

Caesarean birth: Consumption, safety, order, and good mothering

Joanne Bryant^{a,*}, Maree Porter^b, Sally K. Tracy^b, Elizabeth A. Sullivan^b

^aUniversity of New South Wales, National Centre in HIV Social Research, Robert Webster Building, UNSW, Sydney, NSW 2052, Australia

^bUniversity of New South Wales, AIHW National Perinatal Statistics Unit, Sydney, Australia

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Abstract

This article draws on qualitative data to explore the beliefs through which decisions about caesarean birth are made and to consider how these might contribute to the increasing rate of caesarean birth. A total of 36 interviews were conducted in Australia, including 12 hospital-based midwives, 6 obstetricians, and 18 women who had experienced caesarean birth within the 2 years prior to the research interview. Data reveal a belief derived from the pervasive discourse of neo-liberalism that women are self-governing autonomous subjects in their birth experience, with entitlement to the consumption of birthing information and services, as guided by obstetricians. Feeding into this belief are coexisting discourses that serve to organise 'free choice' in terms of safe/unsafe, order/disorder, life/death; and with ontological meanings, by structuring women's mothering identities as good/bad. The neo-liberal obligation to manage risk and pursue success for both mothers and babies means that women (and others) are obliged to choose what is set up as the most obvious and sensible option: safe, ordered caesareans. The structuring of discourses in this way shows how caesareans can be positioned as a preferential means of birth.

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Introduction

Australia, like other western countries, has experienced an increase in the proportion of deliveries by caesarean section, from 19.4% in 1994 to 28.5% in 2003 (Laws & Sullivan, 2005). A large quantity of medical literature examines factors associated with caesarean birth and provides insight into the possible reasons why the proportion

of caesarean deliveries is increasing. Pre-existing conditions like hypertension (Gofton, Capewell, Natale, & Gratton, 2001), obesity (Vahratian, Siega-Riz, Savitz, & Zhang, 2005) or older maternal age (Peleg et al., 1999) are found to be associated with caesareans. Complications of pregnancy, labour or delivery are also associated with caesareans, such as breech presentation (Kaushik & Gudgeon, 2003) or induction of labour (Soliman & Burrows, 1993). Caesarean delivery has a powerful proliferating effect in that a prior caesarean is often treated as an indication for another (Kamal et al., 2005). For instance, in Australia in 2003, only 18.4% of women with a history of caesarean gave birth vaginally (Laws & Sullivan, 2005). Clinical indications are not

*Corresponding author. Tel.: +61 2 9385 6438;

fax: +61 2 9385 6455.

E-mail addresses: j.bryant@unsw.edu.au (J. Bryant), m.porter@unsw.edu.au (M. Porter), stracy@ozemail.com.au (S.K. Tracy), e.sullivan@unsw.edu.au (E.A. Sullivan).

the only factors associated with caesarean delivery. Non-medical research suggests that ‘maternal preference’ is a factor driving increasing rates of caesarean (Kerr-Wilson, 2001) because women fear the pain of vaginal birth (Wax, Cartin, Pinette & Blackstone, 2004), have concerns about postpartum sexual functioning (Lin & Xirasagar, 2005) and the safety of the baby (Faundes & Cecatti, 1993). Other research suggests that obstetricians’ fear of litigation or desire for convenience (Hopkins, 2000) contributes to the increasing number of caesareans.

By explaining increases in the rate of caesarean birth in terms of biological deviances or individual desires (women’s and obstetricians’) the existing body of research takes a largely reductionist approach to understanding the increase in caesarean rates. That is, it reduces a complex phenomenon to biological or psychological explanations that are fixed within individuals, and deny the influence of social contexts. Sociological analysis can challenge reductionist approaches by showing how medical phenomena such as caesarean birth can be produced at least partially through social belief systems (Behague, 2002; Hopkins, 2000; Lee, Holyroyd, & Ng, 2001; LoCicero, 1993). These types of analyses show, for instance, how caesarean birth is a phenomena structured by broader gendered power relations (LoCicero, 1993), and acts as the site of new medical technologies that can be taken up by women as a marker of empowerment and social status (Behague, 2002). In the main, these types of analyses recognise that caesarean birth engenders social meanings that serve to produce and reproduce its occurrence. Such sociological analyses of caesarean birth are vastly outnumbered by the abundance of medical-reductionist style analyses. Moreover, the minimal amount of sociological analysis generally does not employ empirical data to explore and understand caesarean birth. This paper draws on empirical qualitative data to describe the discourses used by midwives, obstetricians and women to give meaning to their experiences with caesarean birth. The paper reveals the belief systems through which decisions about caesarean birth are made and considers how this social context might contribute to an increasing rate of caesarean birth.

Method

Qualitative data were collected from 36 respondents, including 18 women who had experienced

caesarean birth, 12 hospital-based midwives, and 6 obstetricians who were trained in or currently training in obstetrics. (In Australia, university medical graduates complete a six year training program in obstetrics and gynaecology and professional exams prior to becoming consultant obstetricians.

All midwives and obstetricians worked at a public teaching hospital in Sydney, Australia. All Australians are covered by national health insurance which provides free maternity care for women in public hospitals but about one-third of women take out private medical insurance or pay for private obstetric care. Women seeking private care receive antenatal care from their chosen obstetrician in private rooms and give birth either at a private or public hospital. In public hospitals women receive care from rostered midwives, residents, registrars and staff obstetricians. Purposive snowball sampling was used to recruit obstetricians and midwives. This sampling technique uses networks (personal or professional) to locate people who fit a certain criteria (Grbich, 1999), in this case people who worked as midwives or obstetricians. It is a commonly used technique when trying to access groups of people who are difficult to recruit (Grbich, 1999). Of the six obstetricians, half were currently training and half were women. Those who had obtained registration as consultant obstetricians had extensive experience, some of whom held teaching positions. All of the midwives were female and ranged in age and experience from young women in their mid-twenties just beginning their careers to others who had been practising for 20 years or more. Three of the midwives had overseas midwifery experience.

Women were recruited through newspaper advertisements placed in three local newspapers. Advertisements called for women who had experienced a caesarean birth within the previous 2 years. Women who were interested telephoned the research team for more information and/or to set up a time for the interview. The 2-year criteria helped to ensure that women adequately remembered the experience of their caesarean delivery. Of the 18 participating women, half were having their first baby. Twelve were privately insured and gave birth at private hospitals. Women reported various reasons for their caesareans: 5 reported having had a previous caesarean, 3 had babies who presented in breech position, 3 reported foetal distress of some sort, 1 had a baby who presented in posterior position, 1 woman reported a lack of progression of labour, 1 had twins,

I reported that her baby was not engaging, 1 reported that she feared labour pain and 2 were unclear or unsure about the reasons for their caesarean.

Interviews were conducted face-to-face and lasted between 20 and 45 min. Interviews took place in a private room at the hospital or in women's homes. All interviews were conducted by one of the authors (MP) and were semi-structured, based loosely on an interview guide (Kaufman, 1994; Minichiello, Aroni, Timewell, & Alexander, 1995). The guide included topics such as views or opinions about delivery (views on risks and benefits of caesarean and vaginal birth, and general opinions about which method is better and why) and views about decision-making processes (how decision making is negotiated and who, in participants' view, was responsible for what decisions). Interview questions made no distinction between 'emergency', 'elective' or 'planned' caesareans. This was done because, firstly, the definitions of what constitutes 'emergency', 'elective' or 'planned' caesareans are contested and shift over time (Menacker, Declercq, & Macdorman, 2006). Secondly, and more importantly, it was contradictory to the purpose of the study to impose definitions because we wanted to explore how the concepts of 'emergency', 'elective' or 'planned' are used by obstetricians and midwives to give meaning to their practices and decisions.

All interviews were digitally recorded and transcribed. Data collection and analysis was iterative (Grbich, 1999) meaning that collection and analysis happened concurrently with themes from early interviews being used to guide subsequent ones. Following this method, the research team met several times during data collection to review and discuss emerging themes and to revise coding structures and interview guides as necessary. Data were analysed for thematic content. Recruitment of participants ended once thematic saturation was achieved or no new themes were observed in the data (Guest, Bunce, & Johnson, 2006). Data were managed using NVivo software.

The study has ethical approval from the Human Research Ethics Committees of the University of New South Wales and other relevant health service authorities. Written informed consent was obtained from all participants.

Neo-liberal consumers

Almost all respondents' expressed the view that decisions made about the birthing process are,

ultimately, the choice of women and their partners. Women spoke about themselves and other women as autonomous individuals entitled to self-determination in their birth experience:

I think it depends on each individual themselves (woman A)

That's why we have choices in life. It's your choice. Like, I fully support people's choice, you know what I mean. If you think that's the best option for you, then you do what's best for you. (woman B)

I think it's really up to the person. You know, whatever they think (woman C).

Obstetricians also expressed the view that decisions around birth are women's choices, and that their role as medical practitioners was to provide guidance.

As an obstetrician I'm here to help guide a pregnancy through. Where it's low risk, leave it low risk. Where it's high risk, offer the interventions which are known to be of benefit, and hopefully not interfere unless there's a good reason to interfere. The mother therefore can through education be guided as to how her pregnancy is progressing, and then she will often express opinions as to how she prefers to be delivered (obstetrician 2).

At the end of the day, I feel very strongly that women, at the end of the day it's their body and it's their right to choose. And I certainly feel that as long as it's an informed consent, I would be very agreeable to obliging either way (training obstetrician 3).

By positioning themselves as guides, obstetricians suggest that it is women who ultimately make choices about their birthing experience. When asked about birthing choices and shared decision-making, obstetricians often slipped into talk about informed consent, viewing these as the same thing. Indeed, the following obstetrician was taken aback that such a question would be asked:

(Interviewer: Do you feel that it's important to have a joint decision making process between the medical staff involved as well as the couples or the woman presenting?) It'll always be like that, because that's the nature of informed consent ... it's astounding that you're asking this question. It is astounding. It's like asking "is the sky blue?" We do not do surgical procedures without

actually explaining to people and asking them whether they agree (obstetrician 1).

For this obstetrician, informed consent was evidence of women's authority over their delivery experience. It was viewed as a *certainty* (like the certainty of the sky being blue) that, if informed consent had been obtained, shared decision making had taken place and a woman had exercised her free choice. Some midwives also conflated free choice and informed consent:

It's all part of the informed consent. They're explained the procedures and what they want to do, and then they have to make the choice whether they're going to follow the recommended care or not (midwife 5).

However, other midwives contested the notion of free choice, viewing informed consent as a fraught process heavily influenced by the desires of obstetricians:

I think it's very fraught... and I don't think it's ever as simple as saying "this is the pros and cons of the situation, now you choose" (midwife 9).

The decision usually, here, in my experience, starts with the registrar discussing with the consultant. The consultant ultimately makes the decision, and then they go back to the parents, or the woman, the labouring woman, and discuss their decision, and ask for consent (midwife 7).

An important caveat to all respondents' talk about individual choice was the way in which this choice is limited by medical circumstances or risks (or more specifically, the current beliefs about what constitutes medical risk). That is, medical conditions that were thought to jeopardise the safety of mother or baby diminished women's choices, as described by this woman who delivered by caesarean when her baby presented in breech position:

I didn't feel like it was my choice. But I felt like that's what we needed to do (woman D).

Likewise, obstetricians felt that certain medical circumstances or risks limited women's choice:

You must distinguish between the attempt at vaginal delivery and an elective Caesarean section. Because these are the only choices we can freely make. Those are the only choices you can debate in an informed consent. (obstetrician 1)

For this obstetrician, there are very clear distinctions between elective and emergency caesareans. In the emergency situation, choice is restricted or removed because of the risky medical conditions.

In the main, the preceding narratives show the way in which women are viewed as autonomous subjects in their delivery experiences. While respondents commonly understood that women's choices are limited by situations deemed to be medically unsafe, women view themselves, and are viewed by obstetricians and some midwives, as self-determining individuals who govern their bodies with the guidance of medical professionals. The privileging of individual autonomy and self-governance, and the positioning of medical professionals as guides or information/service providers, is reflective of the highly pervasive modern discourse of neo-liberalism. This discourse focuses on individual rights as they operate within free market principles. Here, individuals are conceptualised as active 'citizens' with rights (to self-determination and commodities) and obligations (to the community and state). Liberal concepts such as these have traditionally been a part of civil, legal and political realms where, for instance, the women's liberation movement of the 1970s engaged them to claim legal and social entitlements for women. Recent sociological work shows how liberal ideas have shifted into the intimate worlds of sexuality (Bryant, 2006), blood donation (Valentine, 2005), parenthood (Beck-Gernsheim, 1996) and other health-related domains (Petersen & Lupton, 1996). By privileging concepts of self-responsibility and self-management in the private realm of people's lives, neo-liberalism sets up life as a 'project' to be planned and rationalised (Beck-Gernsheim, 1996). Our rights as consumers to self-determination or 'free choice' are paralleled by obligations to prepare for and control our lives, to make the least risky choices and employ modes of "preventative protection" (Beck-Gernsheim, 1996, p. 142).

In the context of birthing, the data in this study reveal how neo-liberalism accords women entitlement to the 'consumption' of birthing services, or the right to choose the services and commodities that best suit their desired birth experience. Here, obstetricians are seen as providers of birthing information and services, which are viewed "like the wider economic service sector... where the rationalisation of health care services is increasingly configured within 'free market' principles" (Pryce, 2002, p 159). Viewing birth in this way has profound

benefits in that it provides space through which women can be afforded the freedom to choose the circumstances of their birth experience. Many women in this study spoke positively about their experiences of inclusion and the sense of control they felt with their caesareans. Women's active participation in their birthing experiences was a major point of agitation of second wave liberal feminism, which sought greater control and choice for women (particularly in relation to birth centres, home births and other demedicalised forms of birthing) (Beckett, 2005). The data in this study reveal how the neo-liberal discourse gives authority to women's choices, providing them with the capacity to negotiate and actualise their choices, which ultimately, for some, results in positive and inclusive birth experiences. However, as the paper will now demonstrate, women's rights to self-determination in birth are mirrored by powerful *obligations* to manage risk for both themselves and their babies. Moreover, the process of risk management appears to be organised in extreme terms of danger/safety, order/disorder and with moral undertones of good/bad. The organisation of choice in this way has the potential to significantly diminish women's 'free choice'.

The indisputability of medical indications

Among respondents the most widely recognised restriction on women's birthing choices were medical beliefs about what is safe. In this study, women reported that their indications for caesarean included previous caesarean, breech presentation, and lack of progression of labour, among others. These indications were considered to be unsafe for either mother or baby and, as such, meant the immediate restriction of women's self-determination with regard to their birth experience. To be clear, it is not the intention of this paper to explore views about what is medically safe or unsafe. What can be revealed here, however, is the way that the notion of medical safety provides a means through which medical professionals, chiefly obstetricians, are engendered with the capacity to limit choices. For example, obstetricians 1 and 2 describe situations that are viewed as unsafe and how, to them, this means the immediate withdrawal of choice:

The registrar can sometimes ring me and it's already a *fait accompli*, do you see what I mean? Cause I'm at home, it's three o' clock in the

morning, and here's a woman who's been six centimetres with oxytocin for the last six hours, okay? End of story (obstetrician 2).

Well listen, there's no choice, the choice between normal vaginal delivery and vaginal operative delivery does not exist. If the same happens with the head at minus one, at five centimetres dilated, there is no choice. The choice between vaginal delivery and emergency Caesarean does not exist. You must do an emergency Caesarean, there's no other option. Do you see what I'm getting at? (obstetrician 1)

Evident here is the way that certain medical indications are viewed as necessitating caesarean delivery and therefore '*fait accompli*', 'end of story', and leaving 'no other option'. Again, this is not to question whether these situations are indeed dangerous for mothers and/or babies. Rather, it is to show the way in which self-determination has an insecure existence, with obstetricians being engendered with authority to limit women's birthing choices. Some midwives also talked about how certain medical indications necessitate caesareans:

There are set medical reasons that you're going to need a Caesarean section, and they'll always remain (midwife 1).

By suggesting that the set medical reasons will 'always remain', midwife 1 reveals a view of medical indications as static or pre-determined. Like the narratives of obstetricians 1 and 2, her talk reveals the way that medical indications are viewed as *absolute* and unquestionable. This has been found in previous research with obstetricians, who presented certain clinical indications as inarguable, "hard and fast", and necessitating a caesarean (Kamal et al., 2005, p. 1056). Foucault's (1973) analyses reveals how medical 'knowledges' have been particularly successful in setting up medico-scientific discourses of the body as unquestionable or self-evident. Medical science views the experiences of the body to be biologically derived and therefore a "stable and discoverable reality" (Petersen, 1994, p. 35). Medical views of birth construct it as a naturally unfolding phenomenon involving a normative pathway of hormone release, uterine contractions, cervical opening and so forth. The medical view of birth as a natural, biologically driven event means that any deviation from the pathway is also viewed as pre-determined. As such, indications for caesarean are seen as naturally occurring and

unchangeable, and are thought to require no further interrogation; they are *indisputable*.

This distinctive feature of medical knowledge—its capacity to set up absolutes—is deployed through neo-liberal discourse to set up a state in which women's choices are arranged in terms of the presence/absence of medical danger. Because of the obligation to manage risk and pursue success for both herself and her baby, a woman will choose the most obvious and sensible option: the one without danger. Thus, while a woman is viewed as an independent self-governing agent in her birthing experience, here it becomes evident how her agency is organized around the set of choices made available to her by her attending obstetrician (mediated through medical knowledge) and the regulatory workings of neo-liberal discourse.

Safe caesarean and unsafe vaginal birth

One of the most powerful themes to emerge from respondents' narratives was one where caesarean delivery was viewed as a generally safe procedure:

I think caesarean has become safer, and caesarean has become more common. Everybody knows somebody who has had a caesarean, and most of those women have recovered perfectly well (training obstetrician 4).

While the degree of medical risk was thought to differ depending on the circumstances of birth, the risk associated with the caesarean procedure itself was viewed by obstetricians as minimal:

If you have an elective Caesarean section, for example, for previous Caesarean section, then your risk of morbidity is probably the same or lower than a vaginal birth. But if you're having a Caesarean section because you have severe pre-eclampsia at twenty-six or twenty-seven weeks, or the baby is a breech at thirty, thirty-one weeks, and there's been an ante-partum haemorrhage, or there's low-lying placenta, then clearly the risks are going to be in relation to the morbidity that's going on, and the reason as to why you perform Caesarean section (obstetrician 2).

Elective Caesarean sections I view as being quite safe. Emergency Caesarean sections, because you're rushing, and maybe the operation you want to do in a quicker time, tends to be a bit more dangerous, although still it's a relatively safe operation (training obstetrician 5).

These obstetricians suggest that medical risk derives from the clinical indication for caesarean, or the pressure of emergency surgery, but not the surgical procedure itself. Obstetrician 2 suggests that, for women with previous caesareans, the surgical procedure carries lesser risk than a vaginal birth. Many women in the study agreed with these views that caesarean birth was a safe and easy option:

At the end of the day, if I had to have another C-section, I would, first would choose the natural option 'cause I think it is better recovery wise, 'cause you can't drive and do all those sort of things. But, yeah, if it was, for the safety of the child, I know what I'm going to expect, and it's quite, you know, it's very safe, it's very easy (woman B).

Indeed, some women talked about the potential dangers of vaginal birth:

[Vaginal birth is] not as natural as we think it is. There's a lot of medical intervention that happens to make it a little unnatural. I mean, years ago when the people were dying when they were giving birth, so, look, I really have the attitude that what's needed is needed. And it's more how it's delivered to you, in the sense that how your Caesarean is delivered to you. I mean, you can have a horrific natural birth (woman E).

The tendency for obstetricians and women to position caesarean birth as a safe, or indeed a safer, option than vaginal birth was contested in the narratives of midwives:

It's a terribly dangerous business to allow women that messy business of, you know, all that kind of talk around "it's the most dangerous journey the baby will ever make, down the woman's vagina". And, so they've lost faith, some of them... I actually think that the belief system amongst obstetricians is now that it's so safe, that why would you risk that whole painful, messy, vaginal, risky business? (midwife 9)

As stated earlier, this study does not aim to assess or compare the clinical safety of caesarean or vaginal birth. Instead, the study data reveals the pervasiveness of the *belief* that caesarean birth is safe, and perhaps safer, than vaginal birth. Regardless of its veracity, the presence of such a belief may provide important context to the decisions made around birthing. Caesarean is a compelling choice

when birthing choices are organised in terms of safe/unsafe. Here caesarean is rendered the least risky option for women who are obliged to properly govern the risk they pose to others and to society.

Caesarean birth as ordered and controlled

In addition to being seen as safe, caesareans were also viewed by obstetricians as the more orderly and controlled birthing option. This is well demonstrated by obstetrician 6 who asked the interviewer what she might choose:

What would you want to do? Would you want a Caesarean section? Or would you want to try to have a vaginal birth and get into trouble in the middle of the night? And then find that someone else is in theatre, or the registrar or the consultant is in theatre doing an ectopic pregnancy, so therefore your Caesarean section is delayed. Or would you like a Caesarean section tomorrow morning at eight o' clock before you go into labour (obstetrician 6).

Obstetrician 6 describes attempts at vaginal delivery as highly disordered compared to the ease of making an appointment for a caesarean. The construction of vaginal delivery as disordered and potentially out-of-control was also evident in women's stories:

(Interviewer: Did you feel like the decision was in part yours?) I think so because I had the choice to go and have an X-ray. And [the obstetrician] also gave me the choice to go into labour naturally. But he said if you go into labour naturally, you don't know how long you'll labour for and then I don't know what team I can have assembled to do an emergency caesarean. He works with a good anaesthetist. He works with great assistants and he said "I can't tell you they'll be available at three in the morning". And he said "I much prefer to be sure now and do it properly than to do something rushed that the end result you'll be disappointed and upset because you couldn't labour naturally" (woman F).

The obstetrician offers her a safer and "properly" conducted birth if she chooses caesarean. The alternative involves many unknowns—a long labour, unfamiliar and potentially less skilled medical staff, and the threat of having a caesarean anyway. In both excerpts birthing choices are structured in

terms of order/disorder. Setting up birthing options in this way feeds into neo-liberal obligations that compel women to make the most obvious and rational choice: a proper ordered delivery. To choose otherwise means that women must face the consequences. (Notably, although woman F's story demonstrates how her decision was shaped by notions of order/disorder, she nevertheless believes that it was her choice to have a caesarean.)

Healthy babies and good mothers

Obstetricians and women spoke of caesareans as particularly advantageous in relation to babies' health and safety. This meant that caesareans were seen to be the best choice for women who wanted to protect their babies—and who were, by consequence, 'good' mothers. Many respondents spoke about their own and others fears about the safety of babies:

You sort of think oh, well, at the end of the day, it's not just all about me and my birth experience. It's probably best to pick what's best for the little one (woman G).

You don't want to be causing your kid an injury. So, you know, if there's a chance that it's going to injure them to do it that way [vaginally], then I suppose it's better off to do a Caesarean (woman G).

The great majority of women would not want any harm to come to their baby, and will be, you know, having a Caesarean section at the drop of a hat if you suggested that there was a significant risk to the baby (obstetrician 6).

Talk about risk to babies was highly emotive for all respondents and was often thought about in exaggerated terms of life or death:

I do believe that my doctor looked at what was best for me and what was best for the children. And I'd never forgive myself if I tried to give birth to a breech baby and then lost one, you know? (woman H)

Women and obstetricians often talked about decisions to proceed with caesareans using frightful visions of 'losing' babies. Woman H also alludes to the way that she would feel responsible for her baby's death, revealing the way this belief feeds into broad social representations of motherhood where mothers are held responsible for the health and well-being of their children. As Beck-Gernsheim (1996)

explains, “the success of the child is defined as the private duty and responsibility of the parents/the mother. And the duty reads the same everywhere: the parents must do everything to give the child ‘the best start in life’” (p. 143). Indeed, not giving a child every chance of success can be construed as selfish, viewed as the characteristic of a ‘bad’ mother (Johnston & Swanson, 2003). Thus, in this way of thinking, choosing *not* to have a caesarean risks the baby’s safety and places a woman’s commitment to ‘good’ motherhood in question. By implication, it is construed to be women’s moral obligation to have a caesarean.

Midwives advanced alternative views in this respect, suggesting instead that caesarean delivery disallows women to develop full and meaningful mother identities:

How a woman gives birth seems to have a profound effect on the rest of her life. And it’s the difference between giving birth, doing birth, and having it done to you that can undermine women’s sense of self (midwife 9).

Labour and birth prepares women for motherhood. I think that happens in a physiological way, you know, in terms of the hormones ... and, sort of psychic connections with the baby. So, I guess it’s not just the physical event is what we’re saying. We’re saying that it’s a deeply emotional, psychological, psychic experience that isn’t necessarily fixed by a surgical operation in every case (midwife 8).

Having birth ‘done to you’ or surgically performed is seen to be damaging to mothering identities because it undermines a feminine ‘sense of self’ and interferes with the mother–baby connection. In this view, vaginal birth is given a special status in the production of mothering subjectivities where a vaginal delivery produces the ‘complete’ mother and a caesarean produces a ‘lacking’ mother. Unlike women and obstetricians, midwives do not subscribe to a view that associates caesareans with selfless, responsible and thereby ‘good’ mothering. Instead they suggest that caesarean delivery runs the risk of creating a kind of ontological deficiency in mothers. While this viewpoint was also expressed by a small number of women, it was not evident in the narratives of obstetricians and most women. This suggests that it likely plays a limited role in shaping choices around birth. The suggestion of a psychic or spiritual dimension to subjectivity runs counter to neo-liberal sensibilities that privilege

the rationality of autonomous subjects. This counter view is likely further hidden by the structural arrangements of the medical system wherein medicine’s scientific knowledge is privileged over midwifery’s socio-psychological (and spiritual) knowledge. Ultimately this may mean the obfuscation of midwives’ view that caesareans can be damaging.

How might social context contribute to increasing rates of caesarean delivery?

This final section of the paper speculates about how the belief systems described above may contribute to the well-documented rise in the proportion of caesarean deliveries in western countries such as Australia. The paper has thus far revealed the main belief systems used by those who make decisions about caesarean birth—women, obstetricians and midwives. It reveals a belief derived from the pervasive discourse of neo-liberalism that women are self-governing autonomous subjects in their delivery experience, with entitlement to the consumption of birthing information and services, as guided by obstetricians. Feeding into this belief are coexisting discourses that serve to organise ‘free choice’ in terms of safe/unsafe, order/disorder, life/death; and with ontological meanings, by structuring women’s mothering identities as good/bad. These coexisting discourses configure caesarean as the safe, easy and ordered option of good mothers. The neo-liberal obligation to manage risk and pursue success for both mothers and babies means that women (and others) will choose the most obvious and sensible option: safe, ordered caesarean. The structuring of discourses in this way shows how caesareans can be positioned as a preferential means of birth.

The tendency to position caesareans as preferable is, of course, not the only factor that could account for rising caesarean rates. However, it is likely to be the *least considered* factor because of the well-documented dominance of medico-scientific forms of understanding. Reductionist-style knowledge such as medicine privileges the natural over the social world and thereby is largely exclusive of the influence of social belief systems. Moreover, contesting voices that recognise the social context of caesareans, such as those of midwives, are largely hidden within medical culture. Midwives’ tended to hold views that were more conducive to choosing vaginal over caesarean birth—that women do not

'freely' choose caesareans, and that caesarean is not always safer or easier. However, recognition of these views, or indeed recognition of the role of midwives in labour and birth, were mostly absent from obstetricians' and women's talk. Midwives views appear to be hidden within the powerful hierarchy that has been shown to characterise medical culture (Henderson, 2002). Culture within hospitals has been shown to involve levels of authority that locate decision making with physicians, and acquiescence with nurses (or midwives) and patients (Henderson, 2002). Glimpses of this hierarchy were evident in the talk of obstetricians in this study, who held suspicions towards the "ideological hang-ups" of midwives, or referred to them as "well balanced" or otherwise. This hierarchy possibly means that discourses that may favour fewer caesareans, such as those of midwives, are suppressed.

In considering the social context of caesarean deliveries, it is important to recognise that it is a phenomenon that is systematically produced, and not the fabrication of particular groups or individuals within the medical system. For example, while obstetricians may be engendered with power to limit (or extend) women's birthing choices based on what they deem to be clinically safe or unsafe, their actions as such are at least partially produced by the system of medical knowledge that deposits such authority with them. Labouring women hold expectations about obstetricians' decision-making roles and in doing so reproduce the hierarchy that engenders obstetricians with decision-making power. Likewise, operational systems (administrative or legal) demand that obstetricians limit women's choices—by disallowing vaginal deliveries of breech-presenting babies, or by posing a threat of legal action making obstetricians risk averse. Thus, while obstetricians clearly hold positions that engender authority, their position as such is produced by the structural features of the medical institution and the value system that upholds it. This is not to say that obstetricians lack agency and are not responsible for their decisions and actions. Rather, it suggests that, like midwives and women, obstetricians also function within the system of medical dominance, albeit in a more dominant and authoritative position.

Some limitations of study should be noted. The obstetricians included in the study worked in both public and private practice. It is possible that attitudes towards caesareans might be different

among obstetricians who work exclusively in private practice or exclusively in the public hospital system. Also, the study aimed to describe discourses and not practice. That is, it revealed the way that people *think* about caesarean, not what they actually *do*. It is possible that people's beliefs or opinions do not always reflect their practices. Indeed, the practice around caesareans is of considerable importance and should be a focus of future social research. There are questions about how the belief systems described here shape the practices of midwives, obstetricians and women. Of equal importance is quantitative survey research to ascertain the extent or prevalence of such belief systems and determine how belief systems might vary depending on demographic factors such as class or gender, or situational factors such as public/private care. Also, with regard to the hierarchical culture of medicine, it would be beneficial for future research to explore how the dominant discourses described in this paper are redeployed through the hierarchy of medical culture: what are the social processes through which discourses that favour caesareans attain dominance, to the detriment of alternative ones (such as those of midwives) that do not? Finally, as identified earlier, the operational or structural features within which medical professional work (such as administrative directives or the threat of legal recourse) need to be explored to determine their contribution to rising rates of caesarean birth.

In sum, debates about the causes of recent increases in the proportion of caesarean deliveries ought to include consideration of the social contexts in which decisions about birth are made. Certainly, it is important to recognise that some women do freely choose caesareans and that they experience these as positive and empowering events because they are given authority to negotiate and actualise their choices. In this way, the reductionist argument of 'maternal preference' rings true for some women. However, as this study shows, there are powerful belief systems that work to organise 'free choice' in terms of safe/unsafe, order/disorder, and good/bad. These feed into a pervasive social obligation to reduce one's risk to society and obliges women to make the safest, most orderly and morally appropriate choice. As such, it is necessary to constantly interrogate and problematise the milieu in which birthing decisions are made so to avoid slipping into a sensibility that birth is socially decontextualised and that all caesareans are freely chosen.

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