SOURCES OF SILENCE

by

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ABSTRACT

Eight case studies are used to examine how women attended by physicians in American hospitals are often unable to assert their preferences or needs during labor and birth for a variety of reasons. There is a complex interplay between the way women are socialized in general, how particular women feel about their births, the way lay people are socialized to medical authority, how doctors are trained to act toward patients, the existence of institutional protocols and the structure of medical group practice.

Even assertive women who may have been able to express their preferences to their primary doctor often were not effectively able to do so to the person who attended the birth. This may be because the attending physician was present for only brief periods during labor, or the baby was delivered by a physician unfamiliar to the woman. Women express needs for more trusting professional relationships as well as professional expertise. Suggestions are made for labor support.

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SOURCES OF SILENCE

The fundamental change in the definition of birth from a normal, natural, woman centered event to a dangerous medical crisis has profound implications. One million births by cesarean in 1991 make this the most frequently performed surgery in the United States (Rutkow, 1986; Stafford, 1990b; Flame 1992). At least one out of every four American women giving birth this year will have a cesarean section (Stafford, 1990), yet we know very little about the social and social-psychological effects of cesarean delivery (Cohen, 1991). This paper reports on a pilot study and proposes further research to examine the effects of cesarean section as reported by women who experience it.

The main research questions are: Does the cesarean experience affect women's attitudes toward birth, toward themselves, or toward their children, compared to vaginal birth? How does cesarean delivery affect women's first experience of motherhood? Does cesarean birth affect women's confidence in their own ability to meet the challenges of motherhood? More specifically, do women who have cesareans commonly experience greater depth and duration of post partum depression than women who do not have cesareans? Do women who have cesareans experience alienation from their own bodies and from their children as a result of this surgery?

The pilot study used in-depth interviews with nine women, six who had vaginal deliveries, and three who had cesareans. All are middle class, six are white, one is Hispanic.

This study examines the social construction of childbirth in eight case studies. Originally the idea was to compare and contrast cesarean births with so called natural births to see how

some healthy women have major abdominal surgery while other women give birth in the way mothers have done for hundreds of generations. This paper will apply the idea of medicalization to childbirth, making observations on the degree to which medical and technological interventions place women's experience along a continuum from natural birth within the family at home to cesarean delivery in a surgical suite.

The fundamental change in the definition of birth from a normal, natural, woman centered process to a dangerous medical crisis shapes how we see ourselves, our children, and our place in society. This change is part of the much larger trend of medicalization. Natural processes such as

> childbirth, sexuality, death as well as old age, anxiety, obesity, child development, alcoholism, addiction, homosexuality, amongst other human experiences ... (are) defined and treated as medical problems

needing expert medical treatment and control (Conrad and Kern 1981:509).

In the 1930's, W.I. Thomas told us that a situation defined as real is real in its consequences. So it is with childbirth. The medical definition of childbirth has had real consequences for how children are born in our society. Nearly one million women had cesareans in 1990 alone! (Flamm 1991).

Our culture is growing more medically and technologically focused, and patterns of childbirth reflect this trend (Cohen, 1983, 1991; Martin, 1992; Rothman, 1982, 1989). Since 1900, birth has moved from the home to the hospital, where today 99% of American women have their babies. Cesarean section rates have risen 500% in the last twenty five years, yet we know very little about the social-psychological consequences of medicalized birth, particularly cesarean birth.

BACKGROUND

Cesarean section is now the most frequently performed surgery in the United States, surpassing tonsillectomy and hysterectomy (Rutkow, 1986; Stafford, 1990b). This trend is much more than a surgical fad because it redefines birth itself, from a family centered cultural experience and a woman's rite of passage, to a medical emergency requiring the intervention of surgical specialists.

While the mortality rate from cesarean birth is quite low, it is still 2 to 4 times higher than for vaginal birth (Family Planning Perspectives 1981).

Our national cesarean section rate has jumped from 4.5 in 1965 to 25% in 1988, with some hospitals reporting rates over 35% (Statistical Bulletin, 1986; Moien, 1987:241; Placek, 1986:9; Myers and Gleicher, 1988; Goyert, et al. 1989; Silver and Wolfe, 1989, Stafford 1990). While there is wide variation in the rate of cesarean section within different settings, overall there is a rising trend across the country.

The cesarean section rate is rising for all women in the United States, regardless of age, marital status, hospital size, type of hospital ownership or region of the country, leveling previous regional differences (Moien, 1987; Placek, 1986:9).

While rates are increasing for all women, they have increased faster for teenagers than for older women. This is important because nearly all future births to these teenagers will also be cesarean (Placek, 1986:9), following the tradition that "once a cesarean section always a cesarean section".

This tradition is being challenged, and empirical research shows that it is not necessary to have a cesarean just because a woman had a previous birth by cesarean (American College of

Obstetrics and Gynecology, 1985; Flamm, 1990).

Despite the American College of Obstetricians and Gynecologists issuing new "Guidelines for Vaginal Birth After Cesarean" in 1982, and reissuing these guidelines in 1985, the doctrine of "once a c-section always a c-section" continues to be followed. 95% of American women who have had a previous cesarean will have another cesarean with any subsequent children (Placek, 1986:9).

The United States has the dubious distinction of having the "highest cesarean rate in the world" at the same time that 15 other countries have lower infant mortality rates (Cohen and Estner, 1983:12; Placek, 1986:9). The cesarean section rate in other developed and developing countries is also rising, following the United States trend as technology is disseminated (Notzon, et al. 1987).

Selected American efforts to reduce the cesarean rate show promise, but are not being adopted widely. At one Chicago hospital the vaginal birth after cesarean (VBAC) rate was 70% among women who attempted a trial of labor, however, this rate was achieved only after a concerted effort during a research study of 4,000 births between 1985 and 1987 (Myers and Gleicher, 1988).

The most recent medical evidence using a data base of thousands of women in California indicates that at least 80% of women who have had previous cesareans can have vaginal births if given the chance, and that women who have had a previous cesarean with the most common low uterine incision have no greater risk of uterine rupture during subsequent births than women who never had a cesarean (Flamm, 1990). Other countries have as high as 43% vaginal birth after cesarean rates (Notzon, et al. 1987).

Guidelines from the American College of Obstetrics and Gynecology recommend cesarean section be performed when the risk of the child being born vaginally is greater than the risk of surgery and anesthesia. This is not the case in 95% of births after cesarean, but that is the rate of repeat cesarean. Repeat cesareans account for one half of all cesareans.

There is some debate as to whether babies delivered by cesarean section are better off than babies delivered vaginally (Bottoms et al. 1980; Cohen and Estner, 1983; Sachs, et al. 1983; Entwisle and Alexander, 1987). Bottoms et al. show an impressive chart graphing the decline in infant mortality and the increase in cesarean sections. One is reminded of the charts that show the growth of the medical profession and the decline of the death rate in the United States. The association seems clear, but a causal link is assumed rather than demonstrated.

Bottoms et al. (1980) stress the safety of cesareans now compared to the past and postulate rather than demonstrate that the relative safety of the operation is the reason for the increase. The authors minimize the risk to the mother and emphasize the possible benefits to the baby.

Bottoms et al. make a key observation about the change in goals for childbirth which are now "undamaged infants and reasonable duration of labor in contrast to the older goal of eventual vaginal delivery" (1980:561). Social, demographic, legal and technological changes contribute to this shift in goals (Bottoms, et al. 1980).

More recent medical studies do not explain why 95% of primary cesareans are not given a trial of labor for subsequent births even though there is hard evidence to show that women with the most common type of cesarean do not have any greater risk of uterine rupture or other complications than women who have had previous vaginal births (Flamm, 1990).

Rates of cesarean section have profound implications not only for health care costs, but for quality of care. At least in the short term, having a cesarean may affect quality of life for mothers and babies as women must recover from surgery at the same time the demands of their newborns are greatest.

So far post-cesarean health of mothers and babies is measured only by mortality or physical morbidity experienced in the hospital, with few medical studies attending to physical limitations at home or social-psychological sequelae (Affonso, 1979). The recognized physical morbidity rate from cesarean birth is fairly high (Minkoff, 1980) and includes possible side effects of anesthesia, pain, infections, difficulty going to the bathroom, trouble standing or walking at first, followed by limitations on lifting, carrying heavy objects or driving.

Little attention is paid in the medical literature to the social-psychological effects of this morbidity on women and their relationship to their babies or older children, or women's continued recovery at home (Statistical Bulletin, 1986, Cohen and Estner, 1983).

However, social psychological sequelae are examined in feminist work, notably that of Barbara Katz Rothman and Nancy Cohen. Midwifery and Feminist approaches to pregnancy, childbirth and cesarean section are very different from the medical approach, and emphasize the negative consequences of cesarean section. While building solid theory, much feminist work either assumes cesareans are harmful events in the steam rolling process of medicalization, or harmful effects are described in intense detail by women who are self selected for their bad experiences with cesarean section and the medical professions. There is much to be learned about how ordinary women themselves view cesarean section, and this is the topic of my research.

However, the social-psychological sequelae are examined at length in feminist work, which approaches childbirth in a fundamentally different way from the medical model. Feminists emphasize the positive cultural, social and psychological meaning of childbirth as a natural, normal, woman centered process which belongs at home, while the medical model frequently assumes childbirth is a crisis situation that requires medical management in the hospital. Given these entirely different definitions of the same situation, it is not surprising that subscribers to the medical definitions frequently assume cesareans are greatly beneficial for children while a necessary inconvenience for mothers.

Feminist work often assumes negative consequences of cesarean section, and broadly defines cesareans as harmful to women with questionable benefit to children. Feminist work that expresses the voices of women rather than assuming harm base their conclusions on data samples that are self selected.

Nancy Cohen, first in in Silent Knife (1983), and now in Open Season (1991), uses women's real experiences and testimony to make devastating indictments of the medical system on grounds of extreme cruelty in the overuse of cesarean sections. Yet we do not know if the women Cohen speaks about are typical of more American women because they have come to her because of problems with their cesarean experience.

Once we begin to understand the social-psychological impact of cesarean delivery, we can offer support if it is needed. Doula studies show fewer women have cesareans if offered support during labor, and it is possible that women who get more support after a cesarean may experience fewer postoperative difficulties. Women who have cesareans are often emotionally traumatized, many saying that having their arms tied down made them feel like they were being crucified

(Affonso, 1979). In response, nursing, some medical and popular literature attempt to portray cesarean as "just another way of giving birth", an alternative worth considering for nearly every woman, and offer rationale for why a woman should not feel bad about her experience.

It is certainly worth investigating the degree of fear women have, the extent of difficulty in day to day postpartum functioning and the extent of postpartum depression, if any. These topics are rarely discussed in depth unless they reach critical levels.

Pilot Study

Doctors, not everyday women with children, are viewed as birth experts. The very nature of the medical expert - patient relationship is unequal. By definition, doctors are in a superordinate position relative to subordinate clients, (Parsons, 1951), and this is compounded when the doctor is male and the client is female, as is the case with most obstetricians and their clients. Inequality of status and power is magnified even more by the vulnerability experienced by women in active labor. Having a baby in the hospital introduces further institutional pressures and technologies into the birth process.

No women who had their children in the hospital in this study had mothers, aunts, or grandmothers present until after the birth. The single home birth described in this study is the only one at which the new baby's grandmother was present. It is this combination of locating birth directly in a medical context under the authority of physician experts that makes this American experience of childbirth so unique. Coupled with the absence of lay experts such as mothers or grandmothers who have been through childbirth before, even the most assertive women with the most stalwart husbands are likely to defer to decisions made by medical authorities "in the best interest" of mother and child.

The purpose of this pilot study is to generate theory about how women experience childbirth in order to have a grounded base on which to build a larger investigation. A brief review of the literature will set the stage for analysis and discussion.

Pregnancy and birth are often defined and treated as illnesses in the United States. Such "illnesses" are treated only by medical experts who have a monopoly on "the right to do surgery and prescribe drugs" (Zola, 1972:83-84; Rothman, 1982).

> Medical illnesses
>
> are not universal, objective, or necessarily reliable. Rather, they are culture-, class- and time-bound, often ethnocentric, and as much artifacts of the preconceptions of socially biased observers as they are valid summaries of the characteristics of the observed. In this view, illness (especially mental illness) is largely a mythical construct, created and enforced by the society (Fox, 1981:390-91).

What happens in medicine and in medicalization reflects trends in the larger society (Fox, 1981:390). Gender, race and class inequalities are reflected in movements toward medicalization (Fox, 1981:391). White males traditionally dominate women and people of color, while professional expertise is usually class bound.

With increasing medicalization, normal variations in labor patterns or physical attributes such as pelvis size are seen as "deviant" and are viewed as requiring surgical intervention (Cohen and Estner, 1983). These same "conditions" would, in most cases, resolve themselves if left alone (Cohen and Estner, 1983; Rothman, 1982).

Medicalization "delivers neonates" instead of allowing women to give birth to their babies (Rothman, 1982). The movement in which women demanded more control of birth has fallen nearly silent (Longeway, 1989, in Creager, 1989; Rothman, 1982). Some aspects of this

movement have been "coopted", and homey birthing centers have sprung up attached to hospitals with the highest cesarean section rates (Rothman, 1982, Ch. 1).

C.S. Lewis once said: "(M)an's power over Nature is really the power of some men over other men, with Nature as their instrument" (C.S. Lewis, quoted in Zola, 1972:387). Updating and going beyond this statement, men's power over the natural process of birth is really the power of some men over women, exerting patriarchal control of birth and the production of children with "safety" and "health" as their instruments.

Promoters of medicalization are not necessarily bad people with evil intent (Zola, 1972:388-89).

> (N)ot because there are visible threats and oppressors, but because they are almost invisible: not because the perspective, tools and practitioners of medicine ... are evil, but because they are not ... the danger is greater, for not only is the process masked as a technical, scientific, objective one, but one done for our own good (Zola, 1972:388-89).

The deepest foundations for medicalization of birth lie in the patriarchal nature of medicine and our society (Rothman, 1982). Doctors "take care of us" like children not old enough to decide things for themselves (Fisher, 1986; Rothman, 1982; Cohen and Estner, 1983). Fee suggests

> medical domination is a kind of "extended patriarchy", then these images have not only maintained the profession, but also they have functioned to sustain a male-dominated society (Fee, quoted in Fisher, 1986:161).

Fisher also refers to Mary Daly, who sees doctors as "mind managers" (Fisher 1986:161; Daily 1978:109). Doctors present limited information to women, who come to believe that technologies, including cesarean sections, are best. This sort of thing has happened throughout history with doctors and other professional males in, or seeking to be in, positions of authority. It

is often so subtle that women play out their expected roles without thinking (Fisher 1986:161; Daly, 1978:109).

Americans generally value technology and the advice of experts (Rothman 1982:34; Fisher 1986). However, technology is not always beneficial. The routinely used electronic fetal monitor has been shown to increase the risk of prematurity, respiratory distress, other sicknesses, and death of infants monitored just prior to birth (McCusker et al., 1988:1173). Electronic fetal monitors contribute to an over diagnosing of fetal distress and precipitate cesarean sections when the fetus is not actually distressed (McCusker et al., 1988; Rothman, 1982).

Where a woman is in her labor process when she goes to the hospital influences her chances of having technological intervention (Rothman, 1982:168). If she is admitted early, she may be seen as "not progressing" after a certain number of hours, and a cesarean will be ordered. If the same woman waits the first 24 hours at home and is admitted for the last 6 hours she has a better chance for a natural birth (Rothman, 1982:168).

More women have their labor induced or are scheduled for a cesarean if their pregnancy goes beyond the medically calculated "due date". Since due dates are usually 2 weeks early, if the baby does not come early, it is considered late! (Rothman, 1982). "The labor process is usually self-contained; left to her own devices, the woman can produce the baby, in nine cases out of ten, with absolutely no professional assistance" (Rothman, 1982:169-70).

When technical and surgical skills are used more, there is a de-skilling of how to "manage" a difficult vaginal birth. In 1970 only 15% of breech presentation babies were delivered by cesarean, while the current rate is 75% and still climbing (Placek, 1986:10). If the immediate reaction of a doctor to a breech presentation is to deliver the baby by cesarean for the "safety" of

the mother and child, and his own "safety" in a legal sense, then new physicians will never really learn how to deliver a breech baby any other way, and it will no longer be an option (Cohen and Estner, 1983).

For women there is the hazard of surgery and anesthesia. Despite its everyday performance, a cesarean section is still major abdominal surgery (Statistical Bulletin 1986:2-8). More women die in cesarean section childbirth than in vaginal birth (Cohen and Estner, 1983). It takes twice as long to recover in the hospital if there are no complications, and 50% of cesareans do result in complications (Statistical Bulletin, 1986; Cohen and Estner, 1983).

A cesarean section leaves a woman in a physically compromised condition just when the demands of her newborn are greatest (Cohen and Estner, 1983). Many new mothers express a feeling of loss of control and some have feelings of failure in their first task in motherhood. Feeling like a "failure" as a woman is reinforced by terms used to describe why technological intervention is recommended. "Failure to progress" is the most common.

Having an operation instead of having a baby seems likely to influence how a woman feels about herself. Technology also distances women from their own experience and from other family members when closeness is needed most (Cohen and Estner, 1983; Rothman, 1982). Even though the United States routinely uses more technology and has the "highest cesarean rate in the world, (it) ranks fifteenth and sixteenth in infant mortality" (Cohen and Estner, 1983:12; Placek, 1986:9).

METHODS

My own experience as a sociologist and registered nurse for the past 12 years has been helpful. While my nursing practice is primarily in mental health, I have some familiarity with obstetrics, having done a rotation at New York Hospital-Cornell Medical Center. I assisted in labor and delivery as a nursing student for one semester, involved in caring for women in labor and giving birth, using technology such as pitocin and electronic fetal monitors as well as caring for women and their infants in the post partum phase after both vaginal and cesarean deliveries. This is particularly helpful in gaining the trust of many of the women I interviewed, as is my familiarity with the vocabulary. As a long time student of physician-client interaction, I have become familiar with the recent trends in the medicalization of emotional and social difficulties.

Nine indepth interviews are included in this study. Eight were done in person, and one woman was interviewed by telephone on two occasions, and mailed journal entries after these interviews. One original post partum hospital questionnaire was filled out, xeroxed, and given to me by one informant who asks that this not be included in its original form because she feels it would identify her to readers. Selected passages of this were used in analysis and as a base for further questionnaire development which 2 other women filled out prior to interviews with them. Here is a very brief description of the eight retrospective interviews.

Nancy -- normal vaginal birth. Tape recorded, unstructured interview in informant's home.

Marleen -- cesarean section. Taped interview, unsturctured, in a restaurant.

Sally -- induced vaginal birth with side effects. Partially taped semistructured interview after questionnaire completed.

Laura -- cesarean section delivery. Tape recorded semistructured interview in informant's home.

Wanda -- normal vaginal delivery. Source of original questionnaire. Taped unstructured interview in informant's home.

Pat -- traumatic vaginal delivery. Taped reconstruction of unstructured interview in informant's home.

Mary -- Unstructured interview, taped reconstruction. Husband in the room some of the time, offering opinions and comments.

Noreen -- Telephone interview twice, tape recorded, unstructured interview. Journal entries mailed later.

Case Studies are included in an appendix at the end of this paper.

Analysis was basically done after interviews were completed, but the original questionnaire was developed more as successive informants brought out different points of emphasis, such as the relative utility of childbirth preparation classes.

Analysis roughly followed the spirit of Glasier and Strauss in The Discovery of Grounded Theory, 1967. Interviews were unstructured or semistructured indepth conversations with women known to the investigator. Most interviews were tape recorded and later transcribed or reconstructed and transcribed soon after the interview. Transcribed pages were then coded, first using line by line in-vivo coding, followed by structured coding in the rest of the interviews, except where entirely new material emerged and new code categories were established. Individual codes were grouped together in meta codes, which were in turn brought together in mega codes which served as the basis for theorizing. The data is very rich and only partially analyzed due to

time constraints. What has been found is quite interesting, if not entirely applicable to all other similar situations.

Despite the obvious similarities among most of the respondents (all but one are college educated and middle class), there are a wide range of experiences, from home birth attended by family only to high tech cesarean with the husband holding the woman's hand while the anesthesiologist offers a running play by play. In this last case the baby is whisked away to a special nursery before the mother can hold it, where the infant was subjected to a spinal tap, bloods were drawn, and preventive antibiotic treatment was initiated because the child had a slight and temporary fever after many hours of labor.

Though the researcher had some nursing background in obstetrics in the distant past, and has read about cesarean sections, considerable effort was made to search for negative cases to balance the originally held viewpoint of the medical system as coercive. It is this discovery of grounded theory -- that there are cases where high-tech intervention may make sense and it is not all bad, is helpful in the analysis. Every effort is made to analyze the meaning and content of the data itself, rather than simply reconfirming previously held beliefs. The theory changed and grew throughout the project.

An adaptation of overview coding, where larger themes could be discerned as a general impression, was tried at the end of this phase of analysis.

FINDINGS AND DISCUSSION

There is considerable variation in the amount of technical and medical intervention in the eight cases studied. In all seven hospital births, there are structural constraints and policies which

seem to require the use of fetal monitors even though none of the infants were in distress prior to this or other medical interventions.

Four of the seven women who gave birth in the hospital had epidural or spinal anesthesia, and six of these seven had IV's. All of the women preferred the birthing room but some were required to move to the delivery room (which is outfitted as an operating room).

Three of the eight women had cesarean sections, which is slightly above the national average of over 25%. Of the three who had cesareans, two were for breech presentation and one followed the classic medicalization route.

The classic medicalization route is illustrated by the following case:

A woman had had a previous miscarriage and never believed the Lamaze technique could work for her. She arrived at the hospital early in her labor. She knew friends who told her to get the consent for an epidural as soon as she entered the hospital to relieve the pain. She did wait until she was approached by staff who encouraged her to have an epidural. She readily agreed to have the epidural, and while it greatly diminished the pain, it required her to lie in bed with an IV going, restricted her movements, slowed the labor and detached her from her experience so that she no longer felt like a participant.

After many, many hours, she was encouraged to push, and was utterly exhausted and disheartened by now. She was frightened because she had "failed to progress" fast enough, and was "afraid of having the baby in the bed". Watching the electronic fetal monitor and hearing the shouted test results from scalp scrapings of the infant still inside her, exhausted and frightened, she felt relieved when the doctor finally said "It looks like this old uterus just isn't going to do it. Let's do a cesarean".

In these medicalized circumstances, it would be difficult for anyone to insist on their own wishes. The rest of the theoretical discussion will focus more closely on this aspect of the findings.

Women who are attended by American doctors in hospitals are unable to assert their preferences or needs during labor and birth for a variety of reasons. There is a complex interplay between the way women are socialized in general, the way lay people are socialized to medical authority, how doctors are trained to act toward patients, and the structure of medical group practice.

Pregnant and birthing women often are unable to speak up and ask for what they need or are unable to assert their will over the will of medical professionals who attend them during their time of labor and birth. One informant illustrates this clearly when she states

> I think I was mad at myself for not speaking up and asking or demanding or saying "I want, this is what I want", and I never did .

Women are often not given choices or the chance to express their needs or preferences; sometimes when these needs or preferences are expressed it has no effect on what happens.

> I didn't even care, I was in so much pain. The doctor didn't say anything about it at the time, but I guess K. had her first poo in the sack, in the fluid, and that's bad. Shortly after that, (the doctor) told me "We're going to move you into the operating room, ... the delivery room". I said "Well, I like this (birthing) room much better" and I want to stay here. Then he told me "We have to move into the delivery room now". He didn't argue with me, he just told me. Then they just took the whole bed, which was a good thing, and brought me into the delivery room.

Even assertive women who may have been able to express their preferences to their primary doctor or midwife were not effectively able to do so to the person who attended the birth because either the attending physician or midwife did not show up for the labor and birth at all,

came very late, or were present only a fraction of the time the woman was in labor in the hospital. This happened in four of the eight cases studied.

> I remember when we went to the hospital ... my doctor wasn't around, we had the resident, actually he was the backup doctor, he had only been in practice about a year. He came and chased me. He came in and examined me.
>
> The doctor's associate showed up first, ... So (the associate) comes in and he's rubbing his eyes and I feel sorry for him, getting him out of bed at 5 o'clock in the morning.

It is rare for an obstetrician to have a solo practice and deliver all his or her clients' children. Most often medical practice is a group practice or the hospital used may be a teaching hospital in which residents and nurses attend birthing women, especially in the middle of the night.

Women may have been unable to demand their own physician in such cases in an angry or assertive way for fear of alienating the doctor or health care staff that did manage to show up. Having some sort of medical person present may be viewed as preferable to nobody being around. However, this can be a source of internal conflict as well. Women may have trouble handling anger with staff who are supposed to be taking care of them.

> Part of it -- this wasn't my doctor. I think I met him once. I think I was, maybe this is my feelings afterwards, looking back on it, getting mixed up -- I felt like "am I dealing with a competent medical professional here?" How the hell can he get that mixed up that he's going to tell me to push, then "OOOps"!
>
> How did that make you feel?
>
> Blew me the fuck away - oh, sorry.

Women simply may have no experience with stating their needs or preferences to a person with medical authority.

> I had never been sick in my life, I had never had a doctor. I didn't know that whether that was the way the relationship had to be, and I thought it had to be like this -- he was cold, and he, I really didn't feel like I could ask questions. He didn't encourage me to ask questions.

Later, when this woman got to know a different doctor and gained experience in stating her needs, she was quite able to assert herself.

Women may be too tired or in too much pain or under too much strain to impress their own needs or preferences on others at the time. Recall one woman saying "I didn't even care, I was in so much pain". This is compounded when women are experiencing the institutional authority of doctors at the same time they experience the institutional authority of the hospital with its protocols and procedures. Women may feel that doctors will always act in their best interest and defer to the doctor's judgment even if it conflicts with their own idea of what they need or want.

As women come to view birth as a medical or surgical event they will have a more difficult time enforcing their will because of fear or because they feel unqualified as experts. Women generally may be feeling anxious and so find it hard to buck the wishes of those in the medical area on whose turf they find themselves.

Women may be completely absorbed in the birth process itself and the physiological changes they themselves are experiencing (for the first time for most informants). Laboring women find that while they have certain preferences, they may become distracted from these by the progression of labor itself.

> I mean my doctors knew what I wanted and I was caught up with the (labor) -- nothing slowed down -- it just went faster and faster, that looking back there were some things that I would have done differently.

There are some things women can do ahead of time to decrease the amount of technological interference and make their birth experience less medicalized. McCall's Magazine ran an article in 1985, of which an extensive passage is quoted below:

"Take responsibility for your health care by finding out all your options" (Belinda Lassen, International Childbirth Education Association, quoted in McCall's, Sept 1985:88).

-Find a doctor with whom you are comfortable and can share decisions.

-Read up on the topic, and take childbirth classes that include Cesarean information and prevention measures. Remember that some hospital based classes will tell what to expect in their hospital instead of emphasizing all the options available.

-Check the Cesarean rates of the hospital or individual doctor you consider. If the rate is high - above 15 percent- or if VBACs are discouraged, look elsewhere. (University hospitals have higher rates because they take more high-risk cases.) [VBAC refers to vaginal birth after cesarean.]

-In case you should need an emergency cesarean, find out ahead of time how to keep it more like a birth and less like a surgical procedure. Ask whether your partner may remain with you, whether you can stay awake and whether you'll be able to hold your baby afterward. Write down your requests before entering the hospital.

-Wait until you are in the active phase of labor to go to the hospital. "if you come in too early, you'll be put in bed and monitored" Lassen says. "Everyone watches the clock, and pressure to perform can actually prolong labor". How do you know when you are in the active phase? Marie Norris, a certified nurse-midwife, says that you should call your doctor's office -- they'll give you advice based on your description. Contractions should come with increasing regularity and intensity and last as long as a minute.

For a pamphlet called *Unnecessary Cesareans; Ways to Avoid Them*, send a check for $2.5O (made out to ICEA) to International Childbirth Education Association, P.O. Box 20048, Minneapolis, Minnesota 55420

Mary Lisbeth D'Amico, McCall's, Sept. 1985:88.

The International Childbirth Education Association and Nany Cohen recommend that prospective mothers talk with other women know who have had children and learn from their experiences, and work to make a network of women friends and relatives to help them through labor and birth. Women need to ask for help from those who may give voice to their wishes while they are concentrating on a baby about to arrive!

SUMMARY

Women in this study find it difficult to make their needs and preferences heard while giving birth in the hospital. Several sources for women's "silence" include

*being generally socialized to passivity,

*being taught to defer to medical authority,

*having no experience in asserting themselves with medical authority,

*not being given choices/chances to express their wishes,

*strict limitations on interaction time with physicians,

*substitution of new/other physicians at delivery as a result of group medical practice,

*being in active labor, feeling tired or in too much pain,

*feeling birth is a medical event, and lay women are unqualified to insist on their desires.

Women are encouraged to speak up, to educate themselves, network, and enlist the support of others in their struggles to have the kind of births they desire.

CONCLUSIONS

The main finding was that all hospital births are medicalized to some extent, and the medical model of childbirth does influence how women perceive themselves, their experience, and their babies, whether they had a cesarean or not.

The cesarean experience is different in degree but not in kind from medicalized vaginal birth. Women with cesareans have a much longer and generally more difficult recovery period.

Often women with cesareans tended to see themselves as having failed in some way, their children being rescued from being trapped inside their bodies.

Women in this study accepted the view of vaginal birth as dangerous for them. Most women who had cesareans report feeling they missed something by not having a vaginal birth, but trusted their doctors to act in the best interest of their babies. All women experienced limits on their choices, knowledge and decision making while in the hospital. All women described mixed levels of social support from family and medical staff, and all reported some difficulty in getting their needs met in the hospital.

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