The obstetricians' attitudes regarding the labor choice of delivery in Porto Velho, Rondonia, Brazil

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Abstract
The articles presents research motivated by the steady increase in caesarean incidence seen in several Latin American countries, and in the developed world as well, which has stimulated necessary and urgent discussions in bioethics field. The study sought to investigate and analyze the beliefs, attitudes, behavior, and conduct of 62 professionals in maternal and child health specialists who work in the city of Porto Velho. The data from this study support the undeniable ethical conflict in the obstetrics practice when it comes to choosing the delivery method that is embodied, primarily, in the ambiguity of the cesarean rates reported in public system versus the high caesarean rates recorded in health insurance.

Key words: Cesarean section. Vaginal delivery. Attitudes. Obstetrics.

Approval CEP number 77.0.047.000-99

Since the 1970s, significant increments have been registered in the rates of caesareans all over the world. Countries which traditionally had very low rates of caesareans, like Turkey and Italy, reached in the beginning of 2000, rates of 30% and 33% respectively [1].

Cesarean section is the more frequently performed surgical procedure in the United States, where approximately one million cases occur each year [2]. Clark [3] showed that

the observed regional variation in the indicators of caesareans should be attributed to the lack of uniformity in the conducts for making decisions.

The reduction in the rates of maternal mortality and also other morbidities observed in poor countries, like Ethiopia, was accompanied by a six fold increase in the cesarean section rate as a consequence of the availability of services to meet obstetric emergencies in a project headed by the International Federation of Gynecology and Obstetrics (Figo) [4]. Not only in Ethiopia, an impoverished nation on the African continent, but also in Sweden, indicators on caesareans showed a significant increase in the last decade [5].

The text *Model of obstetrical care in the supplementary health sector in Brazil: scenarios and perspectives* [6], of the National Health Agency (ANS), reports that since the decade of 1990 the problem of "epidemic" of cesarean delivery has been pointed out in our country [7]. However, its frequency is heterogeneous in different population groups: around 23% in public institutions and 64% in private institutions. According to several studies, the rates are influenced by socioeconomic conditions, sources of funding of health services and the current model of medical care [8]. This heterogeneity reveals inequalities in the provision of cesarean sections, with a predominance of the procedure in low risk and higher income women, which strengthens the influence of non-clinical factors [9].

There are many texts investigating or blaming obstetrician for the "epidemic" of the so-called unneeded caesareans [10-12], which are cesareans performed without indication based on scientific evidence [13]. According to those who defend this view, women like to give birth to their children by vaginal delivery, but influenced by the prenatal physician they end up changing their minds and let the prevailing the opinion and convenience of the obstetrician [14].

In 2006, the National Institute of Health (NIH) announced an official document with *official recommendations* (and also quite appropriate) in relation to cesarean section on request, with the following conclusions: 1) the incidence of births by cesarean section without medical or obstetric recommendation is increasing in the United States and a component of this increase is the maternal request. The available tools do not allow to quantify the magnitude of the problem; 2) there are not sufficient evidences to fully assess the benefits and risks of cesarean section on request in comparison to vaginal delivery and further research is needed, 3) until reliable evidence is available, any decision to indicate a cesarean section on request should be carefully individualized and consistent with ethical principles; 4) since the risk of previous placenta and placenta accrete increase with each cesarean performed, the cesarean on request is not recommended for women who wish to have many children, 5) cesarean on request should not be performed before 39 weeks of gestation or without verification of the lung maturity, because of significant risks of respiratory complications for the newborn; and 6) the mother's request for cesarean should not be motivated by unavailability of mechanisms to pain control.

Furthermore, the document predicts that the NIH or other agency of the U.S. federal government should maintain an updated website in the internet with information on the risks and benefits of all forms of birth [15].

An interesting study made by South Korea researchers deserves attention due to the approach contained in the questions addressed to 505 women of that country, which also shows an increase in the rate of caesarean sections which reached 37.7% of births in 2000. South Koreans found that most women interviewed prefer the vaginal delivery and that this attitude is contradictory with the *epidemic* of caesarean sections

that affects the country. Based on this contradiction the study concluded that the main cause for the raising in the cesarean section rates, observed in the two previous decades, is related to two associated and inseparable factors: the practice of professionals and the health system in which they work [16,17].

Based on so controversial studies and positions, this research aimed to raise the opinion, medical conducts, and ethical attitudes of professionals of obstetrics in Porto Velho, Rondonia, in relation to indication for caesarean section.

Method

Porto Velho, the capital city of Rondonia, has approximately 70 obstetricians and gynecologists, also called gyneco-obstretician (GO). The sample was composed of approximately 90% of these specialists, totaling 62 interviews, all included in this prospective study.

During the first months of 2010, a structured questionnaire with 24 questions of direct response was applied to the professionals. The interviews were conducted by the authors of the research at the maternity wards and at physician's private offices. All professionals of the specialty in the city were visited, but six were not found. Only two doctors did not agree to participate in the research, alleging that they had given up practicing obstetrics.

The contents of the questionnaire were divided into nine items related to the identification and characterization of the professional's profile. The remaining 15 questions were related to the opinions, behaviors, and attitudes of the professionals.

The research project was approved on December 5, 2009 by the Ethics Committee on Research of the Health Center of the Federal University of Rondonia. Data were collected after signing the free and informed consent (TCLE). All the questionnaires were reviewed and data stored in the Statistical Package for the Social Sciences (SPSS 15D) Program.

Data analysis

Among the 62 interviewees, 25 are male (40.3%) and 37 females (59.7%). Of these, 80.6% reported having attended the medical residence and 19.4% did not attend medical residence in the specialty. Most of the 80.6% professionals informed that they were working in the public network and also in the private network, 12.9% said that they worked only in the public network and only 6.5% in the private network. The indicators found show that there is no statistically significant relationship correlation between the gender of the professionals and the preference for this or that mode of delivery.

Table 1. Age group of obstetrics professionals in Porto Velho

Age group	N	%
Up to 40 years	18	29
41 to 50 years	13	21
51 to 60 years	28	45
+ 60 years	3	5
Total	62	100

Table 2. Preferences for mode of delivery in relation to the gender of the professionals

Preferred mode of delivery								
Gender	**Vaginal**		**Cesarean**		**No preference**		**Total**	
	N	**%**	**N**	**%**	**N**	**%**	**N**	**%**
Male	10	40.0	4	16.0	11	44.0	25	100.0
Female	15	40.6	12	32.4	10	27.0	37	100.0
Total	25	40.3	16.	25.8	21	33.9	62	100.0

Data indicate that there is no relationship between the gender of the professionals and the preference for a particular delivery method for the wives, in the case of male professional or for themselves in the case of female professionals. When asked about indicate which mode of delivery they would recommend for their daughters, 43.5% reported that they would recommend the normal birth, 32.3% the cesarean section and 24.2% would not make recommendations.

Table 3. Recommendation for the mode of delivery for the wives or for themselves relating to the gender of the professionals

Recommended mode of delivery								
Gender	**Vaginal**		**Cesarean**		**No preference**		**Total**	
	N	**%**	**N**	**%**	**N**	**%**	**N**	**%**
Male	11	44.0	8	32.0	6	24.0	25	100.0
Female	14	37.8	14	37.8	9	24.4	37	100.0
Total	25	40.3	22	25.8	15	33.9	62	100.0

Interestingly to note that on Tables 2 and 3 approximately one third of the professionals (33.9%) did not show any clear option or precise recommendation in relation to the mode of delivery.

Contrasting with the information contained on Table 3, next question allowed to verify that the vast majority of the total number of children of the obstetric professionals (79.2%) was born through the cesarean section, and the first child was born by cesarean section in 75.5% of the cases and the second in 83.2% of cases

Table 4. Mode of delivery of the first and second child

Mode of delivery	**First child**		**Second child**		**Total**	
	N	**%**	**N**	**%**	**N**	**%**
Vaginal	13	24.5	7	16.8	20	20.8
Cesarean	40	75.5	36	83.2	76	79.2
Has no children	(9)	-	(19)	-	-	-
Total	53	100.0	43	100.0	96	100.0

The following question referred to the attitude of the professional before the pregnant woman who requests elective cesarean section. The five interviewed professionals who reported to agree immediately with the cesarean section at the request of the patient, insisted that they only accept the option of delivering babies by cesarean section and that when the patient insists on delivery by vaginal mode, then, she is advised to seek another doctor.

Table 5. Attitude before the pregnant woman who wants the cesarean section

Attitude	**N**	**%**
Agrees immediately	5	8.1

Agrees after discussing the case	39	62.9
Disagrees and proposes normal delivery	11	17.7
Does not want to answer	7	11.3
Total	62	100

When asked about the recommendation of caesarean section after a previous cesarean (VBAC) 29.1% of professionals stated that they recommend a new cesarean section and 66.1% recommend a normal birth; others 4.8% could not answer.

Table 6. Relating to breastfeeding after the cesarean section

Breastfeeding after the cesarean	**N**	**%**
It is harmful	11	17,7
It is not harmful	32	51.6
Modifies but is not harmful	19	30.6
Total	62	100

When asked if the elective cesarean section protects the physician from litigation, 27.4% responded yes, 62.9% answered no and 9.7% did not want to answer or did not know the answer.

When asked about the occurrence of severe maternal complications in elective cesarean, 30.6% of the professionals answered that there has been elective surgeries with serious complications and 58.1% answered that their patients who performed cesareans never had complications.

When asked if the pregnant woman who uses the public network should have the right to choose the way of delivery, 56.5% of the professionals answered *yes* and 38.7% answered *no*; that the pregnant women using the public network should not have the right to choose the delivery mode.

Discussion

The number of medical professional practitioners of obstetrics is declining, probably due to workload hours worked and negative impacts caused on the family and personal scope[19]. In relation to Porto Velho, the implantation of medical residence in the specialty of Gynecology and Obstetrics at the Hospital de Base Ary Pinheiro may change this picture, with the formation of new and young specialists.

Data collected in this study demonstrate that, regarding the choice of delivery mode the area of obstetrics is full with ambiguities and contradictions. These became evident regarding the indication of a specific delivery mode for themselves or for their relatives, the approaches adopted in the second cesarean section or the opinion about breastfeeding.

Although this study has found reverse answers, on the question on the recommendation on the mode of delivery to their wives or for themselves (in the case of female professionals), the surveys conducted between female obstetricians showed that the vast majority prefers the instrumental delivery for themselves. And this is also the preference when it comes to the wives and daughters of obstetricians [20-26]. The apparent contradiction between the findings reported in these studies and the results of this study made in Porto Velho is minimized by the information that in fact, the vast majority of children of obstetricians respondents, of both sexes, was born by cesarean

(80%). It can be concluded that there is a gap between opinions expressed and the actual choices among the respondents.

The literature reports that physicians perceived the obstetric risks as being lower in elective cesarean sections. An indefectible proof of this is that the caesarean is the preferred method for the so-called overvalued w increasingly frequent in Women who become pregnant tardily and cases in which technologies that use assisted reproduction technologies, the so-called *precious babies*. Minkoff discussed the matter in 2005, who reports very high rates of cesarean sections in the *precious pregnancies* [27].

Facing an overvalued pregnancy in old pregnant woman, on her first pregnancy, obese, the recommendation for the normal delivery embeds an enormous risk of litigation, because if there is any complication for the mother or the fetus certainly the charging will come superimposed on a repetitive question: "Why haven't you performed a cesarean doctor?. " I transcribe and agree with Sergio Costa's assertion that: *there is no doubt that, even if unnecessary or even if it entails greater risk to the mother or the neonate, an elective cesarean section has much less risk to the physician* [28]. This assertion, it is worth mentioning, is confirmed in a scientific research by German experts in obstetrics, where are emphasized the forensic aspects from obstetric practice [29].

In relation to the raise of caesarean sections the conclusion of Canadian researchers of Halifax, *New Scotia*, seems quite reasonable: *the recent substantial increase observed in cesarean rates can be explained by the concomitant changes in maternal age, the number of children, weight gain during pregnancy. The obstetric practice, which has changed following the changes in the maternal characteristics is related to the concepts of safety for the mother and the fetus. Attempts to reduce cesarean rates, especially those directed restrictive should be tempered with the understanding of temporal changes of maternal characteristics with rational change in obstetric practice* [30].

Regarding the ambiguity found in the responses on the approaches adopted in the second cesarean or the opinion about breastfeeding, identified in the interviews, it can be considered that it is related to the content of guidelines which lay low rates of cesarean as indicators to classify the quality of services rendered by public hospitals. These documents would be influencing the opinions of professionals regarding the procedure.

Final considerations

The data from this study support the undeniable ethical conflict in the practice of obstetric specialty when it comes to the choice of the delivery mode. From the interviewed professionals, 56.5% believe that the pregnant woman attended in the public system should have the right to choose the mode of delivery, while 38.7% think they should *not* be entitled to that choice. In practice, however, what is observed is as result of the programs of the Ministry of Health aimed at promoting only vaginal delivery, pregnant women using the public network end up not having assured their right to choose the mode of delivery. While this occurs in the Unified National System of Health (SUS), in the additional health prevails stratospheric indicators for cesarean sections, revealing an ethical contradiction focused on more vulnerable women coming from the lower income strata of the population. If only a minority (8.1%) of obstetricians in Porto Velho assumes that they only perform caesarean deliveries, others express divided opinions. However, it should be stressed, regarding caesarean section requested by the pregnant woman, the vast majority (71%) agrees with the request.

Only 17.7% insist on birth through normal delivery. One can conclude, thus, that the behavior of specialists in obstetrics working in that capital city, in relation to the choice of the mode of delivery, differs little from the data found in the international literature. In this sense, it must be emphasized that these professionals are acting in an ethical manner to protect the autonomy and right to choose by their patients.

Resumo

Atitudes dos profissionais de obstetrícia em relação à escolha pela via de parto em Porto Velho, Rondônia, Brasil

O artigo apresenta pesquisa motivada pelo aumento constante da incidência de cesarianas, verificado em vários países latinos e também no mundo desenvolvido, o que tem estimulado necessárias e inadiáveis discussões no campo da bioética. O estudo buscou investigar e analisar a opinião, atitudes, comportamentos e condutas de 62 profissionais especialistas em saúde materno-infantil que atuam no município de Porto Velho. Os dados deste trabalho corroboram o inegável conflito ético na prática obstétrica quando se trata de escolha da via de parto, que se materializa, principalmente, na ambiguidade dos índices de cesarianas registrados na rede pública em contraposição aos elevados índices de cesarianas verificados na saúde suplementar.

Palavras-chave: Cesárea. Parto normal. Atitudes. Obstetrícia.

Resumen

Las actitudes de obstetricia en la elección de la modalidad de parto en Porto Velho, Rondônia, Brasil

El artículo presenta una investigación motivada por el aumento constante de la incidencia de cesáreas se produjeron en diversos países de América Latina y también en el mundo desarrollado, que ha suscitado un debate necesario y urgente en el ámbito de la bioética. El estudio se realizó para investigar y analizar las creencias, actitudes, comportamiento y conducta de 62 profesionales especialistas en salud materno-infantil que trabajan en la ciudad de Porto Velho. Los datos de este estudio apoyan el conflicto innegable éticos en la práctica de la partería, cuando se trata de elegir el método de entrega que se materializa principalmente en la ambigüedad de la tasa de cesáreas reportado en la opinión pública frente a las altas tasas de cesáreas registradas en el seguro de salud.

Palabras-clave: Cesárea. El parto vaginal. Actitudes. Obstetricia.

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Received: 9.20.2010 Approved: 11.5.2010 Final approval: 11.15.2010

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QUESTIONNAIRE

1. Name or initials (optional)
2. Age:
3. Gender: (1) Female (2) Male
4. How many years ago did you graduate?
5. How many do you work in Porto Velho?
6. What is your titling?
   (1) Specialized physician without internship
   (2) Specialized physician with internship
   (3) Specialized with a Master's degree
   (4) Specialized with a doctoral degree

7. Do you work:
   (1) Just in the public network
   (2) Just in the private network
   (3) Both public and private network

8. Your largest workload is
   (1) In the public network
   (2) In the private network

9. The majority of delivery that you carry out in public network is
   (1) Normal delivery
   (2) Cesarean section
   (3) Does not work in public network

10. In the private network, the majority of delivery that you carry out is
   (1) Normal delivery
   (2) Cesarean section
   (3) Does not work in private network

11. Do you have preference on carrying out any type of delivery?
   (1) Normal delivery
   (2) Cesarean section
   (3) No preference

12. In which moment and how do you usually approach your patient regarding choosing the type of delivery ?
   (1) Right at the first months of pregnancy, I start to incite patient in order to manifest her preference;
   (2) I wait until third month in order to get a better evaluation of pregnancy and, then, I start to talk with patient about the type of delivery that she prefers;
   (3) I wait for patient to approach, that is, I let her to ask about labor and then to discuss which would be her best option
   (4) I explain her, right at start, that cesarean section deliver is more advantageous than normal, and I explain which are these advantages;
   (5) I explain her, right at start, that normal delivery is more advantageous than cesarean section, and I explain her which are these advantages;
   (6) Did not want to reply

13. Do you have children?
   (1) Yes
   (2) No

14. Your first child was born via which type of delivery?
   (1) Normal delivery
   (2) Cesarean section
   (3) I do not have children

15. And your other children?

(1) Normal delivery
(2) Cesarean section
(3) I do not have other children

16. If you wife was pregnant, would you, personally, recommend her the type of labor?
(1) Normal delivery
(2) Cesarean section
(3) It does not apply

17. Do you have grandchildren?
(1) Yes
(2) No

18. Would you have preference for your grandchildren to be born via:
(1) Normal delivery
(2) Cesarean section

19. If your daughter was pregnant and asked you to advise her on which would be the best type of labor regarding the baby, which type would you recommend?
(1) Normal delivery
(2) Cesarean section

20. When a patient, at beginning of pregnancy, asks which is the best type of delivery, you recommend:
(1) Normal delivery
(2) Cesarean section

21. When a patient arrives at your office requesting to have a baby via cesarean section, even if there is not indication for this type of delivery, you:
(1) Agree promptly
(2) Agree after discussing the case with patient
(3) Disagree and propose normal delivery
(4) Do not wish to reply

22. Do you agree that patient has the right to choose the type of delivery both at public and private networks?
(1) Yes
(2) No

23. Do you believe that the fact of carrying out a cesarean section at patient's request protects physician more from possible

denouncing at the Council than if he carried out normal delivery?
(1) Yes
(2) No
(3) Does not know what to reply
(4) Does not want to reply

24. Did any of you patients present severe maternal complications in elective cesarean section already?
(1) Yes
(2) No
(3) Do not want to reply

25. Did any new born whose deliver or first attendance was undertaken by you present fetal complication, such as prematurity, in carried out elective cesarean section?
(1) There was not any complication ever
(2) There was one complication
(3) There was more than one complication