MEDICALIZATION OF BIRTH: THE SOCIAL CONSTRUCTION OF CESAREAN SECTION. A QUALITATIVE ANALYSIS

by

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To Sis, with love.

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CHAPTER 1

THE MEDICALIZATION OF BIRTH: SOCIAL CONSTRUCTION OF CESAREAN BIRTH

> The cesarean birth has been the concern of religions, nations and people from antiquity to the present (U.S. National Institute of Health, 1981:21).

> ...In 1878 ... a pregnant woman in labor had a 50% chance of survival post-cesarean if she performed her own surgery, or if gored by a bull, compared to a 10% reported survival rate if attended to by a New York surgeon (Harris, 1887; 1879, as cited in U.S. National Institute of Health, 1981:24).

> Once a cesarean section, always a cesarean section. (Craigin, 1916, as cited in U.S. National Institute of Health, 1981:23).

> The birth of a baby is the birth of a family. A myriad of births take place at once: women become mothers, husbands become fathers, daughters become sisters and sons become big brothers (Peterson, Ryals & Hartigan, 1992).

Birth is an important cultural and social event in every society (Kehoe, 1981). The social meanings attached to birth reflect much of what a society values in itself, its members and the larger world. Power relationships in the birthplace mirror power relationships in other social institutions and in the larger society (Rothman:1982, 1989).

During the last hundred years, birth in the United States has become increasingly medicalized. 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 larger trend of medicalization., in which natural processes such as

> … childbirth, sexuality, death as well as old age, anxiety, obesity, child development, alcoholism, addiction, homosexuality, amongst other human experiences were being defined and treated as medical problems (Conrad and Kern, 1994:390).

The topic of this dissertation, Cesarean section, may be the most medicalized type of birth. It epitomizes how birth has been redefined from a family-centered cultural experience to a medical emergency requiring the intervention of surgical specialists. Cesarean section is also the most frequently performed surgery in the United States, surpassing tonsillectomy and hysterectomy (Rutkow, 1986; Stafford, 1990b). More than one quarter of American births, totaling about one million cesarean sections, were performed in the year 2002 alone (Martin, Hamilton, Ventura, Menacker, Park, and Sutton, 2002). The United States is second only to Brazil, where the national cesarean section rate is 36%; some Brazillian hospitals have rates over eighty per cent (Hopkins, 2000).

American cesarean section rates have risen 500% in the last thirty years. 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). 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).

Even as the rates of Cesarean section are rising, its benefits have been increasingly contested. Cesarean section is major abdominal surgery that costs about

twice as much, doubles the hospital stay, and has a mortality rate between four and ten times greater than normal vaginal delivery. Half the women who have a cesarean experience significant side effects such as bleeding or wound infection (Cohen and Estner 1983:31; NIH: 1980). The overall benefits of cesarean section for babies are disputed (Bottoms et al 1980; Cohen and Estner 1983; Sachs, et al 1983; Entwisle and Alexander, 1987; Wagner 1993; Flamm 1995).

What accounts for this dramatic rise in Cesarean rates? A number of explanations have been proposed including, for example, increasing detection of fetal distress, increasing induction of labor, expanding medical indications, doctors' convenience, and women's requests. Most of these explanations, however, focus on broader social trends. We still do not understand the processes leading to Cesarean sections, or how these processes are experienced by women themselves. .

This dissertation will examine the social-psychological and social structural antecedents of cesarean section as reported by women who experience it. My dissertation addresses this research questions: How do healthy, well nourished women with healthy fetuses explain how they come to have cesarean births? How do women in different social classes account for why they had a cesarean section or why they did not? What social processes work on these two different groups? Do they give different or similar reasons for having cesarean sections? Do they have similar or different outcomes?

The theoretical framework for this research is based on social construction theory, originally discussed by Berger and Luckman (1966). How are cesarean sections socially constructed? . How do women experience and assign meaning to pregnancy and

childbirth? How are Cesarean sections interpreted or constructed by the women affected by them?

Cesarean section epitomizes the medicalization of childbirth, a process in which control of childbirth was taken from women and midwives and transferred to doctors and hospitals. As mothers lost power and control over the birth process, so too their own perspectives were eliminated from the dominant medical discourse about childbirth. By allowing women to tell their own stories, we are listening to the voices that have been silenced. We are, as Dorothy Smith recommended, beginning from the standpoint of women.

Explanations for Rising Rates of Cesarean Sections

Maternal Characteristics

The single biggest predictor of whether women will have a cesarean section is if they had one for a previous birth. This is despite large studies showing the likelihood of uterine rupture for vaginal birth after cesarean (VBAC) is essentially the same as that for women without previous cesarean (Flamm, 1991).

The rates for repeat cesarean decreased in the 1990's partly due to increases the number of VBAC's. VBAC's rose from less than 5% to 28% (Menacker, Declercq and Macdorman, 2006). However, the trend toward VBAC was short lived and the cesarean section rate is rising again (Flamm, 2002; Menacker, Declercq, and Macdorman, 2006). Part of the problem is the increased rate of artificial labor induction, which can be dangerous for women with previous cesarean section. Inducing labor in women with a previous cesarean section raises the uterine rupture rate above that of vaginal birth.

Maternal social characteristics such as health insurance, education and country of origin affect the likelihood women will have cesarean sections.

Women with private insurance are most likely to have a cesarean section followed by women with Medicaid (Gould 1989; Russo CA, Wier L, Steiner C. 2009). Gruber (1999) found that when Medicaid reimbursement for cesarean section was lowered, the likelihood of cesarean also fell. Women with the least likelihood of cesarean section are those no insurance (Russo, Wier, and Steiner, 2009).

Ironically, women who have health insurance are more likely to have prenatal care, to be well nourished, better educated and have fewer low birth weight infants. Yet insured women are more likely to have a cesarean section. Women with Medicaid or no insurance are more likely to suffer from poor nutrition, have less prenatal care and less access to treatment for complications. Poor women are more likely to have low birth weight infants but are less likely to have a cesarean section.

Insurance status is not an entirely clear cut issue. Canada, where all citizens are covered for health and childbirth services, has a similar rate of cesarean as the United States. Though Denmark and Sweden also cover all women for childbirth services, they have far lower cesarean rates. In Denmark and Sweden midwives commonly assist at home births and have even lower infant mortality rates than the United States or Canada (Wagner, 1993).

In the United States, the higher women's education, the more likely they are to have a cesarean section (Gould, 1989). There is little or no data on why cesarean section rates are higher in more educated women. It may be related to more highly educated women having babies at later ages and having fewer children, so that a premium on

perfection is placed on the fewer children born. Educated women have better income and are more likely to have health insurance at the same time they have better nutrition and produce larger babies. Ironically, cesarean section for "macrosomia" is a new and growing reason. This diagnosis means the doctor predicts that the baby too big to be born vaginally. This is frequently diagnosed before labor, a time when the pelvis and vagina expand to meet most birth demands.

More highly educated women have more prenatal care. Hence problems that do develop can be caught earlier. Women with higher educational levels are closer in social class and race to physicians and may also come to share doctor's higher value on cesarean birth as "better" for their babies.

Maternal physical attributes that affect the likelihood of cesarean section include women's age, weight and physical health.

Older mothers are more likely to have a cesarean, especially women over the age of 35 (Menacker, Declercq and Macdorman, 2006). Older mothers are more likely to have pregnancy and labor complications, and are also more likely to have insurance and higher education levels (Martin, Hamilton, Sutton, Ventura et al. 2009; Menacker, Declercq and Macdorman 2006).

Being overweight increases the cesarean rate for reasons that are unclear. Overweight women tend to have poorer nutrition and poorer health generally. Women who are or become very overweight are more likely to become diabetic during pregnancy (Weiss, Malone, Emig, Ball, Nyberg and Comstock, et al 2004). While little research is done on staff or patient feelings about discrimination against larger size women in obstetric settings, some obese women report feeling discriminated against in interaction

with midwives and physicians (Nyman 2008). The discussion of potential bias against larger size women in birth care has just begun (Robbins 2007).

Chronic diseases such as diabetes, heart disease, Lupus, asthma, and HIV increase the likelihood of maternal complications in pregnancy and birth, and increase the cesarean section rate. Mothers with chronic diseases experience more physical stress during pregnancy. Diabetic women may have trouble regulating their sugar metabolism or their kidney function and may have unusually large size babies. Women with heart disease can develop heart failure, and those with Lupus often develop clotting problems leading to miscarriage.

Cesarean sections are recommended for HIV positive women to prevent direct contact of maternal blood with the fetus. Women with active Herpes sores may infect their fetus and cause permanent damage, and so are recommended to have cesarean sections during outbreaks.

In order to look closely at social influences on cesarean section, women with pre-existing medical conditions named above were excluded from this study

Other maternal physical attributes that could affect the likelihood of cesarean section include abnormal pelvis size or shape resulting from a birth defect or an auto accident, for example. In the past, some women who suffered from rickets had malformed pelvises that made vaginal birth difficult or impossible. Interestingly, while the actual incidence of physical deformities has decreased, more laboring women now receive a diagnosis of cephalopelvic disproportion (CPD), indicating the baby's head is too big to pass through the mother's pelvis.

Cephalo-pelvic disproportion (CPD) is frequently over diagnosed (Cohen, 1991).

A correct diagnosis of CPD can only be done during labor because the baby's head must descend into the pelvis before disproportion can be gauged. What might look like a large baby may be able to pass through the pelvis because women's ligaments and bodies expand temporarily to accommodate quite large babies. Related to this condition is "macrosomia", meaning "big baby"; mentioned earlier. Women are frequently discouraged from even attempting to deliver large babies vaginally by doctor's scenarios of babies shoulders being broken or extensive perineal tearing. Women with normal concerns or fears of passing a baby vaginally may loose heart and opt for a cesarean if their physician indicates this is best, without even trying for a normal vaginal delivery.

Some physical or medical conditions do not develop or become apparent until women become pregnant. Toxemia is a condition that only arises during pregnancy, and most often during first pregnancy. Toxemia, also called pre-eclampsia, may lead to eclampsia, which is a dangerous and sometimes fatal condition characterized by swelling, high blood pressure and protein in the urine. Kidney and liver damage, seizures and death can result (National Women's Health Information Center, 2009). Artificial induction of labor is recommended but cesarean section could follow if induction is not effective. Other conditions arise at the time of labor and birth. These few conditions are absolute indications for cesarean section. Placenta previa is a condition where a woman's placenta is attached to the part of the womb close to the cervix and may block the opening of the cervix, causing hemorrhage. A woman's placenta may also prematurely or abruptly detach from her womb, leading to life threatening hemorrhage.

The length of time women are in labor is a more subjective indication for cesarean section. Medically, long labor is termed dystocia or "failure to progress". Arrested labor

is when labor stops entirely or stops being "productive", that is, stops advancing the fetus through the birth process. The standard labor schedule was made decades ago, and the linear progression mapped there no longer matches what is observed today, yet is still the basis of medical expectations for labor today (Zhang, Troendle, and Yancey 2002). The labor schedule describes three stages of labor and prescribes time tables for each stage. If women's labors do not adhere to these schedules, comments are generally made urging more speed in labor. Depending on the context, these comments may have either an encouraging or discouraging effect on women and the course of their labor.

Maternal Preference

Women who have one cesarean section are less likely to have any further children (Porter, van Teijlingen and Templeton 2003). Those who do have subsequent children are most likely to have them by cesarean section. Is this due to maternal preference or something else?

Nelson's research (1983) shows that middle class women tend to want more active involvement in birth and tend to believe they will have some control over what happens. Nelson describes working class women's desire to be "put out" or remain passive in the birth process if they have to remain conscious. This is consistent with other findings about social class and interaction with health care personnel (Conrad and Kern 1994).

Midwives and childbirth educators encourage women to make a birth plan, outlining their preferences, goals and expectations for birth. This might include the presence of certain support persons, playing certain music, use of relaxation strategies

and plans for pain relief such as baths, showers, back rubs and physical movement.

Recently, a flurry of medical articles claim women now demand cesarean sections, that women prefer surgery to normal vaginal delivery and that doctors are being asked to perform unnecessary cesarean sections (Flamm 1995). A few doctors have even raised the question "Should all women be offered prophylactic cesarean at term?" (Feldman and Freiman 1985).

Nurses Gamble and Creedy (2000) reviewed ten medical articles about women ostensibly asking for cesarean sections. Gamble and Creedy found that in the medical literature there was no distinction between when women agreed with their doctor's recommendation for cesarean section and when women asked for cesareans themselves (2000). When women perceived their baby's life or health was endangered they did ask for a cesarean section, but women did not ask for cesareans in the absence of current or past medical reasons (2000).

In other work, women who have not yet given birth may say they prefer a cesarean in order to avoid fear of pain in labor and the unpredictability of spontaneous delivery. Celebrity cesarean sections by appointment are widely publicized.

Fetal Characteristics

Some fetal conditions clearly require cesarean section, while cesarean section for other fetal characteristics is considered a more subjective decision. Clear indications for cesarean section include birth defects such as spina biffeta, the damaging effects of which can be minimized by avoiding vaginal delivery. Similarly, if the umbilical cord is wrapped tightly around the fetus' neck or if there is other physical impediment to oxygen

reaching the fetus. If fetal movement stops or the heart rate decelerates, or if the fetal heart rate does not change appropriately, the fetus may be in distress and must be delivered immediately. If a fetus persists in a transverse or other position impossible to deliver, a cesarean section is necessary. More indications are added to reasons for cesarean as time goes on. Many other fetal characteristics are sometimes used to perform a cesarean section. If a fetus is in a breech position, if labor takes longer than the allotted time (times vary from hospital to hospital, some as long as thirty six hours, others as brief as six hours), if labor is not progressing according to expectations. Many women delivering twins or other multiple births are automatically sectioned.

Fetal distress is diagnosed far more frequently than actually incidence (Banta and Thacker 1979; 2002; Schwartz and Young 2006). Fetal distress may be due in part to induction of labor with pitocin, which may stress mother and baby (Simpson 2004).

Pitocin frequently increases contractions beyond the tolerance of many women to endure without medication (Simpson 2010). Pain medication, whether in the form of epidural anesthesia or narcotics injections, tends to lower maternal blood pressure and slow the breathing and movement of the baby. This can lead to concern for health of the fetus and slower monitor tracings, indicating a stressed fetus.

Though routine use of electronic fetal monitors is known to increase the unnecessary cesarean section rate (McCusker et al: 1988), it is still done as a way to document labor progress. Why would hospitals use electronic fetal monitors even though most of the time the alarm tracings are inaccurate? Irene Butter discusses the frequent implementation of untested technology in birth and the negative impact of this policy (1993). A more recent article outlines specific electronic fetal monitor tracings that

indicate actual fetal distress and minimize the surgical impact of false positive results (National institute of Child Health and Human Development Research Planning Workshop 1997). Still, continued use of inaccurate technology begs the question: do electronic fetal monitors have some other effect congruent with the needs of hospital routines other than monitoring fetal heart beats? Are electronic fetal monitors a way to physically restrict women's movement from the labor bed? Has the hospital become "contested terrain" (Edwards, 1979).

Wagner (2000) raises several challenges to the claim that women make informed choices for cesarean section over vaginal birth. He argues that some doctors promote cesarean section as a better form of birth. Wagner show how doctors promotion of women's choice of cesarean section is more related to benefits for doctors than benefits to women or children. Vaginal Birth after Cesarean is better for women and babies than repeat cesarean section, but since VBAC is not "doctor friendly", it is not encouraged. Wagner argues that obstetricians present information in a biased way, minimizing cesarean section risks to benefit themselves rather than their patients. Fetal lacerations occur 1.9% of the time yet are rarely recorded by obstetricians (only 1 in 17 cases of fetal laceration were recorded by obstetricians) (Wagner 2000). Cesarean section when the baby is not in trouble is more dangerous than a vaginal birth, and if women are choosing this in the absence of complications Wagner feels they are not uninformed of the risks but are misinformed. Because of physicians' greater power and cultural authority, patients typically do not question their recommendations (Starr 1982; Anspach 1992).

Maternal-Fetal Interaction

Maternal-fetal interaction refers to the position of the fetus in the mother's womb. Some fetal positions may make it difficult or impossible to deliver vaginally. Indeed, bad fetal position, called malposition, is related to increased rates of cesarean, operative vaginal delivery, vaginal tearing and increased maternal blood loss (Senecal, Xiong and Fraser 2005). Babies in frank breech position, (where the baby's buttocks or feet rather than her head comes first) were vaginally delivered in the past. Vaginal breech delivery is becoming less and less common.

This has lead to de-skilling of doctors in the techniques for delivering breech babies vaginally. Fewer breech vaginal deliveries means fewer doctors are skilled in the technique which means fewer new doctors are taught the old ways, which increases the likelihood of difficulty with unpracticed procedures. This in turn increase the risk for damage to babies if delivered vaginally by inexperienced doctors.

Other poor positions for the fetus include transverse lie, where the fetus is in a position transverse to the cervix instead of parallel with it. A position where the fetus persistently has its head posterior to the cervical opening or is facing up "sunny side up" instead of down may increase the duration and pain in labor and make delivery much more difficult.

Poor fetal position may or may not be detected. Doctors are not as finely trained in assessment of fetal position compared to nurse midwives or to lay midwives. Attempts to turn the fetus to a more birth friendly position often need to be made prior to the engagement of the fetus in the pelvis, so early assessment is key.

Doctor Preferences or "Practice Style"

When asked about their own preferences for birth, 31% of female obstetricians prefer cesarean section even in the absence of any medical indications (Al-Mufti, McCarthy and Fisk:1997). It follows that if obstetricians are more likely to prefer cesarean for themselves or their wives, then when they do their best for their clients they would naturally be more likely to offer cesareans than if they preferred normal vaginal delivery.

Some doctors have higher cesarean section rates than other doctors, even controlling for type of practice or severity of maternal complications (Goyert, 1989). This is termed "practice style" (Goyert, 1989). In an effort to explain variations in doctors' cesarean rates, Tussing and Wojtowycz (1993) looked at demographic characteristics. They found doctors' own demographics have significant effects on cesarean section rates. Tussing and Wojtowycz examined New York State doctors' age, gender, location of medical education and medical school graduation year and compared cesarean section rates. They found that female doctors have a slightly lower overall cesarean rate than males do, but were more likely to perform a cesarean section for dystocia, or "failure to progress" in labor (1993).

Doctors who graduated from medical before 1977 did not have lower rates of cesarean section than doctors who graduated after 1977. In fact, more recent graduates had lower cesarean section rates for dystocia (Tussing and Wojtowycz: 1993).

Board certified obstetricians have significantly higher cesarean rates, yet doctors who are also professors have lower cesarean rates. Foreign medical school graduates were more likely to perform cesarean sections than those attending American medical

schools (Tussing and Wojtowycz:1993).

Doctors' Concerns About Malpractice

Another issue for doctors is malpractice liability. In an atmosphere where defensive medicine is common, when there is doubt about the safety of vaginal birth a cesarean is more likely to be performed (Wagner 1994; Cohen and Estner 1983).

Medicalization of Childbirth

A final explanation for increasing use of Cesareans is historical. The history of cesarean birth is part of the history of medicine in the West, and extends the range of physicians' professional dominance. Several excellent sociological analyses examine the rise of regular physicians who used their social capital and status as white males with ties to upper and middle classes to push out other local practitioners, including midwives. Midwives, practitioners of chiropractic, herbalism, barber surgery, naturopathy, homeopathy, osteopaths and apothecaries were pushed out of work by regular doctors. This occurred when regulars' own methods were not better than and frequently were worse than the practitioners they replaced. (Paul Star 1984; Freidson, Wertz and Wertz 1994).

Richard and Dorothy Wertz document how regular doctors sold their attendance at births and invented instruments like forceps and other technologies such as anesthesia to make their practices more attractive to middle class women who were part of a social movement to use more science for the betterment of their families. (1994)

Regular doctors united as a group and lobbied for the establishment of government licensing requirements. Rival medical schools were closed and only schools whose admission and graduation standards were controlled by the AMA were established after issuance of the Flexner report in 1910. This decreased competition and excluded all persons not selected by the regulars(Conrad and Schneider 1994). Since 1900, birth has moved from the home to the hospital, where today 99% of American women have their babies. Cesarean section rates rose 500% from 1965 to 1989 (Menacker, Declercq, Macdorman, 2006; Statistical Bulletin, 1986; Moien, 1987:241; Placek, 1986:9; Myers and Gleicher, 1988; Silver and Wolfe, 1989, Stafford 1990), yet very little is published about social psychological antecedents or consequences of medicalized birth, particularly cesarean delivery (Cohen and Estner, 1983).

Perspectives on Cesarean Section

As the previous section suggested, there is considerable disagreement about the benefits of Cesarean sections and the indications for using them. The debates around Cesarean sections have been framed from two broad perspectives: the medical perspective and the social perspective.

<u>The Medical Model</u>

The medical model frequently assumes childbirth is a crisis situation that requires medical management in the hospital. Many of those who subscribe to the medical model assume cesareans are greatly beneficial for children while a necessary inconvenience for

mothers. Some obstetricians even recommend prophylactic cesarean section at term be offered to all women (Feldman and Freiman 1985).

At the same time, other obstetricians are much more critical of what they view as the overuse of Cesarean sections. Both the proponents and critics share similar assumptions. Medical critics do not question the value of Cesarean sections when used appropriately, but rather criticize practitioners for going beyond appropriate medical indications.

High cesarean section rates and the obstetric tradition of "once a cesarean section always a cesarean section" were challenged by Bruce Flamm MD (1990; 1995), the American College of Obstetrics and Gynecology (1982;1985), the World Health Organization (Wagner, 1993) and other medical experts publish on causes and propose solutions to the problem of unnecessary cesarean sections.

Bruce Flamm's work uses a database of thousands of births to show that at least 80% of women who had previous cesareans can have vaginal births if given the chance. Women who had previous cesareans 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). Repeat cesareans account for one half of all cesareans, and increasing the VBAC (vaginal birth after Cesarean) rate is one way to decrease the overall cesarean rate (Flamm, 1990).

Other selected American efforts to reduce the cesarean rate were promising, but were not adopted widely. At one Chicago hospital the vaginal birth after cesarean (VBAC) rate was 70% among women who attempted 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 American College of Obstetricians and Gynecologists (ACOG) issued new "Guidelines for Vaginal Birth After Cesarean" in 1982, and reissued these guidelines in 1985, and several times in the 1990's. The guidelines state that cesarean section should be performed only when the risk of the child being born vaginally is greater than the risk of surgery and anesthesia. These guidelines reinforced a lower cesarean section policy until the year 2002, when the policy began to favor cesarean section more than in the past (ACOG Committee Opinion Number 271. 2002). Rates of vaginal birth after cesarean declined.

Why has the doctrine of "once a c-section always a c-section" continued to be followed 95% of the time, even when it went against ACOG guidelines (Placek, 1986:9). Medical studies do not explain why the rates continue to be so high, but convenience, fear of malpractice and "maternal request" have been identified as possible reasons (Wagner, 2000).

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 earlier charts showing 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 . (McKinlay and McKinlay 1977).

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). Doctors themselves cite social, demographic, legal and technological changes that contribute to this shift in goals (Bottoms, et al 1980).

The World Health Organization takes a public health point of view of childbirth, and issued a report on their international conference on childbirth in 1994. Its conclusion was "There is no justification for any region to have caesarean section (CS) rates higher than 10–15%" (WHO 1985). Entitled *Search for the Birth Machine*, and edited by Marsden Wagner MD, the report argues that midwives are the appropriate caregivers for normal pregnancy and birth (1994). The international consensus concluded that doctors' care should be reserved for pregnancies and birth that require technical and surgical expertise. The United States is among only a few countries who use surgeons to give routine pregnancy and birth care, a practice that uses monies and resources that could better be used elsewhere in preventive women's health practices.

The report goes on to cite research that showed midwives in the U.S. at that time had less than a five per cent cesarean rate (Rooks, et al 1989). A smaller study of doctors in one city showed they had a rate that was more than 2.5 times greater than in a birth center run by midwives (Baruffi et al 1990; Wagner 1994).

The editor, Wagner, acknowledges that cesarean section for "premature separation of the placenta, placenta previa, eclampsia or a pathologically small pelvic outlet has saved the lives of many women and babies. For other conditions, such as possible fetal distress and prolonged or difficult labor, caesarean section may be beneficial" (1994:181).

Wagner states emphatically that cesarean sections are dangerous for women and for babies. Overall maternal mortality rates are four times higher for cesarean delivery than vaginal birth (Petitti 1982; Wagner 1994:183). Elective repeat cesarean section mortality is twice as high as mortality for vaginal birth (Petitti, 1982; Wagner 1994: 184). Maternal mortality often not reported. In one American study,

> Five of sixteen maternal deaths after cesarean (nearly a third) had not been reported (Ruben et al 1981). Nine of these sixteen deaths were found to be due to the cesarean section per se.... the cesarean section mortality was six times higher than the maternal mortality rate for all vaginal births (Wagner 1994:184).

All surgery carries risk. Serious physical injury during cesarean section can result (Wagner 1994:184) Physical sequelae accompany even cesarean sections that go well. Cesarean section mothers take longer to recover, need more help at home, return to work later (Wagner 1994:184).

If women have one cesarean section, then a second cesarean section is routine for subsequent births. As the head of the obstetric section of the World Health Organization, Wagner recommends vaginal birth after cesarean and argues against routine elective cesareans (1994:182-183). Wagner details cesarean risks for the baby. Cesarean babies tend to be born prematurely due to miscalculation of due date, so have lower birth weights because they are delivered too early. Cesarean section babies tend to have more

respiratory distress syndrome, which can be fatal (1994:185). Babies born by emergency cesarean section have higher mortality rates and higher need for the intensive care unit. Subsequent children born by elective cesarean also have higher mortality rates (Hemminki 1987; Wagner 1994:185).

Doctor and hospital convenience is also a factor, as evidenced by the majority of both elective and emergency cesarean sections occur Monday to Friday during daylight hours (Hurst and Summey 1984; Wagner 1994:188).

In sum, Wagner argues that cesarean section has become epidemic. While cesarean section certainly saves lives of individual women and babies the costs of widespread cesarean section far outweigh the benefits. Countries with highest cesarean section rates do not have correspondingly lower infant mortality rates. Developed countries with the lowest cesarean section rates also have low infant mortality rates. The over-use of cesarean is part of the struggle for control of birth and part of the increasing influence of technical and medical interests over basic public health measures (Wagner, 1994).

The Social Model of Health

Social psychological sequelae of cesarean birth are examined in the social model. The social model treats childbirth as a normal natural process that occurs nine out of ten times without medical intervention. The social model assumes that the interests of mother and child are congruent rather than opposed. The comparison of the social model of childbirth with the medical model is well characterized by Marsden Wagner, MD (1994)

and Robbie Davis Floyd (1992). For the reader's convenience, I have summarized the main points of contrast between medical and social models in Table 1.

Feminist perspectives on childbirth illustrate one use of the social model. Feminists emphasize the positive cultural, social and psychological meaning of childbirth as a natural, normal, woman centered process, which belongs at home. They emphasize the negative consequences of cesarean section.

Feminists argue that modern western medicine inappropriately treats women as diseased (Cohen, 1983). Medicine treats pregnancy as an illness and the normal birth process is made into a medical-surgical crisis. Feminists argue that medical intervention has not been shown to improve overall birth outcomes (Cohen, 1991). They point out that the United States ranks 25th in the world in infant mortality despite high cesarean rates (Morbidity and Mortality Weekly Report: 1999). There has not been any consistent correlation between rates of cesarean birth and infant mortality rates (Wagner 1994: 178).

Some feminists argue that capitalism and patriarchy combine with medicine to systematically disempower women throughout their lives, especially in childbirth (Ehrenrich and English, 1973). Every phase of women's lives, from menstruation to ovulation, gestation, lactation and menopause, is treated as an opportunity to control women's reproductive power and selfdetermination (Cohen, 1983, 1991; Ehrenreich and English 1993; Rothman 1982, 1989; Martin 1987, 1992; Scully 1980, 1994). Feminist criticisms of Cesarean sections are discussed in the sections that follow.

Table 1: Models of Childbirth, from Marsden Wagner, 1993; Davis-Floyd, 1992

Comparison	Social Model	Medical Model
Subscribers	midwives, public health, social scientists, women's groups.	doctors, obstetricians, some nurse midwives, nurses.
Approach	holistic	reductionist
Philosophy	humanistic	atomistic
Outlook	most births happen without intervention	birth dangerous for mother and baby
Underlying belief	birth is natural process	birth is dangerous, need to be closely monitored
The body	trust women's bodies	body as machine, can break
Technology	distrust of technology	trust technology
Unit of analysis	mother and baby family unit	two patients: mother; baby
Mother and baby	interests congruent	interests may conflict
Whose knowledge counts	midwife, caregiver, mother, baby	medical knowledge legitimate lay women cannot understand complexities of birth
Relationships	relationship between women and attendant very important	relationship between mother and attendant secondary to staff rotational schedule
Control	mother in charge of birth, midwife assists	doctor in charge of birth, makes objective decision
Risk	avoid labels "high risk", inaccurate, may lead to self-fulfilling prophesy	risk assessment helpful. Some doctors specialize in high risk pregnancies
Import of social support	social support is important part of care	social support secondary to medical intervention
Role of social support	family and social support system intact at birth	family and social support limited
Interventions	interventions see p 34	medical interventions necessary, life savings
Target	lower, some mid income women	middle and higher income
What counts as knowledge	qualitative experience of attendants important	quantifiable measurements most important
Orientation of caregiver	midwives 'help people out'	doctors "deliver" the baby to the parents
Technology research	urge research into assessment of technical interventions before use	technology used without formal assessment eg: electronic fetal monitor standard of care
Goal	health mothers and babies	health of mothers and babies
Responsibility	shared mother and caregiver	doctor

Women as Diseased. Ehrenreich and English analyze the history of doctors advice to women over the past one hundred fifty years (1979) and have come up with startling examples of sexism and maltreatment. In the last century, hysterectomies and clitoridectomies were performed to stop masturbation which was believed to cause insanity, rebelliousness or simple disagreement with social roles.

Rothman points out that women are often treated as if their bodies are dangerous to the fetus rather than sources of nurture and a safety, a place for the fetus to grow (1982; 1989).

Ironically, Hillan points out that while women are treated as diseased during pregnancy and birth, once they have had their cesarean section, they are no longer considered sick and are expected to care for their newborns as if they were not weakened and in pain from major abdominal surgery. For example, lifting is generally not allowed after surgery. Telling a woman not to lift her newborn or leaving her unable to lift her older toddler at home is unrealistic at best. Hillan discusses how Ann Oakley (1983) showed that cesarean section :

> is conceptualized differently from other types of abdominal surgery. The term section is used as opposed to 'surgery' or 'operation' and thus is associated with a difference in the way in which the effect of cesarean section and other surgical procedures are seen. A common, generally accepted consequence of major surgery is depression yet the same assumption is not made about cesarean section (Hillan, 1992:160).

Like other surgical patients, women may feel depressed or more emotional than usual, worry about the scar, and usually take longer to recover physically and psychologically (Hillan 1992:160; Janis 1958).

Barbara Katz Rothman identifies ways in which Western medicine treats the human body as a machine, one that breaks down and can ostensibly be fixed or improved

with technology (1982:34). Rothman argues that pregnancy and birth in the hospital are inappropriately treated using an industrial production model. There medicine uses ideology labeled as science to predict and control women and birth. Rothman argues that babies are commodified, and that women are treated more like vessels to contain babies rather than adult human beings equal to their doctors (1982; 1989).

Emily Martin builds on Oakley and Rothman's ideas and goes into greater theoretical depth. As an anthropologist, Martin does a cultural analysis of reproduction generally and includes cesarean birth in her analysis. Martin views science as culture, and shows how medical science uses many cultural stereotypes which can lead to biased observations and recommendations. She details doctors' pejorative language in describing woman and birth. The uterus is described as an involuntary muscle not under women's control, so it is not the woman but her uterus that expels the baby at birth (1992:xi). At least the early obstetric textbooks described environmental influences that affected the pace of labor, information wholly lacking in today's textbooks.

Martin examines the contradictions within the medical model's use of the machine metaphor and the industrial production metaphor. Martin says women's changing bodily processes can better serve as a model for a new systems theory that sees the body as dynamically adjusting to differing demands and environments.

Robbie Davis Floyd argues that birth is used as an opportunity for ritual indoctrination with societal ideals of womanhood and especially motherhood (1992).

Nancy Cohen is a writer and activist who believes that 95% of all cesareans are unnecessary, that cesarean delivered babies are no better off and are often harmed by cesarean section. She argues that women often experience post traumatic stress after

cesarean section, have difficulty bonding with their children and have fewer children as a result. She says that babies become imprinted on the drugs for pain and anesthesia their mothers receive during labor during surgery, thus grow up to be drug addicts.

Cohen entitled her books about cesarean section *Silent Knife* (1983) and *Open Season* (1991). Her first book had a political impact by successfully promoting vaginal births after cesarean (VBAC). Cohen's polemical style obscures her extensive research. She views obstetricians as failed surgeons who see cutting babies out of their mothers as the best, most convenient and cost effective method of birth (for doctors). She offers support for the argument that obstetricians value surgical birth over normal vaginal delivery.

Cohen has encountered hundreds of women who have had bad experiences with cesarean section, but does not discuss any women who felt more positively about their cesareans. Her portrayal of women describes them as mostly duped by a highly misogynistic medical system and calls for more resistance by women. Cohen claims that cesarean section is an abuse of obstetrician's power and is a form of rape. She argues that women are silenced from making complaints or even recognizing their angry feelings with doctors for operating on them.

Disempowering Women. Giving birth produces changes in social roles and in psychosocial identity. Ann Oakley (1980) documented that even normal births involve loss on several levels. Women may have loss of "self confidence, loss of body image, loss of previous employment" (Hillan 1992:159)

Others go farther in condemning routine over-use of cesarean sections. In Sheila Kitzinger's chapter "Birth and violence against women. Generating hypotheses from women's accounts of unhappiness after childbirth" (1992), Kitzinger makes a case for medicalized birth, including cesarean, as a form of rape. She cites the United States Department of Health and Human Services report on cesarean section findings: that as a result of cesarean section women experienced feelings of powerlessness, decreased autonomy, and lower self esteem (1981). Kitzinger's interview analysis goes on to say "... doctors define birth, while women experience it" (1992:63). Kitzinger argues that hospital birth disempowers women because control is taken from women by the more powerful medical system. Doctors may emotionally blackmail women into submission. "....By threatening her with the baby's death, obstetric power is legitimized" (1992:73). Further parallels between medicalized birth (including cesareans) and rape include the following: in both cases women are silenced, not allowed to talk about their experience; when they do speak up they are either ignored or their responses medicalized; women feel guilty for what happened and blame themselves; there is little or no social support for the traumatic experience, and "these emotions are perceived as trivial" (1992:67).

Depression following the event is very common, but not expected. Women feel out of control, violated, and may experience depersonalization. They complain of sometimes severe physical pain and that they have been mutilated. They may have been "stripped, forcibly exposed, [her] legs splayed and tethered, and [her] sexual organs put on display" (Kitzinger,1992:67). Rape and birth trauma survivors are first "shocked, numb and emotionally anaesthetized" (Kitzinger,1992:73). While most women do not file formal complaints, Kitzinger says women traumatized in birth describe the medical

birth experience as raper survivors describe their experience, as "butchery". After birth, traumatized women have "feelings of helplessness and self-disgust when they were unable to control bladder, bowels or leaking amniotic fluid" (1992:74). In rape and in traumatic birth, women take a long time to recover and feel they should be 'over it' even though they still have significant emotional trouble (1992).

Rationale for This Research

As was noted in the previous sections, the medical model focuses on medical indications for cesarean section while excluding the perspectives of the women who undergo this procedure. Feminist work does address mothers' concerns, but this body of work often assumes negative consequences of cesarean section and broadly defines cesareans as harmful to women and of questionable benefit to children. Feminist writers that captures the voices of women, rather than assuming harm, base their conclusions on data and samples that are self-selected. Nancy Cohen, for example, uses women's accounts to indict the medical system on grounds of extreme cruelty in the overuse of cesarean sections (1983; 1991). Yet we do not know if the women Cohen speaks about are typical of American women because they have come to her because of problems with their cesarean experience.

This dissertation attempts to bring feminist issues about childbirth and cesarean section into a study using a more heterogeneous sample of socio-economically diverse women. In order to highlight the social contribution to cesareans, I excluded women with physical illnesses. Rather than making *a priori* assumptions about women's childbirth

experiences, this research seeks to *discover* their experiences of childbirth and cesarean section.

The next chapter, Chapter 2, Research Methods, describes how this study was conducted, the sample, how women were chosen, how they were contacted for interviews, and how the interviews were conducted and analyzed.

Chapter 3, Pathways to Cesarean, describes the women who requested a cesarean section, the context in which requests were made, reasons for their requests, and the response to their requests for cesarean section and whether they had a cesarean or not.

Chapter 4, Women who Agreed to Cesarean Section, details the findings and analysis for women who agreed to cesarean section. Agree-ers are defined as women who neither requested nor tried to avoid a cesarean section. Issues of informed consent are addressed.

Chapter 5 is concerned with self-described Cesarean Section Avoiders, and includes women who wished to avoid cesarean, whether or not they were able to do so. The contexts, reasons and strategies women described are included in the analysis.

Finally, Chapter 6, Conclusions, presents conclusions of this study and raises questions for future research.

CHAPTER 2

RESEARCH METHODS

This research was approved by the Institutional Review Board at University of Michigan Medical School. As noted in the last chapter, the purpose of this research is to describe and analyze the experiences of women undergoing cesareans. I enlisted the support of a faculty member at a large, university-affiliated teaching hospital, who helped me obtain a sample of women who had given birth in a large, university affiliated teaching hospital.

Since patients' encounters with the healthcare system are likely to vary according to socioeconomic status and ethnicity, my goal was to recruit a diverse sample of women. When the first source yielded primarily insured white women, to obtain a more diverse sample I applied for and was granted approval to recruit women from two community clinics whose population included more women on Medicaid.

The Sample

Division by Class

Nelson (1983) found that middle class and working class women have different expectations and preferences in childbirth. With cultural changes and the mushrooming use of birth technologies in recent years, the actual preferences of middle class and

working class women may have changed substantially, but there may be new differences across classes.

For this reason, participant's private insurance status or medicaid/WIC eligibility are used as class markers for initial selection of whom to interview. Women with private insurance are grouped as middle class, while women with WIC eligibility or medicaid are grouped together as working class or low income.

Four groups of women comprise the sample

11 women with private insurance who had a vaginal birth
11 women with private insurance who had a cesarean birth
9 women with medicaid or WIC who had a vaginal birth
16 women with medicaid or WIC who had a cesarean birth

Table 2: Insurance Status by Birth Mode

Insurance Type	Vaginal	Cesarean
Private Insurance	11	11
Medicaid or WIC	9	16

Age

Although teens' pregnancy and birth have much in common with the experiences of older women, some clinics routinely categorize pregnant teens as "high risk" because of early childbearing. To make sample groups as comparable as possible women under age 18 are excluded (Nathanson, 1994).

Recruitment Sites

Women were purposively selected from one large teaching hospital and two women's clinics. The hospital serves primarily but not exclusively persons with private insurance, and the clinics primarily serve low income women with medicaid or who are eligible for the Women, Infants and Children Food Program (WIC) for low income women and their families.

Postpartum Health Not Adequately Assessed in Past

So far, postpartum health of mothers is measured only by death rates or immediate post operative complications occurring in the hospital (cite severs try Siefert, KA. Sent for possible, but unlikely article history of US Mothers act 1921 that decreased mortality). It is important that we ask about psycho-social as well as physical well being after women go home, because there are sequellae that do not require hospitalization but are nevertheless important. Indeed, complaints women may voice are often silenced by the admonition "Well, you have a healthy baby, that's the important thing".

Short Hospital Stays

The trend toward very short hospital stays means there is now there is less chance to learn about the social-psychological effects of cesareans than in the past. It required an Act of Congress in 1996 to for insured women to be entitled to two days in the hospital to ensure their physical safety after a vaginal delivery. Women with cesarean sections get slightly longer (Newborns' and Mothers' Health Protection Act, 1966).

This Method Taps Women Otherwise Unavailable for Follow-up

Interviewing women who came to the hospital for recommended six week check ups would have been an easy and quick way to obtain a sample. However, the head of obstetrics stated that sixty per cent of women giving birth there do not return for follow up checks (personal interview, 7/94). To interview women who did and did not return for recommended checkups required a different strategy.

Sampling

Starting with birth delivery logs and patient charts, women were manually selected from daily lists. This was time and labor intensive, so patient names and addresses were obtained from the hospital's records department which provided computerized lists of women who recently gave birth at their facility.

Hospital Based Recruitment

Letters requesting participation were sent to women's home addresses a month after birth. Women were asked to return a stamped self-addressed envelope indicating whether or not they were interested in being contacted for an interview. A telephone number was included if potential participants preferred to phone and leave a message.

Letters were printed on University of Michigan Center for Research on Social Organization stationary and Sociology Department envelopes were hand addressed. Letter salutations addressed individuals by name and stamps with themes of "love" or cherubs were used to make requests as appealing as possible. The return envelope was

enclosed so that when the letter was opened the return envelope with the pretty stamp fell into the potential interviewee's hand.

A follow-up phone call was made to women who did not respond. While most were happy to grant an interview, a few women declined citing busy schedules or family emergencies such as a family death, illness or their own early return to work . Two women were under age 23, involved in chaotic social situations, and preferred not to talk with a researcher. Once a refusal was made, women's decisions were respected and no further attempts were made to contact them. One woman agreed to an interview, but said she was involved in a legal suit against the hospital. She was respectfully disqualified.

The Study Itself

This study examines women's accounts of and feelings about their cesarean or vaginal births. In-depth interviews are an appropriate methodological approach.

Sample Size

The sample consists of forty seven face to face, in-depth, semi-structured interviews. For women with cesarean, eleven women were insured and sixteen had Medicaid. Eleven insured vaginal birth mothers and eleven Medicaid vaginal birth mothers were sufficient to achieve saturation on the main research questions, as evidenced by hearing the same stories over and over by the end of interviewing. The author did all interviews.

Selection Criteria

Medical Risk

To concentrate on the social and social-psychological rather than medical aspects of birth, the sample was composed of women without pre-existing medical conditions. The list of medical exclusions was adapted from the criteria used by Deborah Oakley et al. in their MD-Midwife study (Oakley, Murray, Murtland, Hayashi, Andersen, Mayes, and Rooks 1996).

Selection Criteria: Excluded Medical Conditions for Cesarean Study

The following conditions excluded women from this study: insulin dependent diabetes, hypertension, (if on medication at time of pregnancy), heart disease, chronic kidney disease, chronic lung disease (emphysema, uncontrolled asthma, TB), current addiction to a drug, alcoholism if currently drinking, epilepsy or seizure disorder (if on medication), multiple gestation (more than twins), adult mental retardation, acute mental illness (on medication or hospitalized during pregnancy). Initially hospital records but later women's self reports determined whether such conditions were present.

Social Class and Race

Race and class are salient characteristics in American health and healthcare, are often confounded with each other and at times confound research results. Empirical clarity suggested this small study focus on either race or class.. Social class rather than race were chosen to include in this study for a number of reasons. From a theoretical (Wilson 1979 and 1987) viewpoint, from my own professional training in class analysis,

and because of welldocumented race-related interviewer effects in face to face interviews, it made more sense to concentrate on the effects social class. Most of this sample was white; 44 women were white, 4 were women of color, including African American and Asian women). If successful, the current study will serve as a base to apply for research funds to study the responses of more women of color to their cesarean and vaginal birth experiences.

Importantly, common stereotypes cast middle class women as white and low income women as black, while neglecting middle class blacks and lower class whites. Many studies have been done on the two groups that fit the stereotype, but very little research has been done on the others. Working class and low income whites make up a substantial proportion of the general population, but like middle class blacks, have been nearly invisible in most research. Low income whites are visible in this study. A few women of color were interviewed. There may or may not be systematic differences in the way women of color and white women feel about their birth experiences in predominantly white hospitals. There is some evidence that African-American and white mothers have different views of mothering (Chodorow, 1978).

Cultural Variables

Culture is a powerful influence on perceptions of birth experiences (Jordan, 1978). In the location of the study, it was most practical to select women whose first language was English and who grew up in the United States.

Practitioner Type

Doctors attend more than ninety per cent of births in the United States, but more and more women are now attended by midwives (Martin, Hamilton, Sutton, Ventura, Menacker, Kirmeyer, and Mathews 2009). This is especially true at large research hospitals and low income neighborhood clinics like the ones used in this study. It is possible that women who choose midwives may not be typical in ways that have not been measured.

Midwives have different practice styles than doctors, and women report they receive more individualized attention from midwives as a group (Turnbull et al 1996). It is logical then, that women's feelings about their birth experience may be influenced by provider practice style. In order to maintain provider effects as consistent as possible, then, women who had midwives instead of physicians were also excluded from the study.

Timing of the Interviews

While interviews occurred as close to the actual birth in time as possible, it may have been intrusive as well as logistically unfeasible to conduct interviews any sooner than six weeks. For retrospective interviews, errors of recall should be minimized or at least standardized as much as possible. The time frame for interviews was generally limited to between five and ten weeks after birth. As one of the original research questions asked about the possibility of a relationship between feelings of depression and cesarean section, this time period appeared ideal.

Referrals

Referral numbers were provided to women who indicated they felt overwhelmed or depressed and in need of social-psychological support. Only two women were interested in availing themselves of such services at the end of the interviews. Phone numbers were provided and in one case a woman gave permission for the researcher to followed up with the county maternal support team.

Background of the First Sampling Site

Most persons admitted to this regional referral hospital are privately insured. Using insurance status as an indicator of social class, thirty privately insured women were recruited, half of whom had vaginal births and half of whom had cesarean sections. About fifteen percent of the births at this hospital are to women covered by medicaid, which was used as an indicator of low income socioeconomic status.

Recruitment

Initially, all potential respondents were sent letters of introduction containing self addressed stamped envelopes, requesting they indicate whether or not they were interested in participating in the study. The recruitment of women on medicaid was more difficult and considerably slower than the recruitment of privately insured women for a variety of reasons. Poverty and young age both contribute to making women's pregnancies higher risk, and low income women tend to have their babies at younger ages. Because so few medicaid mothers were seen at this site, and because of the strict

exclusion criteria of the study and difficulty contacting them, it became necessary to adapt the approach to recruit more women of lower socioeconomic status.

Whether by policy, preference or availability, a large porportion of young, healthy, low income women at this hospital are served by midwifery rather than physician services, making them ineligible for this study.

Those women who did meet the study criteria were often difficult to locate. They frequently moved in the month between delivery of their babies and my contact attempt, often left no forwarding address, and some even severed contact with parents or by now former boyfriends whose addresses they used earlier. Several telephones were disconnected and no new numbers were available.

Initial Contact with and Response by Potential Interview Participants

Once contacted directly, most women, regardless of insurance status, were willing to be interviewed. Many returned the response envelope with suggested times and directions to their homes. Two women even included detailed maps and one sent herbal tea. Several women did not wait for the mail, but telephoned immediately to arrange an interview.

Fewer than five women returned the self addressed stamped envelope directly declining an interview, and no follow-up was made to determine the reason for refusal. One woman very early in the study declined because she had actually had a miscarriage instead of a birth. Efforts to pre-screen potential respondents avoided making such a mistake again.

Those who did not respond by mail were contacted by telephone when possible, and in-person visits were made to two homes without phones to seek study participation. No one was ever found at one residence. Two other woman promised an interview when contacted by phone, but changed it twice and were not home at the time of the final appointment. I spoke to the grandmother of one infant, and she told me her daughter was visiting the infant who was unexpectedly hospitalized. No more follow-up visits were attempted with this person.

Further Sample Selection Sites

In order to speed the completion of the sample, another source of low income women was sought. After a referral, recommendation, and review by the governing board, permission to recruit women who attended a free clinic was granted.

Recruitment Strategy Adjustments

The original recruitment strategy of obtaining a list from the health facility and sending letters with stamped self addressed envelopes to addresses women provided had to be modified. The clinic was not willing to provide names and addresses, but was willing to offer women who met the selection criteria the chance to telephone me for a later interview appointment if the study would pay respondents a fee of twenty dollars for their time.

It was agreed that a staff member at the clinic would, at the end of their visits, ask eligible women who came to her office for other services if they were voluntarily

interested in the study. The financial incentive appealed to potential respondents, but in the end, most clinic clients did not meet selection criteria.

This was often because of very young age or the presence of medical risk factors such as substance abuse or physical illness. The clinic officially serves women and their children up to the age of twenty one, but many mothers turned out to be younger than eighteen. Three women from this source participated in the study.

Approaching a Third Sampling Site

Another community hospital clinic was approached and their Institutional Review Board approved recruitment of participants only indirectly Simple study advertisements were posted in the clinic or distributed by clinic personnel.

Many women responded by phone, however, most were ineligible because of medical risk factors or race, so it was agreed that staff would distribute the flyers according to the study criteria. At first, nursing staff and the physician balked at recruiting only whites. I provided a detailed explanation, they agreed to follow study criteria. However, few actual interviews were forthcoming after that.

Months later, the hospital appeared closed because of the transfer of medicaid services to another facility. After putting a lot of effort into recruiting women from this source and only getting four interviews, permission was granted to recruit from the physician's private clinic. At the same time the author decided to go back to the original large research hospital to capture the few remaining medicaid interviews.

The Interviews Themselves

Most interviews were conducted in women's homes, but a few were conducted at restaurants, the hospital cafeteria or clinic waiting room if preferred by the respondent. Questions were asked face to face, notes made and interviews tape recorded. Tapes and questionnaires were locked in the researcher's office. Respondents' full names are known only to the author, kept separately from any tapes.

The approximate length of the interviews was one and one half hours. A very few interviews lasted one hour, some were three hours. Most questions were open ended to allow women to define their own responses. The interview technique, guiding people through an interview with open ended questions, is a commonly used and effective way to explore issues in psychosocial research. The author gave her phone number and offered to accept any follow up calls should respondents wish to talk more. Only one woman made a follow-up call.

Conduct of the Interview

Each interview began with screening for medical and demographic study criteria. A carefully constructed list of 24 open ended questions based on the pilot study was used as a semi-structured interview guide (see Appendix 2).

Semi-structured rather than a more structured questionnaire was chosen for a number of reasons. In women's birth stories observing how they are constructed is important. One of the great benefits of asking women about their birth experiences is that nearly every one wanted to talk at length and in detail to an attentive listener.

A semi-structured interview (where women's feelings about all question areas were discussed but not necessarily in the same sequence) was also more practical than a set sequence of questions. This is mostly because women's answers to the first substantive question, "Please tell me about your recent birth experience", often lasted thirty to sixty minutes, during which time they answered the substance of later questions before being asked.

The researcher is confident of the validity and reliability of the questions because most of the time women talked about answers before questions could be asked. Lastly, the researcher clearly communicated to women being interviewed that they were the "experts" and she came to learn from them, rather than judging their responses.

Interview Fee

Because of the difficulty recruiting low income women for interviews, the last twenty five women to be recruited received a twenty dollar check at the end of the interview. There is no indication that the twenty dollar fee influenced what was said, beyond encouraging women to agree to do the interview in the first place. It was not unusual for working class women to offer to be contacted again if I had any further questions.

Funding of the Study

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Health Care Education and Research Foundation Student Award, (now called the Michigan Blue Cross and Blue Shield of Michigan Foundation Student Award).

Processing Interviews

Interviews were transcribed, and a case summary made for each interview, noting major points. Field notes taken during all interviews were done mostly as a backup if the tape recorder failed, but also as a way to note significant ideas or subjects to come back to, to be sure all the questions on the interview guide were covered, to note changes in facial expressions, tearfulness or to note if/when someone else entered or left the room.

Field notes made after the interviews recorded my first impressions of the interview as well as the 'process' I went through in thinking about the interview. Field notes also were useful for recording the initial interview summary, as a way to note non-verbal information such as the way women presented, a description of the dwelling or family situation, if an unusual circumstance such as a respondent's husband or mother stayed within earshot for more than a few minutes during the interview, and as a backup in case the tape recorder failed during the actual interview.

This is an example of field notes recorded after an interview:

> She was talking about all the fears she had about a vaginal birth that she really never had anybody to talk to about this. She never once mentioned reading a book, but she had a lot of fears about the consequences of a vaginal birth and um...whether she would be, whether she would change, whether haven given birth vaginally would change the way she felt sexually. Would change whether she became loose, physically looser after having the baby. Whether she would be as satisfying to her boyfriend, whether she would...whether it would hurt afterwards because sometimes it would hurt before. Um...whether she would be cut down there and it would burn when she urinated. She assumed an episiotomy was necessary. She knows a friend that was like superwoman and had this baby in like three hours. But, she is like completely opposite.

> She is very concerned about her physical appearance, and she is very attractive, and she's you know a little heavier, but she did just have a baby, and she wanted to get into a size five which is like really, really, really small. And it's really not realistic, but it's very important to her and one of the reasons that she's thinking about not getting pregnant again is because she doesn't want to look like she looked and she was very uncomfortable the whole time.
>
> This whole labor, 39 hours it really sounds like that baby was posterior, or there was a weird head position of the kid because first of all, he was breech and then they turned him but she never dilated beyond 6 and it's quite curious whether it was her fears about all the things that would happen if she did pass the baby or whether it was all the people in the room.
>
> All her friends, all her boyfriend's friends, all these medical students, all the stuff. She didn't say medical student, all the doctors... She didn't feel she could tell them to go away even though she knew that her boyfriend wanted at least her friends to go away. His friends didn't stay very long, but there's all these men. She said that she, you know you could see her. They had her upside down, you know her bottom's up. She wouldn't care if she looked good, but she didn't look good.
>
> And the part that's also interesting is that she observed her sister have her baby. And her sister had a bowel movement on the table when she was having the baby and she did not want that to happen. She did not want her boyfriend to see her have a BM and you know that's understandable. That's a very private act. And she didn't care about having her legs wide open, and she didn't care about urinating, but she did care about the BM and she asked for an enema and they wouldn't give her one. So, I think she had a lot on her mind.

The audio tape failed on two or three occasions, each time for only part of an interview. Each failure occurred after an interruption (for the telephone, a crying baby, someone at the door, another small child playing with the recorder during the interview). In these few cases, field notes were used to fill in as much information as possible soon after the interview.

The investigator performed all the interviews herself and transcribed ten interviews. The balance of the transcripts were done by paid assistants, and were reviewed by the investigator for quality purposes as soon after the interview as possible. Intermittent checks of the transcripts were made against the original tapes. When the

transcript was unclear or there appeared to be an error, the original tape was reviewed and the transcript adjusted.

Analysis

The majority of analysis is qualitative in nature, focusing on interview transcripts. Simple quantitative analysis was done on demographic items. All interviews were conducted by the author, but research assistants' helped transcribe tapes.. Transcripts were entered into computer program Microsoft Word. Each original interview transcript was preserved on hard drive, disk and hard copy and set aside.

Additional copies were made of each interview transcript, including interview summaries and field notes. After conducting the interviews, thematic memos made throughout the study were collected and set aside without reading them again. Sixteen interviews were re-read a few times, four interviews in each category of birth and insurance type.

Emergent themes were noted, more thematic, methodological and theoretical memos made, and questions to explore listed . Old memos were compared with new themes and memos. Files were made for each interview, and the remaining interview transcripts were reviewed at least three times over the course of the study. Interviews were trimmed down to essential quotes on main themes, and categories within themes. Foremost were comparisons and contrasts among women's agency and their insurance status, the proxy for socioeconomic status. Women in this study were categorized into groups by whether they requested cesarean sections, agreed to cesarean sections or tried to avoid cesarean section.

Finally, a brief updated literature review was conducted.

Table 3. Women and Cesarean Section: Type of Health Coverage

	Type of Health Coverage		
Cesarean Attitude	**Medicaid**	**Insurance**	**Row Totals**
Request	8	4*	12
Assent	6	7	13
Avoid	2	5	7
Column Totals	16	16	N=32

*Includes one insured women who requested a cesarean but had a vaginal birth.

CHAPTER 3

WOMEN WHO REQUESTED A CESAREAN SECTION

Women who Requested Cesarean Sections

This chapter examines American women's attitudes and feelings about their births, focusing on women who requested cesarean section. Recent medical literature claims that women request cesarean section for non-medical reasons (NIH Consensus Statement 2006). Australian nurses Gamble and Creedy (2000) critiqued ten published English language research studies on women's requests for cesarean section and found that women ask for cesarean section only if there is some perceived medical necessity. This chapter asks when and why do women request cesarean section, and uses an empirical sample.

This chapter uses primary data and compares the birth experiences of women who report they requested cesarean sections. Why do women say they requested cesarean section? When they request cesarean section, do women receive one simply because they ask or is there more to the story? How do the experiences of Medicaid mothers compare to privately insured mothers? How are women's requests for cesarean socially constructed? What is the context in which women make their requests? What information or experience do women use to decide they need a cesarean, and what is the source of that information? For example, do women feel their babies are in danger, or are there

differences in intensity of labor pain or labor duration for requesters versus others? Do women perceive there are alternatives to cesarean section? Are there any differences in the characteristics of the group of women who request cesareans versus women who agree to cesarean or try to avoid one? When women request a cesarean section, do they actually want a cesarean or do they want, for an example, an end to their labor and perceive cesarean as the only way to bring labor to an end?

This chapter is organized into four sections. The first section examines women who request cesarean section and the reasons they requested cesarean section. Half the women requested cesarean for perceived medical reasons: the baby's health, the mother *and* baby's health, or the mothers own health. Other women requested cesarean section because of exhaustion, diminished physical well being and overwhelming pain. One woman requested a cesarean due to fear of repeating her first traumatic labor and eventual cesarean section.

In contrast to claims in the medical literature, no women in this study requested cesarean for convenience or to preserve vaginal integrity. Women in this sample only requested cesareans for perceived medical reasons or because they felt unable to deliver vaginally.

The second section examines what happens when requests for cesarean section do not mean women will have one. The third section examines how requests for cesarean section do not mean one will be performed soon. Delays and reasons for the delays are analyzed. The fourth section discusses the findings in the previous three sections.

Twelve women report they requested cesarean section[1]. Eleven of the twelve who requested it had the surgery.

Reasons for Requesting Cesarean Section

Women gave the following reasons for their requests:

A) Perceived medical reasons, 6 (2 insured, 4 Medicaid), including 1 concerned about doctors' competence to deliver her complex birth vaginally

B) Exhaustion, diminished physical well being, long labor, pain, 5

C) Fear of repeating failed, painful previous labor and cesarean section, one, self-insured.

These reasons are consistent with general obstetric indications for cesarean section. Difficult fetal position is commonly involved with long and exceptionally painful labors, yet women report breech or other less than optimal positions are unexpected and often undetected by their doctors until it is too late. Not one woman requested a cesarean section for convenience or preservation of her vaginal integrity.

Assessing medical indications per se is not the goal of this chapter. Examining women's *perceptions* of medical necessity is the goal. Women describe their perceptions readily, and these are data. As W.I. Thomas showed, phenomena perceived as real are real in their consequences (Thomas , 1928). Women's perceptions of medical problems involve either the health of the baby, health of the mother herself, or both.

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[1] Two women reported fleeting inquiries about cesarean section during moments when they did not feel they could deliver their babies vaginally, but delivered shortly thereafter. These women are not included in the "requested a cesarean section" group because cesarean was mentioned but did not appear to be a definite request.

Cesarean Request for Baby's Health

Focusing on cesarean section requests for the baby's health, one insured woman says she requested cesarean section for her unexpectedly breech baby because she feared attempts to turn the baby would hurt him.

> I: Did they explain to you why they felt they needed to do a Cesarean?
>
> R: No, that was my decision. They asked if I wanted...they wanted...if I wanted them to try and turn him or what. So, then I said, "No." 'cause I was just too small and he was pretty big....I was more worried if they tried to turn him around if they would have hurt him....I got all the way through labor. I was dilated and everything, ready to give birth but that's when they checked and found out he was breech.... (Enid)

After a similar late assessment of fetal position, another woman cried for a cesarean section so her baby would not be hurt in the labor process:

> R: Yeah, they couldn't get up there and try to move the baby either because of the situation with the head already down there, but these are things they did discuss but I guess it was just discovered too late in the day or whatever. So that's when they started talking cesarean and they got me prepped for a cesarean and I remember crying, and I remember cause they said they wanted to do a cesarean but they were going to wait and give it another hour or hour and a half or something like that. I remember crying, and I remember saying 'Just take the baby. Don't let her bang her head anymore. Don't let her bang her head anymore'. Because I remember the doctor was describing to me that with each contraction the baby's being pushed, but it's not going anywhere. So then I imagined my baby in pain you know banging up against somewhere and not getting anywhere so I remember saying 'Don't let her bang anymore'. Molly

Another woman was convinced that her untried birth canal was too small for a vaginal delivery, and resisted one doctor's suggestion she try to deliver vaginally:

> R: Yes, because I couldn't have a vaginal birth because she was too big and my birth canal was too small. And they told me um...one of three things would have happened to my child. I would have had brain damage to her. I would have broke her shoulder or arm but that could be repaired. Third thing...I'm not sure. I don't remember the third thing, but I know they said there were three things. And once they said brain damage I said no. I said why should I force something to come into this world and give

> it brain damage if it don't have brain damage right now. I might as well have a c-section which is what I did.
>
> R: ... the second doctor tried to talk me into have a vaginal after I was hooked up and ready to go. I said no, cause you know I'm here. I got my mind all worked up now. I'm going to be cut. I'm going to do this. I'm going to do that. And I spoke to the doctor that was going to do the surgery and he says 'no, I'm not going to wait for you to have a vaginal'. I never went into labor. I've never went into anything. I've never had no pains, no cramping, or nothing. They just took her on the day that she was due. (Tammy)

Cesarean Request for Health of Both Mother and Baby

The fourth woman to ask for a cesarean section for perceived medical reasons considered it first because of her own rising toxemia, was more inclined to cesarean section when she learned of the baby's breech position, but became adamant about having a cesarean section when she began to doubt the competence of obstetric residents to perform a safe delivery in her complex situation.

Gina did allow the residents to attempt an external version of her breech baby in order to bargain for a cesarean . She bargained with weekend staff who admitted inexperience in dealing with vaginal delivery of complex cases such as hers. She also recognized potential conflict between what she felt were her interests and the interests of the teaching and research hospital. Having a cesarean section for medical reasons also allowed her to avoid scary aspects of vaginal delivery.

> The pregnancy, everything went really good until near the end of my pregnancy, I was developing toxemia.... So, they sent me to the hospital to induce me because my labs were getting worse. I guess, the some type of acid level in my blood...kept getting higher. .... When, I went in, they found out that she was breech and so then, they wanted to try to turn her. And, at first, I didn't want to do it but then I figured that with it being a

teaching hospital that I was better off letting them get through everything that they had to...to rule out everything 'cause they had talked about trying to deliver her breech and a couple of other things and when they mentioned delivering her breech, I said, "Absolutely not." that I didn't wanna do it. ... the way I felt is if they thought it was important to induce me with my lab work, I didn't understand why they were waiting to do a C-section.

... [W]hy wait until I get sick or the baby gets sick. I was getting really frustrated but....one time when I was talking to my doctor, he had said something about they were doing a study on toxemia, so I felt like I was their guinea pig and I didn't like that at all. I felt like...that they left me go further than they may have if they weren't doing the study.

... Well, they had even told me when they had asked me about delivering her breech. They told me that they had never done someone with all of my scenario, like with toxemia, with the baby breech, like they said, everything that I had, they had never done a breech delivery with all my circumstances. So, that was another big decision in me not letting them deliver her breech. I thought, "No way are you gonna test on me." But then, it ended up they couldn't have done it anyhow because her head wasn't flexed, so.

...And I was scared of delivering her vaginally anyhow......
I never thought I'd have a c-section. When I found out she was breech, I was like, it was weird because I was... part of me was really sad but part of me was kinda excited because I thought, 'Well, a c-section is just so much easier, you know when it's gonna happen.' Although, with my situation, it didn't end up being that much easier but it was so cut and dry. You go in for surgery and they take her and it's done with where if I would've had a vaginal birth, you never know how long you're gonna be in labor for, how things're gonna go. And, in the healing process, I can't imagine having stitches and stuff like where you have to go to the bathroom and stuff. To have them in your stomach is so different. ... It just seemed so much more painful to go the other way (Gina)

Social construction of women's cesarean requests begins when women understand from their doctors that their bodies are dangerous for their babies or that doctors' de-skilling in detection of poor fetal presentation and uncertainty with vaginal breech delivery make cesarean section safer. Women ask for cesarean to protect their babies from harm in several ways.

Women whose baby's poor presentation or position was discovered too late in labor to for doctors to do anything about it requested cesarean because they accepted it as the safest alternative for the baby at that time with the skills the doctors seemed to have, not because they preferred cesarean section for themselves.

Enid had been told she was small and the baby big, so she worried that staff would hurt her breech baby if they tried to turn him at the last moment. Molly described doctors inability to reposition her baby and was told contractions were pushing the baby but it had nowhere to go. She imagined the baby in pain and banging her head, so asked for a cesarean for the baby's safety.

Tammy requested cesarean because she had been convinced by her doctor for her first birth that she had a small vaginal canal that would cause her babies to have brain damage or a broken shoulder. She felt her choice was either to bring her babies unharmed into the world via cesarean section, or to inflict disability on her offspring. Morally, she could not have chosen otherwise.

Gina had a breech baby and was developing toxemia. Her doctors were inexperienced in vaginal delivery of breech babies and had never delivered a mother who also had her toxemic condition. She wanted a mode of birth her doctors could perform safely. Coupled with her un-addressed fears of vaginal delivery and misconceptions about cesarean being easier and less painful, Gina swayed toward 'choosing' cesarean.

Cesarean Request for Mother's Health and Well Being

Two women asked for a cesarean section for their own health and well being. Few conditions are absolute indications for cesarean section. One of these conditions is

cephalo pelvic disproportion (CPD) due to pelvic anomaly; another is placenta previa which requires a cesarean section because the placenta is positioned closer to the opening of the womb than is the baby; placenta previa can result in fatal hemorrhage. Ironically, a woman with a congenital hip problem who also had placenta previa had a difficult time obtaining the cesarean sections she needed.

Holly requested a cesarean section for all four of her children, but only had 3 cesarean sections. She was scheduled for a cesarean section for congenital CPD, but went into labor a month early when her doctor was out of town.

> I went in New Years Eve. I had him on the fourth. 36 hours in labor. They said, Well we're going to just let you go ahead and have it vaginally. I was supposed to have a cesarean a month later but I had him. It took forever. And you know it popped my hips out and I have problems with them now, but he was born healthy (Holly).

For her second birth Holly was diagnosed with placenta previa before she had premature contractions, so was hospitalized. Staff would not believe her when she said she was in labor.

> They come back and tell me, You can't be in labor. I said, Why not? Well, first of all you're only 28 weeks pregnant. You cannot have the baby. You're not in labor. You know it just must be something else. Put me on the monitor. I had labor contractions three minutes apart. The nurse goes, She's really in labor. We need to do something. SO they go down and find my obstetrician you know. They put me on the monitor belt and they get it all ready. They're going down to make the cesarean room ready cause they know I can't have him obviously. Well, I'm waiting there on the gurney and I'm waiting and I'm waiting and I'm waiting and I'm having contractions and stuff. They were telling me You can't be in labor so we have to hurry up and get you into the operating room.
>
> I: What do you mean you can't be in labor?
>
> R: Yeah, they told me if I was in labor then it would rupture the placenta. At this point they told me that.

I: And so you're having contractions?

R: I'm in labor three minutes apart and I'm waiting and waiting. It must have been twenty minutes gone by. I'm like, Brian will you go down and see where the doctors are at? Am I ever going into surgery? What's going on? Then I felt this incredible big gush. And then I was like, Oh my God. I can't look. Tell me. Don't tell me. Tell me. Don't tell me. You know he looks under the blankets. He's like I'm going to go get a doctor right this second. You know and I'm sitting there scared wanting to look down. I kind of look over the edge and I can see the blood dripping out the sheets.

I: Onto the floor?

R: Yeah. And I'm like Oh my God. So I'm just laying there going Oh my God. The nurse comes by and sees what's going on you know as my husband's running back with the doctor. They rush me in. They're like putting stuff all over me, plugging me up, put something on my face and they're like count backwards from 100. And then I fell asleep.

For her first two births, Holly informed staff that she had serious, objective indications for cesarean birth, but this information was not taken seriously. Why was this? It is not certain, but it may have been because she was not viewed as an authoritative source of knowledge.

Holly had a scheduled cesarean section for her third child

...(the) pregnancy was just fine. No complications whatsoever. Nothing. They said all right you're going to have to have it cesarean. We'll plan. We'll schedule a day. She's due the fourteenth of May. What day do you want it on? All right let's go on the first. It was a couple of weeks [early] just in case. They said, Well if you go into labor you need to come to the hospital right away so we can take her. Okay. Went right up to the day. Went in for surgery. Had her. Not a problem. Not a problem with the surgery at all. I was awake during it. No problems after. She was perfect. Eight pounds, ten ounces. Big girl. 21 inches long.

and cesarean section after spontaneous labor with the 4th.

I drove myself to the hospital, but while I was driving my contractions got three minutes apart and it was really hard to drive. And my son and daughter were like counting my contractions so we could breathe together and everything. I got down there. I got in there, and I was like Oh no

> what am I going to do with them? I'm really in labor. I'm really having a baby. (Doctor) Tammy comes in and she's like Oh good I'm here. She got there and she's like We'll get you all prepped up but we've gotta find some place or someone to watch the kids (Holly).

Olivia's first cesarean section was an emergency performed after an unsuccessful post-dates induction.

> ... my son he was two weeks overdue and that's why they induced labor was because he was just getting too big. He was 21 inches and eight pounds, seven ounces so he was a pretty big boy. And then with her she was twenty inches and eight pounds, five ounces so both of them are big and I was about a week or two short of my full 40 weeks [with her] ... She was pretty big. I mean a lot of people look at her now...I mean she doesn't look like a two month old. She looks more like she's around 4-5 months. She's just big (Olivia)

For her second birth, Olivia requested a cesarean section and a tubal ligation for her own health and well being. At age 23, as her due date approached, it became clear doctors at the religious hospital at which she started were not going to perform the tubal ligation. She had to change doctors and hospitals at 8 months gestation to get a tubal ligation. The tubal ligation was part of the reason Olivia requested a planned cesarean section for her second birth. In the last five years she had an emergency cesarean section, two subsequent abortions and now insisted on a tubal ligation. The doctors at the secular hospital were reluctant to perform the sterilization, even though she had serious genetic illness in the family.

> ...I mean it's not right to prolong somebody that long, and then all of a sudden they're like, Sorry can't tie 'em and then you have to sit there and switch hospitals...try to find the hospital and a lot of people don't want to take a person that far along when they're pregnant even though it was a planned cesarean I mean it was just the point to where I have other things in my background...other reasons why I didn't want to have anymore children and they kind of overlooked everything else so it didn't really....I mean it worked out towards the end, but even you know as the day happened that I was going to have my operation they were still skeptical and they almost didn't do it because I mean I had to write three or four

> different forms stating that I wanted my tubes tied, and then they had problems coming up with all my records and everything else. It was just a hassle to where they almost didn't do it so....but I mean they got tied so (Olivia).

Are requests for cesarean construed as matters of control for staff? We can consider the cases of Holly and Olivia: after her first two births where cesarean requests were turned down and the negative consequences of displaced hips and then placental hemorrhage, Holly was able to get the cesareans needed.

Olivia endured a change of hospitals and doctors at the end of her pregnancy and still came close to forfeiting her second cesarean section, which she felt she needed to get the tubal ligation.

Cesarean Section Request for Exhaustion, Diminished Physical Well Being and Pain

Five women said they requested cesarean section because of exhaustion, diminished physical well being and overwhelming pain. Four of the five who had cesarean section are described below. The fifth woman, Vicky, demanded but was denied a cesarean, and had a vaginal birth. .

After 34 hours of labor with pitocin but without adequate epidural coverage, Fran begged for a cesarean section only to be threatened by the doctor:

> [the epidural would work] ...for 45 minutes, then it'd go away again, even with the drips. And they had to keep me on my left side, because it would numb my right side but not my left side. At 1:00 Saturday afternoon I finally dilated all the way. I pushed until they took him cesarean at 5:19. It was horrible. The doctor that was in there, I didn't know who it was, he must have been a superior doctor because the doctor that was my doctor was still an intern. He told my brother and my husband -- and my brother is in the medical field, so he knows better, but -- he told them that if -- because I wanted them to take him cesarean, I hurt so bad, and they knew they were probably going to have to, and it hurt so bad I was just, couldn't take it, and I said, "Please just take him," you know, I mean, it really hurts.

And they're like, "No, you'll be all right. Push some more." You know. And then they come in and tell me to quit pushing and then they get me prepped for surgery.

I How did you feel about everything (?)?

R I was mad because -- I wasn't -- and when I -- well, it wouldn't have been so bad, but the doctor put his knee on my bed when I said I wanted them to take him and says, "Do you realize you could die during surgery?" And he went and told my husband and my brother that I could die or the baby could die if they took him cesarean (Fran).

Denise felt frustrated and angry after pitocin induction for pre-eclampsia resulted in fetal distress but no delivery.

R: So I was on it the 27th and all night through to the 28th and the 28th they decided to up it as far as it would go....they usually go to 20 on the Pitocin level and they decided to up it to 24, but I had to have a uterine catheter which measures the contractions in the uterus to see how strong they are. To make sure that my uterus doesn't rupture from the high level...in the middle of the night I had a three minute contraction. They gave me an epidural and I couldn't feel anything and they were giving me more stuff to sleep cause I didn't sleep and I guess they knew that I was going to have him the next day either way and that I needed to get rest. SO I was sleeping and all the doctors and nurses come in. They were putting masks on my face. I mean I was sound asleep and I wake up and I see all these people and people putting masks on my face and telling me just to hold still and don't move. Well, I had a three minute contraction that was very high on the monitor and I didn't feel it. I didn't wake up. And it lasted....it was that strength for the whole three minutes.

I: A really high strength?

R: Yeah, and his heart beat went down to 80 for the whole time of the contraction. The whole three minutes so they didn't like that at all so that was real early in the morning. Like 4:00 or 5:00 maybe on the 29th and they just lowered my level back down. And then I hadn't dilated so they decided to do the c-section.

I: How did you feel when all of this was going on?

R: Very frustrated. Very. That I was never going to accomplish anything. I felt like I was on the Pitocin and it wasn't...I wasn't ever going to have the baby. And I was getting mad at the doctors because I felt like they were...I don't know how I felt towards them. I was more mad after

> the fact because you know I had went through all that pain of you know....it wasn't severe pain, but I had went through the uncomfortable pain and then I still had to have the c-section. I was in a lot of pain with that so I was mad.
>
> I: When you were mad...are you still mad?
>
> R: No, I don't think about it. I mean I liked all the doctors and stuff I just didn't agree with some of the things they did, but you know they just kept telling me a c-section is major surgery and we're not going to do it unless we have to. I just thought it was ridiculous that I was on the Pitocin for four days with no results and they still ended up doing the c-section (Denise)

Although her labor was spontaneous, Beth had an even longer labor but was not allowed to stay in the hospital :

> I was mainly in a week of labor (laughs). It started the first day I was having cramping--and I couldn't take it--I was just like staying home screaming, and I knew something was up and I would go to the hospital and they would say I was like dilated at like four, um, they wouldn't, they sent me home. They said I'm fine, go home, wait till. . .
>
> ... I couldn't talk to anybody, I was sittin' here, I would be like gripping hold of things cuz it hurt so bad and I was to a point I said, to my husband I said take me, I'm going to tell them to do something because I'm not listening to them anymore. So I finally went and it was like Sunday night, I said let's go and we finally went and the one doctor that was on call that night, he couldn't believe they kept sending me home. So, I was still dilated at four, he said admit her. So, he did admit me and uh, he called my doctor... and then he decided to break my water--they said they couldn't wait anymore because I was weak; I couldn't go any further and so they broke my water. So they finally broke my water and they thought let's see where we go, if I dilate further. I only went to five and then um,..... they were going to give me an epidural just in case anything happened. While they were getting ready to do that, the thing went wrong. They really never told me what was going on much cuz there was nobody, it was just my husband and a nurse in the room, and then all of the sudden they just like pushed my husband off to the side and a roomful of doctors and nurses and everything cuz monitors were going berserk and that's when they said get her down to the um, the room and just in case they ... could to take him... and they were just monitoring me for a while down there. They finally got an epidural in me, um, and then they just waited for a while and then they decided I was just dilated at five, I wasn't going any further and he wasn't going anywhere and they had to do a cesarean....

found out that he wasn't, his head was like caught and he was tilted, he tilted his head. So he wasn't going anywhere so they had to do that plus after they got him out they had uh, also work on my uterus because stuff was wrong with that and they, ...it was just (laughs) a long process. It was very difficult for me, and tiring (Beth).

Uma's baby never moved into the birth canal, and after many hours she asked for a cesarean section. When doctors resisted performing a cesarean section, she declared that the baby wanted the cesarean section

They did another test,...where they check his scalp. They did that. But um he didn't drop yet, so they couldn't get a good one. Oh and then they wanted to make my contractions stronger so they gave me.....I can't remember what it was called...

I: Pitosin?

R: Yeah. They gave me that for awhile and they were get(ting) stronger. And then after awhile I started pushing and...the baby wasn't moving at all and I was pushing and so he kept trying and then a whole bunch of doctors were in there after that first hour. They were all in there because they all wanted to see whether or not...I told them I needed a c-section because he wasn't moving at all.

I: You told them?

R: Yeah, they were thinking about it, but they didn't want to do it if they didn't have to...I was okay for the first hour. I was just fine, but then not after the first hour. Not at all. I kept telling them that I needed a c-section. They were like Well, we have to do what's good for you and the baby. I said well the baby wants to have a c-section.

I: Why does the baby want to have a c-section?

R: Because I couldn't want to push anymore.

I: Now, if the baby wasn't dropped how could you push?

R: They were trying....maybe he would drop. Maybe they were thinking he would drop when I pushed. He wasn't moving at all because I was fully dilated (Uma).

The medical staff waited to perform a cesarean section until the baby's heart rate started going down and staying down and Uma's heart rate climbed and stayed high. During the cesarean section there was so much bleeding that she required nine pints of blood and nearly died.

> R: So she [baby]came out and they took her and then I just felt a lot of pressure...they were massaging my stomach and that's what hurt. And then they had me......they told him [boyfriend] to leave the room then they told the anesthesiologist to put me to sleep. ....I was happy because it hurt. I said, Yeah put me to sleep. So then I just went to sleep.
>
> I: And why did they do that?
>
> R: Um...I didn't know at the time. I didn't even think anything of it, but um...because they couldn't stop the bleeding.
>
> I: They didn't tell you that?
>
> R: No, they didn't tell me that because I would have gotten paranoid. But they couldn't stop the bleeding, and I had him at nine at night, and then I was in surgery until two because they couldn't stop the bleeding. And um.. they were worried because...Well, I lost a lot of blood I think nine units or something.
>
> I: Oh, my. You know that's two more units than your body has.
>
> R: Yeah, I didn't know how many, but....
>
> I: You only have seven.
>
> R: I don't know.. I lost eight or nine and they didn't know if the hospital was going to have enough blood for me. There's something in your blood that you need to add to it. I don't remember what it was, but they didn't think the hospital would have enough for me or anyone else because I took a lot of it. So they were getting scared. And then they tried to...they clamped the small arteries and it didn't work. Then they packed and it didn't work. And then they just went ahead and did a hysterectomy, and I remember that. And they called a lot of doctors in too, they called in a lot of them. Some of them...I actually can remember said to my mom that they tried too hard or that they let it go on for too long. They should of have just done it right away, but they didn't want the hysterectomy because I was only 21. But then they went ahead and did it, and I was in

> intensive care for I think two days. And I was intubated. That's when they had the tube down my throat (Uma).

Why were all these women made to wait? Women describe intense, unmanaged pain and lack of progress in labor, a cruel response to a cesarean request after 34 hours of failed induction, no timely assessment of fetal position, turning a laboring woman away from care and support for up to a week. The most devastating consequence of a delayed and near fatal cesarean was a hysterectomy which came after applying pitocin to a woman with an undescended fetus in her womb. It appears maternal condition was not enough for a cesarean until fetal distress began.

They are all young women on Medicaid, in their late 20's, all but one with husbands or boyfriends. How did the tragedy of a total abdominal hysterectomy happen to a 21 year old woman? The data are not definitive. However, they suggest that cesarean sections may be delayed at least in part because of the mother's insurance status. Are cesarean sections delayed in the case of young women on Medicaid in hopes of an eventual vaginal delivery, but offered more readily to insured women nearer age 30?

<u>Fear of Repeating Earlier Birth Experience</u>

The third category for cesarean requests includes fear of pain, exhaustion and diminished physical well being experienced in an earlier labor and delivery.

Nancy had insurance but it did not cover her birth because she became pregnant a week before she purchased the policy. She paid cash for a cesarean because she feared repeating her first experience, a long painful labor that ended with cesarean section. She hoped that the insurance's surgical coverage would pay for the cesarean section, but it did not. This middle income married woman paid a bill that was over ten thousand dollars.

I: So you've had two cesareans?

R: Yep. Second one was by choice.

I: Okay.

R: It was my, my decision...Well I asked the doctor in the six week check, if I had another baby would I get an automatic c-section or you know, what would the doctors think then. And, she said, oh no you would first try to deliver vaginally just like you did this time and if that wasn't working then you would do a c-section. No way in hell was I gonna go through that again.

I: What was it that you didn't want to go through again?

R: I think that the contractions with the (pitocin). I think those were much harder than had they been started with nature. Yeah, I think they were harder, they came faster. I didn't like the experience of having to stay in bed because I do think that walking and things like that does help labor along. It's far as the c-section itself and the pain afterwards, I can deal with that. But, I guess with the [vaginal birth] you do have, it is on your mind. You don't know how long you're going to be ....

I: So, you were kind of afraid [what] you were going to see if you would go into labor?

R: Hmmm, yep.

I: When you were thinking about it what was it that you were thinking that made you afraid? Is that...

R: Yeah, oh yeah I was afraid.

I: Did your doctor talk to you about chances of ... You must have been mighty scared to have a vaginal birth ?...

R: See I discussed, yeah I discussed that with my doctor in the beginning. She wanted me to do a vaginal birth and I told her of my experience the first time and that I was frightened and from a financial standpoint we thought the cesarean would also be cheaper in the long run because if I didn't go into labor again by myself then I would have to go back through the steps of having the gel and then being induced and then the inducing not working and then having the c-section. And I think the cost would have mounted higher than just a (scheduled) c-section to start. (Nancy)

Here, Nancy rationalizes cost effectiveness rather than discuss her fear in detail.

Women's Request for Cesarean Does Not Guarantee That a Cesarean Section Will Be Performed

Eleven of twelve women who asked for cesarean section received one. What was different in the case of the twelfth woman? She was older (around age 30), had insurance, and was exhausted. Vicky had an extremely painful twenty one hour labor and delivered a baby who's face up presentation contributed to the difficulty and length of labor.

Toward the very end of labor Vicky demanded her husband find her a doctor who would do a cesarean section, but did not report asking her doctor directly. Vicky felt unable to push the baby out due to fatigue and an inability to command her own body after an epidural. She appears to have experienced dissociative feelings common to people who experience trauma (Olde,van der Hart et al 2005). Her description of her experience is poignant:

> I: Can you tell me what you feel a C-section would have done for you or what you thought it would have done for you at the time?
>
> V: It wouldn't have been as painful. And, at the time, it would have taken me out of that excruciating pain that I was feeling.... they kept telling me to push, well, I'm too damn exhausted, I've been up for almost 24 hours. I don't have the energy...And then, I'm screaming to my husband, "They're killing me, they're killing me." I wanted him to take me out of there and find me a doctor that would do a C-section.
>
> I: Tell me what you were thinking when you felt like they were killing you.
>
> V: That I can't [take] this any more. I cannot take another second of this any more. Get me out of here and get me a doctor that'll do a C-section now. I can't take another minute of this. My head was going back and forth. I almost bit the nurse. It was awful. It was the most awful thing on the face of the earth.
>
> I: Were you worried about dying?
>
> V: Yeah, I was.

> I: Can you tell me about that?
>
> V: I guess I'd go into like a blank space and it's like, "I can't take any more of this pain." And it's just a blank space like grayish and whatever. I can't tell you what emotions. It's more like a void and a nulling and sort of like being out in nirvana. Just out in limbo, somewhere and it's gray. And, ...I am not pushing any more, I'm gone, good bye. There's nothing more. Then, my husband said, 'All of a suddenly the baby just came out and the doctor was surprised too because she almost, it was like she caught 'em. And, I think he pushed himself out of there [because] I sure as hell didn't do anything at the end there. I was too damn tired. I was out of it. My husband wasn't going to take me out of there to find me a doctor so I gave up. I said, "Fuck this shit." And, I...I just remember it just gray and I'm just going like this. That was it. And, that I might die (Vicky).

She describes no help from the doctor who was there, yet the doctor was close enough to catch the baby when she unexpectedly emerged.

Requests for Cesarean Section Does Not Mean One Will Be Performed Soon

In fairness, most of the women were young and it may have been hoped that a vaginal birth would eventually occur. However, six women were convinced long before doctors that they needed a cesarean section. Some were in dire straits and suffered in the extreme (Fran and Beth, Vicky).

Three women got their cesarean sections in a timely way. More striking were the six Medicaid women who were made to wait anywhere from several hours to several days; one had to wait a week for her cesarean section. Two women did not get requested cesarean sections at all and eventually had vaginal births.

Women Who Had Cesarean Section in a Reasonable Time

The three women who said they asked for a cesarean section and had one in a timely manner included Enid, quoted earlier. Eighteen years old, Enid was married to a military serviceman and had Champus insurance. She was fully dilated when doctors discovered the baby was breech. She says she was given the choice of cesarean or vaginal delivery, chose and received a cesarean section shortly thereafter without incident.

Molly was in her twenties, unmarried and on Medicaid. She said her doctor told her that she could continue a difficult, painful and unproductive labor that was hurting the baby or she could have a cesarean section. Of course she "chose" the cesarean section, and had one shortly thereafter.

Tammy was working as a bookkeeper when her first baby was born. She had this to say when asked in an interview:

> I: Can you tell me about your first birth and that pregnancy?
>
> R: It was a c-section and it was wonderful. I was working right up until the day I gave birth. I had no problems, no swelling, no problems whatsoever. And they scheduled a c-section because he was just growing too fast. He was eating my fat and stuff and he was just getting too big in my stomach so they just took him out the day that he was due...
>
> I: Do you think it made any difference whether you had a cesarean or a vaginal birth how you would have felt?
>
> R: Yes, because I couldn't have a vaginal birth because he was too big and my birth canal was too small. And they told me um...one of three things would have happened to my child. I would have had brain damage to him. I would have broke his shoulder or arm but that could be repaired. Third thing...I'm not sure. I don't remember the third thing, but I know they said there were three things. And once they said brain damage I said no. I said, Why should I force something to come into this world and give it brain damage if it don't have brain damage right now. I might as well have a c-section which is what I did (Tammy).

For subsequent births Tammy and other women who said they asked for a cesarean section waited longer and had to ask more than once. What were the reasons women say they waited for the surgical births they felt they needed? How long did they have to wait?

Reasons for Delay in Receiving Cesarean Section After Women Requested Them

Doctor resistance to women's request for cesarean section and insistence on control of delivery were main reasons for delays in receiving requested cesarean section. All but one of these delays occurred with women who were on Medicaid, most of whom were in their teens or early twenties.

Tammy had a cesarean section for her first baby, described above. However, when she moved away during her second pregnancy, it was more difficult to get the cesarean section she felt she needed. When the staff doctor admitted her in labor to the hospital through the emergency room, he told her she could have an elective cesarean section after a test to determine the baby's maturity. Although the baby passed the tests, when Tammy got to the operating room it was a different story.

> R: ...the second doctor tried to talk me into have a vaginal after I was hooked up and ready to go. I said no, cause you know I'm here. I got my mind all worked up now. I'm going to be cut. I'm going to do this. I'm going to do that. And I spoke to the doctor that was going to do the surgery and he says no, I'm not going to wait for you to have a vaginal. (Tammy)

Other women had to wait much longer after admission. These women's experience of labor pain and progress were discounted, and they were treated poorly by the doctor even though they had supportive family present. Age (nineteen, EG: was in labor 34 hours and pushed for four hours. She practically begged for a cesarean section:

> ...because I wanted them to take him cesarean, I hurt so bad, and they knew they were probably going to have to, and it hurt so bad I was just, couldn't take it, and I said, "Please just take him," you know, I mean, it really hurts. And they're like, "No, you'll be all right. Push some more." You know. And then they come in and tell me to quit pushing and then they get me prepped for surgery (Fran).

Ironically, if they could not control prenatal care from the beginning, doctors resisted seeing Medicaid mothers at all, at least those who switched hospitals or were new to the area.

> ...try to find the hospital and a lot of people don't want to take a person that far along when they're pregnant even though it was a planned cesarean ...(Olivia)
>
> R: ...I went from [Philadelphia] to [here] and by the time I got here ... no doctor would really see me because I was just about ready to give...and they're not gong to start prenatal care on me all ready to give. So what they told me what to do was, when I was ready to give birth just go into a hospital and just take it from there, cause they cannot refuse you....
>
> I: How did you feel about that?
>
> R: Well, I was scared. I was scared for awhile cause I said 'Boy, I hope nothing happens' ...like they said we just go to the hospital. Now, I didn't know at the time...I felt I guess it was contractions that was happening and I had some blood discharged so I said something's wrong ...I went into the emergency room and from there they took care of me. They monitored me and everything like that and I had to wait. I went in about 3 o'clock in the morning and I had to wait until about 7 o'clock in the morning to see the doctor that was going to be on for the day. ...He said, they were going to take a sonogram and if it showed over 40 weeks then they would, if I wanted to have a c-section, they would take the baby from me then. So I had the sonogram done, and I was 41 weeks with him, ...he asked me if I'd like to have a c-section. I said, Yes. And they did a c-section on me... ..in my mind I was probably going to have another c-section, but you know since I wasn't under no doctor's care I didn't know how far along I was at the time. I mean if the baby was coming and he was already in my birth canal there's nothing I could do I would have to have a vaginal section, but since.. when he took the sonogram and the baby was not in the birth canal I was safe in that way. That's why I decided to have a c-section cause I was afraid again you know bringing another child in this world to give brain damage or nothing to him. But, if I didn't have a choice then I

> would have to go vaginal, since I had a choice I wanted a c-section. (Tammy)

Cesarean Section May Be Delayed to Preserve Women's Fertility, Whether She Wants It or Not

Twenty one years old, Uma, the woman who said her 'baby wanted a cesarean', not only had her cesarean section delayed, but could have lost her life because she hemorrhaged during the surgery.

> But they couldn't stop the bleeding, and I had him at ten at night, and then I was in surgery until three because they couldn't stop the bleeding. And um... they were worried because...Well, I lost a lot of blood I think nine units or something...
>
> they ....said to my mom that they tried too hard or that they let it go on for too long. They should of have just done it right away, but they didn't want the hysterectomy because I was only 21. But then they went ahead and did it, and I was in intensive care for I think two days. .... (Uma)

In a different situation, Olivia's doctor agreed to perform a cesarean for her second child and to perform the tubal ligation she felt she needed. Sterilization for women age twenty three was against hospital policy so the doctor planned to go before the hospital's appeals board. Olivia was not reassured.

> R You know you have to be 25 years of age, and that I don't think is right because if it's your choice and you don't feel, that you don't want anymore children. I mean I had even told them that I had two abortions and you know this was my last child. I couldn't have no more you know my working...and it's expensive to raise a child now a days. And I just told them, I can't handle no more and you know it kind of made me frustrated and angry ....
> I mean it worked out towards the end, but even you know as the day happened that I was going to have my operation they were still skeptical and they almost didn't do it because I mean I had to write three or four different forms stating that I wanted my tubes tied, and then they had

> problems coming up with all my records and everything else. It was just a hassle to where they almost didn't do it so....but I mean they got tied so.... (Olivia)

The value of women's knowledge about their own labor process was diminished by doctors portraying themselves as advocates for the baby and against what the mother felt was necessary. It is not clear why doctors would ignore so called "objective" factors like the station of the baby and insist the mother push when this would likely have no effect, and insist on her pushing after an hour with no movement at all. Some rules were observed even when they did not seem to apply, such as a maximum pushing time of two hours.

> R: I was okay for the first hour. I was just fine, but then not after the first hour [of pushing]. Not at all. I kept telling them that I needed a c-section. They were like Well, we have to do what's good for you and the baby. I said well the baby wants to have a c-section.
>
> I: Why does the baby want to have a c-section?
>
> R: Because I couldn't want to push anymore...
>
> I: Now, if the baby wasn't dropped how could you push?
>
> R: They were trying....maybe he would drop[pad]. Maybe they were thinking he would drop when I pushed. He wasn't moving at all because I was fully dilated (Uma)

Nor is it clear why there would be a wait when lab values indicating rising toxemia continue to climb. Gina said

> ... the way I felt is if they thought it was important to induce me with my lab work, I didn't understand why they were waiting to do a C-section.... [W]hy wait until I get sick or the baby gets sick. I was getting really frustrated ....(Gina)

Or why after more than 30 hours of labor and 4 hours of pushing, Fran felt threatened when she asked for a cesarean section

> R: I was mad because -- I wasn't -- and when I -- well, it wouldn't have been so bad, but the doctor put his knee on my bed when I said I wanted them to take him and says, 'Do you realize you could die during surgery?' And he went and told my husband and my brother that I could die or the baby could die if they took him cesarean.... My mom just let him have it. I mean, she was there and she was so mad, she just busted. She'd been holding in because -- my husband had been telling them the whole time I was in labor, 'She can't have him.' You know, you guys know, Dr. E knew that my hips didn't shift, you know, they kept telling him, 'She can't have it. She can't have it normal.' You know. I guess it just took them a while to notice. But that doctor, he was kinda -- he kinda apologized after I had surgery ...(Fran).

Some delays were for institutional reasons. Labor and delivery rooms, even operating rooms can be full.

> ... the doctor that was on call said they couldn't do anything because up at that time there was no room in the hospital, much, cuz everyone was having babies left and right ...(Beth)

> No, there was no...the labor and delivery was full so I couldn't go down and be induced (Denise)

Staff had to get a delivery room ready

> They're going down to make the cesarean room ready cause they know I can't have him obviously. Well, I'm waiting there on the gurney and I'm waiting and I'm waiting and I'm waiting and I'm having contractions and stuff. They were telling me 'You can't be in labor so we have to hurry up and get you into the operating room'.
>
> I: What do you mean you can't be in labor?
>
> R: Yeah, they told me if I was in labor then it would rupture the placenta. At this point they told me that.
>
> I: And so you're having contractions?
>
> R: I'm in labor three minutes apart and I'm waiting and waiting. It must have been twenty minutes gone by. I'm like, Allen will you go down and see where the doctors are at? Am I ever going into surgery? What's going on (Holly)?

For Nancy there was a threatened delay due to failed institutional tracking of an insurance problem

> R: [phone call] Ah it was somebody from the billing department... And she, [said] do you know that it's gonna cost you in excess of $5000? Do you plan on having a check for us upon checking out of the hospital? And I just said, pardon me? You're just now finding out that I'm going to have this baby on the 20th and your just now wanting to call me up and ask me if I'm going to have a check for you? When I, you know I've been in the hospital system throughout the whole pregnancy. You know I had an ultrasound and all of that and I'd already been put on a payment plan for the blood work expenses and the ultrasound that I had incurred in all of that...the way she spoke to me I finally just said to her I said, well it's a little late for me to decide to have an abortion or any other choice right now cause it seemed like that's what she was telling me?
>
> I: She was telling you what?
>
> R: That I should have thought twice before getting pregnant. You know I should have because I don't have insurance and I don't have a $5000 check for them. She was just and I didn't ask names or anything at that point. When I got off the phone I was in tears (Nancy).

Holiday staffing, staff rotations and the availability of attending doctors can delay or deny a cesarean section that had been planned in advance.

> I went in New Years Eve. I had him on the fourth. 36 hours in labor. They said, Well we're going to just let you go ahead and have it vaginally. I was supposed to have a cesarean a month later but I had him. It took forever. And you know it popped my hips out and I have problems with them now, but he was born healthy (Holly)

After several trips to the hospital and being sent home, an entire week of excruciating pain led one woman to say:

> I couldn't talk to anybody, I was sittin' here, I would be like gripping hold of things cuz it hurt so bad and I was to a point I said, to my husband I said take me, I'm going to tell them to do something because I'm not listening to them anymore. So I finally went and it was like Sunday night, I said let's go and we finally went and the one doctor that was on call that night, he couldn't believe they kept sending me home. So, I was still dilated at four, he said admit her. So, he did admit me and uh, he called my doctor ...(Beth)

Sometimes staff was slow to act. In the case of Holly with premature labor and placenta previa, and in the case of Uma and the hysterectomy, staff does not seem to have acted quick enough. Recall Holly's story:

> Then I felt this incredible big gush. And then I was like, Oh my God. I can't look. Tell me. Don't tell me. Tell me. Don't tell me. You know he looks under the blankets. He's like I'm going to go get a doctor right this second. You know and I'm sitting there scared wanting to look down. I kind of look over the edge and I can see the blood dripping out the sheets.
>
> I: Onto the floor?
>
> R: Yeah. And I'm like Oh my God (Holly)

Or for Uma:

> they ....said to my mom that they tried too hard or that they let it go on for too long. They should of have just done it right away, but they didn't want the hysterectomy because I was only 21. But then they went ahead and did it, and I was in intensive care for I think two days (Uma).

Some delays had consequences. For Uma:

> I was in surgery until two because they couldn't stop the bleeding. And um... they were worried because...Well, I lost a lot of blood I think nine units or something (Uma).

There was an occasion of possible conflict of interest:

> one time when I was talking to my doctor, he had said something about they were doing a study on toxemia, so I felt like I was their guinea pig and I didn't like that at all. I felt like...that they left me go further than they may have if they weren't doing the study (Gina).

There is certainly a valid argument for waiting for eventual vaginal delivery, especially with younger women because every first cesarean section increases the likelihood of subsequent cesarean sections if the woman has more children. Some women, however, are so put off by their too long or too painful labor that they decide not to have more children. When asked how her birth may have affected her, Vicky responded:

> Geez, I don't know. I just told my husband, "I'm not doing this again unless we find a doctor that'll give me a C-section, if that's an effect at all. It's not a pain I wanna go through again. We can only afford to have one baby, so. I adore him. I pretty much forget the pain (Vicky).

Discussion

All women who asked for cesarean section said doctors urged them to try to deliver vaginally. Each woman acted to preserve the best health of her baby, herself or both. One woman (Nancy) felt so completely unable to face a repeat the trauma of her first labor and cesarean section it took her seven years before she was willing to become pregnant again. When she did become pregnant and prepared for birth, she chose to go to directly to cesarean section to preserve her own emotional integrity. Nancy reported a high fear level only after her first birth, so this feeling had more to do with her actual experience rather than unusual levels of fear in advance of experience

To paraphrase Karl Marx, (wo)men do not make decisions just as they please, but must choose among available options. The idea of a "rational man" making individual 'rational choice decisions' about health care has been challenged. As Anspach (1993) showed, medical decisions are often social ones made within an ecology of knowledge. Women in the present study made the best choices they could given the knowledge they had. Hospital birth under medical authority severely limits knowledge about birth alternatives.

Women in this study generally viewed doctors as the correct source of authoritative knowledge on childbirth. A few women were aware of institutional practices that could conflict with their own interests. Some women internalized interpretations of

what is "safe" in childbirth from earlier experiences. For example, Gina believed vaginal delivery of a breech baby was dangerous in inexperienced hands. Tammy believed the doctor for her first delivery when he told her that she had a prohibitively small birth canal so she insisted on having cesarean sections even though subsequent doctors who cared for her in subsequent deliveries tried to dissuade her.

The way women's choices are structured influences the choices they make. Molly literally cried for a cesarean section even though her doctor would have allowed her to continue to labor another hour and a half. Why? Molly recalled the doctor's explanation which painted a mental picture of her baby suffering in labor, which MollyT understood as literally "banging his head" against her uterus. Not much of a choice after all. If most cesarean sections are done for poor fetal position, why are assessments of fetal position during labor so inadequate? All four breech babies in this study, and others in poor birth positions were not detected until too late in labor to do anything about it. Obstetricians are after all surgeons, and surgery may be the preferred way for surgeons to deal with such a problem. Cesarean section is viewed as the only solution to a variety of problems that could be addressed in other ways if more alternatives were seriously considered. Family practice physicians, nurse midwives and lay midwives may be more likely to apply early fetal position assessment and other methods of pain and pain relief than simply going to cesarean section.

Women with babies born in the face up position tend to have longer and more painful labor. They may be more likely to have an epidural, a side effect of which can be even slower labor. There is controversy over whether epidurals increase the likelihood of cesarean section (Thorp et al 1989; Philipsen and Jensen 1989; Wagner 1994) .

Because an epidural is used to block pain during the middle stage of labor, the normal process where endorphins are stimulated by slowly building pain does not get the appropriate trigger and when the epidural wears off women are faced with serious pain without their body's natural coping chemicals. The pain can be overwhelming. At the same time, there may be residual numbness that makes it difficult or impossible to feel one's muscles enough to assist in pushing the baby out.

Birthing women are routinely denied food and drink to prevent vomiting and as a precaution in case surgery is necessary. However, pushing a baby out of the body takes a lot of physical energy which is undermined if no food is allowed. The hard work of birth may induce thirst and sweating, and if body fluids are not replaced dehydration and fever can result, making labor more difficult and suspicion of infection more likely.

Birth can bring women in touch with more primitive emotions than commonly accessed in a post-industrialized culture, which can be frightening. Overwhelmed by pain and feeling completely out of control, fear of death is understandable, especially if one expects relief from staff who do not seem to be helping. So desperate was Vicky for pain relief she asked her husband to take her out of the hospital to get a cesarean section, and when he did not she appears to have dissociated from her surroundings.

While Vicky describes her perception that her call for cesarean was ignored, she also was extremely distressed. In fact, she may have been unable to perceive help short of cesarean section that might or might not have been offered. We do not know if help was offered, only that if it was it was certainly inadequate.

Table 4 Displays individual and average or modal values on important items for women who requested cesarean section.

Table 4: Women Who Requested a Cesarean Section

Name	Insurance Type	Age	Marital Status	# Prior Births	Prior Birth Type	Fetal Position	Reason/dx	Comment	Cesarean?
Fran	Medicaid	20	Married	0	-	-	Unproductive labor	Says MD stated she could die when she requested cesarean	Yes
Uma	Medicaid	21	Single	0	-	Not dropped into pelvis for birth position	Emergency Fetal distress	Hemorrhage resulting in total abdominal hysterectomy	Yes Also hysterectomy
Olivia	Medicaid	23	Single	1	Cesarean	-	Elective repeat, Also seeking tubal ligation,	Avoid previous labor and birth experience	Yes
Maryann	Medicaid	25	Single	1	Cesarean		Repeat cesarean Classical scar	Mother feaed repeat last labor birth experience	Yes
Beth	Medicaid	26	Married	0	-	-	Unproductive labor	1 week labor Send home from hospital many times	Yes
Holly	Medicaid	28	Divorced	3	Vaginal	-	Maternal hip defect & history of placenta previa	Denied cesarean for previous birth despite hip defect. Another birth emergency cesarean delayed in case of placenta previa	Yes
Molly	Medicaid	28	Single	0	-	-	Unproductive labor	Mother 'don't let her bang her head any more'	Yes
Tammy	Medicaid	37	Single	2	Cesarean	-	Elective repeat cesarean	Mother understood her vaginal canal too small and	Yes

Name	Insurance Type	Age	Marital Status	# Prior Births	Prior Birth Type	Fetal Position	Reason/dx	Comment	Cesarean?
								would damage baby	
Enid	Private	18	Married	0	-	Breech	Breech	Feared doctors would hurt baby by external version	Yes
Gina	Private	24	Married	0	-	Breech	Toxemic, induced, breech	Mother feared staff inexperience deliver toxemic vaginal breech	Yes
Nancy	Private, CASH	26	Married	1	Cesarean	-	Elective repeat cesarean	Feared repeat first labor &birth Hoped insurance cover cesarean	Yes
Vicky	Private	31	Married	0	-	-	MD declined Mother's request	Mother felt pain intolerable. Dissociative feelings at end labor	No
Average or Mode	**Medicaid**	**23.6**	**Single/Married**	**0.7**	**Cesarean**	**Breech**	**Variable/long labor**		**Yes**

CHAPTER 4

WOMEN WHO AGREED TO CESAREAN SECTION

Introduction

Chapter 3 examined cases where women requested cesarean section. This chapter examines cases in which women agreed to cesarean section. Chapter 5 will examine interviews where women tried to avoid cesarean section. Each chapter examined statements and representative types of statements and their contexts .

Simply, women who stated they purposively wished to avoid cesarean and acted consciously to do so are categorized as Avoiders, whether or not they had a vaginal birth. Women who requested cesarean reported that they explicitly asked for one. By contrast, Agree-ers did not state they wished to avoid cesarean and did not request cesarean. Instead, they agreed to the doctor's recommendation to have cesarean sections.

This chapter seeks to answer the following questions: Why do women agree to cesarean section? In what ways are women's agreement to cesarean section socially constructed? Do women feel they made a truly informed consent? Do women seem to have had the basic information needed or are choices framed in such a way that women would have to consider a cesarean a better alternative than vaginal birth? How much do women feel part of the cesarean decision? Does this matter to them? What hospital practices contribute to increased likelihood of cesarean section? How and when does

consideration of cesarean section arise? At what stage and how thoroughly are fetal position and presentation assessed? When poor fetal position or presentation is found, are alternatives to cesarean such as efforts to turn the baby employed? How confident are women of their doctor's skills in turning the baby if needed?

Further questions include: are there signs of potential trouble with babies in advance of full-blown emergencies? What are doctor's responses to these signs or symptoms? What about women's access to quality and continued prenatal and birth care? How are women with longer than average labors supported emotionally and physically in the hospital? What are the roles of pain control and exhaustion in women's decisions? What do women say about why doctors recommend cesarean?

Decision Making and Informed Consent

Cesarean section decisions are made in the context of informed consent. In the hospital setting, professionals are expected to obtain women's informed consent to undergo a cesarean section.. What is required for informed consent to medical or surgical treatment? Professor of Obstetrics Lisa Harris MD (2001) describes the meaning of informed consent:

> In order to meet requirements of informed consent, a physician must disclose information, present treatment alternatives if they exist, and recommend a plan. A patient must be competent, understand the physician's disclosure, voluntarily choose among alternatives, and authorize the treatment plan. A patient may also give informed refusal by declining to authorize intervention, but otherwise satisfying the above conditions . Although physicians may think of informed consent as a legal or institutional requirement, or as the event of signing a consent form, informed consent in idealized clinical practice is a process intended to promote good communication and patient autonomy.

For true informed consent to occur, Harris says doctors must give persons information about their recommended treatment and treatment alternatives. Patients must be competent and understand what they are told, then freely choose to authorize that treatment or not. Rather than just a legal or procedural exercise, Harris makes the important point that informed consent is designed to "promote good communication and patient autonomy" (2001: 94).

However, medical decision making often falls short of the informed consent ideals. Anspach (1993) showed how medical decisions tend to be made interactively within the social and cultural context of neonatal intensive care, rather than medical decisions being made by individuals alone, as traditionally thought. According to Anspach (1993), consent to medical decisions is possible when all relevant information is communicated and the range of potential outcomes is known and considered. In contrast, *assent* means doctors make medical decisions and then seek patients' agreement to those decisions, which may not entail presenting some choices more favorably than others or omitting information on some alternatives altogether. Anspach shows how informed consent to medical treatment can be empowering, while assent can be disempowering to parents (1993).

This chapter examines how women in this study describe and explain the decision to have cesarean sections. It asks two specific questions. First, which women agree to cesarean sections, and why do they agree? As we will see, women on Medicaid and those with private insurance report agreeing to cesarean sections, but the reasons they give are very different. While it is important to understand *why* women agree to cesarean sections, a second, more important question is *how* they came to agree to cesarean

sections or the decision-making process. As I will suggest, why women agree to undergo cesarean sections and how they came to agree are actually closely related.

At this point, it is important to mention a cautionary note. The processes described in this chapter were not observed directly. Direct observation of women interacting with their doctors as cesarean decisions were made may well have provided a more accurate picture than interviews with women six weeks later. However, direct observation also has shortcomings: it is unknown whether the presence of an observer during the cesarean section decision might have changed the interaction itself, something known as the Hawthorne effect (Campbell et al, 1995). Since this is an interview study focused on women's understanding and stories about their births and not an observational study, we will be unable to document the actual consent process itself, but rather women's understanding of their role in the cesarean decision and their feelings about the processes that lead to their cesarean sections.

This being said, the ideal of consent will be compared with what women recall of their actual experiences. As I will show, while legal informed consent was always obtained before surgery, women's descriptions of the decision-making process often fell short of genuine informed consent. To understand why this informed consent is rarely achieved, I examine several constraints on women's choices in the delivery room: access to care, access to appropriate quality of care, and the information about cesarean section women recall being given just before their decisions to undergo them.

Who Agreed to Cesarean Sections and Why?

Who agreed to cesarean section? Thirteen women agreed to cesarean section, seven who were on Medicaid and six who were privately insured. Cesarean section Agree-ers then, were fairly evenly divided among types of insurance. All but one Agree-er had a cesarean section for the first time; one insured woman had a scheduled repeat cesarean section.

Note that differences appear in the contexts and the reasons privately insured women and women with Medicaid agree to cesarean. Looking at insurance type alone, Table 5, below, shows a stark contrast.

Table 5: Women Who Agreed to Cesarean Section by Insurance Type

Insurance Type	Emergency Cesarean Section	Non-Emergency Cesarean Section
Medicaid	6	1
Private Insurance	1	5

Women with Medicaid tended to agree to cesarean section for emergency reasons, while privately insured women tended to agree to cesarean sections in non-emergencies, when their labors were deemed unproductive or not progressing toward delivery in the expected manner. There were, however, notable exceptions to this pattern. One insured woman had a cesarean section in an emergency situation delivering twins, and one woman with Medicaid had a cesarean section rather than a forceps delivery for her baby with an apparent brain defect.

Women with Medicaid: Agreeing to Cesarean Section for Emergency Reasons

Women with Medicaid tended to agree to cesareans for medically urgent or emergency problems, termed "emergent" here. Medically emergent reasons for agreeing to cesarean in this group include fetal distress or problems with the baby's heart beat that signaled impending fetal distress. Fetal distress may cause oxygen deprivation to the baby's brain, which can cause handicap or death. A fetal heart rate that is too low or too high can signal danger, as illustrated by this description. Kay was on the labor unit attended by a nurse who called for help.

> … the heartbeat was . . . . . They found it. They found it and then they would lose it. They would find it and lose it again. They had me on my one side. They couldn't find it there and they put me on the other side. Couldn't find it there. They had me on my knees and on my elbows, I guess, and my butt up to try find the heartbeat and they found it. They had my boyfriend hold it and they got mad at him, saying that he moved it, and it wasn't him, it was the baby. So, they said, well, I think there is an umbilical cord wrapped around something on the baby, the leg or the arm. So, I was thinking, okay, the baby isn't coming out because he's stuck. Then, we got to where they couldn't find it at all, and when they did find it, it would go up 200 and back down to 80, back to 0 and stay at 0, and then go back up, and go back down and it was really scary. (Kay)

The problem with not being able to find the heart beat or when the heartbeat goes extremely high and low is that the baby is deprived of oxygen and may die or be seriously damaged. Note that in the urgency to find the fetal heartbeat, the woman's position was changed. This is a departure from women's usual position on their backs in bed.

Often more than one medically urgent concern was present at the same time. For example, Burgandy faced premature labor with the baby in breech presentation and undescended position.

> … they checked me and I was still dilated to two but it was my water that had broken and then that's when a lot of confusion started. Then they told me that he was breech and he was still up there and he was 34 weeks along. And that they were going to have to take a c-section (Burgandy).

At first Burgandy was mistakenly told that premature labor had started and the baby was about to be born, but when amniotic membranes break at 34 weeks and the baby is not descended to a position to be born and his presentation is breach, the baby could well die if a cesarean is not performed.

Some prematurity was severe: 40 weeks gestation is considered full term but the next woman was hospitalized at 28 weeks gestation due to premature labor. After five days in the hospital she had a cesarean for unexpected breech presentation and feces in the amniotic fluid.

> And what happened was when that [water] broke she turned up this way and her head was here. And that's when they noticed that they had to do the emergency c-section and also when my water did break she had a BM in my water and I guess that's also why they had to do the emergency c-section and she was born at 10:58 that Friday morning and that was an experience. (Miranda)

Premature rupture of amniotic membranes containing feces is a serious sign of fetal stress, and this coincided with the baby turning to a breach presentation, requiring an emergency cesarean section.

While most emergencies were experienced by women on Medicaid, one emergency cesarean was performed on a privately insured woman who had twins, which tends to be a riskier birth. She describes her experience

> I had about five hours of labor and it was fine. I mean, I...it was going well and then their heart rate started to slow down quite a lot and one of the two labor and delivery nurses was just incredibly efficient and asked and called for ultrasound machines and got every [body] mobilized and it was like 15 minutes later, those guys were delivered. And, then the first baby had the cord wrapped around his shoulder as he was starting to descend....

> And, because I [was] wheeled down the hall at a great rate and there were tons of people in the room, I was just...hadn't really expected to be...to have surgery, so it was kind of scary (Marsha)

Marsha's labor was normal at first but as the babies started to descend through the pelvis, the umbilical cord wrapped around the first baby, cutting off oxygen to the second baby which could result in brain damage or death. The nurse observed this development, confirmed it with ultrasound and alerted medical staff to begin preparation for emergency cesarean immediately. Both babies were delivered by cesarean within fifteen minutes.

<u>Women with Private Insurance Agreed to Cesarean for Nonproductive Labor</u>

In contrast to women with Medicaid, most privately insured women underwent cesarean sections for labor that was not progressing toward delivery in the expected manner. Three privately insured women describe their experiences with nonproductive labor, called dystocia.

> I: Can you tell me how it is that you came to having a cesarean?
>
> R: ... And when I got to 40 weeks it was like nothing had happened. I wasn't dilated you know. My cervix pretty much closed the whole time. I mean I never dilated at all. And um.... once I got to the 40 weeks my doctor wanted to try to see if you know...if I could have the baby vaginally. So he let me go the next two weeks. Two weeks overdue, and then nothing happened. Nothing was happening. I went in for a stress test and that's when I found out I was having contractions, but I didn't know I was having contractions. So they had me come in to be induced. They hooked me up to the machine, and I was having great contractions like I should have been having the baby. My contractions were that good and they weren't even painful. Like I could feel my stomach tighten up a little bit, but it didn't hurt. It wasn't uncomfortable. But the contractions were so good that they didn't even need to induce me…my contractions were 3-5 minutes apart and there was nothing going on. It wasn't even painful. It just felt like my stomach was tightening up. And the contractions were actually doing more harm to the baby so that's when they went ahead and [I] had the cesarean (Constance).

Two weeks past term, Be was having contractions but was not feeling any sensation like pain. Her contractions were not effective in causing the baby to progress toward birth and were characterized as doing more harm than good to the baby, which could not come out of her closed cervix.

Like the women that have just been described, Bo's labor also failed to progress.

> I: Could you please tell me about your first birth and that pregnancy?
>
> R: Well, it was long. (laugh) I got high blood pressure with him.... with Jay and I was on bed rest and I went two weeks over. My labor was 24 hours and I dilated to five.
>
> I: (writing notes) One second here. Your labor was 24 hours?
>
> R: Yes. And then after 24 hours they decided to take it cesarean. They tried inducing it and that's how I got the five cause I was at three, and then they tried inducing it again and it was stopping my labor so then they took him.... (Cassie)

Though Bo developed high blood pressure and was two weeks past her due date, her labor did not progress adequately and pitocin was ineffective. After 24 hours she had a cesarean for labor that failed to progress.

The third woman, Diane, had her first cesarean for labor that did not progress adequately, and a second cesarean for her next child for what appeared to be the same problem.

In short, two women went two weeks beyond their due dates without dilating adequately. The third woman had two cesareans due to an inability to dilate during labor.

The Process – How the Decision to Have a Cesarean Section is Made

Two out of thirteen women feel they were a major part of the cesarean section decision.

So far, I have discussed the reasons women gave for having cesarean sections. What is not clear, however, is the nature and extent of their participation in decision making. Of thirteen women who agreed to cesarean section, only two report being offered a choice about whether to have a cesarean section or not. Neither was an emergency cesarean section. Of the two women who described being a major part in cesarean section decisions, one woman was insured, the other had Medicaid. Even though they describe making choices, these choices were limited. The women were asked to choose between having a cesarean section, which was presented as protecting the baby but posing a lesser risk to the mother, or choosing to risk potential damage to the baby. These women did not seem to be aware of the risks having a cesarean section or foregoing vaginal birth pose to the baby. They also did not mention rare or serious risks to themselves of hemorrhage or death from cesarean section surgery.

The insured mother had this to say about her decision to have a cesarean :

> R: ...They said. they used the word the "trend" is to have a cesarean when it's a breach baby. Now, the reasons why it's good to have a cesarean was that there's a less of a risk to the baby itself when it's coming through the birth canal and you know being that the head and the neck is last that kind of thing. I can't remember specifics. And then the...what was the negative? But then with a cesarean it's higher risk for the woman to get maybe an infection or you know it's a major surgery, so we felt that the risk for the baby... less risk for the baby is more important for us so we decided to go with the cesarean, and basically I was already numb. They rolled me in and everything was right on schedule, and... (Dedre)

Dedre recalls reasons she and her husband chose cesarean section, but does not remember the alternate choice very well. Whether this is a function of her recollection or

of what was actually presented to her is unclear. On the one hand, information can be presented in a way so as to assure agreement (Anpach 1993): most mothers would assent to endure a risk themselves if it meant sparing their baby from danger. As Robbie Davis-Floyd notes, birth is a rite of passage in which women internalize the cultural meaning of motherhood, in which women are expected to put their babies before themselves. Moreover, an "industrial" production model of childbirth, in which the body is treated as a machine, may have made the decision to have a cesarean section seem routine. Thus, when Dedre describes being rolled in to the operating room she notes her cesarean section fit well into the hospital's schedule.

On the other hand when making important decisions under stressful circumstances, there is a social-psychological tendency to remember factors that support the choice one makes and to overlook drawbacks of that choice (Festinger 1957)). It appears this may have occurred in the case of insured Dedre..

Privately insured Dedre's labor progressed normally over several hours and cesarean section was considered when breach presentation was discovered. In contrast, a mother with Medicaid described in detail the alternatives she considered before giving her informed consent to cesarean section. Frieda had a long, slow labor, during which she learned her baby appeared to have an abnormality in his brain. Frieda was transferred from her community hospital via ambulance to Big Hospital and recalls being offered the choice of either forceps delivery or cesarean section.

> … something wrong with his head, I, you know, I just wasn't keen on the idea of forceps, and I just wanted get it over with and make sure he was alright. So I just said go ahead and you know, give me the c-section. (Frieda)

Frieda had to choose between risking possible forceps injury to the baby's potentially compromised brain, or in the face of hunger and exhaustion embrace the cesarean promise of making sure the baby was all right. She chose cesarean for these reasons and to "get it over with" after a long and eventful labor. Cesarean section presented as a way to spare the baby from further damage to his brain doctors might inflict if she chose otherwise.

Thus, in the two cases where women recall doctors giving them information to make a choice among alternatives to cesarean and cesarean section, both agreed to cesarean section in what they described as the best interest of the baby. The appeal for Dedre, an upper middle class insured professional, was cesarean section as a trend that lessened the risk to the breech baby coming through the birth canal. She and her husband made clear their decision favoring less risk for the baby, not mentioning any risk to her but pointing out how the epidural already made her numb and everything was right on schedule. The cesarean section appealed to Dedre's professional value of contol and efficiency in scheduling work to be done.

Assent: Agreeing to the Doctor's Decision to Perform a Cesarean Section

Eleven of thirteen women report being asked to agree to the doctor's decision for cesarean section and report little discussion of the range of risks or possible outcomes. To understand why most of the women in this study agree to decisions already made by physicians, it is important to understand several factors that influence the decision-making process: women's access to prenatal care, the quality of appropriate care they

reported, and the quantity and quality of information women report they received just prior to the cesarean decision.

Agreeing to Cesarean Section and Medicaid Women's Access to Care

No women with private insurance described problems accessing care. The only woman with Medicaid who reported problems with access to care was an 18 year old who had poor access to care on many levels. Daphne reports she was turned down for prenatal care by many doctors and finally accepted by Big Hospital to due to the advanced stage of her pregnancy. Against new policy, Daphne was not assigned an individual doctor within the hospital clinic, then recalls being blamed for not having a doctor when she arrived in labor for admission to the labor and delivery unit. Though she had already labored two days at home, after two more days of labor Daphne had general anesthesia for her cesarean delivery . After her cesarean section but before discharge from the hospital, the birth control injection she requested was administered to her roommate instead.

Women with little access to care may feel they have no alternative than to accept whatever care that is available, even if it is not to their liking. This is illustrated by Daphne, who was single and age 18 and entered prenatal care at 4 months gestation at Big Hospital's clinic. Daphne was rejected from private and public medical practices nearer her rural home because she was four months along in her pregnancy before she realized she was pregnant and sought care.

> R: I was four months pregnant and the doctor I had called referred me to Big Hospital.
>
> I: And why was that?

> R: Because he wanted me to get okayed by Big Hospital before I could you know...cause I was at four months. He said that was too far along to take me so he referred me to Big Hospital. All the doctors I called told me I was too far along and they couldn't take me at four months so I ended up going to Big Hospital cause that was the only choice I had. If I would have had a choice after I went for my first visit I would have tried to find another doctor because even...I mean I never had the same doctor. Never. When I went in there I had a different doctor. (Daphne)

Daphne's access to care was limited by the unwillingness of doctors in her home area to accept her as a patient, which may have been for liability reasons. As soon as she realized she was pregnant, she tried to see a doctor but could do so only at Big Hospital. She valued prenatal care enough to make the one hour trip each way even though she felt she was not treated well once she got there. Daphne did not have a car and it was a hardship for her to get a ride for the long trip into Big Hospital for prenatal care, but she found no other choice.

<u>Agreeing to Cesarean Section and Appropriate Quality of Care</u>

Some poor women felt they had less than adequate care and complained about communication gaps with medical staff. Some poor women received prenatal care in impersonal, bureaucratic settings, where there was limited continuity of care, and lacked an ongoing relationship with a health care provider—factors that complicated their communication with health professionals.

In addition to having to travel an hour to the only prenatal care that would accept her, Daphne came to Big Hospital with another disadvantage. On Medicaid, Daphne was an obstetric clinic patient who was not assigned her own doctor, despite a new hospital policy requiring each person to be assigned a doctor. She saw whatever resident was on

rotation on the day of her visits, and felt the impact this had on her entry to the maternity unit months later.

> R ...it wasn't like they told me it would be.
>
> I: How did they tell you it would be?
>
> R: They told me that I'd have one doctor, and they never gave me a doctor and so when I went into the labor room...or when I went up to check-in to maternity they asked me who my doctor was and I didn't have a doctor so they gave me a hassle about that. Just all the people coming in my room whenever they felt like it you know (Daphne).

When Daphne got to the hospital for her delivery the reception was not friendly, and she felt blamed for not having a specific doctor even though she had wanted one. Ironically, not having one specific doctor seemed to open her up to unwelcome traffic from a variety of staff, not a respectful experience for Daphne.

Further problems with communication and loss of information to follow up were part of the reason some poor women felt they had emergency cesareans. One women felt that early warning signs of trouble she experienced and reported were not properly followed-up by medical staff. As mentioned earlier, Miranda requested time off from work due to the physical and emotional stress of her food service job where she routinely lifted fifty pound buckets of ice and performed other strenuous tasks. Her doctor would only authorize lifting restrictions, which proved impractical. Rules for granting permission for women to be off work may be shaped around office jobs and not the physical labor some poor women find themselves doing on a regular basis.

> I: Did you explain to the doctor that you were having trouble?
>
> R: Yeah, I explained to her that what my situation was at work. That I did this. That I did that. And you know they expect me to lift ice buckets and stir the ice machine and doing this and doing that. She was like Well...how did she say that? Something about that I had to be within so

many weeks before she could release me from work and I can't remember how she said that.

I: And how did you feel about that?

R: I felt disappointed.

H: Well, I was pissed off because I was expecting...you know we were up north and find out all this stuff and everybody we talked to was like, Well we've never heard of such a thing. And then we come back here and her doctor was like Oh, yeah. Stuff like that can happen. And it was like no explanation, no bother you know Oh, it's fine.

R: So I had also figured from that point that she would at least monitor me a little bit more and she didn't. She said come back next month. Cause you know my appointments were regular once a month until I got closer, and she was still telling me to come back once a month. And the whole time from the first day I started...or from the first time I found out I was pregnant they were like...now if anything happens you call us if you think something's wrong. Well, I did that. Um....anything if I felt different. Like I felt a lot of pain down in my pelvic area a lot and I would call on that. Is this normal? Oh, yeah that's normal. That's just your skin stretching. That's just something. And then finally when I was working I found out through these...when I was actually in the hospital they told me what contractions were the tightness...I felt those when I was working. I would have like four or five of those during the day. I thought she was moving because that's what my OBGYN told me that's what I would feel is her movement, and I thought that moving and kicking were two different things. When I felt that I felt she was just kind of moving, but I was having contractions and I never knew it. And that was through the whole time so....

I: How do you feel about the treatment that you received?

R: From her after all this I feel disappointed. I feel that she should have at least watched me a little bit more after that incident that happened with my uterus, and she didn't. From that point on...that was in August...Yeah, about a month and a half later I quit work because work wasn't even helping me either. Since it was a two person cafeteria. The company sucked. Since the time of that incident that happened I asked if they would send more help, and they wouldn't do that. I'd ask if they would let me have less hours because I found out in order to keep my insurance the least amount of hours that I could have worked was thirty hours a week and I was working forty and they told me no…(Miranda).

Miranda felt she asked for help from her doctor and did not get excused from work. Miranda felt problems like her premature contractions were ignored due to her inexperience and poor communication by medical staff. She felt that Big Hospital did not respond to her symptoms as readily as the community hospital had done. She felt no one watched her closely enough and she ended up with a cesarean section emergency at 28 (out of full term 40) weeks gestation because of the poor quality of her prenatal care at Big Hospital

Middle class jobs may more readily accommodate women workers by allowing more flexibility in hours and assignments. Miranda's workplace refused to accommodate her physical limitations even though official written work rules would have permitted her to reduce her hours. Miranda continued to work under stress until she felt she had to quit and lost her health insurance.

When Miranda went to apply for Medicaid she had not even filled out all the paperwork before she was hospitalized for five days for very premature labor. At the end of five days, at 28 weeks gestation, she had an emergency cesarean for breech presentation and stool in the amniotic fluid, the latter a sign of stress.

> And what happened was when that [water] broke she turned up this way and her head was here. And that's when they noticed that they had to do the emergency c-section and also when my water did break she had a BM in my water and I guess that's also why they had to do the emergency c-section and she was born at 10:58 that Friday morning and that was an experience. (Miranda)

The emergency cesarean followed signs that her very premature baby was seriously stressed and turned breech at the last minute.

The examples of the poor women who agreed to cesarean section showed they had difficulty accessing care, and that staff neither listened, gave them information nor followed up on their concerns until babies were in distress.

Emergency Cesarean Sections and Informed Consent

Lack of access to adequate prenatal care increases the likelihood of emergency deliveries, in which women are asked to agree to split-second decisions to deliver via cesarean sections. Recall that women with Medicaid tend to have cesareans for emergencies or potential emergencies. Having to make decisions in the context of emergencies complicates the consent process.

The first example is of a woman who said she was heavily drugged and was told she was having a cesarean section in order to prevent a serious medical emergency.

> I was really heavily drugged so not a lot of things were coming together. I was moving real fast and I guess the reason why they did say that the C-section was necessary because they waited two hours for the left side of my cervix to dilate- it would not dilate. My blood pressure was high for one thing they were kind of worried about that- and I pushed twice throughout the labor. Each time the baby's heart beat would drop and it would increase as soon as I stopped, so the doctors were scared that it wouldn't happen so they told me they were going to do a C-section (Ivana).

Ivana describes being drugged for pain and having difficulty. Her labor was progressing very fast but the left side of her cervix was not dilating after two hours. Ivana relates the doctors communicated their care and concern for her and her baby when they were worried about her blood pressure being high and were scared the baby's heartbeat would not recover if she pushed again as part of vaginal birth. Note her use of medical measurements of blood pressure and the baby's heart rate as measures of well being and

safety. Ivana describes that the decision was made by the doctors to do a cesarean section to prevent harm to the baby from depressed heart rate caused by pushing.

Women in active labor are appropriately focused on coping with labor pain and accomplishing birth. They are exquisitely vulnerable, and while tuned in to themselves they may be necessarily distanced from goings on around them.

Kay tells the story of her own detachment while observing the alarmed staff.

> R: I wasn't really scared because I was dazed and, you know, in so much pain and with all this going on I was just trying to relax... They were calling doctors at every hospital. There was an emergency code blue. Told them don't take your time, rush, call on their cell phone and tell them to get here now, we can't find the heartbeat. They took me out of the room real fast and took me back to the [delivery] room. They put a shot in my back. They gave me this cover, and I couldn't see them do nothing to my stomach ... and then, I guess they started to cut me open ...
>
> I: How did you feel emotionally during all this?
>
> R It didn't really bother me. I was scared, but I wasn't. I was just dazed, like I'm glad it's over. I'm glad she's okay and I wanted to go to sleep. That's what I felt.
>
> I: Well, sure.
>
> R: Yea. When I got to the hospital, ... I was in another world. I was just trying to deal with pain and it was like I was in a box and everybody was around me and I could hear everybody talking but I wasn't paying attention. Just relaxed and try to deal with the pain (Kay).

Perhaps in shock, when medical or nursing staff interpret and communicate what they understand to be a serious threat to the baby, women like Kay could hardly be expected to object to surgery. Her emotional and cognitive distance was reinforced when the "cover" or operative drape prevented her from observing her belly being cut open for the cesarean section. Kay felt glad the delivery was over, that the baby was okay and she wished to sleep. Kay describes being dazed and in another world, being scared but not

bothered when an emergency code was called when the baby's heartbeat could not be located.

Even though the informed consent process is followed, procedural explanations are offered and risk documentation duly provided, in an unexpected emergency situation it is difficult for the ideal of consent to be achieved. Drugs and appropriate concentration with coping with labor make the ideal of informed consent difficult.

Routine hospital procedures, things that are viewed by staff as normal such as a request for consent before any surgery, can be interpreted quite differently by women or their loved ones. Anxiety may be so high that just signing consent papers can overwhelm loved ones who are supposed to be offering social and moral support to birthing women. Having to depend on a loved one in a panic is not experienced as supportive.

Kay described that her boyfriend was so afraid when she was asked to sign consent papers for the cesarean surgery he thought she was going to die.

> S: They had me sign all kinds of papers. That's what scared him, because he thought I wasn't going to make it . . . . ..
>
> I: They had you sign a will?
>
> S: Something like a will, like if I go, or something like that. They had me sign all kinds of papers.
>
> I: If you go, you won't sue them? (Pause) Is that what you meant?
>
> S: I don't know what they had us sign the papers for, but they had me signing this and that. Okay to do this, okay to do that. They explained to me what they were going to do [it] to me and why they were doing this to me. They were very good about that. They made sure the doctors got there fast, called every good doctor they could. They talked to me, they checked me to see if I was dilated, did blood work to make sure everything was okay, got her out, got her breathing fast. They didn't take their time getting her out (Kay).

When questioned closer about the consent process, Kay defends the staff and assures the interviewer staff did all procedures properly and got the baby out and breathing quickly. She indicates that staff actions were quick and efficient throughout delivery.

Sometimes a cesarean section decision made by the doctor can be a welcome relief from unrelenting and unproductive labor. Darlene described a very long labor that stressed the baby, herself and her boyfriend.

> I: When you were in that 39 hours of labor, did you feel at anytime that you were holding back or that the baby was holding back. What was in your head about why the baby wasn't coming out?
>
> R: I didn't know. I was like why is the baby taking so long. I didn't know why it was taking long. I was getting really anxious. I was like I want to see my baby. I want to make sure he's all right. You know, once my temperature went up and his heart rate went up I was getting really worried where I started crying because I was so scared then I got sick and threw up.
>
> I: Well, of course you did.
>
> R: I was like gees, and Herb took a picture of that. Mr. picture taker. Took a picture of me throwing up. [To baby] Your father is so inappropriate sometimes. But, um...I didn't know why it was taking so long. I was relieved that he said we're going to do the cesarean at this time. I was totally relieved. I was like all right. It felt like I could relax when he said that.
>
> ...Dr. Y was really, really nice and he told me that we could probably wait another hour to see if he dilated anymore, but his heart rate.... Once my amniotic fluid was infected and that could have been because they were checking me or whatever. His heart rate went up to like 200 and my temperature was like 102. They were trying to get my temperature down to get his heart rate down. They were running around like crazy because they went in and had this like funnel thing sticking out of me. It's hard to make sure that his bloodstream didn't have an infection either (Darlene).

Beside herself with worry, Darlene says her anxiety about the how long the baby was taking to be born caused her to vomit. She wanted to see the baby to be sure he was all right. She incorporated the medical indications of her rising temperature and the baby's heart rate to explain her fear. Her boyfriend's anxiety was expressed by taking her picture in an embarrassing moment, and not experienced as supportive. Darlene was offered a limited choice about whether to continue labor for another hour or proceed with the cesarean, and describes relief when cesarean section was decided by the doctor.

In short, for Medicaid women in this study, making decisions in the midst of an emergency complicated the consent process. High anxiety and time constraints made informed consent an unattainable ideal.

Private Insurance, Medicaid and Communication

Anspach (1993) found that people facing medical decisions are offered differing amounts and kinds of information depending on medical staff's assessment of parents' medical and cultural sophistication, usually tied to socioeconomic status. In her study, persons perceived to have greater sophistication received more information and exercised more power in making medical choices.

In the current study of cesarean section, women with Medicaid and women with private insurance describe the information they received and whether doctors asked them to consider a range of factors and weigh a decision (consent) or to agree with a decision made by the doctor (assent). Insured women did report being offered more information or being advised of a wider range of potential risks or outcomes than most women with Medicaid. However, with the single exception of Dedre choosing cesarean for breech

birth above, insured women do not report being offered more choices or chances to be involved in the cesarean decision making process than women with Medicaid. Thus the experiences of insured women undergoing cesarean sections differed from those of parents described in Anspach's (1993) study of neonatal intensive care.

The most highly educated woman in the sample had private health insurance and a graduate degree; her professional colleagues were nationally ranked doctors. She felt she had no participation in the cesarean decision but was comfortable with it.

> I: How much, if any, input do you feel you had about the Cesarean?
>
> R: I don't...I didn't feel like I had any, but I didn't...it's not as if I said, "Wait a minute, I'm not going to stand for this." 'cause I have a lot of respect for my obstetrician and his ability to judge when something is necessary. And, he knew that I wasn't keen on that type of intervention and .... If there was an alternative but there wasn't. I mean, I didn't feel like there was (Marsha).

Marsha's trust in her obstetrician's judgment made following his recommendation comfortable. Here Marsha felt that she had a cesarean section because there was no alternative. No alternative to cesarean section in this case arose because when she tried to deliver her twins vaginally, the cord was wrapped around the first baby, cutting off oxygen as it descended.

Whether it was knowing and respecting her doctor well, her age, her marital or insurance status or some other reason, Marsha was given more information and explanation than Daphne, the teenage mother with Medicaid who felt her nurse would not giver her vital information she asked for about her baby's condition.

Below, Daphne relates a very different experience than Marsha

> I: Can you tell me about your birth and the pregnancy?

R: Most of it was okay. I just...when I went into labor... on a Sunday and I didn't go to the hospital until Tuesday and I didn't like my nurse. She...we didn't get along and her heartbeat kept dropping.

I: The baby's heartbeat kept dropping?

R: Yeah, and I was concerned about that and she wouldn't fill me in on that so I really didn't like her, but I mean other than that...

I: Well, that's kind of important.

R: Yeah.

I: She wouldn't fill you in on it eh?

R: No. And that's when they decided to take her cesarean is when they couldn't stabilize her heartbeat. (Daphne)

Daphne describes that the nurse would not give her information on her baby's heart beat that kept dropping. Whether this was because Daphne was intentionally excluded from the information or for some other reason, Daphne certainly experienced being excluded from learning important information about her baby's condition. Daphne indicates that others decided to perform the cesarean section and did not see herself as having had a part in the decision.

Ironically, Daphne, as a mother who was physically giving birth felt deprived of information by medical staff who were interpreting electronic fetal monitor tracings. This illustrates how far removed some women in modern medical facilities feel from their own surgical birth experience and knowledge of that experience.

Women with Medicaid were not the only ones who were not given all the relevant information they may have needed. Privately insured, Diane also received less information from the doctor rather than more. She related that she was not informed of one of the reasons for her first cesarean section, that the doctor thought the baby was

going to be very small and underdeveloped. Then, an interesting paradox arises at her second birth, when her unproductive labor is attributed to the baby being too large.

Diane's description of her first cesarean is as follows:

> I: Now, could you say again what he [the doctor] told you?
>
> C: He said that he didn't feel the baby had grown like past the five months, that she was a small, there was probably going to be lots of problems, that kind of stuff. Had everybody really worried except for me because they didn't let me know that.
>
> I: Wonder why?
>
> C: I guess they didn't want to worry me right then 'cause this was all right before they were gonna do the surgery.
>
> I: Why were they gonna do this surgery?
>
> C: That was because I hadn't dilated past three. And so, this doctor that hadn't seen me through the whole time. He did the ultrasound and I don't know if he read it wrong or what but he felt there was going to be problems. And so, the surgery itself was fine, I felt. The C-section went well. And, she was seven pounds, five ounces. She was totally healthy. There was nothing wrong. Her chin was just stuck. (Diane)

Diane's doctor did not tell her he anticipated a small and sick baby, but did tell her relatives in attendance at the birth. Her failure to dilate more than a third of the way necessary for birth was the reason given her for the cesarean. She felt the surgery proceeded well. The baby was a normal size and not sick as the doctor had expected.

For her second baby:

> I: ... [the doctor] told you the reason that was because you wouldn't dilate.
>
> C: Yeah, they did. Because I wasn't dilating, things like that.
>
> I: Do you think that that is why the surgery was actually done?
>
> C: Yes, I do because it happened with her too, so. I didn't go past five, with him, I mean. And, his head was stuck. He was big. I guess I just

> can't have big babies. He was eight pounds, seven ounces, so. I just am too small, I guess, to have 'em naturally (Diane).

To make sense of the problem of not dilating due to the baby being too small the first time and too large the second time, Diane explains by internalizing the last explanation, that she was just too small to have babies naturally. The problem is seen to be her anatomy, not the inability of the doctors to adequately assess fetal position or presentation.

Another insured woman who had a cesarean section for unproductive labor, Constance was having her first baby and did not realize she was in labor but had had contractions for some time. Unrecognized, nonproductive contractions were viewed as harming the baby, so the cesarean section was performed. Constance recalls no communication of the reason for the cesarean even after the surgery.

> R: I went in during the 40th week and then during the 42nd week when I went in they were going to induce me because you know they didn't want me going further than that. And then that's when I was having strong...my contractions were 3-5 minutes apart and there was nothing going on. It wasn't even painful. It just felt like my stomach was tightening up. And the contractions were actually doing more harm to the baby so that's when they went ahead and had the cesarean?
>
> I: And why was that?
>
> R: He said the baby was in the right position, but my doctor was saying either he was too big to have him because my bones never separated or that the cord might have been too short and he couldn't get down far enough. I never did ask him about that. If it was the cord. I never really had a chance to have a conversation with him about the birth, you know about why I did have to have a cesarean. I figured they would know after they took the baby out they would be able to tell. I don't know I just never really got around to asking him about it. Probably because he was here and that was all that mattered, and I wasn't overly concerned about the problem why he didn't get here the way he should have. (laugh)
>
> I: What do you tell yourself about why you had a cesarean?

> R: Um...because it was necessary. Because, you know, you can't really rely on doctors. They do the best they can, but you know babies come the way they're supposed to come. You know, you can do all you want but if you're going to have a cesarean you're just going to have one. My son was destined to be a cesarean (laugh). (Constance)

Lacking information regarding the reason for her surgery, she attributed her cesarean section to fate. Though she was having contractions they were not painful and she did not recognize them as contractions. She was only made aware of her contractions in the hospital and stated "there was nothing going on", meaning her labor was not progressing.

When asked, Constance did not answer why the contractions were doing more harm to the baby but offered her doctor's explanation for why labor was not progressing, which encompassed two possibilities: that her pelvic bones had not expanded or there was a short umbilical cord. Interestingly, Constance never had a conversation with her doctor to determine why she had a cesarean section, though she asserts the cesarean was necessary. Constance indicated one cannot rely on doctors but that the baby's fate determined whether she had a cesarean. Rarely do women say their doctors are unsure, but Constance and the next woman, Burgandy, both assert that doctors are sometimes unsure.

There is a perceived knowledge gap between women and their doctors and the nursing staff. When doctors or nurses do not communicate information it could be a problem in communication, but some women felt that staff do not always communicate information because they may not understand precisely what problems are occurring during delivery. The next example is of a woman with Medicaid who was transferred to

Big Hospital by ambulance and who felt doctors were just not sure about what was happening during her labor and delivery.

> I: And how would you describe it?
>
> R: Oh, I would describe it interesting. It wasn't bad at all. I mean not for what you get out of it. Not bad at all.
>
> I: You were like totally dilated. Did you ever wonder why they didn't let you go?
>
> R: They were afraid that the baby's head would be crushed.
>
> I: By what?
>
> R: The birth canal.
>
> I: Were you afraid of that?
>
> R: I was afraid of whatever they were afraid of. I wasn't a bad...it was exciting. I was just...I didn't know too much when I got to that point about the c-section so...
>
> I: I'm not sure what you mean.
>
> R: Well, I knew all about the labor and deliveries, regular birth and they weren't telling me so that's why I was...
>
> I: Why do you think they weren't telling you...
>
> R: Cause they weren't too sure, and I wasn't even at Big Hospital for an hour. I wasn't even there for an hour when I had him. Everything just went so quick. (Burgandy)

Rather than staff failing to communicate information, Br felt doctors were not sure and did not have time to figure out what was happening before she delivered. She felt satisfied with her cesarean which she understood as saving her breech baby's head from being crushed by vaginal delivery.

Misconception: A Barrier to Informed Consent

Women's ideas of what a cesarean section would be like were often very different than the reality they experienced. When they agreed to cesarean section, women anticipated it would be less painful than vaginal birth and underestimated postoperative physical debilitation and painful recovery from surgery.

When asked how her cesarean birth compared to what she expected, Darlene had this to say:

> So, I expected it to be a lot easier than it was. I didn't expect for a cesarean for you to feel so much pain. I though maybe little stitches here. I didn't realize that your muscles would lose control that much and that it would hurt that bad.
>
> I: Nobody told you.
>
> R: No.
>
> I: You just thought it was like an operation?
>
> R: Yeah, I thought maybe stitches and that was it. I didn't think it would hurt that bad. I thought I would have more control over my body than I did.
>
> I: Tell me what you mean.
>
> R: I thought well,
>
> I: Um...You were saying you thought you would have more control over [your] body.
>
> R: Well, I mean I would be able to move as freely as I did before and I tend to move hardly at all. Sitting on the toilet. Oh I wish I would have had a higher toilet. You sit down, it's so hard to sit down and get back up after you had a cesarean. I mean, you need a special seat made for people who have had cesareans.
>
> I: Sure.
>
> R: Because it's really hard to sit all the way down. Getting out of bed, picking up the baby, it's just really hard. I've had to have Herb do things

for me like the first few days after I had the cesarean. But, you heal quicker than you would think afterwards also…(Darlene)

The idea of a cesarean section as "a few stitches" is unrealistic but common. This may reflect the frequency with which the surgery is performed and women's understanding of doctor's explanation perhaps designed to reassure them or to minimize the impact the surgery will have. Very simple things like getting up and down to the toilet or bed, or trouble picking up the baby were a surprise to Darlene.

The recovery from the after effects of Patty's first cesarean was also unexpected.

I: Can you tell me how you felt the first few weeks after your first birth?

R: Horrible the first week. I was extremely sore. I didn't anticipate the after effect of being so sore. Yeah, that first week was terrible but after that it got a lot better… (Patty)

Patty was also surprised at the pain after her cesarean that persisted for more than a week, so much that she described it as horrible. She describes feeling better after that.

Sometimes women have misconceptions because they have been given information by their doctors that GOER'S research has shown to be *Obstetric Myths rather than Research Realities*. Patty expressed her desire for vaginal birth after her first cesarean and understood from her doctor that the risk of hemorrhage was far too great.

That was my first, but I did want to try to deliver vaginally with the second one, but the doctor that I had at the time... We didn't have insurance at the time and so I wanted to you know try to go natural with the second one so we didn't end up with another big hospital bill for one thing and I didn't get to do that the first time so I was a little more ready to do that the second time, but the doctor said my c-section had been 17 months before and he said, No they're too close together you need to have you know another c-section. I said Well he's the doctor and I'm not going to argue with him so I went aead and went along with the c-section. (Patty)

Later she learned that the risk of hemorrhage that motivated her to go along with the repeat cesarean was much less than she imagined at the time.

> … I wasn't real excited about having to have one the second time, and I think you know it was probably more for financial reasons. But you know I also wanted to deliver natural but they said another big baby and that close together. There's chances of hemorrhaging. Then later on I found out that through another doctor the chances of hemorrhaging were pretty slim or slight compared to what I had in my mind of what they were so you know it would have been nice (Patty).

Patty did not want a second cesarean if she could avoid it, especially because of the cost. Fear of hemorrhage from her first cesarean scar rupturing so close after her first baby with the size of her second child made her agree to a second cesarean.

The experience of two cesareans made it likely she would agree to a cesarean the third time for a large baby.

> And this time [3d baby] you know I thought it would be nice to deliver vaginally but you know if there were any problems it would be better off to have another c-section and you know after telling Dr. X my history. He said, You're chances are you're probably going to have another big baby. He said You might as well pretty much plan on another c-section so you know I kind of had that in my head. It got closer and I progressed. The baby was growing rapidly. They were guessing at him being over 11 pounds you know… he ended up setting up a date for me two weeks before my due date so that he wasn't too big. As it was he was ten and a half pounds. They had trouble getting him out, his shoulders and that and he ended up with some bruises and they had to do an x-ray afterwards to make sure that everything was fine. But he was fine. So you know I felt comfortable with that. You know realizing that it's just too difficult to deliver big babies. You know I was scared to do that.(Patty)
>
> I: When you think about delivering such a big baby as you say. What kind of scary things were you thinking about?
>
> R: Well, it's just that you know I've heard horror stories of people having big babies you know and having to cut them and different things during the birth process. I just figured it was safer to go cesarean.
>
> I: Safer for you or the baby?

> R: Well, mostly for the baby. I wasn't worried so much about me. It's just a matter of a few stitches which the c-section ended up with quite a few stitches anyway (Patty).

Her doctor encouraged her to have another cesarean, not recommending she try a vaginal birth for her third child. Her fears were for the baby and she minimized the "few stitches" from the cesarean, even though her first recovery week for her first cesarean was described as "horrible".

This was reinforced by stories from other people she met.

> By the time this guy [3d baby] came around I pretty much figured out that I would probably have to have one [cesarean section]. You know and then I ran into this gentleman in the store and he was telling me.... you know I was almost due. I was pretty big. He was telling me about his daughter in New York that just had twins and ...they were both over seven pounds. It was like seven and a half pounds. And he said this crazy doctor let her go natural and she was so torn up you know. She was in a lot of pain. You know I started thinking you know.... Yeah, I'm kind of glad. You know I hear these stories from different people and I go Yeah, I'm glad I had a c-section. You know get it done. Make sure he's okay. So that part you know I pretty much had my mind made up that that's what had to be done. (Patty)

Discussion: Agreement to Cesarean Section

To what extent were cesarean sections the result of women weighing their options and making a decision to agree to cesarean section? To what extent did women assent to decisions already made by their doctors?

Although informed consent is the ideal, logically the temporal context of consent seems important in considering whether in actual practice women assent or consent to cesarean sections. An emergency cesarean section may have to be performed within two minutes, an unexpected condition may develop over the course of a day, while other

cesareans are scheduled weeks in advance. It would seem that emergency surgery leaves less time for discussion of options and side effects while having a day or longer to plan and assess options for unproductive labor would offer the chance for a more complete consideration of the ramifications of cesarean surgery.

In these data, women's consent or assent did not depend on whether the cesarean section was an emergency or planned in advance. In contrast to other studies (Anspach 1993), insured women did not seem to participate in the consent process any more than women with Medicaid. With one exception in each group, women assented when it cam to agreeing to cesarean section. Five of six insured women assented for nonproductive labor, while six of seven women with Medicaid had emergencies and assented to cesarean section.

Women have limited information and limited support with which to judge doctor's assertions that cesarean section is necessary. Those offered choices are unlikely to disagree with the suggestion for cesarean. Regardless of insurance status, women reported poor communication of cesarean risks, side effects and information about vaginal birth benefits forgone during the consent process. In communication with their doctors, women were not only uninformed but were either misinformed or misunderstood what they were told.

Most women did not have a realistic view of the gravity of cesarean section surgery. They imagined less pain than in vaginal birth. Cesarean section was imagined as "a few stitches", and even referred to as such when women had a previous cesarean. The difficulties encountered with post-operative recovery came as a shock for many. Difficulties also arose when women were told "obstetric myths" rather than "research

realities" (Goer, 1995)—that is when doctors understate the risks of cesarian sections, and overstate the risks of not having a cesarean.

In every case described in this chapter, the women worked to preserve the safety of their babies in the face of limited choices less desirable than cesarean section. Both Medicaid and privately insured women experience limits on the information and choices they had, despite differing reasons for cesarean section.

Women agree to cesarean sections because they do not have access to other reasonable choices. Women act to preserve the health of their babies and secondarily their own health the best way they know how to do so. The two women who had the most choice in this chapter really were offered little choice at all.

The best doctors work to empower women in birth, but the entire context of birth in the hospital works against women's empowerment. The masculine production model of birth on time and on schedule with one centimeter dilation per hour does not fit well with the reality that half of births do not conform to the labor schedule. Instead of changing the labor schedule, extensive attempts to change women's labor are made, sometimes with results that require cesarean section. Iatrogenic cesarean section can result from routine induction and epidural anesthesia in women who are deprived of food, water and movement.

Agreeing to cesarean section also allows women to avoid other things that are difficult to discuss: fear of pain, worry about being responsible for safety of the baby, and the fear of episiotomy. Women's fears about labor and birth are rarely addressed, and fears are compounded when doctors show low confidence that women can reliably deliver babies without surgery, as in the case of Li with her third cesarean.

Women seem to share doctor's difficulty with the uncertainty of the length and intensity of labor and, understandably, many fear labor pain. Agreeing to a cesarean relieves worry about one's own responsibility in birth by turning it over to trained professionals. Doctors have authoritative knowledge women feel they lack. Unaware of the risks or alternatives to Cesarean sections, the women in this chapter seem to accept a cesarean's illusory promise of a healthier, safer birth for babies.

Table 6: Women Who Agreed to a Cesarean Section

Name	Insurance Type	Age	Marital Status	# Prior Births	Prior Birth Type	Fetal Position	Reason/dx	Comment	Cesarean?
Patty	Private	34	Married	2	Cesarean x 2	-	Repeat; big baby		Yes
Cassie	Private	22	Married	1	Cesarean	-	Failed induction, repeat cesarean	High bp and bed rest first preg 2 weeks overdue, failed induction, 24 hours. Sched 2nd cs	Yes
Freida	Medicaid	25	Single	0	-	-	Failure to progress; baby brain defect	Long labor, get it over with, given choice forceps or cs	Yes
Ivana	Medicaid	20	Single	0	-	-	Failure to progress, fetal decels*		Yes
Darlene	Medicaid	26	Single	0	-	-	Failure to progress		Yes
Burgundy	Medicaid	18	Single	0	-	Breech	Breech premature 36wk		Yes
Kay	Medicaid	21	Single	0	-	-	Bleed, probable prolapse cord	Fetal distress likely	Yes
Miranda	Medicaid	24	Single	0	-	Breech	Premature 29 weeks, breech, meconium stained fluid		Yes
Daphne	Medicaid	19	Single	0	-	-	General anesthesia, failed epidural several days labor	Told she was to have cesarean, not much choice	Yes
Denise	Medicaid	19	Single	0	-	-	Pre-eclampsia, failed induction fetal decels*		Yes
Diane	Private	27	Married	1	Cesarean	-	Never dilated past 3 or 5cm 1st baby chin stuck labor arrested	"I just am too small, I guess, to have 'em naturally"	Yes
Dedre	Private	35	Married	0	-	Breech	Breech	Remember only	Yes

Name	Insurance Type	Age	Marital Status	# Prior Births	Prior Birth Type	Fetal Position	Reason/dx	Comment	Cesarean?
								pros not cons for cesarean. Feared episiotomy.	
Constance	Private	26	Married	0	-	-	Failure to progress	Unproductive labor, could not feel contractions	Yes
Marsha	Private	38	Married	0	-	Twins cord wrapped	Emergency fetal distress chord	Almost wanted cs before, had doubts her femininity	Yes
Danny	Private	27	Married	0	-	Face up	Long labor, not dilate	Cesarean felt like failure	Yes
Average or Mode	**Medicaid 8/Private 7**	**23.8**	**Single 8/ Married 7**	**0.2**	**Cesarean**	**Breech**	**Fetal distress/long labor**		

* Decels means fetal heart rate decelerating in an nonreassuring way, indicates potential fetal distress.

CHAPTER 5

CESAREAN SECTION AVOIDERS

Introduction

This dissertation examines childbirth stories and how women say they thought, felt and acted with regard to cesarean section. Chapter 3 discussed women who said they asked for cesarean section. Chapter 4examined the stories of women who said they agreed to cesarean section. The focus of the current chapter is on women who describe their births in terms of trying to avoid cesarean section, and their reasons and strategies for trying to avoid it.

How was avoidance of cesarean section socially constructed? How did some women avoid a cesarean while others did not? Avoiders understood the seriousness of cesarean surgery and did not share misconceptions common to cesarean Agree-ers in the previous chapter. Avoiders were clear about and had specific preferences for wanting vaginal birth and were able to assert their preferences in part because fetal distress did not occur in their cases.

Successful avoiders with previous cesarean sections had doctors who supported or were willing for them to have vaginal births after cesarean (VBAC), and did not undermine the women's confidence. Prospective VBAC mothers were prepared to do

'whatever it takes' to pursue vaginal birth and stuck to their resolutions in the face of sometimes exceptionally intense pain.

However, determination and information alone were not enough. The lone woman who tried to avoid a cesarean but was not able to do so was perhaps too prepared in advance. She found herself the object of extra pressure from her doctor who enlisted the chair of the obstetric department in persuading her to have unwanted labor augmentation due to a potential but stigmatized serious medical concern.

All avoiders constructed a variety of creative strategies to avoid problems leading to cesarean section. The present chapter looks at strategies women create to deal with labor and how they talk about these strategies in terms of avoiding cesarean section. Before presenting the avoiders' stories, something should be said about the term "avoiders". First, these women are not avoiding emergency cesarean section when the life of the baby hangs in the balance. Such emergencies, as noted previously, account for only a small percentage of the cesarean sections performed in the United States today. The women in this chapter were like most women who face a decision that was ambiguous.

Second, although the women managed to avoid cesarean sections they did not directly resist doctors recommendations, There are several structural reasons for indirect avoidance rather than direct resistance, which I will discuss in the conclusion to this chapter.

In this chapter, I present interview data, describe the context of avoidance and to analyze women's stories about whether, why and how they avoided cesarean section. The first section describes the social characteristics of the avoiders. Next follows a discussion of the reasons women give for avoiding cesarean sections. The third section details the

strategies women use to avoid cesarean section. The final section describes the results of their efforts.

Women Who Avoided Cesarean Section

Who in this sample tried to avoid cesarean section? What were their ages, insurance status, previous birth experiences? Why and how did they try to avoid cesarean section? Were women able to avoid cesarean section or not? Table 5 describes women who said they wanted to avoid cesarean section.

Seven women describe trying to avoid cesarean section. Six managed to have vaginal births while one eventually had a cesarean section. These "Avoiders" ranged in age from 26-37. Four of the six women'who felt they avoided cesarean section were insured, two were on Medicaid. Three insured women avoided cesarean section for their first births (Vanna, Sally, and Terese). One insured woman avoided cesarean section for her second birth, having had a cesarean section for her first birth (Emma).

One woman on Medicaid avoided cesarean section for her third child after two previous vaginal deliveries (Lana). All but one woman were currently married. One woman was divorced but had a live-in partner, was on Medicaid, and had a vaginal birth after cesarean section.

The medical-social construction of cesarean was accepted by all but the last woman (Tanna), who searched for information about vaginal birth after cesarean section in the public library, not the hospital.

The only woman who wanted to avoid a cesarean section but was unable to do so was married, age 37, with insurance. She developed an unexpected, stigmatized,

intermittent medical problem (genital herpes) just before and during her pregnancy. Her baby never descended into the birth canal and was born with the umbilical cord wrapped around her neck. Although Edith had two previous vaginal births, she worried about cesarean section from the beginning of this pregnancy. Edith seemed to experience a self-fulfilling prophecy. She knew about and tried to avoid hospital induced side effects, but had an emergency cesarean section after labor augmentation with pitocin slowed the baby's heart beat to a dangerous level.

Six of seven women who said they tried to avoid cesarean section were able to do so. On average Avoiders were 30.8 years old, married, insured and already had one child at home. The reasons cesarean sections were considered were because of previous cesarean section or slow or difficult labor. The reasons women gave for wanting to avoid cesarean were because of the surgical risk (3), longer recovery time (2); three women gave more than one reason: because vaginal birth allows for more connection with the baby and intimacy as a family (2), pain from cesarean lasts longer (1) and to avoid a visible scar (1). One woman did not specifically state her reason for not wanting a cesarean.

Having described the women who tried to avoid cesarean section, the next topic will be the reasons women said they wanted to avoid cesarean section.

Why Women Wanted to Avoid Cesarean Section

The women give many reasons for preferring vaginal birth and work hard to avoid having a cesarean section. In this study, women's perspectives paralleled clinical facts: women said vaginal birth does not carry the risks of surgery or general anesthesia, and

has a much shorter recovery time. Some women felt that although vaginal birth may be painful, the pain only lasts during labor and birth itself, while the pain from cesarean section may continue for several days. One woman mentioned that vaginal birth does not leave a visible scar.

Other women felt vaginal birth gives them and their partners a calmer, more intimate birth experience, and felt more connected with their babies after vaginal birth. For example, a woman who had general anesthesia with her cesarean section felt especially distanced from her first baby, but felt much more connected after being awake for the vaginal birth of her second child (Tanna).

The following interview excerpts illustrate women's reasons for avoiding cesarean section. Edith notes the first reason for wanting to avoid cesarean section was the risk of surgery:

> And I just didn't want the surgery. It's an assault on my body. My age ... For myself physically I was thinking this would not be good (Edith).

In addition to the medical risks of major surgery, Terese's concerns were with the longer recovery period after cesarean section and the limits this recovery period would place on her activity level.

> Recovery time--I didn't want have to, the fact that I couldn't drive for a while, that instead of a few weeks it might be a month of recovery. That I couldn't exercise the same--just that it was major surgery ... Mainly the length of the recovery time, having just moved here with a new house and everything, I just couldn't; not as many friends here ....(Terese)

Recovery time was also an issue for Sally:

> I know that after the fact, after having a c-section that it's a slower recovery (Sally).

Tanna's first labor was long and painful and ended in general anesthesia for cesarean section when she was 19 years old. Now 26, she felt her recent vaginal birth was "a real birth". She notes that the pain of vaginal birth is confined to the period immediately before birth and had a shorter duration than post-operative pain. She described labor, not vaginal birth itself, as painful.

Insert interview question before quote for context

> S: ...That was another thing that upset me after this cesarean that when you have a real birth and it hurts so bad especially now that I know I went through 16 hours of pain. But after all that pushing and everything that is nothing, the head and the body coming out is nothing. The whole thing is what comes after. The hard part that hurts the most and is the hardest to do is everything that leads up to it. (Tanna)

Postoperative pain concerned Lana,

> Because, ah, I heard a lot of people that had cesareans hurt more... afterwards. (Lana)

This same woman preferred a vaginal birth because vaginal birth leaves no visible scar:

> .... I just didn't want any more scars on my belly, just stretch marks. (Lana)

Women felt vaginal birth is a calmer, more intimate experience

> It was, um, (a) very calm experience. We had the lights down lower. And uh, the whole, the whole birth was very calm and quiet... to have a vaginal birth. (Lana)

> R: I really wanted my husband to experience to be able to touch the baby right away and you know I knew that with surgical fields and all that that he can't do that stuff. He can't cut the cord over an open wound you know. You're not allowed those certain privileges. I really wanted him to experience that because we both talked and this probably will be our last. (Edith)

Having a general anesthetic for her cesarean section compounded Tanna's feeling distanced from her cesarean section birth. She worked hard and felt she missed the reward at the end of labor by missing her first birth. She distinguishes between emergency cesarean section and one that is "decided", or elective. She felt closer and more in touch with her baby right after her vaginal delivery.

I: Tell me more about that....

S: ... I felt I was cheated (on). I felt I worked hard enough to get it. My sister has 2 children (by) vaginal birth and a third by C-section. It was so much easier. Hers wasn't decided. It was an emergency C-section. I prefer having a vaginal birth.

I: Can you tell me why you like it that way?

S: I like the idea that when he was born they laid him on top of me. With Ollie, he was born by C-section. When they brought him to me I was just waking up. I asked whose baby this was? This one I got to watch everything. (Tanna)

To summarize, women in this group worked to have a vaginal birth and avoid cesarean section for several reasons. First, women want to avoid unnecessary risk in surgery and anesthesia. They cite vaginal birth's much shorter recovery time and more limited pain duration. Women felt vaginal birth allows them and their partners a calmer, more intimate birth experience, and some felt more connected with their babies after vaginal birth.

This section examined **why** women prefer vaginal births and want to avoid cesarean section. Strategies women use to avoid cesarean section describe **how** women did or did not avoid cesarean, and are addressed in the next section.

How: Strategies for Avoiding Cesarean Section

Most cesarean sections are done on women who had a previous cesarean section, are older or whose labor is longer or more difficult (Martin et al 2009; Zhang, Troendle, Reddy, et al 2010) . At the same time, these characteristics enabled some women to devise strategies for avoiding cesarean section; they had the time or experience to plan ahead and to think strategically. Those who said they tried to avoid cesarean section felt they had some choice about their actions.

Women use a number of strategies to avoid cesarean section: using previous experience to avoid similar problems in the next birth by seeking knowledge outside the obstetric system; going along with doctor's recommendation for vaginal birth rather than automatic cesarean; accepting strategic support from doctor; accepting emotional and social support from husband; making a labor plan, delaying tactics, asserting preference for vaginal birth over cesarean. Specific cases and strategies for cesarean avoidance will now be examined.

<u>Using Previous Experience and Seeking Knowledge Outside the Obstetric System</u>

For Tanna, planning a vaginal birth after cesarean (VBAC) meant seeking knowledge outside the hospital system and devising her own strategies to avoid a typical planned repeat cesarean section. Tanna's first birth after a long labor ended in cesarean section because the fetal heart rate decreased too much during contractions. More than not having control of the decision to have a cesarean section, Tanna felt she did not even know what was happening at the time. Vulnerable because of labor pain, she and her husband were young and inexperienced at the time of her cesarean section.

I: Did you have any say in it?

S: No

I: What were you thinking about at that time?

S: I was wondering what was going on. Nobody would tell me anything. I wasn't in a position to ask questions because I was in pain. My husband was only 19 and I was 20. He didn't know what questions to ask either...(Tanna)

Tanna's strategy to avoid a repeat of her first cesarean section was to seek as much knowledge as she could about childbirth and vaginal birth after cesarean (VBAC). On Medicaid, Tanna felt she had to go outside the hospital system for knowledge about VBAC, so went to a public library. Ironically, the source for Tanna's information about vaginal birth after cesarean came from a nurse's community health pamphlets at the library. Community and public health approaches to birth are quite different than that of obstetrics, as mentioned in Chapter 1.

Forewarned by her cesarean birth experience, Tanna decided to have a vaginal birth, though it was 6 years later. Forearmed with community health nursing information and confident in her new knowledge, Tanna avoided a second cesarean section and had the vaginal birth she wanted. Tanna's decision reflected her extraordinary independence and determination.

I: How did you make a decision? What information could you use to base this decision on?

S: .... I did it on my own. I went to the library; there was a nurse there that had some pamphlets. I prepared myself for that. I made the decision on my own...

I: Did you have any concerns about having a vaginal birth other than a cesarean?

S: I was just determined to try (Tanna).

Following Doctor's Recommendation for Vaginal Birth Rather Than Automatic repeat Cesarean

Ironically, a privately insured, married middle manager had a VBAC for an exceptionally painful birth by acceding to normative expectations. Going along with family and her doctor's expectations for VBAC was an effective strategy to avoid a second cesarean section for Emma.

Emma was willing to accept the challenge of a VBAC even when her doctor described it as a more difficult birth. She found her commitment to VBAC tested when the "face up" position of her second child made the birth exceptionally painful. Emma stayed with the plan for VBAC even though her labor pain was magnified by the face up position of the baby and lasted much longer than she anticipated. The two women who had VBAC's had doctors that were open to VBAC delivery.

Accepting Strategic Support from the Doctor

Accepting strategic support from her doctor helped another woman realize the end of her labor and actual delivery of her baby were in sight:

> And when the doctor showed me the head that's when I was, you know, that's when I was convinced it was going to work ...

Using Husband as a Support Resource

When possible, women facing longer or more difficult labors used their husbands as resources to help them deal effectively with labor challenges and avoid cesarean section. Key to avoiding cesarean section for long or medically termed "unproductive

labor" is to make exceptionally strong efforts. Toward the end of labor some women tried harder to push, making extra effort even though they felt exhausted. Terese used her husband as a support, and also redoubled her pushing:

> ... I had looked at my husband, and I said I'm going to do [it] now, and he said my face just turned bright red, I think I pushed harder, after two hours, I had nothing left and I thought, I'll do one more and then if this doesn't work they're going to have to cut me open, and the head came out-- and that was the hard part, he had a big head (Terese).

Pushing Harder, Staying in the Moment

Pushing harder and staying in the moment was helpful for another women who avoided a cesarean section about which she worried.

> At one point I remember thinking if I have a c-section that's going to take....I know that's going to take at least fifteen minutes more by the time they give me.....if I could only push harder maybe it will take less than fifteen minutes to get this baby out. Um...I guess I was thinking that it was a matter of how hard I pushed. (Vanna)

Having a Labor Plan

One older mother, Edith, made a plan to deal with intense, prolonged labor pain as part of her goal to avoid cesarean section. Having a definite plan seemed to help her feel more confident going in to labor. Edith planned to use an epidural to maintain emotional equilibrium and increase her feeling of self control. Edith felt an epidural would enable her to cope well with labor pain and thus avoid cesarean section.

> I'm older. I'm less tolerant of pain as I get older, and I might wig out. I mean emotionally or something. I might start screaming or hollering at people and I've never done that before, and I just don't want to do that. And it's not necessary.

> The drugs are safe enough and the babies are perfectly healthy with or without them (Edith).

She discussed her birth plan with her doctor:

> We had discussed fully about the not having a cesarean stuff, ...so I had this list where I didn't want medical students in the room, ...if it was a boy I wanted him circumcised. I had his pediatrician, their number written down. I had it all typed out on a computer sheet. A list, and I had a copy on my chart. And a copy with me in my hand when I walked in. I wanted it posted on my door so that they understood....I went and organized all of this (Edith).

Edith wanted to avoid other medical interventions that might lead up to cesarean section. She declined prenatal testing and wanted to avoid labor augmentation and cesarean section. Labor induction and augmentation are controversial because there are conflicting reports about whether women who have these interventions are more likely to have cesarean section (WHO 1985a:98, as cited in Wagner, 1994: 136). She used delaying tactics to postpone going to the hospital and to avoid labor augmentation once she got there.

> I: What made you think that you might have to have one (cesarean section)? That you would need to avoid it since you had other vaginal births? ...
>
> R: Um.. I had Herpes which I got when I was a single mom. ....they said that....if you're active at that point when you're delivering that they have to do a cesarean, and I wanted to avoid that at all costs... Avoiding it. Big time. That was the major stress in this pregnancy. Towards the end I was just getting more and more adamant and so she (the doctor) wanted to bring me in, the day I delivered him she wanted to bring me in. I didn't have the active lesions that was why, and because she felt secure with him being the weight that he was and that I was already dilated to five and, you know also she was a little concerned about where the cord was at. She thought that I might have a prolapsed cord. So that was a little frightening for me. I was thinking about that cause I also knew if it was a prolapsed cord that would be a c-section. You can't deliver the cord before the baby. Um...so and I didn't really want to go in to be induced. I didn't want the pit drug. I'd heard horror stories about it ... This was going to be awful. ....and the bath, and the tea, and I wanted some kind of protein so

> scrambled eggs...3:30 came and I was still at the house. I procrastinated. I didn't want to go in (Edith).

Delaying Tactics

Edith used delaying tactics to postpone entrance to the hospital and to postpone a common intervention, labor augmentation. She was already in a slow and manageable labor, dilated at 5 centimeters, (10 centimeter dilation is complete) for some time. She continued to work at her desk job in the hospital, then went home and resisted her doctor's offer of the drug pitocin for labor augmentation.

Only when her doctor consulted the head of the OB service who invoked this woman's age as a risk factor as well as her recent history of herpes outbreaks did Edith follow the recommendation to come into the hospital to speed up the labor. Ironically, the doctor's concern about helping her avoid a potential cesarean section set in motion the use of pitocin to augment labor, which in the end precipitated a cesarean section.

> That they weren't sure, but they were pretty sure that the Pitocin was helping constrict...or the Pitocin was causing my contractions and the baby was not moving down and they were concerned because his heart rate dropped, and the decision would be mine if I wanted a cesarean. I said No. We went through this process three times. Last time I had no choice (Edith).

Asserting Preference for Vaginal Birth

Whenever her doctor asked if she wanted to go on with labor or have cesarean section, Edith chose to go on until the baby appeared in danger. This sort of decision

making, opting for continuation of labor unless or until the baby appeared in danger also characterized the decisions made by other women in this group.

In summary, six women were able to avoid cesarean, one tried to avoid cesarean section but had surgery when fetal heart rate went too low after medical intervention. While none directly refused cesarean section, women employed a wide variety of strategies to avoid it. Strategies included using previous experience, seeking knowledge outside the hospital system, agreeing to doctor's recommendations for vaginal birth rather than automatic cesarean and perceived normative expectations for VBAC, acceptance of strategic support from doctor, use of emotional and social support from husband, pushing harder and staying in the moment, making a labor plan, enduring very intense or prolonged pain, delaying tactics, asserting preference for vaginal birth even when physician offered cesarean section.

Results: What Happened in the End?

Of the six women who avoided cesarean birth, none of the women felt the health of their baby was threatened during labor or delivery. In the case of the single cesarean section, medical intervention treated the risk to the baby from a potential herpes outbreak as if it were an actual, current risk by augmenting labor with pitocin. The pitocin precipitated a serious crisis when enhanced uterine contractions cut off oxygen to the baby who had the umbilical cord around her neck, and an emergency cesarean ensued.

As long as fetus is not compromised, women can and do assert themselves. But these women sometimes need support from doctors or husbands to believe they can do it. However, in this group, husbands were not instrumental in avoiding cesarean section.

The only husband to play a major role helped support cesarean section decision. By then it could have been too late.

Discussion

Women are able to avoid cesarean section when their babies are not viewed as being in immediate danger. This is important because "failure to progress" is a big reason for cesarean section now and does not usually entail any immediate danger to the baby. Cesarean sections are portrayed as a medical miracle that enables doctors to save babies from the "danger" of women's bodies. This was the reason Edith's slow labor was augmented in an effort to control delivery, to make it happen between herpes outbreaks. Instead of waiting until delivery was imminent and then assessing the presence or absence of herpes lesions, the medical tendency to intervene was followed and Edith's labor was speeded and made harder by pitocin. Edith's reluctance to have pitocin augment her labor was met by the doctor bringing in a higher medical authority, the department head, who then invoked Edith's age as a reason. It is more likely that guilt and embarassment over contracting herpes and feelings about being an 'older mom' brought Edith to the hospital.

Still, the only way Edith said she would agree to cesarean section was if the baby was in distress. She said she was told by staff that pitocin may have precipitated the fetal distress. The first three times the pitocin stopped, so did the distress. Finally, the baby's heart rate dropped very low (50 beats per minute, when the normal is 150 or so). Edith's husband took her face in his hands and said "we have to do this". Immediately Edith worried that the baby had been harmed. Indeed, her husband said he thought the baby

was dead. When she talked about the umbilical cord being wrapped around her baby's neck, she said "I choked him." This telling comment shows how deeply women internalize untoward events in delivery. This may be exacerbated by the way those around her, her husband and the medical staff, responded to her during delivery. Why do women work to avoid cesarean section rather than overtly resist it? Why can't women "just say no" to cesarean section? Why not speak out against operative delivery? Curiously, doctors have much more power than the women giving birth. Many women have limited birth knowledge and experience; most women accept birth as a medical event, look to doctors birth knowledge and authority as legitimate; never having done it before or having had a previous cesarean section, women may lack confidence in their own ability to give birth vaginally. Each of these reasons for women avoiding rather than directly resisting are discussed in turn.

First, there is a large power differential between women and their doctors. This is mainly because today authoritative knowledge of birth rests with doctors and because the way birth is structurally isolated from the rest of social experience. Most American women have relatively limited birth knowledge and experience, and those in this sample had little input from others, including their own mothers. Even educated women, powerful in their own professional careers, can be overwhelmed by their own desire for a perfect baby and disempowered by doctors who emphasize fear of the unknown.

Once in the hospital, women are dependent on the staff and doctor. To be sure, some women have the support of their husbands, but husbands are less experienced and can be co-opted by medical authority and the use of technology. By the time cesarean avoidance is necessary, women are very tired their self-confidence waning. Epidurals

which may have worked are cut off and the pain may be sudden and extremely intense. Normal stimulation of endorphins has not occurred, so women can be shocked at the severity of the pain. Moreover, since all women are treated as if they are preparing for surgery instead of engaging what is for many the most strenuous physical challenge of their lives, they are prevented from having food and drink. Particularly women who have cesarean section for prolonged unproductive labor are sleep deprived and exhausted, they may find themselves unable to be assertive. The fact that women are not in own home or surroundings or in in their own clothing, placed in the lithotomy position which increases their physical and emotional vulnerability. Finally, because women's socialization begins by encouraging accommodation and being 'nice'; women are often not stylistically confrontational. Factually, women cannot afford to alienate their only supports at a new and very vulnerable time.

Despite all of the forces that propel women toward cesarean section, these women managed to show considerable agency in avoiding cesarean sections. In fact most women nevertheless still prefer vaginal birth. As mentioned earlier, vaginal birth is safer for mother and baby in that side effects of surgery and anesthesia are avoided and recovery time is shorter and women are more likely to breastfeed (Wagner, 1994). In addition, there are less tangible but still powerful benefits of vaginal delivery. Vaginal birth provides a feeling of accomplishment, helps women make the transition to the next maturational stage of motherhood, provides a sense of mastery, contributes to feelings of positive self worth, builds confidence, often gains new respect from husband or partner.

Table 7: Women Who Avoided or Tried to Avoid a Cesarean Section

Name	Insurance Type	Age	Marital Status	# Prior Births	Prior Birth Type	Fetal Position	Reason/dx	Comment	Cesarean?
Edith*	Private	37	Married	2	vaginal	Cord around neck	Potential herpes breakout. Final diagnosis fetal distress	Surgical risk, vaginal more intimate	Yes
Tanna	Medicaid	26	Divorce	1	Cesarean	-	Previous cesarean	V. feel closer to baby Vaginal "real birth" Surgical risk CS pain longer	No
Lana	Medicaid	27	Married	2	Vaginal	-	Slow labor	V. more intimate CS pain longer CS scar	No
Terese	Private	34	Married	0	-	Face up	Long painful labor, pregnancy related diabetes, overdue	CS recovery longer	No
Emma	Private	34	Married	1	Cesarean	Face up	Prev cesarean; Long painful labor; premature labor	VBAC normal way to go; avoid surgical risk	No
Sally	Private	27	Married	0	-	-	Difficulty pushing	Cesarean recovery longer	No
Vanna	Private	31	Married	0	-	-	Slow labor	-	No
Average or Mode	**Private/ Medicaid**	**30.9**	**Married**	**1**	**Vaginal or cesarean**	**Face up**	**Long very painful labor**		**No**

* Edith tried to avoid a cesarean but was unable to do so.

CHAPTER 6

CONCLUSIONS

The striking rise in the rates of cesarean sections has been a topic for the popular press, physicians, and feminist critics of medicine. However, there have been very few empirical studies that examine the actual process leading to cesareans—and even fewer from the standpoint of the women most affected by the problem. This dissertation is an effort to fill in those gaps.

Summary of Findings

Contrary to claims in recent medical literature about women's requests for cesarean section (Marx et al 2001; Gamble and Creedy 2000; Gamble et al 2007), the women in this study asked for cesarean only when they believed vaginal birth would cause serious harm to themselves or their babies, or after their attempts at vaginal delivery failed. Doctors tended to resist women's requests for cesarean. Some women were told that they "could die from cesarean section". When doctors declined to perform cesarean sections it was usually for women with Medicaid. Doctor's resistance to cesarean continued until very late in labor, sometimes with serious consequences: hip displacement, hemorrhage or hysterectomy.

Women who agreed to cesarean sections typically did not understand the seriousness of the surgery and assumed that cesarean section would be quicker and less

painful than vaginal delivery. For some women, cesarean section was viewed as a way to end labor, to "get it over with" or as a way to turn over responsibility for the outcome to doctors. Women were surprised at post-operative pain and limitations on their movements that affected their ability to care for their infants. In most cases, the choices about cesarean were framed for agree-ers by the professionals. Often women were simply asked to choose between cesarean section and compromising the health of their babies.

Most women who wanted to avoid cesarean were able to do so when their babies were not in distress. Women used a variety of creative strategies and some were willing to endure severe pain to avoid cesarean section. Husbands or boyfriends may or may not behave in ways that are supportive. Women who had a doctor who supported vaginal birth after cesarean or who were able to negotiate with doctors around cesarean were better able to achieve their goal of vaginal delivery.

Explaining the Patterns

Until recently, most of the cesarean controversy centered on unnecessary cesareans. Lately, however, doctors have suggested that women are requesting cesarean in the absence of medical indication. Almost no one has talked about cesarean sections being delayed or denied for Medicaid mothers or others. Medicaid mothers may be less likely to get unnecessary cesareans, but they suffer long and hard before they get necessary ones.

Historically, sociology has examined power in doctor-patient relationships and found most often patients are subject to doctor's authority. Whether asking for cesarean or trying to avoid it, birthing women patients all too often feel they are not being listened

to. Giving birth is painful and requires enormous physical, emotional and mental energy that is not supported when women are denied food, drink and the freedom to move around. Birth requires all women's physical, emotional and mental resources, and there may not be much left over to express their needs or demand satisfaction with their experience. This leaves women birthing in hospitals in a relatively powerless position and feeling disempowered.

There is a great need for basic knowledge about women's bodies and the birth process. Most women used one standard book, *What to Expect when you're Expecting*. Most middleclass women attended birth preparation classes, many of which seemed to concentrate on orientation to hospital procedures. Most women had very little experience with childbirth and had never seen a birth before their own; few discussed birth with their mothers or had their mothers involved in helping them prepare for birth. Some women did rely on the experiences of their sisters or listened to friends discuss their births, but were often more frightened than reassured by others' stories,

Often, women do not have accurate or reliable information on childbirth. Even if women had a previous cesarean and experienced a difficult recovery, they may continue to minimize the impact of cesarean as "a few stitches", congruent with the common perception that cesarean is not really regarded as serious surgery.

In the doctor-patient communication women describe here, two countervailing trends appeared. For cesarean agree-ers, some felt the risks of vaginal birth had been exaggerated and the risks of cesarean were often minimized. For cesarean requesters, women sometimes reported they were dramatically confronted with the risks of cesarean section and their requests not fully considered. In both cases, women felt they did not

have an accurate understanding of their choices and little knowledge to refute their physicians' assertions.

When women believe something is wrong with their own bodies or wrong with their babies that prohibits vaginal birth, the only moral choice they have is to act to preserve the baby's health. When cesarean section is presented as the only alternative to a dead or damaged baby, women must ask for or agree to cesarean.

Paradoxically, doctors may resist some women's requests for cesarean even when important indications in favor of surgery are present. It may be doctors' contrasting values on avoiding unnecessary cesarean section or preserving young women's fertility that influence how long women with difficult labor wait for cesarean section. Doctors know well that Medicaid limits reimbursement for cesarean section, that women who have one cesarean are likely to have subsequent cesareans if they have more children and that having a cesarean makes it less likely women will have any more children. From this perspective, women who ask for cesarean section often are made to wait for one.

Meaningful Alternatives to a Medicalized Cesarean Section are Often not Considered

Because birth is treated as an illness in the hospital and authoritative birth knowledge resides with surgeons, non-surgical alternatives are often not considered. For women with long or difficult births who asked for cesarean section, surgery seemed the only option in the face of inadequate labor support and poor pain control. Husbands usually know less than their wives about birth and may not know how to be supportive.

Fifty years ago, babies who were born in the breach position were delivered vaginally. The de-skilling of vaginal breach delivery over generations of doctors now means cesarean section is safer than (unskilled) vaginal breach delivery. While only about 4% of babies present as breach, the impact of cesarean for breach delivery is greater because most subsequent children will be delivered by cesarean even if they are not breach.

Changing the current practice will be difficult because most doctors who are skilled and comfortable with manual breach delivery have retired or died. Some midwives have these skills and would be able to teach doctors if accepted as experts. This seems a near impossible task given the relative status of midwives and doctors as well as the litigious atmosphere of obstetrics at this time. From 1999 to 2009 it appeared that when Medicaid reimbursement for cesarean section was reduced, the number of cesareans declined (Gruber et al 1999). A new analysis of the original study disputes this conclusion (Grant, 2009) and warrants closer examination. The next best strategy would be promotion of vaginal birth after cesarean (VBAC).

Despite great differences in pain experience most women are treated with one generic pain protocol These differences are not merely due to differences in perception of pain. Pain in labor and delivery can be orders of magnitude higher for poor fetal position or presentation than birth where the fetal presentation and position are optimal. In this sample, by the time poor fetal position or presentation was noticed it was usually too late to try to change it. Each of the four breach births was unexpected.

Epidural anesthesia tends to distance women from the actual experience of birth and may slow labor and make women unable to push when it is time for delivery,

requiring pitocin or further interventions. Epidurals are not always administered correctly and do not always work; sometimes they work more than they are supposed to and can impair maternal breathing and lower maternal blood pressure too far.

Use of narcotics may decrease pain temporarily but also slows down maternal and fetal breathing and heart rates. This may require resuscitation of the baby when it is born, lower APGAR scores and potential damage to the baby's health as well as making the mother less aware and possibly groggy when she needs to focus her efforts on delivering the baby.

The effects of epidural anesthesia serve the organization of hospitals as well. In addition to the cost (over 500 dollars) usually covered by insurance, women are quieter, request fewer additional medications and are easier to keep track of if they are, in effect, tethered to their beds. The fact that epidurals usually make walking around or squatting for birth impossible means that sometimes labor will slow down, requiring further intervention to speed labor along.

Alternative methods of pain control including breathing, meditation, hypnosis, water therapy and other comfort measures could be implemented for women with less severe pain and epidurals and narcotics reserved for the most severe cases of pain. Many of these innovations are common in Europe.

Continuous labor support makes pain more manageable and reduces the likelihood of cesarean birth (Kennell 1991). However, need for early labor support is often unrecognized in the hospital. Some women who labored a while at home but technically were still in earlier stages of labor went to the hospital because they were in pain, but when they did not meet the criteria required for admission, they were sent home.

Being sent home while in labor is experienced as rejection and may feel devastating, undermining women's sense of safety and efficacy in the tasks ahead.

Proper assessment of fetal position and presentation is important for labor and pain management. Assessments of fetal progress can be communicated to women, and staff can acknowledge that some fetal presentations make labor much more painful and take much longer than others. Instead of trying and often failing to force difficult labors into the parameters of the standard labor chart by using medical interventions, women can be prepared to cope with long or more painful labor as a normal variant of labor due to the baby's presentation. This practice, along with adequate labor support and pain measures tailored to specific problems would make long or difficult labor more meaningful and manageable and requests for cesarean section less likely.

Good labor support is often tied to good pain control. When inadequate labor support and poor pain control make labor intolerable, women who can no longer endure difficult labor will ask for cesarean. In effect, some of the demand for cesarean section is created by the present labor and delivery system. Improving labor support and pain relief could decrease the cesarean request rate for women with very difficult labors.

Some Women are Socialized into the Medical Model Themselves

In some ways doctors cannot be faulted for waiting as long as possible to perform a cesarean section on some women. However, many times labor and pain are so poorly managed that women end up adopting other medical values, preferring cesarean section as a more definitive, efficient and predictable experience than labor.

Some women are socialized into accepting a medicalized model of childbirth by doctors, our medicalized culture, or a very negative experience with labor in the hospital. Women who had cesarean sections in the past or were told they would need one for the current pregnancy because their birth canals were too small or otherwise would harm their babies or themselves, did their utmost to obtain a cesarean section. Women insisted on cesarean section against current doctor recommendations, changed hospitals at the last minute or paid ten thousand dollars cash for a planned repeat cesarean section when insurance refused to cover it as a pre-existing condition.

Our culture emphasizes the superiority of technology and science over natural processes like birth. Since 99% of American women have medicalized births in the hospital. it would be unusual for women to seek an alternative approach particularly if they had never heard of one or if nonmedicalized births were discredited.

It is important to develop and disseminate resources like 2008's *Our Bodies, Ourselves: Pregnancy and Birth*, expand doula and midwifery services and freestanding birth centers (Zeldes and Norsigian: 2008).

Consequences of High Cesarean Section Rate for Health Care

The extremely high cost of rising cesarean section rates is not justified by health outcomes compared to other countries with less medicalized childbirth. Although the United States has cesarean section rates among the highest in the world, 27 countries have lower infant mortality rates (Martin et al 2008).

The high cost of surgical birth and the resources needed to support it mean monies cannot be spent in other areas. Insurance rates go up and insurance coverage shrinks; and

as mentioned above, some women who have had cesarean sections are now being denied coverage because cesarean section birth is considered a "pre-existing condition".

Significant monetary costs not covered by insurance are paid by Medicaid, out of pocket or absorbed by hospitals, a practice eventually paid for by consumers. A single cesarean costs up to eleven thousand dollars, thousands more than the cost of normal vaginal delivery (Zupancic 2008) , and often takes years to pay off. When women are asked to pay the hospital up front for a planned cesarean. there can be fear and anguish if the money is not readily available.

Cesarean birth means four to ten times more maternal deaths than vaginal birth, so the current cesarean rate of nearly 30% is especially concerning. Imperfectly implemented epidural anesthesia results in unacceptable surgical and pre- and post-operative pain and the necessity of general anesthesia, which brings risk of physical side effects as well as death. Although often unrecorded in the operative report, 1.5% of cesarean babies are nicked with a scalpel during cesarean section (Wiener and Westwood 2002).

The present rate of cesarean section means more use of personnel and hospital resources like blood, operating rooms, anesthesia, electricity and drugs. Longer hospital recuperation time needed after cesarean section means more use of personnel, beds, medications, linens, food, security, space, heat and janitorial services.

Money spent on over a million cesarean sections per year could be better spent on prenatal care, nutrition and safety measures for pregnant women and the prevention of low birth weight in poor infants. This would in turn save millions in neonatal intensive care costs. The money saved could be spent on training midwives and doulas (paid birth

assistants). As in Germany, midwives and doulas could provide home visits for women who are pregnant or who desire help in labor and during the post partum period. Assigning every pregnant woman a midwife as well as a designated doctor would increase the quality of care for mothers. It would also increase the demand for midwives and paid birth assistants, thereby decreasing the unemployment rate especially in cities like Detroit, Michigan, which has a disproportionate amount of low birth weight babies and high unemployment.

The practice of obstetricians, who are surgeons, attending routine deliveries is not as financially or professionally rewarding for them as performing cesarean sections. Saving medically complex cases for obstetricians would reinforce education of pregnancy and birth attendants in recognizing early signs of trouble that may lead to the necessity of cesarean section. Early identification of cases that do not typically end in successful vaginal delivery may spare women from unnecessary suffering and promote cesarean section in a timely manner when necessary.

Consequences for Women

The experience of accomplishing childbirth is empowering and an important developmental step in adjusting to the role of motherhood. This empowerment is a needed resource to build on in women's new or expanded roles as mothers. Women sometimes feel they have done all the work required for birthing their babies but in the end felt cesarean section robbed them of that achievement. Cesarean birth fosters dependency on doctors and distances women from the experience of birth, decreasing women's autonomy.

Women with positive birth experiences feel empowered and strengthened and report their husbands have a new respect for them. Women with negative birth experiences can feel disempowered and less capable of coping with the challenges of motherhood.

Some women expressed fear of surgery and the possibility of death in response to hearing they would have to have a cesarean. Cesarean birth can be viewed by women as failure in their first task of motherhood and potentially impact their views of themselves and their relationship with their children.

Not all women feel disempowered by cesarean birth. Those that accept medical reasons for cesarean section tend to regard themselves and their babies as fortunate to have avoided permanent disability or death.

For as many cesarean sections as are unnecessary, the morbidity and death from surgery, the longer recovery from cesarean, the post-operative pain and limits on physical and emotional strength are unnecessary as well. Impaired breast-feeding and limits on home making and outside work are also unnecessary and a terrible waste of resources. Babies from elective cesareans are more likely to have to go to the intensive care unit and remain hospitalized.

When especially first time mothers come to the hospital with extreme pain and ask for help, they should not be turned away. Nor should they be allowed to labor with poor labor support and no explanation of what is taking so long until they beg for a cesarean just to end the suffering.

Policy Implications

The findings suggest a need for developing less medicalized forms of childbirth. Midwives should be the primary caregivers of pregnant women in the United States, as they are in most countries. Midwives have lower rates of cesarean birth and can always turn over cases requiring surgery if they practice with back-up doctors. Midwives use a woman centered model rather than a medical or production model, and as such generally are experienced as more supportive to women than doctors. A common saying is "With midwives, women have to prove they cannot have a vaginal birth, while with doctors women often have to prove they can". Doctors often refer to efforts to have a vaginal birth as a "trial" of labor, as if it may not be the best way to delivery a baby.

Doctors will resist midwives taking over their professional turf. However, many obstetricians might be happier to attend births requiring high tech surgical interventions rather than "babysitting fetal monitors" and getting up in the middle of the night. Many obstetricians are already leaving the field due to malpractice concerns.

Birth should not be isolated in hospitals, but births that do occur in hospitals can use midwives and continuous labor support using doulas as well. There needs to be a whole birth system reform, and there is no better time than the present. The first step would be to take out the financial incentive for cesarean birth by equalizing payments for vaginal and cesarean. Gruber found that when Medicaid reimbursement for cesarean sections was lowered, the cesarean rate went down (1999).

Insurance companies have already tried to drop coverage for women who have had previous cesarean births, but this punishes women financially without impacting the point of cesarean origin: the practitioner. Establishment of standards of care,

standardization of reimbursement regardless of delivery mode and periodic review of doctor's "practice style" by peers have been shown to decrease cesarean section in the past. These and other methods could be developed for wider application.

Childbearing women need to be informed that cesarean section is major surgery so they can have more realistic expectations than most due at present. The problem arises as to how to inform women about cesarean section risks and benefits without making that discussion a self-full filling prophesy. There are a variety of ways to enhance women's education around childbirth and cesareans. When women become pregnant they may see a midwife or nurse practitioner instead of routinely going to an obstetrician. Education can start in any of these caregiver's offices.

Treating the rising cesarean section problem as a public health issue would encourage the use of public service announcements, neighborhood introductions to reproductive health and cesarean education at girls and boys clubs and scout groups as well as teen health clinics. Childbirth educators can be featured in health classes in high schools, and childbirth programs challenging the current headlines depicting birth as "an accident waiting to happen" (Zeldes and Norsigian, 2008) can be supported.

Instead of trying to keep youngsters away from information and education about sex, we should involve high school age children in birth, which could work as reality orientation, increase the use of birth control and make pregnancy and childbirth a recognized consequence sex without promoting early childbearing.

Adult women do not now have much experience with birth before they have their own children. Integrating younger women into birth preparation, delivery and infant care of their peers and relatives, or introducing natural mentorship relationship fostering

customs may address women's orientation to childbirth before they become mothers themselves.

Communication among women and their caregivers needs improvement. Very often women patients are diffident and reluctant to speak out. Now women often do not mention their biggest fears about childbirth, such as death or reliving traumatic sexual experiences, to their doctors either because it never occurs to them to do so or out of fear the doctor might think badly of them.

Some women in this study who agreed to cesarean section were relieved they could avoid having their genitals cut in a typical episiotomy or having to recover with stitches and pain in their genitals. Learning how to avoid episiotomies or changes to practice that omit routine episiotomy would be helpful.

Many women have fears about the uncertainty of how long labor would last or how painful it would be and how they would cope with it. Unfamiliar with labor and childbirth except through books or classes on birth preparation, the real experience of labor and delivery is intimidating for many. Integrating lay women into the births of their relatives and other peers would help allay some of these fears.

When women are more informed about childbirth and cesarean sections generally, obtaining a truly informed consent before cesarean birth becomes more possible. Women will have a better understanding of what is said to them and may be better able to ask questions.

In this study, most women who consciously tried to avoid cesarean section were able to do so unless there was a serious medical indication. Specific strategies women

employed can be publicized in peer to peer group gatherings where it can be a normal part of conversation instead of trading "horror stories" as can be the practice now.

Doctors and nurses need to be trained to listen to women as part of their care. Greater emphasis is needed on fetal position and presentation assessment. It is not enough that the baby is head down but proper flexure is necessary for smooth delivery of the head. Developing better assessment of fetal position and presentation will improve prediction of the fewer cesareans that would be necessary using a more holistic approach to birth.

Doctors can be taught to empower women through medical school training and taking classes with midwives. Motivation for this can be encouraged if it can be shown that empowering women may improve the doctor-patient relationship and decrease the likelihood of litigation as a way to settle disputes, heal hurt feelings or cope with a bad outcome.

The routine use alternative methods of labor induction and support such as vacuuming, walking around, sexual activity, castor oil and others can be incorporated into birthing care.

The fundamental problem for medicine is the view of women's bodies as dangerous to babies instead of supportive of birth, which professionals may control seek to control thru medicalization. Placing most births in hands of midwives would go a long way in addressing the medicalization of birth and by extension the over use of cesarean birth.

Future research should focus on the following areas. Pain relief during labor and delivery, the actual parameters of normal labor and normal variations of labor and birth,

and how to promote trust in natural birth processes. Large-scale research is very much needed on gestational hypertension, diabetes, toxemia and other serious and common problems of pregnancy.

Further empirical evidence must be gathered regarding the assertion that women ask for cesarean for convenience or fear of normal childbirth. Research is needed on alternatives to cesarean section besides continued unproductive labor and pain or forceps delivery. Incorporation of massage therapy, chiropractic care and other measures into labor preparation should be explored.

Incorporation of evidence based measures in routine pregnancy and birth care should be promoted. Goer wrote *Obstetric Myths vs. Research Reality* in 1997, but her findings have been largely ignored. How can more evidence-based practice be implemented? This should be put to obstetric medical educators.

Prospective research on the role of women's agency in determining whether they have cesarean or vaginal births should be pursued.

The limitation of this study is that it did not include direct observation of women's labor and birth. The strength of the study is that it gives voice to ordinary women's subjective experience of cesarean section. All policy so far excludes women's cesarean section experience. We need better care than provided by the current system. Nonmedicalized treatment of pregnancy is both possible and necessary.

Perhaps no form of obstetrical care has been as debated as cesarean section, but the debates exclude those who are most affected by the problem—the women themselves.

This dissertation has been an attempt to give voice to these women, their experiences suggest a need for developing and using alternatives to the medicalized model used in the United States.

APPENDICES

Appendix 1. Women who Requested, Agreed to, and Avoided a Cesarean Section

Women's Agency	Name	Insurance Type	Age	Marital Status	# of Prior Births	Prior Birth Type	Fetal Position	Reason/dx	Comment	Cesarean?
REQUEST										
Request	Fran	Medicaid	20	Married	0	-	-	Unproductive labor	Says MD stated she could die when she requested cesarean	Yes
Request	Uma	Medicaid	21	Single	0	-	Not dropped into pelvis for birth position	Emergency Fetal distress	Hemorrhage resulting in total abdominal hysterectomy	Yes Also hysterectomy
Request	Olivia	Medicaid	23	Single	1	Cesarean	-	Elective repeat, Also seeking tubal ligation,	Avoid previous labor and birth experience	Yes
Request	Maryann	Medicaid	25	Single	1	Cesarean		Repeat cesarean Classical scar	Mother feaed repeat last labor birth experience	Yes
Request	Beth	Medicaid	26	Married	0	-	-	Unproductive labor	1 week labor Send home from hospital many times	Yes
Request	Holly	Medicaid	28	Divorced	3	Vaginal	-	Maternal hip defect & history of placenta previa	Denied cesarean for previous birth despite hip defect. Another birth emergency cesarean delayed in case of placenta previa	Yes

Women's Agency	Name	Insurance Type	Age	Marital Status	# of Prior Births	Prior Birth Type	Fetal Position	Reason/dx	Comment	Cesarean?
Request	Molly	Medicaid	28	Single	0	-	-	Unproductive labor	Mother 'don't let her bang her head any more'	Yes
Request	Tammy	Medicaid	37	Single	2	Cesarean	-	Elective repeat cesarean	Mother understood her vaginal canal too small and would damage baby	Yes
Request	Enid	Private	18	Married	0	-	Breech	Breech	Feared doctors would hurt baby by external version	Yes
Request	Gina	Private	24	Married	0	-	Breech	Toxemic, induced, breech	Mother feared staff inexperience deliver toxemic vaginal breech	Yes
Request	Nancy	Private, CASH	26	Married	1	Cesarean	-	Elective repeat cesarean	Feared repeat first labor &birth Hoped insurance cover cesarean	Yes
+Requested cesarean had vaginal birth	Vicky	Private	31	Married	0	-	-	MD declined Mother's request	Mother felt pain intolerable. Dissociative feelings end labor	No
Request	**Average or Mode**	**Medicaid**	**23.6**	**Single/Married**	**0.7**	**Cesarean**	**Breech**	**Variable/long labor**		**Yes**
AGREE										
Agree	Patty	Private	34	Married	2	Cesarean x 2	-	Repeat; big baby		Yes
Agree	Cassie	Private	22	Married	1	Cesarean	-	Failed induction, repeat cesarean	High bp and bed rest first preg 2 weeks overdue, failed induction,	Yes

Women's Agency	Name	Insurance Type	Age	Marital Status	# of Prior Births	Prior Birth Type	Fetal Position	Reason/dx	Comment	Cesarean?
									24 hours. Sched 2nd cs	
Agree	Freida	Medicaid	25	Single	0	-	-	Failure to progress; baby brain defect	Long labor, get it over with, given choice forcepts or cs	Yes
Agree	Ivana	Medicaid	20	Single	0	-	-	Failure to progress, fetal decels*		Yes
Agree	Darlene	Medicaid	26	Single	0	-	-	Failure to progress		Yes
Agree	Burgundy	Medicaid	18	Single	0	-	Breech	Breech premature 36wk		Yes
Agree	Kay	Medicaid	21	Single	0	-	-	Bleed, probable prolapse cord	Fetal distress likely	Yes
Agree	Miranda	Medicaid	24	Single	0	-	Breech	Premature 29 weeks, breech, meconium stained fluid		Yes
Agree	Daphne	Medicaid	19	Single	0	-	-	General anesthesia, failed epidural several days labor	Told she was to have cesarean, not much choice	Yes
Agree	Denise	Medicaid	19	Single	0	-	-	Pre-eclampsia, failed induction fetal decels*		Yes
Agree	Diane	Private	27	Married	1	Cesarean	-	Never dilated past 3 or 5cm 1st baby chin stuck labor arrested	"I just am too small, I guess, to have 'em naturally"	Yes

Women's Agency	Name	Insurance Type	Age	Marital Status	# of Prior Births	Prior Birth Type	Fetal Position	Reason/dx	Comment	Cesarean?
Agree	Dedre	Private	35	Married	0	-	Breech	Breech	Remember only pros not cons for cesarean. Feared episiotomy.	Yes
Agree	Constance	Private	26	Married	0	-	-	Failure to progress	Unproductive labor, could not feel contractions	Yes
Agree	Marsha	Private	38	Married	0	-	Twins cord wrapped	Emergency fetal distress chord	Almost wanted cs before, had doubts her femininity	Yes
Agree	Danny	Private	27	Married	0	-	Face up	Long labor, not dilate	Cesarean felt like failure	Yes
Agree	**Average or Mode**	**Medicaid 8/Private 7**	**23.8**	**Single 8/ Married 7**	**0.2**	**Cesarean**	**breech**	**Fetal distress/long labor**		
AVOID										
*Avoid	Edith	Private	37	Married	2	vaginal	Cord around neck	Fetal distress, potential herpes breakout	Surgical risk, vaginal more intimate	Yes
Avoid	Tanna	Medicaid	26	Divorce	1	Cesarean	-	Previous cesarean	V. feel closer to baby Vaginal "real birth" Surgical risk CS pain longer	No
Avoid	Lana	Medicaid	27	Married	2	Vaginal	-	Slow labor	V. more intimate CS pain longer CS scar	No
Avoid	Terese	Private	34	Married	0	-	Face up	Long painful labor, pregnancy related diabetes, overdue	CS recovery longer	No

Women's Agency	Name	Insurance Type	Age	Marital Status	# of Prior Births	Prior Birth Type	Fetal Position	Reason/dx	Comment	Cesarean?
Avoid	Emma	Private	34	Married	1	Cesarean	Face up	Prev cesarean; Long painful labor; premature labor	VBAC normal way to go; avoid surgical risk	No
Avoid	Sally	Private	27	Married	0	-	-	Difficulty pushing	Cesarean recovery longer	No
Avoid	Vanna	Private	31	Married	0	-	-	Slow labor	-	No
Avoid	**Average or Mode**	**Private/ Medicaid**	**30.9**	**Married**	**1**	**Vaginal or cesarean**	**Face up**	**Long very painful labor**		

\+ Requested cesarean but had vaginal birth

• Decels means fetal heart rate decelerating in an nonreassuring way, indicates potential fetal distress.

* Tried to avoid cesarean but was unable to do so.

APPENDIX 2

Interview Guide

Medicalization of Birth: Social Construction of Cesarean Section
Margaret Ann Murphy
Not for duplication or distribution

Introduction: As you know, I am interested in learning about how women feel about their birth experiences. I will ask you a few general questions, then we'll talk about your first birth, (then your second birth, and any births after that) and anything related to your births that you feel is important.

1. How are you doing today?

2. How is your baby doing?

3. How many children do you have?

4. What are their ages?

5. Please tell me about your first birth and that pregnancy.

6. Please tell me about the first time you saw your first baby, and the feelings you had.

7. Please tell me about your relationship with the doctor you had for your first birth.

8. Please tell me about your relationship with the nurses you had for your first birth.

9. What kinds of things did you do to prepare for your first baby's birth?

10. How confident did you feel about your first birth?

11.* (Ask only if cesarean) How did the decision to have a cesarean come about?

12.* (Ask only if cesarean) Can you describe the experience of having a cesarean?

13. What kinds of equipment or medication were used in your first birth (and labor?)

14. In what ways, if any, did having this birth experience affect you?

15. Do you feel having your baby the way you did made a difference in what this baby is like?

16. Do you feel the type of birth you had influences how you feel about this baby? (If so, How?).

17. Some women have difficulty becoming emotionally attached to their babies at first, other women do not have difficulty becoming emotionally attached to their babies. What was it like for you when your baby was just born?

18. In what ways, if any, do you think having the type of birth you did affected your partner, if you have one?

19. How did your (labor and) birth compare with what you expected it to be like?

20. Tell me about how you felt the first few months after your first birth.

IF RESPONDENT HAS ONLY ONE CHILD, ASK THE NEXT QUESTION:

21. Some people feel that the type of insurance or whether they have insurance has an effect on their medical treatment, while other people say insurance does not have an effect on their medical treatment. How do you feel?

22. Is there anything else you would like to say about your birth experiences?

END OF INTERVIEW FOR WOMEN WITH ONLY ONE CHILD.

Thank you for your time and help in learning more about women's feelings about their birth experiences.

This interview was conducted by the investigator face to face with respondents. Responses were recorded on tape, then transcribed. Notes were also taken during the interview, with the permission of the respondent.

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