CS, VBAC, and the Ironic History of Taiwan's Obstetrics*

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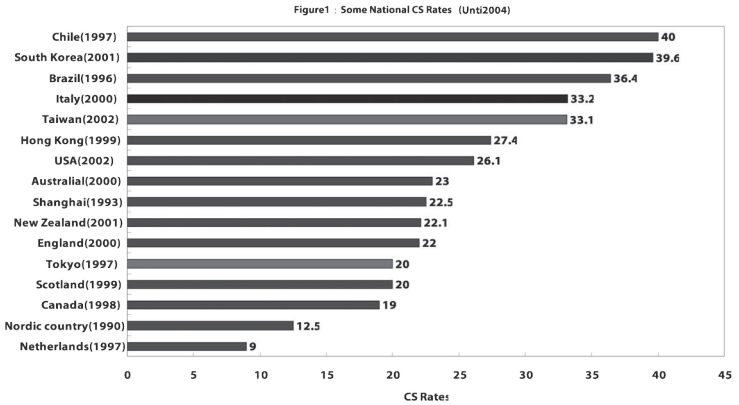
Introduction

Since the early nineties of the last century, Taiwan's national CS (Cesarean Section) rate has been among the highest in the world, well over thirty percent. Many studies of this problem from the perspectives of public health or hospital management have been undertaken, but most of them only problematize non-clinical factors in explaining this high CS rate: e.g., birthing women's attitudes and the National Health Insurance payment system. The controversial explanation in terms of birthing women and their families' superstitious beliefs in "picking up auspicious days for elective CS" which had previously been criticized has again re-emerged[1]. From the viewpoint of STS (Science, Technology, and Society), this paper intends to problematize instead the clinical factors of Taiwan's obstetric science, with particular focus on "obstetric practices" and post-war obstetric traditions. One important obstetrics-gynecology (OBGYN hereafter) tradition is usually associated with the name of a renowned gynecologist, Dr. C. T. Hsu, and his OBGYN department in Taipei Municipal Chung-Hsing Hospital (TMCH), which was famous for its gynecological-surgical operations in the 1950s and 60s in treating female patients with cervical cancer. While Dr. Hsu's tradition very much emphasized a surgery-oriented gynecology in the 50s and 60s, it is interesting to note that his hospital division had a CS rate as low as 16 percent in the 70s and was interested in practising "vagina birth after CS" (VBAC). Hence, the first puzzle: why was it the case that the TMCH gynecology with its strong surgery-oriented tradition should practise an obstetrics in the 70s with a moderate CS plus an interest in VBAC?

On the other hand, the major obstetric institution in post-war Taiwan was the OBGYN department of National Taiwan University Hospital (NTUH), with its conservative reputation for being strict in its indications for all kinds of surgical operations. NTUH was also probably the first major medical institution in Taiwan that had seriously engaged in a series of post-war VBAC. And yet, after the 1970s, both NTUH and TMCH were ready to change their "philosophy" regarding Cesarean Section, by walking away from VBAC and joining in the accelerating trend of rising CS rates in Taiwan. Thus, how should we

understand the historical connections, or even the contradictions, of doctors' practices between an early conservative obstetrics and a later high CS rate performance?.[2]



I. Medical education, training, and the "re-emergence" of VBAC as a medical-social technology

While it might be rare for research in Taiwan to focus on doctors' practices[3] in contributing to Taiwan's high CS rate, such detailed studies are easy to access in the relevant US literature. Except in occupational surveys, why does research in Taiwan (by doctors, nurses, people in public health or hospital management) tend to refrain from understanding more of Taiwanese OBGYN doctors' practices and its history? In this section, I will briefly discuss the current issue of Taiwan's high CS rates since the 1990s from the perspective of OBGYN doctors' medical education, training, and their perception of the "new" VBAC technique. Interviews of some OBGYN doctors also inform us of their medical education, especially their training in surgical operations.

For obstetricians in Taiwan, and surely for those in the U.S., *Williams Obstetrics* is often considered to be the "bible" textbook of this medical discipline. If we casually browse through its more recent editions, such as the 20th edition in 1997 and the 21st edition in 2001, especially the chapter on "Cesarean Delivery" , we shall certainly be impressed by their enthusiasm for the VBAC technique, emphasizing its crucial role in bringing down American CS rates during this period. Impressive also is the way this chapter was written: the research, technique, and current state of VBAC are first discussed in minute detail, before engaging in the discussion of the CS techniques from which the very title of this chapter comes.

Ironically, perhaps due to the sheer weight of this bible textbook, it was probably not closely read in Taiwan by medical students and used more like a source book. Other textbooks which were considered more concise and straightforward, such as *Current Obstetrics and Gynecology* (Lange), or some Chinese textbooks were more frequently read. Therefore, it is not clear whether this recent "US enthusiasm" for VBAC was ever imported into Taiwan's OBGYN field. Conversely, if it did get through, then when, how, and to what extent? According to Gu Chikai's master thesis[4] and his survey of Taiwanese OBGYN doctor's attitudes toward VBAC, only 25.5% of all 537 OBGYN doctors surveyed considered the technique of VBAC as something to be positively encouraged, whereas 64.7% of some 310 pediatricians surveyed like to recommend VBAC. Some Taiwanese OBGYN doctors[5] believe it is the primary CS rate, not the VBAC, that should be the real focus of attention, since Taiwan's birth rates in this decade are among the lowest in the world. However, we should pay close attention to the following facts: i) the rising VBAC rate is responsible for bringing down recent CS rates in the US[6], and ii) the indication of a "prior CS" is the primary factor (about 44%) responsible for upholding Taiwan's high CS rate.

One of my interviewees, an OBGYN doctor, Dr. Wu, recalls his first encounter with VBAC about seven years ago during his residence period. "All of my college professors and my hospital VS [Visiting Staff] then spoke of only one doctrine: once a cesarean, always a cesarean." Probably, the experience and history of VBAC were not mentioned or discussed at all in medical colleges in the 1990s. But then Dr. Wu by chance read an English paper about VBAC in which a 97% success rate was reported. This encouraged him and some other young resident doctors to try out VBAC, a technique which at the time they thought to be some kind of "new trend" in the science of obstetrics. This daring move of course was discouraged by all VS in his resident hospitals.

I am not saying that VBAC is a simple medical technique, as there are a number of medical indications (in addition to the emergency preparations necessary should a rare uterus rupture occur). Concerning Taiwan's recent poor VBAC rate (about 5%), some OBGYN doctors again blame the "female patients and their families" for their mistaken conceptions of VBAC ("dangerous and painful" vs. the safe and perfect CS). However,

besides blaming patients' misconceptions, doctors might also want to reconsider their poor skills[8] in doctor-patient communications. Some perceptive OBGYN doctors believe this is a crucial missing link in their medical education and skill training: to communicate with and persuade birthing women and their families about VBAC.

From the perspective of STS, we might like to consider a successful VBAC rate in society as an "Actor's Network" of VBAC technology, in which elements in this network work together to practise VBAC and, as a result, bring down the national CS rate. In the case of VBAC, this is usually a network consisting of clinical indications (enforced rules), adequate hospital preparations, doctors with favorable educational and training backgrounds, the willingness of birthing women[9], a good social knowledge of the relative risk analyses of NSD (Natural, Spontaneous Delivery), CS, and VBAC respectively and, finally, favorable financial factors in terms of insurance payments and state policies. In short, it is a successful network of three dimensions that should lay the ground for a successful VBAC technology: medical and doctor's characteristics, patient's family and social encouragement, financial and policy support.

In considering our interviews and discussions with OBGYN doctors, it is important to "re-frame" the relations among NSD, CS, and VBAC in order to conduct effective risk analyses of these three techniques. First, all three techniques have their respective, comparable risks, mortality and morbidity rates, and indications. The construction of a plan to chart these factors openly and to compare them fairly to the patients and their families is essential. Nowadays for a birthing woman in Taiwan, usually a doctor would begin considering whether she will have an NSD (or even VBAC), and would treat CS as a "last resort" should complications of NSD arise. But, as a last resort, CS is not without its own complications which could sometimes be even more serious.

II. Taiwan's Post-war VBAC, its Decline, and the Coming of a High CS Age

When contemplating Taiwan's high CS rate (36% in 2003), instead of pointing to "women's superstitions" in selecting auspicious dates to give birth, one might wonder whether there are some historical roots in modern Taiwan's medical history to explain such phenomena. In a way, this is not surprising. Taiwan's OBGYN in the past has been famous on several accounts, all of them pertaining to surgical operations: D&C, hysterectomy, cervical cancer surgery and Radical Hysterectomy (hereafter, RH) in particular. And Taiwan women's health activitists have long been concerned with some of these "famous," but possibly abused, gynecological operations. Thus, it seems natural to assume that when surgery has been strong in the gynecological tradition, it would surely influence its close ally, Taiwan's obstetrics.

History, of course, is more complicated. Even in Taiwan's post-war gynecology, there were at least two very different traditions: NTUH (National Taiwan Universtiy Hospital) and TMCH (Taipei Municipal Chung-Hsing Hospital). Take the primary example, cervical cancer. As my own study has shown[10], TMCH had been very famous in performing RH to remove the cervical cancer and a big chunk of the patient's body, but NTUH had not resorted to such surgical operations until the 1970s. Thus, only TMCH and its followers, under its OBGYN grand master Dr. Hsu CT, had been really famous in surgical operations. And, in a way, TMCH's gynecological tradition had more or less influenced its obstetric practices. When reflecting upon TMCH's CS rate from 1960 to 1979, research doctors[11] in TMCH concluded that their CS rate over a period of twenty years is simply the highest in Taiwan (overall incidence 13.96%). Various explanations are offered in terms of the low socio-economic status of the patients, fewer obstetrical beds than gynecological beds (30 vs. 50), too many emergency referrals from clinics and so on. But one thing is clear from their explanations: the blame of "women's superstitions" was not used at all; this seems to be a new discourse that emerged in the 1990s.

NTUH, the prestigeous medical institution in Taiwan with its "Imperial University" colonial past, has been quite different in the post-war years. First, NTUH was not very interested in advancing its gynecological surgery; rather it treated cervical cancer patients with the radiation method. On the other hand, NTUH received birthing women usually "five to six times" more than the TMCH and had been well known in being very strict in indications[12] for using forceps or surgical knives. Under these historical circumstances, it is really not surprising to find that NTUH had engaged in quite a few VBAC cases (132 trial labors and a 79.5% success rate, 1955-62)[13] in the post-war years. Moreover, with its prestige, its sheer quantity of deliveries, and its near monopoly of college medical education at that time, NTUH's low CS rate[14] (6.2% incidence from 1951 to 1963) and its willingness to try VBAC must have had some effect on Taiwan's OBGYN community at large. In this sense, NTUH was proud to claim that the policy[15]

they adopted concerning delivery following previous CS is "Once a section, not always a section".

As though in friendly competition with NTUH, in 1983, under the guidance of Hsu CT, TMCH published and analyzed its own record[16] of post-war VBAC cases, albeit with a time lag of almost twenty years! From 1973 to 1982, there were 224 trial labors with a 77.2% success rate within a ten-year period. Compared with NTUH's much earlier VBAC record, TMCH's record perhaps is not that impressive. But one interesting aspect of this late record is that TMCH should still be practising quite a few VBAC cases at a time when Taiwan's overall tendency in delivery was moving fast toward a more favorable stance on Cesarean Section.

Perhaps it is fair to say that Taiwan's CS rate was beginning to pick up from the late 60s to 70s, and NTUH's own record is very significant in this respect. Let me briefly mention a series of papers concerning NTUH's CS rates from the early 50s to the late 70s:

-First, in Chen HY, Lee JC, & Wei PY's 1962 paper on post-war VBAC, the policy "Once a section, not always a section" was still proudly announced.

-Secondly, in Chen HY, & Lee TT's 1965 paper on NTUH's CS rate (6.2%) from 1951 to 63, the paper begins by stating that "Cesarean section today is rather safe", and "The number of repeat sections has increased year by year even though 'Once a section, not always a section' has been the policy of this clinic."

-Thirdly, three years later, in Lin YF & Chen HY's 1968 paper, the CS rate from 1964 to 67 is an increasing 9.8%. The authors wrote "Abandonment of difficult vaginal deliveries, more repeat sections (more than doubled) and more contracted pelvis diagnosed by X-ray pelvimetry are thought to be the main contributing factors to this increase of incidence." One important result especially concerning this paper is the gradual abandonment of VBAC and more repeated section (from 13% in the first paper to the present rate of 26.4%).

-Fourthly, in Huang LH, & Chen HY's 1974 paper, the CS rate is now 11% from 1968 to 1971. The authors proudly begin by stating that "In modern obstetrics cesarean section is accepted as an essential armamentarium. It is now one of the safest operations and has replaced many obstetrical operations such as difficult forceps, internal version even breech extraction…" And in discussing the yet again rising "repeat section" rate from

the 12.98% in the 2nd paper, 26.4% in the 3rd paper to the current 32.2%, the authors wrote[17]:

> Repeat section rate has increased from 12.98% in 1951-63 to 32.2% in this study period, showing steady change of the policy from "Once a section, not always a section" to "Once a section, always a section" in this clinic.

Perhaps the year 1974 was a critical moment in the modern history of Taiwan's Cesarean Section, with the new policy announced by NTUH, Taiwan's major obstetric institution, well known in the past for its conservative stance on OBGYN surgical operations. To be sure, concerning Taiwan's foremost gynecological problem, cervical cancer also, NTUH changed its stance even earlier in 1968 from the radiation method to the development of RH.

But why? Why this steady change? What was the understanding in the medical discipline of obstetrics that prompted a senior NTUH obstetric professor like Chen His-Yao to claim: "In modern obstetrics cesarean section is accepted as an essential armamentarium"? A couple of years later, a corresponding change of "philosophy" is also announced in TMCH's 1980 review paper[18] about their twenty-year series of CS:

> There are many factors that contributed to the increasing cesarean section rate …However the most important thing is that the philosophy of obstetricians has been changing. We are now not only paying attention to the life of the mother but also to the quality of the new life.

Would CS really be good, comparatively speaking, for the quality of both the mother and the new life? As already discussed in section I from a contemporary viewpoint, not only is this claim questionable, but also most likely false. But let's go back to the historical and international contexts of these claims. At least one important contributing factor to this change of philosophy seems to have come from abroad, following the major change of attitude in the US obstetric community from the early 1960s.

In NTUH Prof. Wang Yao-Wen's major article "Vaginal delivery following Cesarean Section" in 1964, the first part is an impressive "review of the literature" which refers to

a total of 68 papers. Since this is the key article in the 1960s about Taiwan's post-war VBAC, I made a short analysis of the composition of those 68 papers. Three quarters of the papers[19] come from the US! And the remainder is from the British Commonwealth, France and Europe, with none from Japan. Although over half of the papers were published in the 1950s, papers from the 20s, 30s, and 40s constituted 38% of the references. According to Wang's own account, he cited 21 papers (13 after 1950) for VBAC, but only 9 papers (7 after 1950) for "Once a CS, always a CS". By implication, in the 1960s, Taiwan's major obstetric institution—the department of OBGYN at NTUH was under heavy influence from the US obstetric community. Therefore, in the next section, let me briefly analyze the various editions of the foremost US obstetrics textbook (or "bible"), *Williams Obstetrics*, in order to show the important change in attitudes concerning post-war CS.

III. *Williams Obstetrics* and its Attitudes toward CS and VBAC

As I discussed and praised the treatments of CS and VBAC in the 20th (1997) and 21st (2001) edition of the *Williams Obstetrics* at the beginning of section I of this paper, it might seem that this US obstetrics bible textbook stands for a progressive position regarding VBAC throughout. This is not the case. Or perhaps it is difficult to say what stands for a fixed "progressive" position in the post-war obstetrics. In the pre-WWII years, when Prof. J.Whitridge Williams was still writing by himself the well-known *Obstetrics* - for example, the 5th edition published in 1926 - he had something interesting to say concerning the deliveries following CS[20]:

> As it is generally believed that the cicatrix following a cesarean section represents a locus minoris resistentiae and may rupture during a subsequent pregnancy, many writers have laid down the dictum "once a cesarean, always a cesarean." …I do not entirely agree with such teaching. Naturally such a uterus is less efficient than one which has never been incised, and to my mind that fact should be regarded as a potent argument against the use of cesarean section for non-pelvic indications, except in the most pressing condition.

Clearly Williams had reservations about this dictum and he even used this controversy as an argument against the use of CS for non-pelvic indications. But that was 1926, and Professor Williams did not live long enough to read the post-war *Williams Obstetrics*. Take its 12th edition, edited by N. Eastman and L. Hellman, and published in 1961, New York. At a time when Taiwan doctors in NTUH were still calling for VBAC, color pictures were introduced into this edition of the *Williams Obstetrics*, including many gruesome and bloody uterines that were ruptured. Striking colorful pictures may have been a sign that important changes were ahead. There were two statements made there that are particularly relevant to the concerns of this paper.

The first statement is in chapter 34, "Injuries to the Birth Canal", the only place where delivery subsequent to a Cesarean Section is formally considered. Williams' original optimistic considerations of the "uterine scar" were replaced by the pessimistic attitude that we obstetricians can hardly "shed the slightest information on the integrity of the scar under the stress of labor." It is very interesting to read that medical doctors should admit their ignorance concerning certain techniques and were ready to abandon it. Thus, the authors wrote:

> …it is understandable from the discussion above that the attitude generally held in the United States today is that, in most instances, one section indicates this mode of delivery in the following pregnancies.

The second statement is in chapter 44, "Cesarean Section." When discussing the incidence of CS, our authors began with the following statement[22], which I believe is also a moment of "tremendous shift" in the history of US Cesarean Section:

> There was a time when the excellence of an obstetric service was judged by the paucity of cesarean section performed. In the past decade, however, there has been a **tremendous shift** in the viewpoint regarding the validity of this criterion …Furthermore, the idea that a cesarean section converts a healthy gravida into an obstetric cripple has come to be viewed…with increasing skepticism. (bold faces mine)

Now, if we jump from the 12th edition of *Williams Obstetrics* in 1961 to the 15th edition in 1976, a clearer statement[23] concerning doctors' general attitudes toward VBAC is again announced when "delivery subsequent to a Cesarean Section" is discussed, and also when the current concern in the US for "fewer but better babies" was strong and repeated CS supposedly was the best way to avoid all unnecessary risks:

> …in case of nonrecurrent cause for cesarean section, the general dictum "once a cesarean, always a cesarean" has been followed by **the majority of obstetricians in this country** but probably by only a minority of obstetricians in several other countries. (bold faces mine)

However, in spite of the enthusiasm for repeated CS and the feeling of "medical majority" , the authors of *Williams Obstetrics* were aware of the fact that this is basically only an American medical phenomenon. Again in the next 16th edition published in 1980, although there were two new authors/editors appointed for this famous textbook, the same feeling of "medical majority" for "once a cesarean, always a cesarean" was repeated and stated[24], albeit with an essential qualification "The reverse appears to be true in several other countries" .

There was something new however in this 1980 edition. Probably for the first time, it reported a huge "trial of labor" for 526 birthing women selected (thus a high "trial rate" of 83%) from a group of 634 women with one previous low transverse CS. The "success rate" of this trial group is 60%, which is quite good considering the trial rate was very high. But 40% of the trial group labored unsuccessfully and then underwent repeated CS; probably they suffered more than ordinary repeated CS. Realistic costs and risks analyses were subsequently undertaken and evaluated[25] concerning this trial group as well as cases from other studies. This might actually indicate the beginning of a new phase in CS/VBAC cost analysis in the new age of high US medical costs, which might prove to be a new chance for the "return of VBAC" in the US.

By stating their ignorance and emphasizing the risks concerning the nature of "uterine scar" under labor stress, US obstetricians were somehow justified in skipping the VBAC during the 60s and 70s and to follow instead the path of repeated CS. But this does not mean there were no medical problems with this alternative path. For one, the danger of uterine rupture still remained for repeated CS, albeit perhaps at a slightly lesser extent, since the CS might be performed at an earlier stage or before the onset of labor. Secondly, it is not easy to accurately measure the right timing for performing the repeated CS, for fear of the newborn baby's "iatrogenic" prematurity. Thirdly, there was a fear of "respiratory distress" for the newborn. Various strategies (amniocentesis, or the guidelines from Parkland Memorial Hospital) concerning the "timing problem" , with their prospective pro and cons of course, were discussed and analyzed in the later new editions of *Williams Obstetrics*. Naturally, a more detailed analysis which compares these two different obstetric roads to solve problems arising from deliveries subsequent to a CS is necessary.

In closing this section, I believe I have shown how in the 60s and 70s, American obstetricians was embracing the CS technique, and how they were walking away from the VBAC, as symbolized by the three editions of *Williams Obstetrics* from 1961 to 1980. Moreover, since Taiwan' s post-war obstetricians were usually under the influence of their American examplars, as I have indicated from an analysis of the 68 references in Wang Yao-Wen' s review article, it comes as no surprise that Taiwan' s obstetricians also tended to follow their American counterparts in practice, with a time lag of course. In short, this at least is one important reason which explains the decline of Taiwan' s post-war VBAC and the arrival of a high CS age from the 70s to 80s.

One remaining but important question in the Taiwanese context is this: As American obstetricians declared their ignorance regarding the nature of "uterine scar under labor stress" and thereby used it to justify walking away from VBAC, had Taiwan's obstetricians done any real research on it, or were they just copying what American doctors had decided in taking a different road? Further research regarding this issue is required.

Reference

*This is a shortened and slightly modified version of the original paper for the conference "Body Knowledge and Gender in Asia" International Workshop 2006, sponsored by the Center for Gender Studies at International Christian University in Tokyo. Many of the original medical papers discussed in this paper were collected by Prof. Wu Chia-Ling, who kindly handed her files of CS to me for this research.

[1]See 吳嘉苓 (2000) and Fu & Wu (2004) for a cogent criticism of this kind of explanation.

From our interviews, we found that most pregnant women were encouraged to select an auspicious day only if she had already had medical indications for CS and a time period for operation was set up. Then an auspicious day would be selected, like a compensation for surgery, within that time period. Also see Lo (2003) for a renewed but problematic attempt to advance this explanation.

[2]The following Figure 1 was prepared by Prof. Wu Chia-Ling, to whom I express my gratitude.

[3]Focusing on the so-called "clinical factors", see our recent conference paper, Fu & Wu (2004).

[4]古智愷(2002), master thesis, p.71. A survey on whether NSD is a better mode of delivery for baby's health found that pediatricians consider NSD better by a wide margin in comparison with OBGYN doctors: 75.1% vs. 41.4%. See also Gu's master thesis (2002), p.70.

[5]According to an interview with Dr. Chan (2004).

[6]See *Williams Obstetrics* (1997, 2001).

[7]This was the common state of affairs gleaned from interviews with Dr. Wu, Dr. Chan, and Dr. Lai.

[8]It is relatively easy to identify missing links in OBGYN doctors' complaints of the supposed "ignorance and obstinence" of the patiresentation, and persuasion in recommending VBAC to the birthing women. This can be easily found in our interviews.

[9]It is interesting to consider here nurses 蔡秀娟、廖彩言 (1999), who present a different argument for VBAC constructed through the psychology of "motherhood".

[10]See Fu (2005), *Assembling the New Body*, ch.5, "Dr. C.T. Hsu and the Two Roads of Post-War Gynecological Surgery". My interview of Dr. Ruen, a close student of Dr.Hsu's, also amply confirm the point raised here. In ch. 3 of the same book, I discuss how Taiwan's OBGYN doctors were good at D&C in performing an abortion.

[11]See Yang YK, Lin MH, Tsai CL, Chang CC (1980) and similar results also came from Wu J, Tsai SL, Chang CC, Hsu CT (1975), where TMCH's CS rates from 1960 to 1975 were collected and discussed.

[12]There is much evidence for this. For example, see my interview with Dr. Wang YW.

[13] A total of 234 deliveries in 201 patients with a previous CS scar over an eight-year period (1955 to 1962) were reviewed. Of these 234 deliveries, 132 were given a trial; thus the "trial rate" is 56.4%. See Wang Yao-Wen, (1964).

[14] See Chen HY, & Lee TT, (1965). We should also note that Japan's post-war CS rate was even lower, with a mere 2.5% CS incidence from 1949 to 1958 in 84 leading hospitals. Thus it is not surprising that NTUH, with a strong colonial tradition under Imperial Japan, had a low post-war CS rate. See Chen HY, & Lee TT, (1965), p.91.

[15] See Chen HY, Lee JC, & Wei PY (1962).

[16]See 黃炳昌、楊麗川、徐千田等（1983）

[17]p.172.

[18]See Yang YK, Lin MH, Tsai CL, Chang CC (1980), p.151.

[19]Including the two editors of the 11th edition of *Williams Obstetrics*, Nicholson Eastman and Louis Hellman. Wang also included another obstetrics textbook, *Obstetrics*, 11th edition, 1955, Philadelphia, by J.P. Greenhill, who also edited the *Year Book of OBGYN*, 1953.

[20]See p.498. And on p.514 Williams again took up this issue by claiming that this dictum "is an exaggeration." He believed that this dictum is "in part based on the belief that the uterine incision heals by the formation of scar-tissue, and that the newly found connective-tissue stretches and sometimes yields when the uterus becomes distended." Then Williams gives three reasons to explain why this is not so.

[21]All the quotations and citations in this paragraph come from p.985 of the 12th edition.

[22]pp.1182-83 of the 12th edition.

[23]pp.733-34 of the 15th edition.

[24]pp.866-7 of the 16th edition, published in 1980.

[25]See pp.868 of the 16th edition, plus the interesting Fig. 33-7 on the same page.

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Prof. Lai MS, interviewed (by Wu Chia-Ling) Sep., 2004, National Taiwan Universtiy, School of Public Health
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帝王切開術 (CS)、帝王切開後の経膣出産 (VBAC) と戦後台湾の皮肉な産科学史

傅大為

1990 年代初頭から、台湾における帝王切開術の割合は 30 パーセント以上と世界の中でも最も高いものとなっている。この論文は、STS（科学技術社会学）の観点から “産科学実践” と戦後産科学の慣習に目を向けることを目的とする。たとえば、外科手術を多用した初期の婦人科と、70 年代の帝王切開（CS）の節制と帝王切開後の経膣出産（VBAC）への関心をむける産科とがある TMCH（台北中興病院）の仕組みはどのようなものだろうか。

他方、あらゆる種類の外科手術に対して厳格であるという世評を持つ NTUH（National Taiwan University Hospital: 台湾国立大学病院）の産婦人科は、戦後帝王切開後の経膣出産に熱心に取り組んだおそらく台湾で最初の主要な医療機関であろう。しかしながら、1970 年代以降には NTHU は、TMCH とともに自らの帝王切開術に対する “哲学” を変え、VBAC から離れ、台湾における CS の加速的な隆盛へと合流する用意を整えていた。我々はどのようにこの歴史的つながりを、あるいは戦後初期の産科学と後の高い帝王切開率という医師の実践の矛盾を理解すべきなのだろうか。更には、50 年代から 70 年代にかけての VBAC への関心は、多くの議論やそれを復興させようとする人々の努力にもかかわらず、90 年代にはほぼなくなってしまったのである。

我々は、VBAC の技術をある種の “主体ネットワーク” として、理解することができるだろうか。また、戦後の産科学史の奇妙な歴史を様々な主体ネットワーク（NTHU、TMCH，台湾助産婦協会、アメリカ産科学協会など）のつながりと競合という点から理解できないだろうか。

おそらく、台湾での CS 率が勢いを増し始めたのは 1960 年代後半から 70 年代にかけてだろう。だが他の手段と比べても、CS が母と子の両方に充分に配慮しているという主張は、疑わしいどころか、ほとんど誤っているように私には見える。にもかかわらず、主要医療機関が CS 賛同に向かって哲学を変化させた重要な要因の一つは、1960 年代初頭からのアメリカ産科学会における姿勢の大きな変化からきているように思われる。1960 年代から 70 年代にかけて、アメリカの産科医たちは CS 技術を信奉し、VBAC から離れていった。そして戦後台湾の産科医たちはアメリカの影響下にあり、多少のタイムラグはあるもののアメリカの産科医に追随する傾向があった。

1990 年代には、高 CS 率に対して対策を立てようと、台湾の国家機関である DoH（Department of Health）の代表が、産婦人科医とともに台湾の女性保健活動家を招集した。しかし女性保健活動家による非難、産婦人科医による反対のため、見解の一致は得られなかった。

さらに、台湾の医療専門家たちの学術団体・コミュニティである “産婦人科協会”（TAOG）は、当然台湾の高 CS 率について懸念を表しており、現状を調査し効果的にそれに対処する専門調査会を組織することを望んでいた。しかしながら、1991 年から 95 年にかけて TAOG は、NTUH の体制とそれによって育てられた多くの開業産婦人科医と、1949 年以後に中国本土から渡って来たエリート医師たちのグループによる VGH（Veteran General Hospital: ベテランジェネラルホスピタル）との間の内部軋轢による騒然とした年月を経験し、高 CS 率に関しての手段は一切講じられなかった。1996 年に TAOG が安定したとき、彼らはすでに急騰していた CS 率に直面せねばならなかったのである。この時 TAOG 内には “権威の分割”（NTUH 対 VGH）があり、それは TAOG が、医学的権威としての、統一されたエリート集団によって構成されている学術・医学団体ではないことを示している。そして TAOG 会報（1996 年から 2003 年の 73 報）には、VBAC に関する技術や提携、影響はまったく論じられていない。CS による出血や難事についての特別研究や、CS における新しい技術や進歩が報告されているが、基本的に、高 CS 率問題の対処のための教育や医療行為の改善における努力と知識が効果的に集結される TAOG の空気のようなものは、これらの会報では現れていない。

2000 年から、望ましい CS 率の指針と VBAC のクレジットカウントが政府の医院評鑑（HEC：Hospital Evaluation Criteria）に加えられ、病院経営者は、DoH からのクレジットを得るために、あるいは好意的に評価してもらうために、いかにして病院の CS 率を下げるかにより注意を払うようになった。DoH の医院評鑑にこれら低 CS 率とより多くの VBAC の例が包含されることが、TAOG の努力に起因したのかどうかについては、今後の研究が期待される。