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Editorial

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Caesarean Section in Current Scenario: A Clinician's Perspective

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Editorial

It is in your moments of decision that your destiny is shaped…!!

Tony Robbins would have not thought while quoting this line that at some point in time it would be very aptly applicable to all the obstetricians worldwide. Lower segment caesarean section (LSCS) is the most widely and most widely used medical procedure by the doctors worldwide to combat maternal and child death. It is so incorporated in our society that it is stated as the medicalisation of women health by the healthcare providers and social scientists. Technology has largely replaced the human thinking skill and knowledge. The promoters of evidence-based medicine, that to supported by various objective parameters also advocate and rely on the use of modern medical gadgets rather than the assumptive and presumptive decisions taken by the skilled clinicians on the basis of their medical teaching and experience.

Studies have shown that over the past few decades, childbirth has largely influenced by medical technology. It is fairly evidenced by the higher rates of unnecessary obstetrical intervention raise concern for the mother's health. Many workers suggested that over-medicalisation of maternal care has become a worldwide epidemic. It is often argued that with thriving private practice in many countries, obstetricians increasingly prefer LSCS birth over normal childbirth. In addition, there is evidence from Western countries that women too often prefer to deliver the child through the LSCS. The rates of caesarean section in many countries have increased beyond the WHO-recommended level of 5-15 %, almost doubling in the last decade [1]. In high-income countries like Australia, US, Germany, Italy and France, the rates have gone up very high [2]. Similar trends have also been documented in low -income countries, particularly in Latin America and some countries in Asia [3-5].

According to the latest data from 150 countries, currently, 18.6% of all births occur by LSCS, ranging from 6% to 27.2 % in the least and most developed regions, respectively [6,7]. Latin America and the Caribbean region have the highest LSCS rates (40.5%), followed by Northern America (32.3%), Oceania (31.1%), Europe (25%), Asia (19.2%) and Africa (7.3 %). Based on the data from 121 countries, the trend analysis showed that between 1990 and 2014, the global average LSCS rate increased by 12.4 % [6,7]. Data from countries like Iran, Brazil and México show section rates reaching upto 91.9%, 85.8%, and 85.6%, respectively [8,9], also the same countries have the highest rate of caesarean section in public sector being 78.5%, 71.0%, and 47.8 % respectively [10].

As per most recent National Family Health Survey 4, the average rate of LSCS in India is 17.2 % ranging from 5.8 %in Nagaland to 58.0 % in Telangana. It shows the higher inter-regional variations of LSCS in India. What has been alarming in the case of India is the wide heterogeneity in the incidence of LSCS across states and regions. Over the last 23 years, the increase in LSCS delivery has been substantial in many states in the country. Interestingly, all the southern states in India recorded LSCS delivery as high as that of recorded in countries with the highest level of LSCS in the world. The rates recorded in Telangana, Andhra Pradesh, Kerala, and Tamil Nadu are alarming. The data indicate that states with marked demographic transition also records high incidence of LSCS rate, although, the real cause of such an increase would be different [7].

This much of high levels of caesarean rates cannot be justified on any ground but some causes and possible concerns have been reported like fear of pain; concerns about genital modification after vaginal delivery; misconception that CS is safer for the baby; the convenience for health professionals and also for the mother

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and family; fear of medical litigation and lower tolerance to any complications or outcomes other than the perfect baby; Chinese cultural factor of choosing the date of the baby's delivery on the basis of luck and fate for the future of the baby; In India, the family sometimes demands that the baby be born on a auspicious date and time, obviously by caesarean section, as dictated by horoscope/astrological calculations and most importantly mother's request for LSCS [11-19].

Conclusively, considering only medical factors in this multifaceted state of affairs is likely to be a useless exercise to reduce unnecessary LSCS. High-quality research studies are required to explore the possible impact of these different factors when considering potential interventions to reduce unnecessary LSCS. In India, now days fear of litigation, violence against doctors, and fear of bad outcome all are responsible for the early decision of LSCS. Obstetricians feel very uncomfortable in conducting prolonged labor for the normal delivery because public do not give acceptable response in emergency surgery and on bad fetal outcome. Obstetricians often blamed by the patient and her family members that why this emergency LSCS was not done as elective LSCS if things were not in doctor's control that's why obstetricians do not take sufficient risk in conducting the normal delivery rather they take early and safe decision of LSCS far earlier than any emergent situation arises. Proper government involvement, good understanding regarding the normal delivery and its possible complications by the patient and her family members, good doctor-patient relationship and faith will motivate the drive for normal delivery and will reduce the unnecessary LSCS.

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