I. CESAREAN SECTION OR VAGINAL DELIVERY

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Optimal cesarean section rate is a compromise between the lowest possible number of cesarean sections compatible with the best clinical outcome. However, there is today a fear that the obstetrician will not be sued for having performed a cesarean section but by not performing cesarean section. It is important to remember that the preoperative complication rate in cesarean section is about 11 %, the majority of complications occurring in conjunction with emergency cesarean section, and taking the form of injection of hemorrhage. The risk of maternal death is 9-12 times greater after cesarean section than after vaginal delivery.

Although cesarean section has its given place in a number of obstetrics situations it is no panacea, and avoidance of its indiscriminate use entails continual review of obstetric policy and awareness of the appropriate indications. Whereas in high-risk pregnancies the indications for cesarean section are numerous (placenta praevia, abruptio placentae, cephalopelvic disproportion, dystocia, fetal distress, multiple pregnancy, intrauterine growth retardation etc.), in low risk pregnancies they are largely confined to breech presentation and fe5tal asphyxia. Other determinants of the cesarean section rate are such practical variables as the birth rate, obstetrical policy, the availability of resources, the medico-legal climate and the gravida's wishes.

Although local cesarean section rates may be subject to change fluctuations in the incidence of the above mentioned indications, at a national level it would seem reasonable to expect the cesarean-to-vaginal delivery ratio to bear some relation to the high-to-low risk pregnancy ratio. A review of national trends shows the cesarean section rate to have stabilized at around 12% in Sweden whereas in the USA, for instance, the rate has continued to increase and is now almost 30%, and in Italy - 23%.

II. CESAREAN SECTION OR VAGINAL DELIVERY

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Achieving an appropriate national level of the cesarean section rate entails the investment of considerable resources in continuous education at the local level, and perinatal audit systems permitting daily review of all cases scheduled for cesarean section. At a national (or international) level, maintaining awareness of current policy and knowledge regarding cesarean section also entails the regular participation of consultants and postgraduate students at national and international meetings and workshops. Such initiatives can cultivate in obstetric staff an awareness of prevailing trends and of advances in our knowledge. For instance, it has been shown to be possible to reduce the incidence of cesarean section for fetal asphyxia by improved postgraduate education in the use of cardiotocography and fetal sampling. Moreover, the cesarean section on the basis of pelvic and fetal size. In Sweden, the adoption of such educational initiatives as outlined above reflects the changing attitude in favor of vaginal delivery, and has resulted in reduction in cesarean section rates at units where they were high. It is also noteworthy that the reduction in cesarean section rates has been unaccompanied by any increase in perinatal mortality or in the frequency of fetal asphyxia, and thus does not appear to entail any increase in perinatal risk. Another noteworthy findings is that improvement in our knowledge of cesarean section has been accompanied by a reduction in the frequency of elective cesarean section.

According to the above mentioned the proposals to reduce cesarean section rate are:

education for the health care professional and the population about the advantage of vaginal delivery; consultants available to evaluate indications;

correct diagnosis of labor by the most experienced professional at the moment;

changes of juridical implications;

the possibility of vaginal delivery after previous cesarean section;

fetal monitoring is not at the service of cesarean section, but at the service of save vaginal delivery.