Chapter 5

The Introduction of "Natural Cesarean" in Swiss Hospitals: A Conversation with One of its Pioneers

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Introduction

In Switzerland, as in most high-resource countries, labor and delivery are conceived of as risky and unpredictable events that can only be considered "normal" in retrospect (see e.g., Maffi 2012; Scamell and Alaszewski 2012; Maffi and Gouilhers 2019). Anticipation regarding what could go wrong is not limited to birth but is already present throughout the course of pregnancy. Risk surveillance during pregnancy includes a range of tests to assess the mother's and the fetus's health, along with various recommendations regarding optimal behaviors to maximize the future child's health (Manaï, Burton-Jeangros and Elger 2010). Such continuous medical surveillance reveals a risk-oriented comprehension of birth that healthcare professionals and society share. The ongoing debate in many countries of the Global North about the safety of home birth or birth in a freestanding birth center versus birth in medical settings further reflects the prevalent preoccupations about risks. These discussions occur within a context in which maternal and infant mortality and morbidity are at their lowest levels ever, while residual risks (serious complications and deaths associated with birth) are deemed socially and medically intolerable (Lupton 1993; Burton-Jeangros et al. 2013, 2014). The focus on risk in managing pregnancy and childbirth reflects the broader cultural context of Euro-American societies in which the discourse of risk orients public institutions' policies and private behaviors (Lupton 1993; Beck 2003).

In 2017, 98.3% of all births in Switzerland took place in hospitals, and almost one-third (32.3%) of all children were born via cesarean (OFS 2019a). Half of these cesarean births (CBs)

were planned, while the other half were emergency cesareans. The Swiss CB rate decreased by 1.4% between 2014 and 2019 (OFS 2019b). However, in comparison with other European countries, the cesarean rate in Switzerland remains among the highest (Euro-Peristat Project 2015), behind Cyprus (56.9%), Romania (46.9%), Bulgaria (43%), Hungary (39%) and Italy (35.4%). (For comparison, the countries with the lowest rates include France (19.7%), Sweden (16.6%), Finland (16.5%), the Netherlands (16.2%), and Norway (16%) [OECD Indicators 2019]). Furthermore, important variations exist across the Swiss cantons—Jura's rate is below 20%, while Glaris's reaches 40%—and healthcare infrastructures, with 45.6% of CBs for women with (semi)private insurance versus 30.7% for those with standard health insurance (OFS 2019a). Variations also occur in accordance with women's sociodemographic features: cesarean rates are higher among older women (OFS 2019a) and among women of non-Swiss origins—for example, those from South America, Africa, or Italy (Hanselmann and Von Greyerz 2013). Depending on the specific birth circumstances, certain women are also more likely to undergo a cesarean birth: 79.9% of multiple births and 94% of breech presentations take place via cesarean in Switzerland.

In 2014, the Swiss Society of Gynecology and Obstetrics (2014) took a stance in favor of vaginal birth, asserting that it should be the default procedure for a normal, low-risk pregnancy, while "planned C-section should be the exception." However, the cesarean rate remains a relatively neglected topic in the Swiss medical literature (Hohlfeld 2002; Morales et al. 2004; Roth-Kleiner 2007; Bonzon et al. 2017; Horsch et al. 2017; Baud et al. 2020). Current Swiss CB rates contradict the growing international movement promoting "normal childbirth" (Downe 2008), which emphasizes how medical practices have become too interventionist, resulting in over-screening, over-diagnosis, and over-treatment (Cassel and Guest 2012; Moynihan et al. 2012; Miller et al. 2016). In practice, healthcare professionals appear to face difficulties in inversing the cesarean trend, and those working in obstetrics are well aware of the adverse consequences of cesarean overuse. In addition, most parents want to limit technical and medical acts because they consider

pregnancy and birth to be important and intimate familial events (Maffi 2012; Chautems 2022). Although maternal requests for cesareans are often evoked as a factor exacerbating the increase of cesarean rates, the literature suggests that these play only a marginal role (see Moffat et al. 2007; Potter et al. 2008; Tully and Ball 2013; ACOG 2019).

Despite the high rate of cesareans in Switzerland, the current social context promotes "natural" physiologic birth. The dominant social representations, which most health professionals also share, conceive of a normal birth as a vaginal one. Hence, cesarean births may foster a sense of failure for women who had planned a "natural" childbirth (Fenwick et al. 2009; Chautems 2022; Davis-Floyd 2022). In this context, natural or "gentle" cesarean has appeared as an attempt to reconcile the natural childbirth ideal with the cesarean birth. The British obstetrician NM Fisk and his team (Smith, Plaat, and Fisk 2008) created the natural cesarean technique, which aimed at mimicking a vaginal delivery. This technique stands out from the classic cesarean, as it allows newborns to be placed immediately on their mother's chests for their first skin-to-skin contact, the mothers to play a more active role, and the environments and hospital staff to be more respectful of the event. Considering that early skin-to-skin contact can increase the rate and duration of breastfeeding (Rowe-Murray and Fisher 2002; Moore et al. 2016), as part of the 10 Steps of the Baby-Friendly Hospital Initiative (WHO 2018), this practice is currently standardized throughout Swiss maternity wards after a vaginal birth. Early skin-to-skin contact can also favor the bonding process between mother and child (Moore et al. 2016). A gentle cesarean is also intended to be inclusive of parents, allowing them to see their baby when the baby is extracted or offering the father (or other parent) the opportunity to cut the umbilical cord (Smith, Plaat, and Fisk 2008). Yet despite the intention to enhance parents' participation, gentle cesarean, like any surgery, is still defined by normative expectations regarding "the appropriate behaviors in the operating theatre" (Maffi 2013:6). The hospital staff's requirements and the operating room's constraints thus frame the parents' participation. Few studies have explored parents' expectations and experiences

regarding this technique.[1]

Our Collaboration

The collaboration among the 3 authors of this chapter started in early 2020 when Caroline and Irene decided to prepare a research project on parents' experiences of cesareans in Switzerland,[2] and asked Alexandre whether he and his colleagues working in the maternity ward of the Hospital Riviera-Chablais (HRC)—a medium-sized public hospital located in the French part of Switzerland—would be interested in becoming partners in this project. Alexandre and most of his colleagues accepted our proposition with enthusiasm. One of the aspects that facilitated our collaboration was our common interest in natural cesarean, which has become a routine practice at HRC. This technique, which Alexandre and his colleague Christian Valla, the former head of the maternity department at HRC, introduced to Switzerland in late 2019, is particularly interesting for all of us, although not exactly for the same reasons. The quality of care and the clinical results are central from a medical point of view, whereas from a social science perspective, it is important to investigate whether and how this technique transforms parents' experiences of surgical birth. We decided to write this chapter in the form of an interview because we wanted to give voice to an obstetrician who has made a reflexive journey transforming him "from doctor to healer" (Davis-Floyd and St. John 1998)—meaning that he transformed several aspects of his training and previous clinical practices in accordance with a humanized conception of surgical birth and his moral concern for parents' and newborns' experiences of childbirth.

In what follows, we trace Alexandre's professional trajectory from medical school to his present position at HRC. We believe that his journey is significant because it uncovers some important characteristics of the two national systems in which it took place (France and Switzerland), of obstetric training (or the lack thereof) in medical schools, of hospital cultures, and

of professional attitudes toward childbirth and the actors involved in it. The interview took place in French, and the authors translated it to English.

The Interview with Alexandre

Irene: Could you tell us about your medical training and how you arrived in Switzerland?

Alexandre: I grew up in Lyon,[3] where I attended medical school. At the end of my last year, I didn't want to choose a specialty and hence I decided to train in general medicine [3 years]. In the French system, you can choose the service and the hospital according to your ranking. I was not among the best students and thus had little choice. The first semester I was in a pneumology department; in the second semester, without having chosen it, I landed in an obstetrics and gynecology department. I initially hated gynecology and obstetrics because I had done an internship in a department of the Hospital Hôtel Dieu in Lyon during my studies and had not liked it at all [in France, internships are done during the 3rd year of medical school]. There, I had seen a female doctor perform a cesarean, and the sight of a woman opening another woman' s belly struck me. At the end of this internship, I had to pass an exam that consisted of inserting a speculum. I did it on a young girl and it was my first time. I remember it as a very unpleasant experience.

Thus, during my second semester of specialization in general medicine, when I was sent to a gynecology and obstetrics department in the Hospital of Montélimart [a small-sized peripheral hospital], I was not very motivated. Unexpectedly, it was a good experience that changed my professional life. I was the first resident there who was not doing his specialization in gynecology and obstetrics. As attending doctors [an attending physician has completed residency] weren't certain what they could get me to do, I had a lot of freedom. There was only one thing I didn't like: the operation theater. I had asked the head of the department not to attend operations. However, he made me understand that I had to attend at least some surgeries. At the end of the day, I had a blast

during this residency. Although I performed cesareans and ultrasounds, I was very inexperienced and was often in awkward situations. I realized that when you know little, you are not experienced, you make mistakes and missteps. I remember one time when a couple asked me when children‘s teeth grow and I answered "at the age of four or five"! I also realized that obstetricians-gynecologists are trained to pay attention to pathology rather than physiology. After that semester, I decided I wanted to change and specialize in obstetrics and gynecology, but I learned it wasn’t possible. I had to finish general medicine first, work for two years as a general practitioner, and then take the specialty exam for gynecology and obstetrics. At that time, I thought about doing my specialization in Belgium or Switzerland because they are also francophone countries. Considering that in Belgium, it was quite complicated to be admitted as a resident doctor, I opted for Switzerland where, at that time [2003], to specialize in gynecology and obstetrics, all you had to do was visit the head of the department and be accepted by them. After finishing my specialty in general medicine in France, I started my residency in 2006 at the Hospital Le Samaritain[4] in Vevey.

It was difficult to adapt to the Swiss system, for example because the names of medications were different. In France, we tend to use the names of the medications’ active ingredients. In Switzerland, health professionals use the pharmaceutical manufacturers’ names. I was familiar with the French names but not with the Swiss ones. Once, a nurse asked me what she could give to a woman with a headache and I said the name of the medication we use in France and she didn’t understand. I felt quite overwhelmed at first.

I spent two years at the Hospital Le Samaritain, one year at the University Hospital of Canton of Vaud (CHUV) and one-and-a-half years at the Hospital of Morges.[5] At the Hospital Le Samaritain, it was just a party: I had a very nice colleague with whom it was very good to work. I had a great deal of autonomy and I liked that. I had never done surgeries [with the exception of cesareans], whereas my colleague was more of a surgeon. Therefore, we had very different attitudes towards the situations to be treated: I was very conservative, leaving surgery as a last resort, while

my colleague was very interventionist, always putting surgery first. It's still like that today. I believe I am much less interventionist than my colleagues at HRC are, even in the case of certain uterine ruptures where I do not want to intervene because I know they heal very well without surgery. My colleague at Le Samaritain always had the scalpel in his hand and operated on everything that came along.

Irene: Could you tell us how and why you developed a different attitude toward childbirth compared to many of your colleagues?

Alexandre: My conservative attitude is probably related to my experience as a general practitioner. During my internship in France, I took part-time responsibility for the office of a general practitioner in Saint Marcel d'Ardèche, a small town located south of Lyon. I learned a lot working as a general practitioner because I had to rely mostly on the clinic and evaluate which patients to send to the hospital to access medicine that was more high-tech. I had to develop a holistic approach to patients through assessing their family and social situation in making medical decisions.

In Switzerland, you have to do two years of surgery experience before becoming an obstetrician/gynecologist. This is at the origin of a very interventionist culture in this specialty. To obtain the FMH [Swiss Medical Association] diploma in obstetrics and gynecology, there is a list of surgical interventions you must perform. However, obstetrics is the poor relative of gynecology: We do not train obstetricians, but we do train gynecologists (surgeons). Therefore, resident physicians fight to go to the operating room. In France in the early 2000s, there was no operating catalogue. What counted was to have practiced five years of obstetrics/gynecology—the number of years rather than the number of surgical acts performed was important. For example, a friend of mine finished her specialization in France after performing three hysterectomies, while in Switzerland I had to perform twenty-five. One colleague I met during my internship in Morges also told me that "obstetrics is for fags!" [Note from Caroline: This was a homophobic comment meant to discredit

obstetricians (who only perform routine surgeries like cesareans or other birth emergency procedures) compared to gynaecologists (who are trained to perform more challenging and varied surgeries including treatment of pathologies not necessarily related to childbirth.)] I believe that in obstetrics, technical acts are few and rather banal: forceps, vacuum, cesarean. I am convinced that other aspects are more important: the psychosocial environment, parents' experience, etc. These are not technical procedures. In obstetrics, we are not in the process of extracting a tumor.

For me, a cesarean is easy to do. I used to feel bothered when performing it a lot, so I was almost happy when there were complications because it became more interesting. The cesarean easily solves all the problems and it is not very complicated to do, which is why it is so easily performed. In my opinion, in Switzerland, there are few gynecologists/obstetricians practicing only obstetrics. I would say that in obstetrics, most of my colleagues are like drivers of a car, but have never put their hands in the engine. I am a driver in gynecology, but I know how the engine works in obstetrics. For example, when I did my internship, most of my attendings preferred to do more cesareans rather than try maneuvers that were more complicated. They argued that the Swiss population was not ready for anything else. More generally, I think the Swiss world of gynecology and obstetrics is rather closed to other European countries' influence: most heads of maternity wards in Switzerland have been trained in Switzerland and are rather locked into their local culture.

When I was working at Le Samaritain, I was a young attending and the only full-time, in-hospital physician: at the beginning I had few outpatients and hence I had a lot of time to read. I also participated in several European congresses and saw that the practices that seemed indisputable in Switzerland were not at all the same elsewhere. For example, in some hospitals where I did my internship, it was mandatory to give the woman five international units (IU) of oxytocin after the child's shoulder came out, while Portuguese obstetricians gave 10 IU after the expulsion of the placenta. I discovered that what seemed so true in Switzerland was not true in some other European countries. I sometimes think that many of my colleagues have lost their sense of what childbirth

involves because the interventions they perform disrupt the process. In many hospitals, you find what I would call a "cold obstetrics." I think many things we do are useless or even deleterious. I will give you some examples.

Let's talk about continuous fetal monitoring. We know that, compared with intermittent auscultation, under continuous fetal monitoring, fewer newborns would have convulsions at birth, but we do not know what the consequences of these are on the children in the long term. We know there is no difference for NICU admission, acidosis, fetal death, or neurological injuries. On the contrary, we do know that continuous fetal monitoring increases the risk of fetal extraction by vacuum, forceps, or cesarean. Nonetheless, habit and medico-legal issues lead to the use of continuous fetal monitoring for all woman in our delivery rooms. We don't dare to change that, despite the mentioned consequences on our patients. Over the years, I have come to trust the women and their bodies much more. A woman gives birth. I wonder why in our hospital we have 30% of inductions of labor, 25% of cesareans and 12% of forceps/vacuum, whereas women who give birth know how to give birth.

Another experience that helped me to develop a critical perspective on my practice was the advanced course on ultrasound that Israel Nisand taught, who a very well-known French obstetrician. Nisand explained that ultrasounds are practically useless, except for a few pathologies, such as certain cardiac malformations that require an intervention immediately after birth. For the rest, there is nothing to do, even if things are detected.[6] For instance, trisomy eighteen and thirteen cause the fetus's death in utero or shortly after birth. However, except for interrupting the pregnancy once you discover it, you cannot change the situation. I believe that ultrasounds are a source of stress for many future parents and can even harm them. Despite my opinion, I still perform ultrasounds to see the fetus because it has become routine, and also for medico-legal reasons.

Finally, I believe I learned a lot in the field when I was doing my internship in the delivery ward. I started thinking about the situations I observed and became interested first in the quality of

care and the clinical aspects. I had the opportunity to attend a special training in patient safety coordination and another one in quality of care. I then realized that healthcare professionals are the third most important cause of death for patients. When I was a resident at CHUV, I was on the team in charge of setting up the procedure for reporting adverse events. I was also the one who created the written protocol of the delivery ward, which did not exist before. At that time, I started to think that it was important to discuss couples' wishes and the possibility of birth attendants being less paternalistic. When you start this kind of reflection, you open your eyes to many things. You realize that science is not everything. In sum, I started to think from a clinical point of view, but I later switched to consider the patients' point of view.

Caroline: What about cesarean birth and natural or gentle cesarean?

Alexandre: I was very bored doing cesarean births because it was always the same procedure. When it comes to natural cesareans, the idea came from Christian Valla, the former head of the department at the hospital Le Samaritain in Vevey. One day, he told me about a technique that we could introduce in our service. He let out: "What if we had gentle (*douce*)—as it is usually called in French—cesareans?" I wanted to laugh at him, but I said to myself, "Go see what this is first." I read the article from 2008 [Smith, Plaat, and Fisk 2008]. It's far from everything you are taught during your training. You have to rethink your convictions and be open to change. For example, I learned that when you find the fetal head, you should immediately pull it out. People get excited, doing it very quickly. You also have to be careful that everything is perfectly sterile. On the paternalistic side, parents should not see anything because the father could faint. You should never lower the sterile drape separating the upper part of the mother's body from her abdomen.

Therefore, you have to get past everything you learned during your training. The pediatricians want the baby right away, to stimulate her or him. The anesthetists say that if it is a high-risk surgery, you need strong light everywhere. They are afraid of bleeding. If you want to do

gentle cesareans, you have to fight against all of that, all these beliefs. Even if it's not just beliefs, because there *are* situations where things can go wrong. You have to show that it is entirely possible, and that even if there is a problem, you can always make up for it. The natural cesarean technique highlights that this event is a birth, not a surgery. The patients are there to give birth, not have a surgery. They want to give birth to their child. We must not forget that.

Caroline: How did you manage to implement natural cesarean in your service? It must have been challenging.

Alexandre: Before the move to Hospital Riviera-Chablais, we started introducing it in Vevey with Dr. Valla and the midwives. We gradually tested small parts of the gentle cesarean protocol: slowly taking out the child's head, then dimming the lights, then lowering the surgical drape. We realized that everything was fine and that the women were delighted. During this transition stage, we had to convince medical staff from different disciplines, both pediatricians and anesthetists. At first, we were walking on eggshells. I was asking questions and I negotiated with the teams to get them accustomed to it slowly. The midwives and pediatricians joined first. It was more difficult to convince the anesthetists, but it depended on the teams and individuals.

When we moved from Vevey to Hospital Riviera-Chablais, we had the opportunity to institutionalize natural cesareans; therefore, they became the default protocol. Attending pediatricians were on board immediately with gentle cesareans. On the other hand, resident pediatricians were not informed of the protocol change; thus, they still wanted to take the babies right after birth, to clear them, to put them on the examination table. It was hard for them. There was little or incomplete training from attending pediatricians. Now, we are training resident obstetricians to perform natural cesareans. I try to explain to residents that even if the woman has an epidural during the surgery, we pull and push on her stomach and she can feel everything, even if there is no pain. Regarding extracting the child, we have to be gentle; this is not a Kinder Surprise

Egg![7]

Now natural cesareans are well established in the hospital, even if there are variations among the staff, and not everyone performs them the same way. Some colleagues are not entirely at ease with the technique and they don't integrate all its components. It is also probably easier now that I am the head of the obstetric unit. I have more influence than before [at Vevey]. Members of the medical staff from hospitals located in French-speaking Switzerland often contact me about natural cesareans. They attend gentle cesareans births to perform them in their institutions. The other day, one physician asked me, “Why have I never done this before?” However, when I present the natural cesarean protocol at national medical conferences, there is still a lot of reluctance, in particular from physicians working in university hospitals, for example, anesthetists or neonatologists. They are often quite condescending with our team because we are based in a regional hospital. They tell me that it would not be possible for them to perform gentle cesareans because they attend premature births. But in fact they have few preterm births compared with full-term ones. I think a relatively small percentage of premature births is not an acceptable reason for refusing to perform natural cesareans. Indeed, there is *no* acceptable reason! It is even possible to perform a gentle cesarean in cases of emergency situations.

I hope that what we are doing at the HRC can help grow a new generation of obstetricians. Although my colleagues at CHUV do not perform gentle cesareans, we are collaborating on other important aspects to improve work conditions in maternity wards. For example, with my colleague David Desseauve [associate physician and head of laboratory at CHUV], we have been able to introduce some hours of the Team Stepps training[8] in the Swiss French-speaking medical school, and we are also training some attending physicians. We hope that this can improve things on both sides by addressing the issue during training and with attending physicians: to make teamwork more reliable, to adequately coordinate and avoid adverse medical events.

Irene: Do you think that natural cesareans also have an impact on the medical staff and on the atmosphere in the operating room?

Alexandre: As I already said, I was bored during cesarean sections. You rarely get a surprise. When I started doing natural cesareans, what I saw touched me. Parents' reactions, the expressions on their faces affected me. This is what made it possible to transform the cesarean section into childbirth. Furthermore, this is contagious—you can see it when you attend this kind of birth – everybody is happy. Natural cesarean is different also for the medical team. For cesarean sections to become childbirths requires a shift in the team culture—that is, [to see birth as] an important event and not a technical routine. It brings humanity to the operating room, because otherwise, it is technical. It is surgery: we are cutting meat. And, based on my experience, I can say that the humanization of the operating room has a positive impact on the morbidity rate and the patients' recovery.

I wonder if it affects [other] surgeries. There are changes occurring. Some anesthetists use hypnosis. They speak to patients; they prepare them. Before natural cesareans, few anesthetists were interested in obstetric patients' experiences. Now they all look at them and interact with them during surgery. They are more present in general. One surgeon told me that natural cesareans have changed his approach to other surgeries under epidural anesthesia. He wants to lower the surgical drape to keep eye contact with the patients. I believe that natural cesareans can help build a new culture of the relationship between the medical team and patients.

Irene: During prenatal consultations, I observed that some women asked to be informed at each step of the cesarean procedure during the surgery. How do you address these demands?

Alexandre: I think they do not actually want to be informed step by step, but just be reassured… If I told them, "I cut the skin, I move apart the abdominals," and so forth, I do not think it would be helpful nor reassuring. I just give them general information, not the details of the technical actions performed. The tone of your voice is very important.

Caroline: There are different elements constituting natural cesareans. What is important in your opinion?

Alexandre: I believe that natural cesarean is primarily based on respect for the child's birth: it is a newborn, a little human who comes to life and we have to respect this moment. It is also a matter of humanity…or rather humanism. It is also a question of respect towards parents, for whom this birth is an extremely important moment. There is an inconsistency between the way we consider the baby before birth as an extractable fetus and what it eventually becomes—a lovely baby. For example, sometimes when you use forceps, you have to pull very hard, and you apply this pressure on a little baby. Whereas, once babies are in the cradle, you hardly dare to touch them anymore. Many doctors who handle them rather roughly at birth are uncomfortable taking babies in their arms when they are in their bassinets. There is a sort of disconnection. The same disconnection happens in surgery. There are times when you have to take a medical rather than a human posture. We are in the action and we do not think about what we are doing. We turn into technicians. There is a disconnection also in obstetrics: we do not realize and we do not want to realize. However, this disconnection has to stop at a certain point; we have to return to this child's birth. We have to respect her or him, going at her or his pace. Natural cesareans contribute to restoring this connection.

Caroline: I was wondering, what do you think of the proposition made to women that they push to deliver their baby in the natural cesarean protocol? Is it helpful for obstetricians?

Alexandre: From a medical point of view, there is no point. It is useless. It is symbolic. At the beginning, it was part of the natural cesarean procedure, so I did it. I wanted to observe if pushing was effective and I asked several patients to do it. I realized that it has little effect on the baby's presentation. However, I had positive feedback from several patients who said, "Thank you for letting me push." They told me it was super important for them. So, I keep doing it.

Irene: Regarding the post-partum period, did you observe some changes in parents' experiences and recoveries since the introduction of natural cesarean?

Alexandre: I have the feeling that yes, there is a change. Before, no one ever wanted to return home the day after surgery. I feel that the parents' experience is different compared to when I was doing standard cesareans. Some patients thank me and tell me, "You healed me from my previous delivery." They also said, "It's so great to have my baby skin-to-skin right after birth!" I know that for them, seeing the birth or having their baby immediately, skin-to-skin, are fundamental elements. I have much more positive feedback with natural compared to standard cesareans.

Discussion

Medical training tends to encourage future physicians to distance themselves from their feelings and to avoid dealing with patients' emotions (Davis-Floyd 1987; Davis-Floyd and St John 1998; Davis-Floyd 2018a). Breaking from "cold obstetrics," which Davis-Floyd (2018b) would call "technocratic obstetrics," the gentle cesarean procedure as Alexandre and his colleagues perform it acknowledges the importance of emotions in obstetrics—those of the patients and those of the staff. From this perspective, gentle cesarean and the humanization of the operating room can potentially reconfigure the relationships among health professionals, parents, and child. It partly disrupts the technocratic hierarchy and the subordination of the individual to the institution and to the practitioners representing it (see Davis-Floyd 2022). Natural cesareans also produce better health outcomes, as women's recoveries can be easier or at least better experienced. This could explain why parents who have experienced gentle cesareans often leave the hospital only one day after the operation, according to the data collected at HRC. The empowerment they feel from their gentle cesarean births may make them less dependent on hospital recovery care. However, as each

practitioner reinterprets the procedure of natural cesarean in their own way, there are significant variations in the ways it is performed, and normative behaviors that comply with the operating room requirements and protocols are still expected from parents (Maffi 2013).

Gentle cesarean proponents generally emphasize the parents' perspectives; the procedure is presented as a "woman-centered technique" (Smith et al. 2008). Our volume lead editor Robbie Davis-Floyd adds a personal note here:

> When my 26-hour labor with my first child, during which I felt completely embodied, ended in a cesarean, I was beyond shocked at the sudden and total mind-body separation I experienced when the epidural took effect. This separation was also visual: I could not even *see* the body that I could not feel. Being "awake and aware," I asked the obstetrician to *please* place the curtain blocking my view above my head, so that I could bear witness to the birth of my daughter, but this was in 1979—a time when such a concept was "beyond conception." I would have given anything to have a gentle, "natural" cesarean like the ones described in this chapter!

Interestingly, Alexandre also insists on the importance of newborns' experiences. Indeed, gentle cesareans include a set of procedures aimed at easing the baby's birth experience in line with the child-centered approach that the French pediatrician Frédérick Leboyer developed more than 40 years ago, in 1974. This approach includes dimming the lights, allowing babies time to establish respiration while still connected to the placenta—a process that Smith, Plaat, and Fisk (2008) called "autoresuscitation"—and placing babies on their mothers' chests as soon as possible, thereby enabling them to initiate breastfeeding in the operating room. As Alexandre stated, in contemporary obstetric culture, physicians are usually alienated from their patients, both women and babies (see also Davis-Floyd 2018b, 2022). The ways in which obstetricians consider and handle babies at the

time of birth contrast with their attitude toward them once they are dressed and lying in their bassinets—in other words, once they appear as members of the society rather than naked, not yet socialized bodies. Before the inscription of the baby's body into the social environment of the hospital, "newborns are considered in many cultural contexts to be unripe, unformed, ungendered, and not fully human" (Kaufman and Morgan 2005:317). This is true also in Swiss maternity hospitals where, as Line Rochat (2017) has shown, an important part of nurses' work in the neonatology intensive care unit consists of helping the parents to bond with their premature or sick child. Although the socialization process and the humanization of the care of sick or premature babies may be extreme cases, they nevertheless very well show the work usually performed in ordinary postpartum care. This work—usually entrusted to nurses and midwives—consists of helping to create a strong affective and physical bond between the mother (much less the father) and the baby. Mothers must devote themselves entirely to their babies to abide by the norms of the "good mother" and avoid being criticized or even pathologized by healthcare providers. In the Swiss NICU where Line Rochat conducted her doctoral research (2019), mothers had to spend days, sometimes months, at the sides of the incubators in which their babies were struggling to survive. They regularly had to pump their milk, touch their babies, speak to them—in short, to forget their personal life and wellbeing, and even their other older children and partner, to build the bond considered as necessary to adequately care for the hospitalized child. No other family members, not even the father, were exposed to this social and medical pressure because they were not seen as playing a primary role. Although in the mentioned NICU the (often) dramatic health conditions of the babies emphasized mothers' sacrificial role, this norm was clearly also present in the regular postpartum department of the same hospital (Rochat 2019; Chautems and Maffi 2021).

The attitudes of medical staff toward women during standard cesareans reveal a deep disconnection that is both symbolized and reinforced by the surgical drape. The woman's head, representing her social personhood, is visually and physically separated from her abdomen, which

becomes a piece of meat that the obstetrician can dissect. This disconnection allows the staff to discuss personal and often insignificant subjects during the cesarean, completely ignoring the woman's personhood and feelings, and that the cesarean is the birth of a child and a most significant event for the parents, as Alexandre described. Removing the surgical drape and making eye contact between the staff and the woman during natural cesareans completely transforms their relationships: attention to the parents, respect for the importance of the moment, and the space in the operating theatre all reinforce the importance of the parents'—and especially the mother's—emotions.

Conclusion: Spreading Natural Cesareans

On a broader scope, Alexandre's professional trajectory sheds light on some specific features of Swiss obstetric training. For example, unlike the French training, the Swiss training includes a list of mandatory surgical procedures—an "operating catalogue"—with a determined number of qualifying surgical acts that must be performed before graduating. This requirement both reflects and reinforces a technocratic and interventionist obstetric culture in which relational aspects and parents' experiences are secondary. Alexandre's reflexive account of his journey and his commitment to a humanistic approach to obstetric care challenges Swiss dominant obstetric culture. Alexandre's and other obstetricians' adoption of gentle cesareans contributes to reinforcing this practice, which is now spreading locally in French-speaking Switzerland and is also being adopted in other parts of the world as other obstetricians and parents become aware of its value.

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Endnotes

[1] Onsea et al.'s (2018) comparative study of experiences with "standard" and "gentle" cesarean is one rare exception. The authors concluded that gentle cesareans may improve parents' satisfaction.

[2] The project's title is "Parents' experiences of surgical birth. A socio-anthropological study of cesarean culture in Switzerland" and is funded by the Swiss National Science Foundation (project number 10001A_197393) for four years (2020-2024). Two hospitals are partners of the project: the University Hospital of the Canton of Vaud and the Hospital Riviera-Chablais.

[3] Lyon is one of the largest cities in France and is located in the central-eastern part of the country.

[4] Alexandre here mentions the Hospital Le Samaritain, which used to be located in Vevey. In 2019, following a large merger involving 5 regional hospitals, Le Samaritain and another small-sized hospital closed and their teams were displaced to a new site. Alexandre Farin has been the head of the obstetric unit since the opening of this new interregional institution Hospital Riviera–Chablais in Rennaz in 2019.

[5] Vevey and Morges are two small cities located on the shores of the lake of Geneva. Two of the hospitals where Alexandre did his internship are peripheral hospitals serving a small population.

[6] Fetal therapy for issues like allommunization and certain congenital anomalies, such as fetal myelomeningocele, have risen over the past 50 years and are commonplace within high-risk obstetrical practice. Here, ultrasound remains critical for detection and counseling (see e.g., Bianchi et al. 2010).

[7] The Kinder Surprise Egg is a hollow chocolate egg that contains a plastic capsule with a small toy inside.

[8] The Team Stepps training is an international program promoting strategies and tools to improve patient safety and the reliability of collaborations and teamwork to avoid adverse events.