Social Science & Medicine 85 (2013) 103–111

Contents lists available at SciVerse ScienceDirect

Social Science & Medicine

journal homepage: www.elsevier.com/locate/socscimed

# Misrecognition of need: Women's experiences of and explanations for undergoing cesarean delivery

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ARTICLE INFO

*Article history:*
Available online 5 March 2013

*Keywords:*
UK
Decision-making
Cesarean section
Authoritative knowledge

ABSTRACT

International rates of operative delivery are consistently higher than the World Health Organization determined is appropriate. This suggests that factors other than clinical indications contribute to cesarean section. Data presented here are from interviews with 115 mothers on the postnatal ward of a hospital in Northeast England during February 2006 to March 2009 after the women underwent either unscheduled or scheduled cesarean childbirth. Using thematic content analysis, we found women's accounts of their experiences largely portrayed cesarean section as everything that they had wanted to avoid, but necessary given their situations. Contrary to popular suggestion, the data did not indicate impersonalized medical practice, or that cesareans were being performed 'on request.' The categorization of cesareans into 'emergency' and 'elective' did not reflect maternal experiences. Rather, many unscheduled cesareans were conducted without indications of fetal distress and most scheduled cesareans were not booked because of 'choice.' The authoritative knowledge that influenced maternal perceptions of the need to undergo operative delivery included moving forward from 'prolonged' labor and scheduling cesarean as a prophylactic to avoid anticipated psychological or physical harm. In spontaneously defending themselves against stigma from the 'too posh to push' label that is currently common in the media, women portrayed debate on the appropriateness of cesarean childbirth as a social critique instead of a health issue. The findings suggest the 'need' for some cesareans is due to misrecognition of indications by all involved. The factors underlying many cesareans may actually be modifiable, but informed choice and healthful outcomes are impeded by lack of awareness regarding the benefits of labor on the fetal transition to extrauterine life, the maternal desire for predictability in their parturition and recovery experiences, and possibly lack of sufficient experience for providers in a variety of vaginal delivery scenarios (non-progressive labor, breech presentation, and/or after previous cesarean).



## Introduction

The incidence of primary cesarean section is consistently higher (Betrán et al., 2007; Declercq, Young, Cabral, & Echer, 2011; Menacker & Hamilton, 2010) than the 10–15% calculated as appropriate (WHO, 2009), suggesting factors other than clinical indications influence the deliveries (Bragg et al., 2010; Stavrou, Ford, Shand, Morris, & Roberts, 2011). Torloni et al. (2011) summarize that mechanisms underlying global disparities in birth mode, and the reasons for the nearly universal trend of increasing cesarean section rates, are unclear. Medically unnecessary cesarean section is a public health concern because of the excess morbidity compared to vaginal childbirth, such as greater child respiratory infections (Merenstein, Gatti, & Mays, 2011), placental complications in subsequent pregnancies (Silver, 2010; Solheim et al., 2011), and greater maternal mortality (Clark et al., 2008; Kamilya et al., 2010). Women of all ages are increasingly undergoing operative delivery and the proportion among older mothers is especially high (Hamilton, Martin, & Ventura, 2010). The increasing rates and associated risks raise questions about why women acquiesce to the 'need' for operative delivery, and where the 'need' is located: with the mothers, the infants, or the hospital

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http://dx.doi.org/10.1016/j.socscimed.2013.02.039

staff? Are women fully informed about the consequences of cesarean section and do they understand their options? This paper examines mothers' experiences of operative delivery in a United Kingdom hospital, and explores how women understand and rationalize their birth experiences.

One of the most prevalent indications for primary cesarean section is 'non-progressive' labor (Zhang et al., 2010), despite lack of association between relatively prolonged labor without indications of fetal distress and detrimental health outcomes (Mancuso & Rouse, 2008). Intervention in such cases may be a consequence of misunderstanding physiology and the perception of Western, technological medicine as offering control over 'unpredictable' natural processes. Ingrained biases arising from discriminatory terminology such as 'failed' labor may contribute to the ways in which both health professionals and women approach childbirth (Davis-Floyd, 1993). Martin (1991) explains that medicine is commonly considered distinct from culture, but medical culture is actually a powerful system of socialization. These influences, rather than lack of physician training or overzealous use of interventions, may potentially underlie the high proportion of cesarean deliveries conducted without medical indication (see Menacker, Declercq, & Macdorman, 2006). Within this technology-centered and biologically reductionist framework, cesarean is a logical intervention when labor trajectories deviate from 'normal' and therefore safe ranges. The use of the term 'emergency' to describe all unscheduled cesareans may mask the uncertainty of actual situations and various strategies available.

There are currently many classification systems for cesarean section, which are based on indications (why), urgency (when), characteristics of the mothers (who), and other aspects of the deliveries (where, how, by whom, and combinations) (Torloni et al., 2011). The term 'emergency' cesarean is frightening to women (Redshaw & Hockley, 2010) and 'elective' may also be misleading. In medical terminology, elective means that an operation is scheduled, whereas in lay terms it conveys choice and possibly demand. Publications increasingly address cesarean delivery "on maternal request" (CDMR) in an effort to identify the driver of rising cesarean rates and therefore effectively target interventions. However, 'request' may be an inappropriate term because fear of childbirth, existing medical complications, and anxiety regarding health outcomes are commonly reported in this group (i.e., Romero, Coulson, & Galvin, 2012; Wiklund, Edman, & Andolf, 2007). The impression that CDMR is common, as evidenced in the UK and US media (i.e., Alleyne, 2011; Cheng, 2011; De Angelis, 2011; Lawrence, 2011; Song, Downie, Gibson, Kloberdanz, & McDowell, 2004), is not supported by the research/clinical literature (i.e., Declercq, Sakala, Corry, & Applebaum, 2006; Thomas & Paranjothy, 2001).

Why mothers 'go along with' technological childbirth interventions such as cesarean section is debated (see Kitzinger et al., 2006; Klein et al., 2006). Fear of the unknown, pain, losing control, and/or concern for offspring wellbeing are key factors (Fisher, Hauck, & Fenwick, 2006). Uterine rupture is also of vital concern, as the consequences can involve significant maternal morbidity and perinatal mortality (Ronel, Wiznitzer, Sergienko, Ziotnik, & Sheiner, 2012). The desire, and cultural pressure, to protect offspring in medical crises and 'emergencies' constrain decision-making. Maternal autonomy in childbirth is also complicated by the diverse values of the parties involved and the meaning of the various outcomes to individuals' lives (Kukla et al., 2009). Kingdon et al. (2009) suggest choice is an inappropriate concept for childbirth because maternal autonomy is also limited by the dynamic nature of individual circumstance and available care. Another reason that cesarean section may be perceived as the safest course of action is structural constraints; physicians trained in vaginal delivery with complications such as breech positioning are uncommon (e.g. Hannah et al., 2000). This is therefore a complex issue because if maternity units do not require staff who meet such descriptions, then vaginal birth may be less likely to be realized and riskier than cesarean section. However, whether expectant mothers are aware of this more nuanced distinction of childbirth in context is unknown. Karlström, Nystedt, and Hildingsson (2011) found that women who had a 'preference' for and were delivered by cesarean felt more dissatisfied with their care and birth experience than others. Further, the reported worst part of mothers' planned cesarean experiences was the process of deciding on the delivery mode.

Instead of isolated and individual decision-making, attention is increasingly centered on childbirth influences within culturally constructed knowledge (Béhague, 2002; Bryant, Porter, Tracy, & Sullivan, 2007; Munro, Kornelsen, & Hutton, 2009; Wendland, 2007; Wittmann-Price, Fliszar, & Bhattacharya, 2009), especially about the 'ease' and safety of cesarean section versus vaginal delivery (Gamble, Creedy, McCourt, Weaver, & Beake, 2007; Walker, Turnbull, & Wilkinson, 2004; Weaver, Statham, & Richards, 2007). 'Preference' for cesarean section is predicted by maternal beliefs about childbirth, including the degree of confidence they have in realizing vaginal delivery (Stoll et al., 2009) and whether they consider birth as a natural event (Haines, Rubertsson, Pallant, & Hildingsson, 2012). The current emphasis on maternal autonomy evidenced by the recent UK policy that women can 'choose' to undergo a cesarean section in the absence of current medical indication (see NICE, 2011), may distract from the importance of women's reproductive histories and the factors that contribute to their understandings of appropriate childbirth processes and outcomes. Few to no 'requests' for cesarean section are documented as occurring in the absence of, what women consider, clinical or psychological indications (Karlström, Nystedt, Johansson, & Hildingsson, 2011; Weaver et al., 2007).

Convenience of both individual mothers and their physicians is often cited as a substantial influence of cesarean section delivery. The "too posh to push" mantra suggests that women are freely choosing to undergo cesarean section. Additionally, due to the discrepancy between intended and actual birth modes in their sample, Potter, Hopkins, Faúndes, and Perpétuo (2008) suggest that the hospital staff must have embellished medical conditions in order to persuade the families to undergo the more institutionally convenient cesarean section delivery. These researchers dismiss the idea that the physicians were uncertain of diagnosing complications due to the fact that they were practicing in urban locations in which they should have sufficient experience. Perhaps the context in which medical professionals are educated and subsequently practice, combined with litigious settings in which the appropriate role of a doctor is deemed as interventionist, is relevant in explaining this difference?

Recent research strives for a holistic understanding of childbirth experiences, based on women's perceptions of risk (Sharma, Eden, Guise, Jimison, & Dolan, 2011), the myriad of meanings underlying notions of 'control' (Namey & Lyerly, 2010), pain (Declercq, Cunningham, Johnson, & Sakala, 2008), previous delivery outcomes (David, Fenwick, Bayes, & Martin, 2010; Kaimal & Kuppermann, 2010; Pang, Leung, Lau, & Chung, 2008), race (Getahun et al., 2009; Rosenthal & Lobel, 2011; Selo-Ojeme, Abulhassan, Mandal, Tirlapur, & Selo-Ojeme, 2008), medical record information (Wibe, Hellesø, Slaughter, & Ekstedt, 2011), midwifery practices (Danerek et al., 2011), and community factors (Leone, Padmadas, & Matthews, 2008). These influences are increasingly viewed as interacting, and are replacing the antagonistic view of defensive medicine that dominated earlier literature (Bassett, Iyer, & Kazanjian, 2000).

The concept of authoritative knowledge as used in medical anthropology (Jordan, 1993; 1997) unifies these multiple domains