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Could Escalated Caesarean Sections Be Viewed as Obstetric Mistreatment?

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1 | Introduction

The mode of delivery plays a crucial role in the health of the mother and her child. By voicing her own preference, a mother-to-be expresses her autonomy and right to make decisions about her body. This paper highlights our concerns about what we see as the excessive increase in caesarean section (C-section) rates in a number of countries, particularly Greece. It focuses on maternal requests for C-sections and discusses the potential role that medical professionals, particularly obstetricians, play in shaping whether a woman decides to have a C-section.

For centuries, a vaginal delivery, commonly known as a normal delivery, was the only way to give birth. Complicated pregnancies meant that mothers and infants were doomed to die or develop chronic morbidities. Abdominal deliveries were very rare in ancient Greece and were reserved for the births of gods and heroes [1]. They were also scarce in Roman times, as the law only allowed a fetus to be removed from a dead woman's womb. This law was called Lex Caesarea, and the term Caesarean section was born.

2 | Risks and Benefits of C-Sections

C-sections are very common and considered a safe surgical procedure, but they have been linked to short-term and long-term sequelae for mothers and children. Maternal complications include excessive bleeding, deep vein thrombosis, endometritis, urinary tract infections and damage to the bladder or bowel. In addition, subsequent pregnancies present with increased risks of abdominal adhesions, placenta previa, placenta accreta, placental abruptions and uterine ruptures. Being born by C-section may increase the child's risk of respiratory morbidity, and intestinal colonisation with altered microbiota may lead to an immune response with a more atopic profile. Decreased perinatal stress may also modify the child's behaviour and reaction to stress in adulthood. The epidemiologically increased risks of asthma, type 1 diabetes, malignancies, obesity and metabolic diseases in adulthood could be due to epigenetic modulations early in life [1].

There is no doubt that C-sections can save the lives of women and children when there are pregnancy complications. They can also reduce morbidity, if they are medically or obstetrically indicated. However, a study published in 2022 reported that maternal risks of infections and thromboembolism were higher in C-sections than vaginal deliveries if clinical indications were lacking [2].

Abbreviation: C-section, caesarean section.

3 | Worldwide Perspectives

The C-section rate has gradually increased worldwide over the last few decades. There are several reasons for this, including previous C-sections, advanced maternal age and multiple pregnancies. Other factors could include breech presentations and the increased prevalence of high-risk pregnancies due to gestational diabetes, pre-eclampsia and fetal distress. However, the increased C-section rates in some countries have exceeded the World Health Organization's recommended level of 15% and maximum level of 20% [3]. In particular, C-section rates have reached or even exceeded 40% in some regions, such as Latin America, the Caribbean, China, Turkey, Cyprus and Southern Europe [4]. According to the last data from the Hellenic Statistical Authority, the C-section rate in Greece reached 62.15% in 2023 [5].

4 | Maternal Requests

Several studies have revealed that maternal requests for C-sections, in the absence of medical indications, have made an important contribution to the rise of C-sections. Some women find C-sections more convenient or believe that it is a safer option. Other reasons include fear of intense pain, pelvic floor injuries, urinary incontinence and sexual dysfunction [3]. However, no randomised controlled trials have investigated these adverse outcomes when women demanded C-sections instead of vaginal deliveries. In addition, few studies have examined the psychological impact of a C-section. While some women view a C-section as a gift to their child, especially if they have saved their life, others suffer significant trauma and need to mourn the delivery they wish they had experienced. Despite this, a systematic review and meta-analysis of observational studies, published in 2011, showed that 10%–15% of women in several countries chose C-sections as their favoured mode of delivery [6].

5 | Motivations for C-Sections

Another issue is whether healthcare professionals influence a woman's decision to have a C-section [3]. Obstetricians support C-sections for several reasons. In addition to them being convenient, they fear lawsuits, defamation and damaged careers if vaginal deliveries go wrong. Junior doctors lack adequate training and experience in instrumental vaginal deliveries. Despite these issues, an important reason driving support for C-sections is financial incentives for some doctors or hospitals, especially in private hospitals [3, 7]. There may also be informal or formal institutional pressure on obstetricians to choose more expensive and less time-consuming C-sections [7]. Furthermore, health insurance companies reimburse hospitals and doctors better for C-sections than vaginal deliveries [7].

6 | 'Obstetric Violence' or 'Mistreatment'

The term 'obstetric violence' has been used by some authors as a broad term to reflect violation of a woman's physical or psychological integrity, during antenatal, intrapartum and postnatal care. This has been shown to lead to feelings of dehumanisation during their care [8]. It can comprise physical mishandling, verbal insults, forced medical interventions, lack of informed consent and the use of procedures that are not medically indicated [9]. However, some authors feel that the use of the word 'violence' is not appropriate, because it implies the intentional use of physical force to cause harm, injury or damage to another person. They prefer the term 'mistreatment during childbirth'. This is deemed a more comprehensive term, as it encompasses a broader range of behaviours, actions and omissions [10]. Whatever it is called, the mother does not experience childbirth as the empowering, fulfilling event it should be [11].

7 | Information and Support

It is obvious that both physicians and women want the same thing when it comes to the mode of delivery and that is to avoid complications. Nevertheless, mistreatment can occur during childbirth if a woman is forced into a C-section against her will or she has not been provided with adequate information and support from healthcare providers during labour [9]. In a broader context, a woman's right can be violated if she has clearly consented to an unnecessary C-section [9], due to the influence of her fully trusted, but otherwise motivated, obstetrician.

8 | C-Sections in Greece

The rise in C-sections in Greece may be also due to the influence that obstetricians have on women's decisions. A woman who is about to give birth for the first time may have only considered the benefits of a C-section if she has been given incorrect or insufficient information. The current low fertility rate in Greece, of 1.32 children per woman, may also mean that first-time mothers are indifferent about the consequences that having a C-section could have on future pregnancies. Furthermore, the vast majority of deliveries in Greece take place in private maternity hospitals, which may promote C-sections.

We believe that the Greek Government could take appropriate measures to reduce the C-section rate, including making sure that the main information that women receive is objective and provided by official state agencies. Other measures could include strict C-section protocols, regular audits and targeted training, which ensure that medical professionals are more aware of women's rights. Finally, well-informed publicity about the currently unacceptable C-section rates in Greece may encourage women to choose vaginal deliveries. Equalising physicians' fees for vaginal deliveries and C-sections seems unlikely for private hospitals and insurance company reimbursements. The emphasis should be placed on reducing primary C-section rates, as these usually lead to repeat procedures.

9 | Conclusion

Women experiencing normal, uncomplicated pregnancies have the right to make decisions about their own body and how they are going to give birth, if there are no medical contraindications. This is particularly important if it is their first delivery. Obstetricians and midwives should provide extensive

information about the risks and benefits of both modes of delivery for mothers and their infants. Women should only choose a C-section or vaginal delivery when they fully understand the possible outcomes of each procedure. Otherwise, their consent for either mode of delivery could be considered mistreatment by healthcare professionals.

Author Contributions

Ariadne Malamitsi-Puchner: conceptualisation; writing – original draft; writing – review and editing. **Despina D. Briana and Camilla Pickles:** writing – review and editing.

Conflicts of Interest

The authors declare no conflicts of interest.

Data Availability Statement

The authors have nothing to report.

References

1. T. Boutsikou and A. Malamitsi-Puchner, "Caesarean Section: Impact on Mother and Child," *Acta Paediatrica* 100, no. 12 (2011): 1518–1522.

2. K. Dahlquist, A. Stuart, and K. Källén, "Planned Cesarean Section vs Planned Vaginal Delivery Among Women Without Formal Medical Indication for Planned Cesarean Section: A Retrospective Cohort Study of Maternal Short-Term Complications," *Acta Obstetricia et Gynecologica Scandinavica* 101, no. 9 (2022): 1026–1032.

3. P. Christopoulos, E. Tsarna, A. Eleftheriades, I. Korompokis, G. Karampas, and N. F. Vlachos, "Mode of Delivery in Greece: A Study of Obstetricians' Personal Preferences Regarding Delivery of Their Offspring," *Journal of Clinical Medicine* 14, no. 7 (2025): 2444.

4. M. Fredriksson, I. K. Holmström, A. T. Höglund, E. Fleron, and M. Mattebo, "Caesarean Section on Maternal Request: A Qualitative Study of Conflicts Related to Shared Decision-Making and Person-Centred Care in Sweden," *Reproductive Health* 21, no. 1 (2024): 97.

5. Physical Movement of Population-Births, "ΕΛΛΗΝΙΚΗ ΣΤΑΤΙΣΤΙΚΗ ΑΡΧΗ (ΕΛΣΤΑΤ)," accessed June 15, 2025, https://www.statistics.gr/documents/20181/156bb70c-5f78-8054-c5f1-336eb8c3e15c.

6. A. Mazzoni, F. Althabe, N. H. Liu, et al., "Women's Preference for Caesarean Section: A Systematic Review and Meta-Analysis of Observational Studies," *BJOG: An International Journal of Obstetrics and Gynaecology* 118, no. 4 (2011): 391–399.

7. I. Hoxha, L. Syrogiannouli, X. Luta, et al., "Caesarean Sections and For-Profit Status of Hospitals: Systematic Review and Meta-Analysis," *BMJ Open* 7, no. 2 (2017): e013670.

8. C. Pickles, "'Everything Is Obstetric Violence Now': Identifying the Violence in 'Obstetric Violence' to Strengthen Socio-Legal Reform Efforts," *Oxford Journal of Legal Studies* 44, no. 3 (2024): 616–644.

9. V. Smith-Oka, "Cutting Women: Unnecessary Cesareans as Iatrogenesis and Obstetric Violence," *Social Science and Medicine* 296 (2022): 114734.

10. M. A. Bohren, J. P. Vogel, E. C. Hunter, et al., "The Mistreatment of Women During Childbirth in Health Facilities Globally: A Mixed-Methods Systematic Review," *PLoS Medicine* 12, no. 6 (2015): e1001847.

11. A. D. Lyerly, "Shame, Gender, Birth," *Hypatia* 21, no. 1 (2006): 101–118.