High Caesarean Delivery Rate in Current Obstetric Practice: Who is to Be Blamed-Patients, Society, Law or Healthcare Providers?

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Editorial

Caesarean delivery (CD) is a safe-life-saving procedure that should be available to every woman that needs it [1]. Developments in the history of the procedure started about two centuries ago by series of innovative trials and errors. The advents of surgical sutures by Sanger [2] in 1887, principles of surgical asepsis by Joseph Lister [3] in 1876, lower segment uterine incision by Johnson [4] in 1786, antibiotic therapy, blood transfusion, and safe anaesthesia changed the early CD from almost 100% mortality to a very safe procedure in the current obstetric practice. This safety liberalized the indications for CD from being the last resort in a dead or dying pregnant woman, to early resort when the mother and her unborn baby are still healthy, elective procedure, and even CD on demand [4,5].

The CD rate increased rapidly worldwide. The rates ranged from 43.6% to 80% in Brazil [6,7], 32% in America [8], and 27.4% to 30.8% in Enugu, Nigeria [9,10], 22.5% in Canada [11], and 23.8% in United Kingdom [12], and between 22.8% to 25.4% in India with Primigravidas accounting for 42.4% of the cases [13]. These rates were from hospital-based studies. They were higher than the justifiable 10-15% upper limits set by the World Health Organization (WHO) in 1985 [14] above which the procedure is associated with greater risks of maternal and perinatal mortality and morbidity when compared with vaginal delivery. The WHO reference range was intended for a defined ‘populations’, but it has been mistakenly used for comparing CD rates in healthcare facilities for decades, and has received intense criticism, concern and heated debates [1].

The increase in CD rates is largely driven by a complex multifactorial labyrinth that involves the health systems, health care providers, even fashion and media [15-19]. Other factors include safety of the operation, women and societal demands for improved maternal and fetal outcomes, increased number of high-risk expectant mothers, advances in perinatal fetal monitoring and neonatal survival, loss of obstetric arts of assisted vaginal deliveries, high rate of primary CD, decrease in vaginal births after a CD, and fear of litigation [19-24].

Women’s autonomy, social desire to deliver the baby at a particular date and time, the desire to preserve the perineum for sexual performance, and abuse of the procedure for profit purposes in hospitals are emerging issues [25-28]. These demands by the patients, society, and the Law on the healthcare givers made feto-maternal indications for CD to be endless, confusing, lack uniform definitions, poor in reproducibility, and unsatisfactory in comparisons of CD rates between health facilities [10,29,30]. WHO endorsed the Robson classification [31] as the global standard for assessing, monitoring and comparing CD rates in healthcare facilities due to its simplicity, validity, implementation, and ease of interpretation? The use of the Robson classification, hopefully, will allow comparison of CD rates in more uniform groups of women, and eliminate confusions and debates.

When CD is medically indicated, it can undoubtedly prevent maternal and perinatal mortality and morbidity. However, CD can be complicated with short- and long-term risks, which can extend beyond the current delivery, and affect future pregnancies. Hemorrhage, blood transfusion, infection, high costs, pulmonary embolism, and maternal deaths are known maternal complications of the procedure [32]. Other long-term complications include aversion to CD and hospital delivery in subsequent pregnancies with many high-risk pregnant women attempting vaginal deliveries with traditional birth attendants. Many of them are referred to hospitals in critical conditions when emergency childbirth complications occur [32]. Perinatal complications, neonatal intensive care units admissions, birth traumas, and deaths continue to rise with the rise in CD rates [28]. Contrary to the belief that high CD rate improves feto-maternal outcomes, a view that fuelled the rising rates of CD; higher rates were associated with a greater risk of maternal and newborn illness and death.

Quality of obstetric care that is safe, effective, efficient, timely, equitable and patient-centered is the key to improvement of maternal and newborn health, and not high CD rates [33-36]. Such quality obstetric services should be available to every woman that needs it including the poor illiterate mothers in the rural areas. Poor infrastructure, lack of well-qualified manpower, and non-availability of essential obstetric services to every woman in resource limited countries pose great risk to women’s future reproductive performances especially after one or more CD. The CD rate in ESUTH, Enugu, Nigeria in 2015 was 30.8%. Previous CD (31.9%), severe pre-eclampsia and eclampsia (12.5%), suspected fetal distress (10.6%), poor progress of labor (8.9%), and prolonged labor (8.6%) accounted for 72.5% of the indications for CD [10]. Only 0.2% instrumental vaginal delivery was performed in the institution within the study period [10,35]. This shows the urgent need to resurrect the “dying obstetric arts” of assisted vaginal delivery in current obstetric practice. Term external cephalic version in uncomplicated breech, vaginal birth after a CD, vacuum extraction, and destructive vaginal operations are procedures that can reduce CD rate. Primary caesarean delivery can also be reduced by careful management of labor with partograph, and accurate assessment of fetal distress.

Conclusion

CD is a major surgery, and the decision to perform it must be based on justifiable medical indications and not on mere patient, society or law wishes. It should, ideally, be taken by a consultant obstetrician and not a junior healthcare provider. Evaluations of CD rates using Robson classification will in future provide uniform-defined indications for
CD among the groups of patients for facility comparisons of CD rates in a meaningful, transparent and useful manner that will generate evidence-based data for the improvement of feto-maternal care. Many CDs can be avoided by quality obstetric care and use of obstetric arts of assisted vaginal delivery that are patient-centered. An increase in the rates of CD is a huge burden on the patients, families, societies and the health system. Health authorities, professional bodies, patients, society and law should work as a team to ensure that this life-saving-major operation is neither denied patients that need it nor abused for unjustifiable nonmedical indications. This will avoid litigations or blames to one another when complications occur.

References


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