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Increase in Cesarean Sections: Autonomy of "Choice" or Logic of Care?

Opinion
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Opinion

Medical explanations for the increase in Cesarean section rates worldwide are often based on the justification of women's desire and request, as shown by studies from the United States [1,2], Great Britain [3] Thailand [4] Australia [5] and Brazil [6] among others. Of the American doctors in Maine, 84.5% agree to perform or tend to perform a Cesarean section on request [2], while 71% of Brazilian doctors readily accept the request for a Cesarean section [7].

Studies indicate an increase in cesarean sections on request, with the percentages attributed to this portion of elective cesarean sections varying between 20% in the United States [1], 17.5% in Taiwan [8], 13.5% in Canada [9], and 6.1% in Nigeria [10]. Some articles dispute the growth in demand for cesarean sections in South Korea, with cesarean rates around 40%, where more than 95% of women surveyed said they preferred natural birth [11]. Something similar is seen in Bangladesh, although 98% of the women surveyed reported preferring a natural birth, only 48% of them had a vaginal birth [12]. In Brazil, in a private service, although 70% of the women did not initially show a preference for a cesarean section, 90% of them gave birth this way [13]. In this study, the authors conclude that, despite the women's initial desire, the interaction with the health service resulted in cesarean section being the most common type of birth.

In these contradictory narratives, it is clear that something occurs between the woman's initial request for a natural birth and the final result. What happens in this gap between the expression of the request for a natural birth at the beginning of the pregnancy and the birth? What impacts the subjective production that produces the change in demand or the acceptance of another outcome?

However, the doctors say they listen to the women's request and they listen to the request for a cesarean section. The women say they were asking for something else. Even though they start with opposing desires, women comply and accept the final outcome of a cesarean section. It is clear that, in the end, there is no questioning. What is clear in the mismatch between the desire expressed by women and what doctors hear is that what is not related in this listening process is the other! Heckert will call "deaf listening" those practices that listen without listening. A listening reduced to the protocol act, an evidence-gathering technique based on the scientific precepts of neutrality, which treats its procedures in a naturalized way and "which produces the effect of protecting and blaming the subjects, since it speaks for, speaks of, in the name of, instead of speaking with the other" [14]. The doctor claims to have heard the request for a cesarean section, prescribes a surgical delivery and, in this role as a specialist/holder of technical and neutral knowledge, after analyzing and "understanding" the women's needs, it is up to him to indicate the paths of care, reserving the woman as the object of his action. Foucault states that the exercise of power is a way of action by some over others:

It operates on the field of possibilities where the behavior of the acting subjects is inscribed: it incites, it circumvents, it facilitates or makes more difficult, it broadens or limits, it makes more or less likely; at the limit it constrains or completely prevents; but it is always a way of acting on one or more acting subjects, while they act or are susceptible to acting. An action on actions. (1995, p. 11). From the perspective of maternal demand for cesarean section, some studies discuss the right to female autonomy in being able to choose the procedure that will be performed on her body, as in the American article [15] or in the English one [16]. Studies from Thailand [17], Australia [18] and Brazil [19] present women's preference for cesarean section as an attempt to have greater control over the experience of giving birth, to be able to choose where and when the birth will take place, as a demonstration of high social status and, often, resulting from an active search for a professional who will agree with the indication. This alternative is not

available to every woman. In Canada, the work of Munro, Kornelsen and Hutto [20] concludes that, although the number of women who require a cesarean section is still small, the persuasive influence on the patient of positive stories of cesarean sections and negative stories of normal births should be considered. They warn of the impact of social influence on women's decision to choose the mode of birth.

The work of Americans Leeman and Plante [15] problematizes the increased pressure for cesarean sections in the absence of medical indications, which, in fact, instead of increasing the possibilities of choice, resulted in a reduction in birth options and, according to the authors, requires actions that preserve normal birth as an option as much as cesarean sections.

The most frequent motivation for choosing a cesarean section in Italy was the safety of the baby [21], that is, the construction of risk and threats continue to be used as virtualities that provoke "decisions" in emergencies.

An elective cesarean section does not disrupt the office schedule, requires fewer hours for birth assistance, avoids call-outs on weekends and at night, and control and control are centered on the doctor and his/her convenience. "There is no doubt that, even if unnecessary or even if it involves greater risk to the mother or newborn, an elective cesarean section poses much less risk to the doctor" [22].

In Brazil, having access to a cesarean section is equivalent, in the social imagination, to having the power to consume technology, to having socioeconomic power. There are more lawsuits and ethical lawsuits for not having performed a cesarean section earlier than for having performed an elective cesarean section [3,22]. The medicalization and judicialization of life go hand in hand.

Health professionals, pregnant women, their families and Brazilian society in general are exposed to Christian culture and its dogmas. "You will give birth in pain" is a prediction repeated at many moments during normal birth care, in different and threatening ways, while a cesarean section is presented as the alternative for pain-free birth. This fallacy is constructed, among other things, by the lack of analgesia in natural childbirth. Even so, 90% of women claim to prefer natural childbirth [6], causing a disagreement with the doctors' narrative regarding what women want, since 81 to 85% of doctors believe that women prefer a cesarean section. What discursive and non-discursive practices affirm this dissonance between women's preference for a cesarean section and the personal interests of obstetricians? McCallum [19] responds that a broad spectrum of factors converge to support this practice and that no group, in particular, is responsible for the excessive use of cesareans as a form of childbirth. All subjective production is a living and changing process of production that occurs on a plane of power relations and power relations present in the field. There is a reciprocal relationship between the production of subjectivities and discursive and non-discursive practices, because "if the human being is caught up in relations of production and relations of meaning, he is also caught up in relations of power of great complexity" [23]. In addition to understanding cesarean sections as "women's requests", doctors support the indication using justifications such as protecting sexual function by preventing pelvic floor disorders. The article by Murad-Regadas [24] studied the association between pelvic floor abnormalities and obstetric trauma through a retrospective study of 255 women with complaints of constipation, and no relationship was identified between the distribution of pelvic floor disorders and the type of delivery. But the argument that female genitals will be preserved is quite appealing in a society where body image and sexuality play such a strong role in the production of the imaginary and in the hegemonic production of a "Brazilian subjectivity". This has been quite effective in associating cesarean sections with high-quality childbirth care, a sexist idea that corroborates the distance between reproductive rights and sexual rights.

In the logic of "choice", as worked by scientific literature, epidemiology would gather research on the effectiveness and efficacy of treatments, presenting the best means to achieve a previously chosen end. But when research, understood as tools that would increase knowledge about the means available to medicine, presents interventionist technologies as more effective and efficient, would there be room for choice?

The understanding of care that we are articulating in this work is that of the logic of care, as proposed by Mol [25] in which care is an interaction in which the action goes back and forth in a continuous process. It is the sharing of responsibilities between the team, the woman and her social network. The team that accompanies a woman during pregnancy and childbirth integrates into the social support network that already exists in that woman's life and begins to build the path based on both the specificities of the situations and the singularities of the woman that present themselves along the way. Care is the willingness to explore the various possibilities and possible paths to comfort and health, in each situation. It requires knowledge, experience, but even more sensitivity, persistence and attunement to experience.

Care is not about implementing knowledge or technology abstractly, prior to the process, but about experimenting with their uses and adaptations in the path of care for that specific woman. Using technology requires the team to adjust to the variables that arise in each situation, and tuning into the 60 variables means discovering what is best to be done at each moment and discovering together, the woman, the team and the social network authorized by her, the best path to be taken.

The autonomy encouraged in the logic of care, proposed by Mol, does not occur despite the modifications and overlaps of the points of incidence of power in its massive action on the "body-species", generating modulations that make various mechanisms that attempt to manage life work. In the logic of care, the woman is called to be active. However, even the woman who seeks humanized care for her birth, who is active in seeking the team, who studies the subject, who prepares her body, who decides on the hospital, despite all these activities, she does not control the world. The world is not obedient to her. It is necessary to grasp this experience of the production of autonomy in its in-between, on a threshold level, of that which deviates and affirms the experience of the lived.

In the confrontations and resistance movements in favor of female protagonism, we can see that there is, therefore, a demand for the "right to be heard" and "the right to choose", often forming the demand for assistance based on the logic of choice identified as women's autonomy. According to Mol [25], in the logic of choice there is an illusion that women would become more active since they would be called upon to choose and know what they choose. By making their choices, women would become masters of their lives, emancipated, free from patriarchy. In the logic of choice, women are the ones who make the decisions and take responsibility for them, bearing on their shoulders the consequences and vicissitudes of the birth process. Mol [25] tells us about two versions of the logic of choice: the market version and the citizen version. In the logic of the market, people are questioned as consumers who can choose the product they want. Women are clients and assistance is exchanged for money and must follow the client's demand. The choice is for the end: in the case of pregnancy, the choice is for the type of birth that will result from the care. In the logic of the citizen version of choice, the woman transforms from a client into a user of the service and the relationships between people are mediated by laws, ordinances and contracts that advocate rights and duties that the parties involved must respect. The contracts, in this version, would aim to resolve medical authority by encouraging the emancipation of women, as a way of celebrating autonomy as participation, even if contractual, in the process. Here, too, the choice is made in advance, by the final product: contracting the type of care and procedures to be received.

We do not believe that the "option to choose" as advocated in the two versions is a proposal that advances female protagonism during childbirth care and we will try to articulate this position throughout the work.

The logic of care that we believe in here affirms care as interactive, as an open process that is shaped and remodeled depending on the events and challenges experienced during its course. Thus, the logic of care is more in tune with the difficulties and challenges of the process than with the outcome of a normal or surgical birth. In the logic of care, fragility is seen as part of life. Managing care means being concerned with specific problems, of specific women, in specific conditions. In this logic, care practices involve the transmission of ideas, questioning, trying to reassure, building the path together, showing solidarity and not giving up. The quality of care is not measured only by the result, but by the path taken, by the persistent effort to seek comfort and support in the various situations presented in the birthing process. In the logic of care, identifying a type of birth to be achieved is not a condition for care, but rather part of the care in which attention and specification are sought and negligence is avoided. It does not oppose technology, but includes it. It is not a product that changes hands, but a question of several hands working together for an experience of life power [25].

Mol [25] warns that the use of the word logic does not mean that all practices are coherent and that everything within them is defined. The logic to which we refer is incorporated in discourses, materialities and articulated practices that are updated in a historically and socially located way. The social field as a locus of materialization of discursive and non-discursive practices, in its permeability to the discourses present in scientific articles, allows us to look at childbirth care from the assumption of the connection in which scientific fields and other social fields are anchored. It was possible to perceive in this study, through scientific texts, and, as we will see later, in the media, the supremacy of the proposal of the logic of choice "disguised" as an emancipatory proposal of the condition of passivity of women in the face of the medicalization of childbirth. In the survey of scientific articles about cesarean sections in various countries, conducted by Barros [26] we sought to think of them as narratives, as ways of making people see and talk about specific practices in surgical birth. These, in their positivity, update techniques and forms of knowledge and wisdom, formalizing realities and the world. This macropolitical survey made it possible to perceive and investigate the heterogeneity of normative rationalities about cesarean sections, present in their contradictions, gaps and differences.

The results of scientific articles in the area often produce conflicting and divergent conclusions, which calls into question the discourse of scientific evidence so widely disseminated as truth about the reasons that qualify the prevalent use of cesarean sections. We were also able to perceive gaps between these conclusions, with regard to the mechanisms that regulate these practices and the places that sexual and reproductive rights occupy in the area of childbirth care.

Some of the ways to radically change the nature of the birth event itself are to link the type of birth as an easy surgical procedure, the date of birth of the baby to the configuration of the stars or to a certain genetic or ontogenetic transmission of how the woman herself was born. It is also to make it seem that surgical birth preserves intact a part of the body responsible for sexuality or to present the procedure as an absence of pain or suffering.

Studying cesareans reflects the healthcare model offered in the country, but it also seeks to discuss the global scenario of cesarean sections as an effect of processes of compositions and associations that involve all the elements present – doctor, parturient, baby, social network, available technological resources – and that give them modular and diverse forms.

In recent years, there has been a change in the way health services are offered and the doctor-patient relationship is promoted, but this change was only a modulation in the way power was exercised. In the past, a paternalistic relationship was common, in which the doctor held the power to indicate and choose a procedure, independent of the user's participation in the selection process. With the increase in the population's education levels and based on the development of ethics and bioethics, there was a shift in the place of power with increasing support for the subject's "autonomy" over their body. This autonomy understood as the possibility of choosing between given options became synonymous with "individual choice" and this began to be valued as a great ideal in health care, as a liberating advance from the type of care that produced subservience. Instead of the doctor saying what is best for the course of childbirth, women would have this right.

But what autonomy are we talking about if our "autonomous" decision is a priori shaped by preconceived information from professionals, by the lack of information about the birthing process, by the growing insecurity in the physical capacity to conduct the process, by the absolute transfer of responsibility to health professionals and by the miraculous promises of speed, preservation of the sexual organ and pain relief? What autonomy can exist if the price for a choice other than the "recommended" one is the risk of being held responsible for any problem and even for the death of one's own child? The exercise of autonomy is also in conflict with statements and signs that guide everyday beliefs in a liberal bias in which autonomy is affirmed as the capacity to fully develop one's individual vocations and potentialities. By accepting this autonomy, are women signing up for all responsibility for the outcome?

Within the logic of choice, scientific knowledge is taken as a collection of facts that gradually increase certainty and security. Professionals would need to have access to these truths and also be encouraged to produce more truths. According to this logic, all scientific truths would be framed within a rationalist repertoire and within a perspective that science would be neutral. Values would be freely placed by women who, by taking stock of the pros and cons, would make their choices [25]. In the logic of choice, all fluidity is located at the moment the choice is made, but a good choice necessarily depends on the balance between advantages and disadvantages, like accounting. It is as if decision-making occurred through a mathematical calculation of pros and cons. Even in this logic, the "autonomy" for decision-making is limited: a woman cannot choose against her own existence or that of her baby. There is a framework in which options are available and which, therefore, frame the range of emancipation. What type of information will be available? What type of technology would not be a matter of choice for an individual woman's choice? What research issues were valued? And why these and not others?

Feeding this belief, there are narratives that coexist to organize "free choice" in terms of safe/unsafe; order/disorder; life/death; all with ontological meanings and that produce and laminate a maternal identity in women as good/bad [27]. The (neo)liberal obligation to manage risk and achieve success for both mother and baby means that women are obliged to choose what is presented as the most obvious and sensible option: planned and safe cesarean sections.

Biopower is not imposed, but is a control through women's adherence in the name of health, through the sale of values, in order to foster voluntary servitude. People assume these divisions as truths, in their ways of existence in which the desire for "quality" health care has as signs of equivalent value the ability to consume technologies. Some will "voluntarily adhere" to the purchase of a cesarean section and defend their right to "choose," denouncing a logic of care through choice, whether in the market version or in the citizen version!

Therefore, we agree here with Mol [25], when he states that the logic of choice is a type of care that abandons the woman, offering her no support or assistance. Once the choice has been made, the only thing

left to do is to implement the chosen end and all responsibility for the consequences will fall on her shoulders. Even in its most democratic implementation, in which the professional is qualified to handle a large amount of information, has a lot of experience in childbirth care, and is able to act competently in the direction chosen by the woman, the emphasis is still on choosing an end.

This functioning is affirmed and produces a logic of care in which time is linear: facts (neutral) – choice (valuative) – action (technical). Women start to manage the care they want and doctors are left with its implementation. Thus, it is no wonder that some doctors end up offering great opposition to the women's movement for the humanization of birth. In the logic of choice, there would be a transfer of power from the doctor who decides to the woman who chooses, in a linear relationship.

Perhaps this invitation permeated by individual responsibility is so difficult that many women prefer that doctors make the choices for them. "What do you think, doctor?" "What would you do if it were your child?" This type of assistance also disregards the imbalance that constitutes the power relations of hierarchical and exclusionary relationships of technical-scientific specializations. In the space that exists in the relationship between doctor and patient, exchanges occur that are not very clear and, despite numerous doctors reporting the increase in cesarean sections on request, we understand that it is urgent to discuss the way in which assistance is offered, and how women understand this assistance.

The way in which a woman will evaluate her birth as having been normal or physiological will depend on numerous arrangements that occurred during the care, on her way of being and existing in the world, on the processes of subjectivation that occurred, on the power of the information received in her relationships with the scientific medical power-knowledge presented by the obstetrician, on the way in which she relates to figures of power... In addition, the social and historical context of each place, the access to different types of care and technological resources produce different processes of subjectivation. We need to discuss the arrangements that occur inside doctor-patient relationship.

References

1. Coleman VH, Schulkin J, Lawrence H (2009) Rising cesarean delivery rates the impact of cesarean delivery on maternal request. Obstetrical and Gynecological Survey 64(2): 115-119.
2. WAX JR, Angelina C, Michael GP, Jacquelyn B (2005) Patient choice cesarean the Maine experience. Birth 32(3): 203-206.
3. Farine D (2010) Cesarean section and operative deliveries: the medical legal challenges. Journal of Maternal-Fetal and Neonatal Medicine 23(1): 20-21.
4. Chanthasenanont A, Densak P, Tongta N, Charintip S (2007) Indications for cesarean section at Thammasat University Hospital. Journal of the Medical Association of Thailand 90(9): 1733-1737.
5. ROBSON SJ, Woo ST, Adebayo A, Keith B (2009) Estimating the rate of cesarean section by maternal request: anonymous survey of obstetricians in Australia. Birth 36(3): 208-212.
6. Faúndes, A, Karla S, Maria JDO, José GC, Maria HS (2004) et al. Brazilian women and physicians' viewpoints on their preferred route of delivery. Revista de Saúde Pública 38(4): 488-494.
7. Ferrari J, Lima NM (2010) Atitudes dos profissionais de obstetrícia em relação à escolha da via de parto em Porto Velho, Rondônia, Brasil. Rev bioét (Impr.) 18(3).
8. Chu KH, Chen JT, Chun SH, Mei CY, Li YC (2010) Women's preference for cesarean delivery and differences between Taiwanese women undergoing different modes of delivery. BMC Health Services Research 10:138.
9. Chalmers B, Janusz K, Elizabeth D, Maureen H, Deshayne BF, et al. (2010) Maternity experiences study group of the Canadian perinatal surveillance system cesarean and vaginal birth in Canadian women: a comparison of experiences. Birth 37(1): 44-49.
10. Aziken M, Omo-Aghoja L, Okonofua F (2007) Perceptions and attitudes of pregnant women towards caesarean section in urban Nigeria. Acta Obstet Gynecol Scand 86(1)11: 42-47.
11. Lee SI, Khang YH, Lee MS (2004) Women's attitudes toward mode of delivery in South Korea: A society with high cesarean section rates. Birth 31(2): 108-116.
12. Begum, B, Rashid UZ, Ashequr R, M Saifur R, M Kamal U, et al. (2009) Comparison of risks and benefits of normal vaginal and caesarian section deliveries in a public tertiary hospital in Bangladesh. Mymensingh Medical Journal 18(1): 12-14.
13. Dias MAB, Rosa MSMD, Ana PEP, Sandra CF, Silvana GNG, et al. (2008) The decision of women for cesarean birth: A case study in two units of the supplementary health care system of the State of Rio de Janeiro, Ciência e Saúde Coletiva 13(5): 1521-1534.
14. Heckert ALC (2007) Escuta como cuidado: o que se passa nos processos de formação e de escuta? In: Pinheiro R, Mattos R. A. de. (Org.). Razões públicas para a integralidade em saúde: o cuidado como valor. Rio de Janeiro: Abrasco 199-212.
15. Leeman LM, Plante LA (2006) Patient-choice vaginal delivery? Annals of Family Medicine 4(3): 265-268.
16. Ching R (2006) Should women be able to choose caesarean section? South African Journal of Obstetrics and Gynaecology 12(2): 84-87.
17. Liamputtong P (2005) Birth and social class: Northern Thai women's lived experiences of caesarean and vaginal birth. Sociology of Health and Illness 27(2): 243-270.
18. Mcgrath P, Ray-Barruel G (2009) The easy option? Australian findings on mothers' perception of elective Caesarean as a birth choice after a prior Caesarean section. International Journal of nursing Practice 15(4): 271-279.
19. Mccallum C (2005) Explaining caesarean section in Salvador da Bahia, Brazil. Sociology of Health and Illness 27(2): 215-242.
20. Munro S, Kornelsen J, Hutton E (2009) Decision Making in Patient-Initiated Elective Cesarean Delivery: The Influence of Birth Stories. Journal of Midwifery and Women's Health 54(5): 373-379.
21. Mancuso A (2006) Women's preference on mode of delivery in southern Italy. Acta Obstetricia et Gynecologica Scandinavica, 85(6): 694-699.
22. Martins CSH (2002) Cesarianas: indicações. In: Federação Brasileira Das Sociedades De Ginecologia E Obstetrícia. Projeto Diretrizes. Brasília: Associação Médica Brasileira; Conselho Federal de Medicina.
23. Foucault MO (1995) sujeito e o poder. In: Dreyfus H, Rabinow P. Michel Foucault – uma trajetória filosófica: para além do estruturalismo e da hermenêutica. Rio de Janeiro: Forense Universitária 231-249.
24. Murad-Regadas SM (2009) Does mode of delivery correlate with the incidence of pelvic floor disorders? Colorectal Disease, 11(1): 40.
25. Mol A (2008) The logic of care: health and the problem of pacient choice. New York: Routledge.
26. Barros (2015) Monalisa Nascimento dos Santos. Reconfigurando um modo de ver o parto / Monalisa Nascimento dos Santos Barros. – Tese (Doutorado) – Universidade Federal Fluminense, Instituto de Ciências Humanas e Filosofia, Departamento de Psicologia.
27. Bryant J, Maree P, Sally KT, Elizabeth AS (2007) Caesarean birth: consumption, safety, order, and good mothering. Social Science and Medicine 65(6): 1192-1201.

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