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Mode of delivery: confusions between choice and autonomy

Via de parto: confusões entre escolha e autonomia

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Abstract

This study aimed to investigate individuals' understanding of the relationship between autonomy and the choice of mode of delivery. The researchers conducted a qualitative study using a collective case study approach, analyzing 30 birth accounts published in personal blogs about experiences with pregnancy, childbirth, and parenthood. The results indicate confusion between the notions of choice and autonomy in childbirth among the parents whose accounts were analyzed. Considering that a cesarean section should only be performed when medically indicated, the findings suggest that framing the procedure as a matter of choice to comfort parents legitimize the notion of the cesarean section as a consumer good. At the same time, the study highlights the importance of clinical listening during prenatal care, which can help identify cases where a cesarean section is preferred due to emotional factors.

Keywords: Cesarean section; Childbirth; Humanizing delivery.

Resumo

O objetivo deste estudo foi investigar a compreensão dos sujeitos acerca da relação entre autonomia e escolha da via de parto. Trata-se de uma pesquisa qualitativa por meio de um estudo de caso coletivo que analisou 30 relatos de parto publicados em blogs pessoais sobre experiências de gravidez, parto e paternidade. Os resultados evidenciaram confusões conceituais entre escolha e autonomia por parte de pais e mães. Considerando que a cesariana deve ser realizada apenas mediante indicação clínica, conclui-se que compreendê-la como objeto escolha, com a finalidade de tranquilizar os sujeitos envolvidos, contribui para sua legitimação como bem de consumo. Destaca-se, ainda, a importância da escuta clínica durante o pré-natal, capaz de detectar indicações de cesariana relacionadas a fatores emocionais.

Palavras-chave: *Cesárea; Parto; Parto humanizado.*

Culture and knowledge take on specific forms in each social context. Today, as a product of the Modern project, but also of individualism and capitalism, the illusion of absolute autonomy – of a man self-constructed – has been disseminated. To sustain this notion of man, relationships have become colder and more distant, with individuals increasingly focused on themselves, their work, and daily activities – that is,

growing more distant from family and friends, from those with whom they share meaningful bonds (Bauman, 2001; Castells, 2010/2018; Elias, 1987/1994; Giddens, 2012; Hall, 1992/2015; Honneth, 2015; Santos, 2013). A much less humanized man, as Oliveira et al. (2006) put it.

Technological advances in healthcare bring benefits but also contribute to dehumanizing practices. The use of technology, objectivity, and scientific rigor, as presupposed in the technocratic paradigm of healthcare, eliminates speech as a fundamental human condition. The technical act strips speech of its dignity by objectifying and depersonalizing it, reducing it to a mere exchange of information in a cold and objective investigation. The human aspect of interactions, symbolic par excellence, is often left out. Thus, the primary dehumanizing aspect of the technocratic paradigm is the avoidance of speech, which constitutes a fundamental element of humanization-driven care (Matos, Magalhães, & Monteiro, 2022; Oliveira et al., 2006).

The humanized birth paradigm emerged as an effort by healthcare professionals to reform care from within the medical system. Humanizing care involves ensuring space for speech – both that of the patient and the professional – so as to establish a network of dialog based on mutual respect and recognition. In this context, healing is understood as arising from the encounter between what comes from within and what comes from outside. Often, the initial complaint masks an underlying issue. Thus, knowing how to listen to the patient is as important as knowing what to say. Healthcare professionals must be able to listen not only to the initial complaint but also to what underlies it so that both professional and patient can collaboratively outline the course of treatment. It is through this attentive listening that the sense of autonomy can be fostered. Empowerment and dependency are intertwined in the professional-patient relationship, making their encounter a powerful opportunity for promoting autonomy (Davis-Floyd, 2001; Matos, 2021).

According to Tavolaro and Tavolaro (2011), the Humanized Childbirth ideal emerged as a consequence of the notions of natural childbirth and the pregnant couple (Salem, 2007), which had been promoted in previous decades. These conceptions are associated with post-traditional values such as freedom, choice, desire, and autonomy, which are inherent to individualist ideology. Over time, these notions became aspirations among certain sectors of the urban middle class, and childbirth came to be seen as "a ritual demarcating the difference of those who sought to break with traditional family models" (Tavolaro & Tavolaro, 2011, p. 46).

Women's choice and autonomy are widely defended values within the humanization ideology (Lima & Freitas, 2020; Neves et al., 2022; Rocha & Ferreira, 2020), which underscores its individualist, post-traditional nature. Although this ideology stems from a social structure guided by a logic that grants individuals control over processes, Tavolaro and Tavolaro (2011) highlight the importance attributed to physiological aspects, which, according to them, position the body as an element constituting the experience of the self rather than something subject to shaping by subjectivity. In other words, when it comes to physiological processes, the notion of choice does not apply. Thus, some form of mandate – whether unconscious or biological – would remove childbirth from the realm of individual choice.

However, because it emerged within an extremely individualistic context, where the power ascribed to the self transcends the limits of what is possible, we consider the greatest risk of the humanization paradigm to be its fragmented assimilation. Specifically, through the concepts of freedom and individual choice, as if patients were solely responsible for determining their treatment while disregarding scientific evidence. Accordingly, this article aims to investigate individuals' understanding of the relationship between autonomy and the choice of mode of delivery.

Method

A qualitative research investigation was conducted using a collective case study approach (Stake, 2016), with data collected from personal blogs on the Internet. The aim was not to achieve an intrinsic understanding of each case but rather a broader understanding of the study object. This method was chosen to explore the social context through the experiences of individuals becoming parents in Brazil.

Participants

Participants were indirectly selected through birth stories they published in personal blogs – 15 written by men and 15 by women. All births took place in Brazil, and participants were from various regions of the country. In the analyzed blogs, data such as participants' age, place of residence, and social class were not available. However, most of the selected accounts described births that occurred in private hospitals or at home in large cities, suggesting that the parents who wrote these accounts were predominantly middle class. Participants' names were transcribed as they appeared in the blogs.

Procedures

The selection criteria were as follows: accounts had to be published in personal blogs and written by parents who wished to share their experiences online regarding pregnancy, childbirth, and parenthood. Additionally, the accounts could not be mere descriptions; rather, they had to convey each individual's perception and unique experience during childbirth. To enhance understanding of birth experiences, accounts of vaginal, natural, and cesarean births were selected. However, accounts of births involving children with syndromes or twin births were excluded. The objective of this selection was to ensure diversity without emphasizing particular conditions. The researchers selected the accounts between July 2016 and March 2017, using the following Google search terms: "*relato de parto*" (account of childbirth), "*blog de maternidade*" (maternity blog), "*relato de parto do pai*" (father's account of childbirth), and "*relato de parto blog de paternidade*" (fatherhood blog account of childbirth). There were significantly fewer birth stories written by fathers than by mothers, requiring the use of additional search strategies to locate them. To ensure that the accounts reflected contemporary childbirth experiences, only those published after 2010 were selected, as most of the current legislation was already in effect by then.

Data Analysis

The selected material was analyzed using categorical aggregation (Stake, 2016), in which recurring circumstances are grouped until a category can be formed. The categories of analysis were then defined. Eight categories of analysis emerged from the selected accounts. To address this article's objective, the category "Choice or Autonomy?" will be analyzed. The other categories were discussed in other articles (Matos & Magalhães, 2020, 2022, 2025; Matos, Magalhães, Cosmo, et al., 2021; Matos, Magalhães, & Féres-Carneiro, 2021; Matos, Magalhães, & Mello, 2022; Matos, Magalhães, & Monteiro, 2022).

Results and Discussion

Choice or Autonomy?

Notions of autonomy, freedom, choice, and desire, which are prevalent in contemporary society and discussed by authors such as Elias (1987/1994), Hall (1992/2015), Bauman (2001), Castells (2010/2018), Giddens (2012), Santos (2013), and Honneth (2015), were evident in the participants' accounts. The word choice appeared multiple times in parents' childbirth narratives, usually in relation to the mode of delivery: Cesarean Section, vaginal, natural. Is this truly a choice? Cesarean section is, or should be, a medical procedure reserved for complications during childbirth. Interventions performed during vaginal delivery are also medical resources intended for potential complications and, therefore, should not be considered elective. In this sense, natural childbirth would also not constitute a choice, as it is a recommended mode of delivery for healthy pregnant women.

However, the very classification of pregnancies as low, medium, or high risk – used in healthcare settings to determine the necessary medical infrastructure – presupposes that all deliveries carry some level of risk, even when both the mother and baby are in perfect health. This contributes to the dissemination of the technocratic model of care and reinforces the perception of cesarean section as a consumer good (Oliveira et al., 2022) – something that can be acquired according to individual preference. "I believe that every woman *must have the right to choose* [emphasis added], whether cesarean or vaginal childbirth, and not be judged for it" [Ana S.].

In discussing the concept of choice, Bauman (2001), Giddens (2012), and Santos (2013) emphasize the contemporary imperative of individual decision-making, given that, in general, social activities are now shaped by personal choices rather than traditions. According to Giddens (2012), beyond being mandatory, choices are subject to preexisting power structures that define the available options in each context. Thus, the social logic governed by decision-making should not be mistaken for an expansion of pluralism but rather understood as a mechanism of power and stratification. For instance, the rate of cesarean deliveries is significantly higher in private healthcare settings than in public ones (Guimarães et al., 2021; Silva & Carvalho, 2023), underscoring this stratification. In other words, not all women have the option to "choose" a cesarean section – only those with the financial means to do so (Ferreira et al., 2025; Silva & Carvalho, 2023).

The social logic in which traditions lose ground also leads to the loss of identifying references, which provide individuals with anchoring through a clear connection between the past, present, and future, fostering a sense of continuity. Since social anchoring fosters autonomy from a Winnicottian perspective – that is, autonomy is always relative, since we depend on other humans as social beings that we are (Winnicott, 1963/1983) –, a contemporary paradox emerges, as indicated by Mizrahi and Garcia (2007): the expansion of individual freedom is inversely proportional to the loss of identifying references. In other words, the fewer identifying references and the less social anchoring individuals have, the more helpless they become and, consequently, the lower their degree of autonomy.

"People need to understand that forcing a cesarean section on someone is wrong, just as forcing a vaginal birth is. And most importantly: I am one of a million mothers whose choice was violated" (Karoline). When Karoline reports having had her choice violated, we are led to an experience in which a woman in labor felt violated because others made a decision on her behalf – one she believed she was capable of making herself. In this sense, she appears to be referring to the autonomy she wished she had experienced during childbirth. However, as Winnicott (1958/1998; 1956/2000) points out, autonomy can only be attained when there is sufficient environmental

support that enables one to be on their own, initially in the presence of another. In childbirth, the healthcare team must provide the necessary support for the woman in labor to take the lead role in the process as an autonomous being.

> We opted for a cesarean section because, despite my pregnancy progressing well, I could not relax. I was too anxious – I gained 25 kg and then lost them, which I don't recommend to anyone – and so was my family. We made the decision together – though I don't fully agree, as I believe the woman should choose, but people saw my condition and shared their opinions – thinking it was the best option at the time. (Ana S.)

Ana S. was experiencing a period of extreme vulnerability, during which she needed social and emotional support to perceive herself as capable of giving birth autonomously. However, her experience was one of having to make a decision, ultimately guided by fear, anxiety, and a sense of helplessness, as she highlights in the excerpt below:

> Months after my delivery, I finally had the courage to say that I did not like what I had experienced, that this "cold" birth did not suit me. It was at that moment that I realized I had let past pain, fear, and lack of knowledge take control. Today, I see everything very differently. And even with all the knowledge I have now, I know that, at that moment, I would not have been able to do things differently or make another choice. Only I know the fear I felt, the memories I lived through. (Ana S.)

In contrast, Gabriela C., who received support from the medical team assisting her delivery – being encouraged to take an autonomous and leading role in the process – describes her birthing experience as liberating, reinforcing Mizrahi and Garcia's (2007) assertion that the experience of personal freedom is closely tied to the social support received.

> I felt the urge to express all of these emotions, and so I did. They were cries of pain – yes, it hurts – but above all, cries of freedom. I was freeing myself from all my doubts and uncertainties, learning to see the world in a lighter way. Yes... all of this transformation happened right there. I realized that life is simpler, more natural, and that we, as human beings, have a tendency to overcomplicate it! (Gabriela C.)

In the narratives of parents who, like Gabriela C., experienced childbirth in which female autonomy was encouraged by both the medical team and family members, the notion of protagonism in childbirth was sometimes conflated with the contemporary societal concept of choice. According to humanization movements, a woman's protagonism in childbirth involves assigning the leading role to the parturient, enabling them to understand their body's physiology and give birth to their child – the perspective that asserts that the woman, rather than the physician, is the one who gives birth (Reis et al., 2021). Protagonism is not a matter of choice – given that childbirth is an event characterized by a high level of unpredictability – but rather a political stance taken by all actors involved in the birthing process. This concept is embedded in the country's public policies, aiming to ensure individuals' social anchoring while fostering autonomy and shared responsibility in healthcare processes. However, in Brazil, the lack of investment in parental autonomy regarding childbirth is evident in both public and private healthcare services. This is primarily due to misinformation and lack of emotional support by healthcare professionals during pregnancy (Brasileiro & Pereira, 2021; Escobal et al., 2022; Matos, Magalhães, & Féres-Carneiro, 2021; Rocha & Ferreira, 2020; Vieira et al., 2020).

"I am grateful to my husband, who supported my choice for a natural birth and accompanied me from the very beginning of this journey, despite his concerns" (Juliana). "I went to sleep knowing I had made the best decision of my life. Grateful for the opportunity to bring another life into the

world, to be a mother again, to give birth. Happy that my choice was respected" (Gabriela C.).

> One scene in particular will never leave my mind: at a certain moment, my mother-in-law sat on the bed, and Lia approached her. They remained there, just the two of them, with my mother-in-law stroking Lia's hair, crying out of emotion, relief, and pride in her daughter's courageous and empowering decision. (Guilherme)

The notion of parturients' right to choose emerged both in cases where vaginal birth was desired and in cases where women feared vaginal delivery and felt safer opting for a cesarean section. This highlights a public health issue in the country concerning childbirth: respect for the natural timing of birth should be a fundamental principle (Matos, Magalhães, Cosmo, et al., 2021), along with respect for the emotions and perspectives of pregnant individuals and the fathers of the newborn. It is common for women to fear natural childbirth, as societal perceptions often associate birth with intense pain, distress, and anxiety. Furthermore, childbirth can evoke deeply personal pain, with wounds so profound that some expectant individuals prefer cesarean sections to avoid confronting them. This raises an important question: Should psychological factors also be considered when determining the indications for cesarean sections?

> At that moment, I realized that I would never be psychologically capable of experiencing any other type of delivery. I would not have the strength, nor would I be able to cooperate. I am deeply grateful to the doctor who assisted us (Dr. Romar) for questioning me – recognizing the extent of my anxiety and my fear of losing another baby – about how I wanted to experience this moment and for pointing out important considerations along this journey, without influencing my decision in any way. I firmly believe that the success of childbirth – when not determined by health-related factors – depends largely on the psychological and emotional state of the mother. (Ana S.)

It is argued that both psychological and physiological factors may serve as indications for performing a cesarean section. In some cases, unconscious imperatives are so compelling that subjecting certain women to vaginal birth would constitute a form of psychological distress. However, it is important to emphasize that this is not a matter of choice. Providing clinical listening to individuals who fear childbirth is essential, as the birthing process can serve as a significant emotional experience, enabling them to process and reframe profound psychological pain. It is crucial that cesarean sections be perceived as surgical procedures indicated for medical reasons, whether physiological or emotional. Furthermore, attention must be given to the risk of this mode of delivery becoming an intergenerational legacy (Lebovici & Solis-Ponton, 2004; Solis-Ponton, 2004).

> I chose a cesarean birth because, except for my eldest cousin, who was delivered using forceps, all other family members were born via cesarean section. My aunt, who experienced a forceps delivery, always told us that she would never have another child unless it was through a cesarean section. Another aunt shared that her water broke during the pregnancy of her third child. However, after having two previous cesarean sections, the third could only be delivered via surgery. My mother recounts that during my sister's birth, a cesarean section was recommended because she did not dilate. (Mari)

The legacies passed from one generation to the next can become family or even social traditions. Traditions provide social support and can serve as catalysts for autonomy, depending on the extent to which society allows for their contestation. As noted by Giddens (2012), in post-traditional societies, traditions have been called upon to justify themselves, losing ground to the ideal that upholds individual choice. However, the loss of identificatory references exposes individuals to helplessness, making it more difficult to attain the autonomy necessary for making choices. This paradox becomes evident in the context of childbirth, as many parents face the distress of having to choose a mode of delivery without sufficient emotional support or information to understand that

female protagonism in childbirth depends on social support – just as it contributes to its production – and that the parturient's autonomy stems from such support (Castelo Branco et al., 2022). At the same time, if post-traditional questioning were not possible, cesarean sections might come to be regarded as the standard mode of delivery. In this sense, it appears that the ideal of freedom based on individual choice, despite leaving individuals vulnerable due to the loss of identificatory references, creates space for differentiation, which is one of the essential components for achieving autonomy. It is possible that women and men who experienced the birth of their children autonomously also engaged in horizontalized identifications (Matos & Magalhães, 2022), which provided the necessary social anchoring for differentiation processes.

Final Considerations

The notions of choice, autonomy, and desire – hallmarks of the individualist ideal – were prominent in participants' accounts, highlighting both the significance of female protagonism in childbirth and the difficulty of experiencing a process over which one has no control. The humanization ideal underscores the importance of female empowerment in childbirth, which is essential for women to cease being rendered passive in the birth of their children. However, in an extremely individualistic context, where individuals are constantly compelled to make choices regarding the course of their lives, the humanization ideal appears to be assimilated as a guarantee of the parturient's right to choose the mode of delivery. It is well established that childbirth is a highly unpredictable event, shaped by unconscious and biological mandates beyond one's control. In this regard, it seems important to emphasize that the notion of choice regarding the mode of delivery does not apply. A cesarean section is a surgical procedure and, as such, should only be performed when medically indicated. With attentive listening, healthcare professionals may be able to understand the desire for a cesarean section and help reframe it throughout pregnancy, recognizing that such a desire may stem from deeply rooted emotional issues. It is essential for professionals to acknowledge that a cesarean section is not a mode of delivery subject to choice. Legitimizing this 'choice' as a means of addressing parental fears reflects a superficial understanding of the individual's concerns and reinforces the perception of cesarean sections as a consumer good. At the same time, respect in interpersonal relationships and clinical listening during prenatal care are fundamental for identifying indications of a preference for cesarean section based on emotional factors. Thus, there is an urgent need to deconstruct the notion of cesarean sections as consumer goods, as it is well known that unnecessary surgery poses risks to both maternal and neonatal health. These risks are both biological and psychological, as deliveries with a high level of medical intervention are more likely to be experienced as traumatic events, as Winnicott (1954/1990) pointed out.

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