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Requests for cesarean deliveries: The politics of labor pain and pain relief in Shanghai, China

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ABSTRACT

Cesarean section rates have risen dramatically in China within the past 25 years, particularly driven by non-medical factors and maternal requests. One major reason women request cesareans is the fear of labor pain, in a country where a minority of women are given any form of pain relief during labor. Drawing upon ethnographic fieldwork and in-depth interviews with 26 postpartum women and 8 providers at a Shanghai district hospital in June and July of 2015, this article elucidates how perceptions of labor pain and the environment of pain relief constructs the cesarean on maternal request. In particular, many women feared labor pain and, in a context without effective pharmacological pain relief or social support during labor, they came to view cesarean sections as a way to negotiate their labor pain. In some cases, women would request cesarean sections during labor as an expression of their pain and a call for a response to their suffering. However, physicians, under recent state policy, deny such requests, particularly as they do not view pain as a reasonable indication for a cesarean birth. This disconnect leads to a mismatch in goals for the experience of birth. To reduce unnecessary C-sections, policy makers should instead address the lack of pain relief during childbirth and develop other means of improving the childbirth experience that may relieve maternal anxiety, such as allowing family members to support the laboring woman and integrating a midwifery model for low-risk births within China's maternal-services system.

"I can't do this! I can't give birth! It already hurts so badly and my cervix hasn't even dilated!" Huifen, a 20-year-old from Henan province, cried out from her hospital bed. The doctors had administered oxytocin to induce contractions, as she was past due and had not yet begun to labor. As the contractions strengthened, she started crying and yelling at the nurses in the labor room.

Dr. Li, one of the hospital's chief obstetricians, checked her belly and told her not to yell and waste her energy. She said frankly, "No woman has not had pain," partly to Huifen, and partly to me, her temporary American student. I silently observed their interaction, explicitly aware that I was the only woman in the room who had not yet experienced the pains of childbirth. She turned to me and shook her head. "This woman has no confidence in herself."

I lingered in the open labor and delivery ward, openly observing the interactions between the laboring women and providers. I was particularly interested in Huifen who so visibly expressed her pain: when Huifen was two centimeters dilated, she begged Dr. Li to give her pain relief. However, she was not yet in active labor, so Dr. Li said she could not give her an epidural. Huifen asked her, instead, then to do a cesarean. Dr. Li told her no, that she should cope with the pain and could give birth vaginally if she put her mind to it. Huifen phoned her husband, who was waiting outside the ward, and told him that she wanted a cesarean. Her anxious husband approached Dr. Li several times and pleaded that she perform the cesarean, which Dr. Li also refused. Huifen, with no other option, endured the pain for a few more hours until her cervix fully dilated, and she was finally able to give birth.

1. Introduction

I was at Jiangbei Central Hospital, a district-level hospital in Shanghai, China, conducting ethnographic fieldwork on the phenomenon of cesarean deliveries on maternal request. Rates of cesarean deliveries—a surgical procedure used to deliver a baby through the mother's abdomen—(cesarean birth, C-section or CD) had risen dramatically in China within the past 25 years, from 3.4% in 1988 to estimates of 58% in 2010 (Hellerstein et al., 2014). In

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particular, C-sections requested by mothers without a medical indication are a significant contributor to the total C-section rate. In China, studies estimate that the proportion of "cesarean deliveries on maternal request" (CDMR)—defined as a singleton birth, cesarean birth on "woman's request," viable fetus, gestational age of 38 weeks or more, and before the onset of labor—to be around 28% in 2011 (J. Zhang et al., 2008, 1079; Liu et al., 2014). Such a phenomenon might be a cause for alarm; while cesarean sections can save the lives of mothers and babies during an emergency, they increase the risk of maternal and neonatal mortality and morbidity when performed without medical indication (Lumbiganon et al., 2010). Furthermore, cesareans increase the risk of uterine rupture, spontaneous miscarriage, abnormal placentation, and other complications in subsequent pregnancies (D'Souza and Arulkumaran, 2013).

In general, factors for women's decision to have a cesarean include anxiety about the ability to give birth, worry about fetal safety, concern about the effect of vaginal birth on their figure or sex life, and the ability to choose an auspicious birth date (Tang et al., 2006). However, another major reason that women request cesareans is the fear of pain (Lee et al., 2001; Li and Zhao, 2007). This is particularly important as, in China like in many developing countries, the focus of maternity care initiatives has been improving access to emergency obstetric care rather than improving the quality of normal childbirth, such as providing social support or pain relief (Khayat and Campbell, 2000; Size et al., 2007). In particular, in China a small minority of women receive any form of pain relief during labor (Qian et al., 2001; Harris et al., 2007; Raven et al., 2015; To, 2007). Even fewer are given epidural analgesia, a particularly effective pain medication injected into the spine during labor, common in high-income countries (Fan et al., 2007; Hu et al., 2015; Qian et al., 2001).

I had come into my research looking to understand the sociocultural factors that influence mothers in China to request to give birth by cesarean, particularly from an ethnographic perspective. During my fieldwork, I came to realize how important perceptions of labor pain, and the lack of pain relief during labor, factored into requests for cesarean births, both before and during labor (Kasai et al., 2010; Fenwick et al., 2010; Raven et al., 2015). This was an ethnographic nuance largely missing in the public health literature on China's high cesarean birth rate: how might we understand women's requests for a cesarean through understanding their experiences of childbirth pain? For example, when I interviewed Huifen before labor, she told me she wanted to give birth vaginally because there were fewer reproductive consequences and less postpartum pain than with a cesarean birth. But she had changed her mind during labor, thinking, as she recounted to me, "What can I do to stop the pain? What can I do to make this go faster?" Even though she knew the consequences that came with a cesarean birth, she wanted it at that moment, as doctors would give her pain relief during and after the cesarean.

Based on a larger ethnographic study exploring the cesarean decision-making process and the birth experiences of women at a district hospital in Shanghai, this paper aims to focus specifically on the issue of childbirth pain and how it relates to particular cesarean requests. I will describe how the environment in which women like Huifen give birth influences how they conceptualize childbirth pain. Within a medicalized setting, the request for a cesarean becomes an expression of pain, and a call for a response. Finally, I show that while women view cesarean sections as a way to control their experience of pain, recent state policies regulating cesarean sections—and the physicians who operate under them—view pain as an irrelevant factor in medical decision-making, leading to a dissonance in state-physician-patient goals for the experience of childbirth.

2. Ethnographic fieldwork: methods, positionality and site

2.1. Methods

This paper draws upon ethnographic fieldwork conducted in the months of June and July of 2015 on the high C-section rate in China and, in particular, the phenomenon of CDMR. Institutional Review Board approval was obtained from the University of Pennsylvania to observe and interview women and physicians in the obstetrics-gynecology department of a district hospital in Shanghai, a large urban center which the literature notes typically has high rates of C-sections (Klemetti et al., 2010; Q. Long et al., 2012). In this paper I refer to this hospital as Jiangbei Central Hospital. Approval to conduct ethnographic fieldwork and interviews was also obtained from the Jiangbei Central Hospital administration.

During my fieldwork, I received permission to shadow physicians and nurse-midwives in the antepartum-postpartum wards, labor and delivery room, and out-patient clinics. I collected and took pictures of various forms, brochures, and posters related to pregnancy and childbirth; attended prenatal classes offered by the hospital; and carefully recorded my daily observations in my field notes. I also spent considerable time in the labor room and patient wards so I could freely meet antepartum and postpartum women and, if possible, see them during labor and after birth. This intensive experience allowed me to observe concrete interactions between providers, women and their families, as well as distinguish what actions and behaviors in birth decision-making were commonplace or not. These two months of observation also allowed me to contextualize interview responses within the environment of birth.

I tape-recorded in-depth, semi-structured interviews with a total of 26 postpartum women, 12 of whom gave birth vaginally and 14 of whom gave birth by cesarean. Of these, I also interviewed 4 before labor, and observed 9 during labor. The characteristics of these women can be found in Table 1. The interviews focused on the woman's expectations of birth, birth experience, opinions regarding vaginal versus cesarean birth, as well as perceptions of labor pain and pain relief. While I purposively selected the field site to access women giving birth in an urban area with high C-section rates, I used convenience sampling to recruit women at the site, as they happened to be giving birth during the timeframe I was at the hospital. Still, I made sure to interview women from different backgrounds, such as those who had shared rooms on the "common ward" and those with private rooms in the "VIP ward"; those who preferred versus did not prefer cesarean birth; and those with different birth outcomes. Before interviewing women, I introduced myself and obtained their consent for my research. I assured them that I was unaffiliated with the hospital; participation in the research was completely voluntary; the interviews would be confidential and anonymous; and they could refuse to answer any question. I also requested their permission to be tape-recorded. For those women whom I met before labor, I asked their consent both to be interviewed and to be observed during labor. There were also women whom I first observed in the delivery room while shadowing physicians and interviewed afterwards. I retroactively asked such women for permission to use their birth story in my research. In addition to these women, I consented and interviewed four inpatient nurse-midwives, two outpatient nurses, and two obstetricians, all female, about their educational experience, own birth experiences, beliefs as to why women request cesareans, and perceptions of labor pain and pain relief. In this paper, I have anonymized the names of the district, hospital, and interviewees to protect the confidentiality of the research participants.

For analysis, I first translated and transcribed the interview recordings using transcription software. I used a thematic approach, following that of grounded theory, to organize the data: first by