INCREASED IN THE USE OF CAESAREAN SECTION: SYMPTOM OF AN EXCESSIVE RECURSE TO DEFENSIVE MEDICINE?

INCREMENTO DEL RICORSO AL TAGLIO CESAREO: SINTOMO DI UN ECCESIVO RICORSO ALLA MEDICINA DIFENSIVA?

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Abstract

Background
In the field of professional liability the case law evaluates the doctor’s work critically placing itself at the patient’s side at the expense of the physician. This attitude has convinced the doctors to try to protect themselves using the defensive medicine.

The defensive medicine does not want to protect the patient’s health but its aim is to avoid legal medical liability following the medical cares.

Objectives
This paper has the purpose of searching the causes of the increase of caesarean section in Italy and if this is a clinical need or if it is a sign of the spread of defensive medicine, in particular with reference to the Italian case law and the recent issue of the guidelines.
**Methods**

The authors analyzed: 1) the data of the Ministry of Health, CeDAP 2009, published in 2012; 2) the data published by the Agency for Public Health of the Lazio Region in February 2012; 3) the guidelines for caesarean section in 2011-2012. They also carried out a systematic review of the Italian case law in case of failed or delayed caesarean section.

**Results / Discussion and Conclusions**

The available data show an increase of caesarean section in Italy, putting it at the first place in Europe for the use of this surgery. In particular, the national distribution is not uniform: in fact, it is more used in southern Italy and in private structures than in public ones and the incidence increases with the increasing age of the mother.

The Lazio Region has several detailed data: they confirm what we have just said, and they underline an increase of births during working days. However, the increase in caesarean section is not associated with an increase in maternal and/or fetal benefits.

The analyzed data attest that medical care is not appropriate; it does not protect health, but it protects the will of both the patient and the doctor and possible interests of health facilities:

1) patient prefers to give birth in small private clinics where the gynecologist works during working days; 2) the gynecologists satisfy their patient’s wishes to avoid anxieties of natural childbirth and to prevent the risk of contentious due to failed or delayed caesarean section; 3) possible interests of health facilities that see an increase of their refunds for health service.

We think that the use of guidelines related to caesarean section and much information given to the mother about complications of caesarean section would limit the use of defensive medicine and would protect the health of both the pregnant woman and the unborn child.

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**Abstract**

**Introduzione**

La giurisprudenza, in materia di responsabilità professionale, ha subito un’evoluzione che l’ha condotta a valutare l’operato del medico in maniera più critica ponendosi sempre più dalla parte del paziente a scapito dell’operato dei sanitari. Questo atteggiamento ha indotto i medici a cercare di tutelarsi ricorrendo alla medicina difensiva, ovvero una medicina la cui condotta non ha il fine di tutelare la salute del paziente bensì il fine di evitare ai sanitari di incorrere in eventuali responsabilità medico legali seguenti alle cure mediche prestate.

**Obiettivi**

Il presente contributo ha lo scopo di ricercare le cause dell’eccessivo incremento del taglio cesareo (TC) in Italia e se questo risponda a reali necessità cliniche o sia segno del dilagare della medicina difensiva, con particolare riferimento alla casistica giurisprudenziale italiana in materia e alla recente emanazione delle linee guida.

**Metodi**

Gli autori hanno analizzato: 1) i dati del Ministero della Salute, CeDAP 2009, pubblicati nel 2012; 2) i dati contenuti nel rapporto pubblicato dall’Agenzia di Sanità Pubblica della Regione Lazio nel febbraio 2012; 3) le linee guida per il taglio cesareo del 2011-2012. Inoltre hanno effettuato una revisione sistematica delle pronunce giurisprudenziali italiane in caso di mancato o ritardato taglio cesareo.

**Risultati/Discussione e Conclusioni**

I dati a nostra disposizione rilevano un incremento del tasso di tagli cesarei in Italia ponendola al primo posto in Europa per il ricorso a tale tecnica chirurgica. In particolar modo si è evidenziata una distribuzione nazionale non
uniforme: difatti risulta più utilizzata nell’Italia meridionale, nelle strutture private piuttosto che nelle pubbliche e l’incidenza aumenta con l’aumentare dell’età della gestante. Dati ancor più dettagliati sono quelli forniti dalla regione Lazio che oltre a confermare quanto sopra riportato, evidenziano l’incremento delle nascite mediante TC soprattutto nei giorni feriali. Tuttavia l’incremento del TC non risulta essere accompagnato da un aumento dei benefici materni e/o fetali tali da giustificare il suo maggior utilizzo.

I dati esaminati testimoniano un comportamento clinico assistenziale non adeguato che più che il bene salute, va a tutelare altro; la volontà della paziente e del medico oltre eventuali interessi delle strutture sanitarie: 1) la volontà della paziente in quanto preferisce partorire in piccole strutture private dove opera, nei giorni feriali, il proprio ginecologo di fiducia; 2) la volontà dei ginecologi di assecondare la propria paziente, evitare le ansie del parto naturale, evitare a se stesso un eventuale rischio di incorrere in contenzioso per mancato o ritardato TC; 3) eventuali interessi delle strutture sanitarie che vedono aumentare l’entità dei propri rimborsi per prestazione sanitaria.

Una maggior informazione per la gestante sulle complicanze del TC e l’utilizzo delle linee guida relative al TC a nostro avviso possano limitare il ricorso alla medicina difensiva e tutelare la salute sia della gestante che del nascituro.

Introduction

Considering the professional liability, the law goes through an evolution that has led to evaluate the physician’s performance firstly with kindness and understanding, then critically, placing itself more and more at the patient's side, at the expense of the physician.

This trend has encouraged the spread of defensive medicine, prompting the physicians to support even more the patient request, to prevent the contentious.

It is not only an Italian phenomenon, but it is widespread in other countries such as the U.S. where there is an incidence between 79% (1) and 93% (2). It is necessary to control this trend because among the practical consequences, there is a serious economic one; it weighs an amount of more than € 10 billion on the financial balance of the Italian State (3). As noted in this Report, it is growing the attention about the prevention and the study of medical error, in order to protect the professional’s position, including the same health facilities in a positive perspective for clinical governance.

OTA (Office of Technology Assessment) states that "defensive medicine occurs when doctors prescribe tests, diagnostic procedures or visits, otherwise they avoid high-risk patients or treatments, mainly (but not exclusively) to reduce their exposure to a judgment of liability for malpractice. When doctors prescribe extra tests or procedures, they practice a positive defensive medicine; when they avoid certain patients or treatments, they practice a negative defensive medicine" (Definition developed in 1994 by OTA, Office of Technology Assessment, U.S. Congress).

In fact, the numerous and varied attitudes of defensive medicine can be divided into positive or negative ones.

The positive defensive medicine carries out with a cautious preventive approach (assurance behavior) while the negative defensive medicine is carried out without the treatment (avoidance behavior); in this case, the physician avoids dealing with specific patients or carrying out high risk operations.

A Government Commission of Inquiry considers defensive medicine one of the causes of the reduction in the quality of health care: the worthless diagnostic investigation represent an unnecessary health care cost that could be avoided; the doctor-patient relationship is delicate and the work of the professional is increasingly influenced by protocols and guidelines (4).

A first study: Among the most interesting researches conducted on the phenomenon of defensive medicine we can remember the provincial Order of Physicians-Surgeons and Dentists in Rome in November 2010 (5) which shows that 78.2% of physicians believe to have a higher risk of prosecution than in the past, 68.9% believe to have three chances out of ten to incur in such prosecutions. On the whole, 65.4% suffer an underserved pressure in daily clinical practice.

Main reasons that influence Physician’s recourse to defensive medicine:

• the current trend of public opinion (65.8%),
• possible legal actions of the judiciary (57.9%),
• experiences of contentious with other colleagues (48.4%),
• fear to be sanctioned by structures they work in (43.1%),
• fear to compromise their career (27.8%),
• fear of seeing their professional image negatively reported by the mass media (17.8%).

Objectives

The aim of this paper is to identify the main causes of the increase in caesarean section in Italy. In particular, we have tried to analyze whether the increase in CS has occurred because there has been a corresponding increase in the indications and conditions that required it or whether it is practiced when it is not necessary. The second option is prevalent, so we have researched the causes for such inappropriate choice, considering the Italian case law on the subject.

Methods

At first, we have studied the European situation, according to the Euro-PERISTAT report on maternal and child health; then we have focused on the Italian situation, analyzing the Ministry of Health data, (CeDAP, 2009, published in 2012); finally we have examined into the reality of Lazio Region, using the data contained in the report published by the Agency of Public Health of Lazio Region in February 2012.

The analysis of the spread of defensive medicine in gynecology was also carried out by a systematic review of the Italian case law in case of late or non-Caesarean section. The Italian case law generally shows that law protects the patient. Finally, in the publication of 2012, we have identified some guidelines for cesarean section as a possible response to the spread of the inappropriate use of CS.

Results and Discussion

According to the Euro-Peristat report, Italy is the first country in Europe with the highest percentage of cesarean cut, followed by Portugal, while other countries report lower percentages, from an average 30% in many countries, to a 15% in the Netherlands and a 14% in Slovenia (6).

In Italy, from the 60s, caesarean section (CS) has shown a progressive increase coinciding with the reducing perinatal mortality and morbidity in the 80s; this was possible to the advances in neonatal resuscitation maneuvers. However, in the 90s the further increase in the number of cesarean was cut, without increase in fetal benefits (7).

More precisely, from 1980 to 2008 the incidence of CS has risen from 11% to 38% (8, 9) and then between 2000 and 2009 it has gone from 332.7 to 383.6 per 1000 live births, reaching a peak of 390.2 in 2006 (10). These percentages show a higher trend than the threshold of 10-15% set by the World Health Organization (UN) in 1985 that aims to protect the well-being of the mother and the unborn child (11).

In Italy, there has been a substantial interregional variability: the lowest values were recorded in the North of Italy with 24% in Tuscany and Friuli-Venezia Giulia while the higher values were recorded in southern Italy reaching 60% in Campania (12).

In February 2012, the Lazio Region Agency of Public Health published a report about births during 2010; the data reported a clear increase in the use of caesarean section (CS), from 22.3% in 1985 to 42.4% in 2010 (44.3% considering multiple pregnancies). This increase involves both public and private health facilities, but in particular private ones (from 32.1% in 1985 to 78.2% in 2010) (13).

The incidence of caesarean cut in Lazio is 44.3%, raises in multiple births (93.4%); and it reaches 62.6% among women with more than 39 years. The increase of caesarean cut is reported also among single births, from 22.3% in 1985 to 42.4% in 2010; this concerns again both types of hospitals recording the highest values in the group of the private ones (from 32.1% in 1985 to 78, 2% in 2010).

Another significant data is offered from the high concentration of those born by caesarean cut during working days, while those born to vaginal birth are distributed evenly during the week.
The reasons that led to a continuous increase in caesarean sections are various:

- possibility to maintain the integrity of the pelvic floor and perineum (14);
- desire to reduce perinatal mortality and neonatal disabilities prevention;
- reduction of the length, anxiety and pain during labor;
- improvement of surgical and postoperative techniques (15);
- increase of the indications resulting from the use of diagnostic tools such as ultrasound and cardiotocography;
- cultural aspects that tend to consider cesarean section as an elective way of birth;
- structural and organizational deficiencies;
- lack of competence in the management of vaginal delivery by health professionals who prefer to practice a cesarean section to avoid to incur in any contentious (defensive medicine) (16).

The progressive increase in the use of CS has led to investigate the actual presence of clinical indications to justify such procedure. A Parliamentary Commission of Inquiry on Medical Malpractice appointed in 2012 carried out a survey about the situation of birth centers throughout Italy. This survey revealed a connection between defensive medicine and improper use of cesarean section. The most interesting data is the percentage of cesarean deliveries in small structures (up to 500 births per year) with an average of 44% which is higher compared to the larger ones (more than 1000 pieces per year) that have an average of 32.8%. The percentage rises to 55.5 if the structure is private (17).

According to the information received from the Ministry of Health, a high rate of cesarean delivery is associated with a high perinatal mortality (18) and this is observed in the wards with a low number of births (19). This is higher in the private sector again (60.5% accredited, 75% non-accredited) than in public one (34.8%).

These data reveal an inadequate health care system. The CS is a surgery and it is not free of complications: the maternal mortality related to the CS is between 10-30/100000 interventions depending on the circumstances and the postoperative morbidity is 10 times higher at least. The CS increases the risk of maternal mortality from 2 to 5 times compared to vaginal delivery (20) and maternal morbidity more than 15 times. The causes identified are: pulmonary thromboembolism, placenta previa and accreta, hysterectomy in following pregnancies and the increase in economic costs. Moreover, the CS helps only in part to reduce perinatal morbidity and mortality because it increases the risk of iatrogenic prematurity, neonatal depression due to anesthetic and respiratory distress (21).

The diagnoses that lead to the CS are: iterative cesarean (36%); fetal distress (18%); shoulder dystocia (14%); breech presentation (14%) (22).

In order to limit the use of CT to strictly necessary cases, in 2011-2012 were published new guidelines for CS in countries such as Italy (23), France (24) and England (25).

The guidelines have been defined by the Institute of Medicine (IOM) as “Systematically developed statements to assist practitioner and patient decisions about appropriate health care for specific clinical circumstances” (26); they involve a multidisciplinary panel of specialists who perform a systematic review of other national and international guidelines previously written on the subject and a detailed study of numerous scientific articles in order to formulate the final recommendations.

The Commission (FIMS 1996) defined them in a similar way: "Recommendations of clinical behavior, produced through a systematic process in order to assist physicians and patients in deciding what are the most appropriate method of support in specific clinical circumstances." The Italian case law has made recurring reference to the guidelines observing conflicting results. In some judgments (Corte di Cass. Sec. N.301/2001 IV, Corte di Cass. N. 282/2002) the physician is considered autonomous in his career choices, but, during his clinical practice, he have to take into account the scientific and experimental evidence; a judgment of the criminal Cassation (Corte di Cass. pen. Sect. IV, Mggio 18, 2006 n.16995) condemns the doctor for not having implemented "medical protocols" and finally the Corte di Cassazione (Corte di cass. pen. , Sez. IV, 2 March 2011, 8254) underlines the relative value of the guidelines because the mere respect of them does not relieve the physician from the liability and he always have to consider the peculiarities of the case.

The value of guidelines in Italy has recently been regulated by Law 189/2012 which considers them an useful tool to verify the guilt of the health worker; it states: "The operator of the health worker who in carrying out its activities respects the guidelines and good practices accredited by the scientific community does not respond to criminal
In such cases, it remains the obligation referred to the Article 2043 of the “Codice Civile”. The judge, also in the punitive damages, take into account the conduct referred to the first sentence.

The physicians need to protect themselves through a detailed search of case law because they have fear of the contentious. The judgments in this field are numerous and show a law dedicated to protect the patient. The main reasons that lead to contentious as a result of late or missed CS are: breech delivery (27), shoulder dystocia and fetal macrosomia (28), cardiocographic traces (29), deficiencies of the health facility (30) and fetal distress (31).

Conclusions

The analysis and the data, underline an increase in caesarean cut in Italy in the last 30 years; so Italy is the first place in Europe for the number of cesarean deliveries, with higher percentages in southern Italy than in the rest of Italy, in private facilities and during working days.

The Parliamentary Commission discovered that this increase is not justified by clinical indications and indicates an inappropriate clinical behavior causing an increase of the complications and mortality in the mother and in the unborn child.

The increase in the cesarean cut is a symptom of the evolution of the doctor-patient relationship: the physician tends to indulge the wish of the woman carrying out the CS, even in the absence of clinical indications; in this way, he protects himself from an eventual contentious for a missed or delayed CS.

This is confirmed by data previously analyzed which confirm that the CS is mainly done during working days, in private and small facilities, where perhaps the gynecologist can plan with the client/patient the birth without waiting the physiological occurrence. The CS is a surgery and, in addition to have many complications for the mother and for the unborn child, it will also be refunded to the structure at an higher rate than a natural birth.

In this respect, it would be hopeful that much information about the complications of CS where issued and that the use of the guidelines of the CS, whose actual practical value has to be found, might limit the use of defensive medicine and would protect the good health of the pregnant woman and of the unborn child.

References

Increased in the Use of Caesarean Section: Symptom of an Excessive Recourse to Defensive Medicine?

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