé de las Casas who claimed that, more than 500 years ago, women in the Caribbean gave birth with no pain (3).
4. Removing of the myths surrounding the fear of the post-partum period, giving way to new active mothers who breastfeed and have become the architects of an increasingly demanding reality: child rearing.
5. Against this background of technological and cultural revolution, we witness a worldwide phenomenon: a growing number of Caesarean sections, many of them performed for dubious indications. In 2013, Caesarean sections accounted for 45.7% of all births in Colombia (4). It is striking that a similar figure applies to unwanted pregnancies in our setting. According to the latest Demographics and Health Survey published by Profamilia, 52% of pregnancies in Colombia are undesired (5). Given these high proportions, it is possible to think about an association between the high frequency of unwanted pregnancies and the higher number of Caesarean sections. A pregnancy to which a woman surrenders perhaps unconsciously rejecting her condition, will result in maternal fatigue and a pressing desire to bring it to term as soon as possible. This brings about multiple visits due to labour and reduced foetal movements ending in failed inductions, Caesarean sections and unsatisfactory foetal condition.

How could a procedure that entered the stage of the history of mankind 28 centuries ago, when Numa

Pompilius decreed that the operation of "cutting" to remove the foetus from the abdominal cavity was a funerary ritual" (6) end up becoming something unthinkable for our professors: Caesarean section as the natural form of delivery?

Caesarean section is a surgical procedure perfomed with the certainty of success for less than a century. In many settings, it has ousted one of the most representative instruments in obstetrics – forceps – which is now exhibited as and old museum piece in some hospitals and clinics.

How can it be explained that Caesarean section went from being an intervention aimed at saving the life of the dying foetus in cases of defective placental function, to becoming a life saver for an exhausted mother fighting against a prolonged obstructed birth, to establishing itself as the universal elective procedure at the present time? On the one hand, there are pregnant women who are reluctant to see their bodies marked by the stretch lines of the third trimester and ask for elective Caesarean section weeks before term, making it a a cosmetic operation; women who hope to preserve vaginal suspension and ask for a Caesarean section for perineal protection; anxious mothers fearful of pain, members of a generation of women for whom birth is characterized by a new trait: tocophobia. We are increasingly embracing the idea that childbirth is a synonym for pain, difficulty, risk, destruction, delay, instead of embracing its real meaning: light, birth, life. Books on obstetrics have included a new indication for the procedure: Caesarean section on maternal request (7).

On the other hand, there is the specialist who wishes to find a justification for performing Caesarean section on the grounds of unilateral maternal autonomy. Our ethical mission is to educate, not to fuel baseless beliefs rooted in folk lore. The name of our profession comes from the word *obstetrare*, "being on the side of", but now we are exchanging the eight hours of conscientiously attending to labour for the thirty minutes of the procedure. Obstetricians must shy from the urge of finding indications to simplify our professional practice.

Caesarean section has evolved as the shortest and easiest way to conclude the pregnancy, in an epidemic that has shaken the Board of Directors of the Colombian Federation of Obstetrics and Gynaecology into action. Together with the Colombian Perinatology Federation, it entrusted a team of prestigious colleagues with the task of reviewing the literature in order to evaluate the evidence and prepare a consensus that may enable the two institutions to come forward with a statement on the rational use of Caesarean section in Colombia (8) The paper - included in this issue of *Revista Colombiana de Obstetricia y Ginecología* - contains a large number of alarming conclusions that call for profound reflection from the medical community.

Likewise, this topic has been referenced by national professors who have been concerned for two decades with a mystifying situation: a rate of Caesarean sections of only 12.9% in the Netherlands (9) and of 50% in Brazil (10). These opposing trends have not had a favourable impact on perinatal mortality rates but have rather created a particular environment in which physician-patient relationships, the devotion of the practitioners, the dignity of the medical profession, and even ethical accountability are under strain. For the World Health Organization (WHO), the ideal percentage of Caesarean sections must be under 15% (11), and when this percentage rises above 33%, it increases the risk of maternal mortality (7).

Through the voices of three of our professors, we paint here the landscape for Colombia:

In 1991, from the ethical vantage point, doctor Fernando Sánchez Torres stated that "Applying a liberal judgement to accept that 20% of Caesarean sections are supported by formal, irrefutable, medical indications, anything outside that range must and should be challenged from the ethical stand point. [...] The principle of beneficence over maleficence must be the underpinning for the clinical judgement regarding Caesarean section or vaginal delivery" (12). Based on these premises, it can be stated that bioethical principles must prevail over any other

medical consideration in the decision to perform a Caesarean section (13).

In 1998, doctor Edgar Cobo stated: "If this does not change, it will continue along a path of shame, filled with specialists practicing one form of private obstetrics and another public form, with poorly informed patients who, contrary to the overwhelming evidence, still believe that childbirth is a historical event and that the surgical option is far better than the natural design of our species" (14). Consistent with this statement, it is worth pointing to the current perspective that the high rate of Caesarean sections is similar in public and in private practice.

In turn, doctor Jesús Alberto Gómez-Palacino, in a compilation of his rich academic production, mentions a list, still valid, of the determinants of increased Caesarean section rates in Colombia (13):

1. The apparent and dubious safety of the procedure.
2. The displacement of traditional semiological and clinical methods by current technology, and the error of misinterpreting electronic foetal monitoring.
3. The diagnosis, not always confirmed, of crown-rump disproportion and acute intra-partum foetal distress.
4. Frequent failed inductions, wrongly indicated from the start.
5. Stereotypical use of epidural analgesia.
6. Impatience, shortcuts, fear of malpractice lawsuits, and limited practitioner time.
7. Demands from patients or family pressure.
8. Intraoperative sterilization procedures.

The problem identified, it is important to mention that a new wave has emerged in the world – fortunately originated by women – in the form of urban midwifery. It is the quest for the feminization of childbirth driven by the need to experience the pleasure it brings, all of this supported by conception of a wanted pregnancy.

All of these reasons prompted us to recommend that we take a step back and reflect on the path we have chosen to tread, because it is the ethical and scientific duty of medical schools, obstetrics and gynaecology associations, public and private healthcare organizations and, ultimately, of every individual practitioner. For this, we need the inspiration and encouragement of two authors who have approached this subject: doctor Michel Odent, and feminist biologist doctor Casilda Rodrigañez Bustos.

Doctor Odent, pioneer of the use of pools in delivery rooms, is an advocate of natural birth and has studied the physiology of the maternal brain during labour. A few thoughts are taken from his book, *La cesárea, problema o solución* (15):

1. "The volume of the foetal brain in the cause of the difficulties inherent to childbirth."
2. "Coupled with the feminine revolution, the advent of the bikini popularized the use of Pfannenstiel's incision, which had been remained in oblivion for over fifty years."
3. "Midwives abandoned the scene with the expansion of the modern Caesarean section technique."
4. The last phrase inspires an important reflection: "In the current scientific context it may be stated that, when giving birth to a child, the mother secretes a true cocktail of love hormones," a concept that the author further explores in his book *La cientificación del amor* (16). And Odent concludes: "We cannot continue to choose a simplified binary strategy: either a natural vaginal delivery that proceeds smoothly, or a Caesarean section during labour, if possible before it becomes urgent" (15).

As for doctor Rodrigañe, in her book *Parirás con placer* (17) the publishers describe her as a radical thinker, unorthodox and feminist as far as maternity and childbirth are concerned. She has done research in biology, history, psychology, anthropology, social science and culture, and she is a member of the Antipatriarchal Association. This author would like to go back to those times when women gave birth and

breastfed with pleasure and their children developed with all their desires fulfilled. She invites to overcome castrated sexuality and to recover the intimacy of motherhood. Her goal is to find in society models of fraternal, just and caring men and women.

As academicians, it is our responsibility to approach childbirth from a holistic perspective, perhaps moving away cautiously from technical excess. As educators, we must guide our generations of students back onto the path our specialty lost at some point, so that they can become practitioners with the proficiency, the awareness and the patience to attend to the natural process of birth.

There is a sign on the wall of the Obstetrics and Gynaecology Department of the *Universidad Nacional de Colombia* Medical School, in our dear Mother and Child Institute, which reads: "Obstetrics in inexperienced hands is the art of disturbing the natural process of birth."

In referring to our professors, we need to acknowledge that they did not perform elective Caesarean sections. They were giants who dominated the art of obstetrics and practiced their profession with the passion of teaching as role models with the poise and confidence conferred by wisdom. It is not too late for us to follow in their steps and again tread the path of the art and science of the noble profession of obstetrics.

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