Women who Choose an Elective Cesarean Section are Probably on the Right Side

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The vignette is increasingly common in obstetric clinics both in the public health system and in social security. Although I do not work in the public sector, my colleagues who do often tell me about requests for elective cesarean sections from some women, given the lack of epidural analgesia in that setting, and the fear of pain. I understand that even when requested, the public sector cannot always meet these demands. Once again, social differences in medicine and public health become apparent.

From this part of the vignette, a debate arises as to whether women can choose the mode of delivery. On the one hand, there is an affirmative response, even supported by Law 259291 (the Law on Respectful Childbirth), which states that women may choose an elective cesarean or draw up a birth plan according to their wishes and values. Since a law is not a treatise on obstetrics or neonatology regarding the reception of the newborn, the interpretation is that women may not have knowledge of the risks or benefits of their requests. Therefore, in honor of autonomy, the role of medical work should be to provide the elements so that these requests are not only emotional but also grounded in existing evidence, which is currently not abundant.

In 2024, Dr. Vincenzo Berghella and colleagues published a clinical perspective in the *American Journal of Obstetrics & Gynecology* on vaginal birth versus planned cesarean section in term, singleton, cephalic-presenting, nulliparous pregnancies. Several meta-analyses and systematic reviews have shown that planned cesarean section, compared with vaginal birth, is associated with better neonatal outcomes, including lower rates of birth trauma, tube feeding, and hypotonia. Among singleton pregnancies, planned cesarean section is associated with significantly lower rates of perinatal death, and among mothers, with lower rates of chorioamnionitis and urinary incontinence.

Since many people now plan to have only one or two children, the risk of these adherence disorders or other complications associated with multiple cesarean sections decreases.

The obstetrician refuses, stating that a cesarean section in this scenario would be "unnecessary." I understand that this attitude could fall within the framework of conscientious objection. However, nowadays, the number of cesarean sections performed is such that this position seems overly fundamentalist and out of context in light of the data provided in the literature. In any case, what is appropriate in these situations is to ask how many children a woman plans to have in the future. If the family size is expected to be more than two children, the increased risk associated with the number of cesarean sections and the possibility of facing a placental adhesion disorder should be explained.

The shift in how pregnancies are brought to term is a discussion I have been hearing for the past 50 years. I understand that, for one or two children, an elective cesarean section is a safe way to be born. In any case, since what is at stake is the life and future of a person, if a vaginal birth is attempted, the more we can demonstrate our obstetric skills, the better. It is often said that birth is the most dangerous moment in a person's life until the age of 18.

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