CHAPTER TWO

MEDICALISATION AND CESAREAN SECTION DELIVERY

2.1 Introduction

This chapter discusses elaborately the current discourse on medicalisation in society. The debate on medicalisation of human health by medical sociologists has been discussed to understand the different issues regarding use of medical technology and human health. The medicalisation of human body in general has received lot of attention both theoretically and empirically in the last few decades. Therefore, it is necessary to understand the important aspects of this debate before specifically focusing on the caesarean section deliveries. The objective, therefore, is to understand the concept of medicalisation within the context of caesarean section delivery. The first section of the chapter deals with the concept of medicalisation and the next section deals with the debate over medicalisation based on different views from medical sociologists and feminists.

2.2 The Concept of Medicalisation

Although there are several views on the medicalisation of human body, for better understanding of the present context, the major theoretical debates can be classified into three. Firstly, the orthodox medicalisation critiques emphasize that the medical establishment itself has become a major threat to health. Proponents of this argument call attention to the notion that patients
in general, because of their lack of medical knowledge, are placed in a position of vulnerability. The patients can only seek the attention of doctors at the period of emergency. Consequently there is little opportunity to challenge doctor’s decisions. The second criticism on medicalisation was mainly dominated by Foucault’s concept of power and medical profession. As against the orthodox critiques, the central notion of this argument is that medical power can be viewed as the underlying resource by which diseases and illnesses are identified and dealt with. The third school of argument came mainly from the feminists. They considered that some of the medical practices are against the notion of women’s autonomy and choice in ensuring reproductive rights.

The following section discusses the major arguments of these three debates on medicalisation of health care. But before we go on to these debates, it is very pertinent and relevant to understand the definition of medicalisation.

2.2.1 What is medicalisation?

According to Becker and Nachtignal, (1992) medicalisation is a process that redefines any human experience into a medical problem. The term refers to the process by which certain events or characteristics of everyday life become medical issues, and thus come within the purview of doctors and other health professionals. Originally, the concept was strongly associated with the notion of medical dominance; with a general trend towards medicalisation being
causally linked to the medical profession's increasing cultural and social authority (Ballard and Elston, 2005). Medicalisation has been defined as a 'process whereby more and more of everyday life have come under medical dominion, influence and supervision' (Zola, 1983, cited in Ballard and Elston). This growing reliance on medicine also appeared to be occurring in other aspects of life such as childbirth, menopause, and ageing (Zola, 1972, Freidson, 1970). It led to a claim that the medicalisation should be understood as manifesting an ongoing shift in social control processes in modern societies (Ballard and Elston, 2005). The medicalisation of childbirth can essentially be broken down into a process in which childbirth becoming a medical event rather than a social one. As a result, it has now turned out to be a negotiation of power balance between the medical world and the human society. The growing reliance on medical technology by the doctors for simple remedial issues has become a concern of present day. This is particularly noticeable in the case of maternal health.

2.2.2 Medicalisation and market:

A number of factors that encouraged or abetted medicalisation, including the diminution of religion; an abiding faith in science, rationality and progress, an increased reliance on expert and a general humanitarian trend noticed in both developed as well as developing countries in the world (Helm and Friedman (2010). As the population began to rely more on medical power, the social context of birth or even death became a medicalized phenomenon rather than
physiological. Many Western medical sociologist including Illich (1976), Helm and Friedman (2010) have considered this as a humanitarian trend.

Sociologists and other analysts have identified direct factors that facilitate medicalisation. Foremost among these, on the ‘supply’ side is the prestige and power of the medical profession. And on the other hand, the ‘demand’ side of medicalisation there has been a growth in consumer demand for medical solutions. This consumerism in health care has given way to the concept of market of medicalisation where, for a simple remedial issue, doctors prefer so much medical intervention.

Until the last decade, medical sociologists rarely examined medicine as any kind of market place. But with the thriving private practice by medical professionals, development in managed care, corporatisation of medicine and the rise of biotechnology industry, medical markets are increasingly important in the analysis of health care. This situation is called medicalisation of market where, medical products, services or treatments are promoted to consumers to improve their health, appearance or well-being. Hence, the idea of medical markets has been described as a ‘theoretical anomaly’ (Light, 2000), as medical markets often do not meet many of the elements in classical definition of a competitive market place. In a free market, consumers are supposed to be informed, appreciate differences in quality, and have bargaining power about free choices of buying. However, most of these assumptions are often violated in health care markets (Lown, 2000).
The use of advertising, development of specific medical technologies in market and standardization of medical services into product lines has contributed to an increased commodification of medical goods and services.

2.3. The debate over medicalisation of human health: A theoretical review

Medicalisation of human body in general has received lot of attention both theoretically and empirically in the last few decades. On the one hand, there is a notion that medicalisation has taken control over human life. But at the same time, there is an alternative view that over the time, medical power helps to eradicate disease and act for the wellbeing of the society. Therefore, it is necessary to understand the important aspects of this debate before specifically focusing on the caesarean section deliveries. Hence, it is important to understand the process of medicalisation in human society and the different arguments in the field of medical sociology.

The major theoretical debates can be classified into three schools of thought. The orthodox medicalisation critique which is dominated by Illich’s notion on health and illness focused on medical dominance. The second criticism on medicalisation mainly put forward by Foucault and his followers on the perspective of power and medical dominance. The third wave of debate concentrates on feminist’s argument over male involvement and dominance over female health.
2.3.1 The Orthodox Medicalisation critique

The orthodox medicalisation critique was one of the most dominant perspectives in the sociology of health and illness in the 1970s and 1980s. It remained a dominant approach even in the 1990s. This view also received support from feminist scholars as well as those who adhered to a Marxist perspective on health and illness (Lupton, 1998). Supporters of the medicalisation critique have generally identified a central paradox: medicine, as it is practiced in the Western societies, despite its alleged lack of effectiveness in treating a wide range of conditions and its iatrogenic side-effects, has increasingly amassed power and influence (ibid). They contend that social life and social problems had become more and more medicalised, or viewed through the prism of scientific medicine as disease. Critics such as Irving Zola (1972), and Eliot Friedson (1970) argued that medicine had begun to take on the role of social regulation traditionally performed by religion and law.

The central notion of the orthodox medicalisation critique was that the medical profession hampers individual’s autonomy. This argument was in line with the liberal humanist ideas. The liberal humanists argue that becoming ‘medicalised’ denies rational, independent human action by allowing members of an authoritative group (in this case the medical profession) (Lupton, 1998). Therefore, the term ‘Medicalisation’ is generally used in the sociological literature in a very negative sense. To be medicalised is never considered as a desirable state of being. As such, medicalisation is
arguably something which should be resisted, in favour of some degree of ‘de-medicalisation’ (Lupton, 1998).

In considering the over use of medical intervention during childbirth, a number of studies, both theoretical as well as empirical, came into existence. One of the important concepts of medicalisation of reproduction emerged from the ongoing debates in the field of medical sociology after the famous criticism of Ivan Illich on over use of medical technology in attaining the health problems (Illich 1976). According to Illich (1976), the medical establishment has become a major threat to the health and the disabling impact of professional control over medicine has reached the proportions of an epidemic. Health, argues Illich (1976), is the capacity to cope with the human reality of death, pain, and sickness. He opined (1976) that, “Technology can help, but modern medicine has gone too far launching into a Godlike battle to eradicate death, pain, and sickness. In doing so, it turns people into consumers or objects, destroying their capacity for health”.

Illich (1976) in his argument focuses on three levels of iatrogenesis or doctor induced disorders in human body. According to him there are three iatrogenic condition prevailed in the society, such as clinical iatrogenesis, social iatrogenesis and cultural iatrogenesis. Among these, clinical iatrogenesis is the injury done to patients by ineffective, toxic, and unsafe treatments. The undesirable side effects of over using of medical procedures, argues Illich, most of the time exploited patients who are in need of it. The social iatrogenesis results from the medicalisation of life when medical damage to individual
health is produced by socio-political mode of transmission. According to him, medicine undermines health not only through direct aggression against individuals but also through the impact of its social organization. This iatrogenesis creates ill health by increasing stress, multiplying disabling dependence and by abolishing the right to self care. More and more problems are seen as amenable to medical intervention. Pharmaceutical companies develop expensive treatments for non-diseases. Health care consumes an ever growing proportion of the budget. Cultural iatrogenesis represents a third dimension of medical health-denial. According to Illich, worst among all of this is cultural iatrogenesis, the destruction of traditional ways of dealing with and making sense of death, pain and sickness. It has thereby undermined the ability of individuals to face their reality, to express their own value, and to accept inevitable and often irremediable pain and impairment, decline and death. "A society's image of death," argues Illich, "reveals the level of independence of its people, their personal relatedness, self reliance, and aliveness. Dying has become the ultimate form of consumer resistance" (Illich, 1976). On the whole, Illich (1976) contended that rather than improving people's health, contemporary scientific medicine undermined it, both through the side-effects of medical treatment and diminishing lay people's capacity for autonomy in dealing with their own health care.

While the dominant perspective of orthodox medicalisation critique was one of total negation of the medicalisation process, there were slightly divergent views from Marxists and Feminists. Although, the direction of
argument remained nearly the same, the Marxian sociologists viewed this aspect somewhat differently. They argue that, there is little opportunity to challenge doctor’s decision particularly for the members of the working class and other socio-economically disadvantaged groups. Research carried out exploring the doctor- patient relationship from this perspective has tended to focus on the ways in which the medical consultation and the power of doctors over patients are used as a mechanism to promote capitalist ideologies to exploit working class. For example, the Marxian sociologist Waitzkin (1984), in his analysis of ‘micro politics of medicine’, looked at the verbal communication between doctors and patients and argued that medical encounter is one arena where the dominant ideologies of a society are reinforced.

Feminist critiques have viewed the medical profession as a largely patriarchal institution that used definition of illness and disease to maintain the relative inequality of women by drawing attention to their weakness and susceptibility to illness and by taking control over areas of women’s lives such as pregnancy and childbirth that were previously the domain of female law practitioners and midwives (Ehrenreich and English 1974; Lupton 1998).

Thus, the orthodox medicalisation critique represented an important shift in thinking among the medical sociologists. They have also brought out the possibility of inequality in medical encounters and in the delivery of health care. Nonetheless, the critique may itself be criticized on a number of grounds. Firstly, the orthodox medicalisation critique has mainly viewed the
negative aspect of the use of power by the doctors over their patients than the benefit from such treatment. Second, the concept is also rooted in a helplessness of patients. According to them the patients as largely helpless, passive and disempowered crushed beneath the might of the medical profession. Thirdly, in their efforts to denounce medicine and to represent doctors as oppressive forces, orthodox critiques tend to display little recognition to medical profession that may contribute to good health, the relief of pain and the recovery from illness. Finally, they also fail to acknowledge the ambivalent nature of the feelings and opinions that many people have in relation to medicine.

As against this, McKeown (1979) argues that, ‘body can be regarded as machine whose protection from disease depends primarily on internal intervention’. In his book, *The Role of Medicine: Dream Mirage or Nemesis*, he emphasizes the importance of distinguishing between the role of medicine as clinical practice, and its larger role as an institution that must be concerned with non-personal and behavioural influences on health.

### 2.3.2 Concept of power and the medicalisation

Another important view that has emerged in the field of medical sociology particularly on the medicalisation concept is one put forward by eminent sociologist Foucault. He challenged the orthodox medicalisation critique and argued that, over the time, the medical power is a disciplinary power that provides guidelines about how patients should understand, regulate and
experience their bodies (Lupton 1998). From this perspective, medical power may be viewed as the underlying resource by which diseases and illnesses are identified and dealt with.

The gradual entry of Foucault’s writings into the medical sociology has challenged the central assumptions of the orthodox medicalisation critique, particularly in relation to its conceptualization of power and medical knowledge. The exercise of power by medicine on modern society plays an important role in the philosophical thinking of Foucault (Lupton 1998). His writings emphasize the positive and productive rather than the repressive nature of power. Foucault differentiates between two types of power: the judicial power based on public rights and the disciplinary power of the norm which is closely linked to the rise of medical/scientific discourse in the eighteenth and nineteenth centuries. The new ideas about sickness in terms of the ‘abnormal’ condition of the body in contrast to the healthy or ‘normal’ condition went hand in hand with the development of new medical practices and techniques, and with the rise of new organizations for medical studies and services (Gupta, 2000). This development gave rise to a new type of power, which was tied closely to the development of a specific kind of knowledge. According to Foucault, the important feature of medical knowledge and practice is their participation in the very constitution of bodies and subjectivities. In The Birth of the Clinic (1975), Foucault argued that, over the time, various medical paradigms have provided important systems of knowledge and related practices by which we have not only understood
but also experienced our bodies. According to Lupton (1998) “the Foucauldian perspective largely departs from the usual approach by going somewhat further in contending that there is no such thing as an ‘authentic’ human body that exists outside medical discourse and practice”. Influenced by Foucault’s concept of power, Marta Kirejczyk (1992) analysed the interlinkages between power, medicine and reproduction. She draws attention to how this mechanism of power works in practice in the field of reproductive medicine in the context of ‘medicalisation and reproduction’. In this regard feminists brought in another perspective on power and medicalisation of life by analysing how it relates to women specifically. According to them, the exercise of the power of medical profession has also led to asymmetrical relations between doctor and patient between sexes.

In spite of several positive notions towards the medicalisation concept that have been put forward by Foucault and his followers, there are serious criticisms against their argument. One feature of Foucauldian writings on medicine that has been the subject of wide criticism was their general focus on analysing the discourses on the medicalisation debate by emphasising the role of power. Despite his own insistence about the productive rather than repressive nature of power, his followers often represent medical power as overwhelmingly coercive and confining (Gupta, 2000). Some writers have even emphasised that the power of medical scientists have had several negative consequences which were not adequately discussed in Foucault’s writings.
2.3.3. Medicalisation of reproduction and childbirth: The Feminist argument

Another view on medicalisation of health emerged from the field of feminist research which mainly considered medical power as a threat to the women autonomy and her demand for attaining reproductive health rights. The feminist movement has led the way in devoting attention to the ways in which medical and scientific knowledge is used to privilege the position of powerful groups over others. One of the important areas of their analysis has been the medicalisation of reproduction and over use of medical intervention during childbirth.

It is well known that the maternal and neonatal deaths have significantly come down in the last century in large part of the world as a result of the increased application of technology during labour and childbirth (Sen 1994). According to the feminists, this fact explains women’s apparent tolerance for a system that in some ways has transformed birth into a passive and alienating experience (Wajcman, 1994). While some of the technological adoptions were of direct medical benefit to women, there were also a host of obstetric technologies that are of questionable value to women or infants.

As a result, the pregnancy and childbirth are increasingly considered as medical problems rather than personal experiences. The prevalence of technological interventions in child birth illustrates this medicalisation. One such intervention is the caesarean section. In this process pregnancy and
childbirth are perceived as medical problems rather than natural elements of the human life-cycle. Technological intervention is then employed to “treat” pregnant women and frequently individual knowledge and experience become devalued and replaced with the “expertism” of professionals (Wilson, 1989).

It has been found that the extent of medical intervention in childbirth has risen exponentially over the last twenty years (Oakely, 1997). In some European countries, operative deliveries are now in excess of 20 percent, which is well above the standard rates that WHO considered reasonable (5-15 percent). Thus, the consequences of a high level of technology are already making themselves felt in terms of increasing caesarean delivery across countries. Even in developing countries like India, the number of caesarean deliveries has increased substantially over the years. In many urban centres and even in some states, the figures are higher than the normal expected range of 5-15 percent.

2.3.3.1 Feminism and childbirth:

According to feminist ideology in western world, medicalisation and control of childbirth are inextricably linked with patriarchy. The rise of medicine as a political and social force within the sphere of female arena and motherhood can be traced as far back as fourteenth century. Physicians who had been trained at universities managed to gain approval from the Church and started to shake the faith of the people in traditional remedies (Towler and Bramall,
1986). This initiated the beginning of the authority of medicine over the mysteries of the body, health, birth and death.

Feminists considered that the widespread use of the so-called technologies, and their acceptance by women, reflect the structure of power and decision making unfavourable to women. In the feminist argument, the control of reproduction has been a central theme for decades (Cristilaw, 2006). Therefore, the history of technological intervention in attaining reproductive health is seen in terms of another form of oppression against women by science and medicine. On the contrary, the child birth was considered as a natural and uncomplicated process in primitive societies. The modern intervention, therefore, is presumed to be the male medical control of childbirth which is a natural physiological process that women midwives and relatives attended in a sympathetic and supportive role in the past.

2.3.3.2 Women’s autonomy, reproductive rights and caesarean section delivery:

The reproductive autonomy is understood as (a) the right of women to choose whether to have children or not and if so, how many and when, (b) freedom to choose the means and methods to exercise their choice regarding fertility management and safe delivery experience, and (c) access to good information on means and methods (Gupta, 2000).

Feminists argue that in most of the cases, technological intervention in childbirth is unnecessary (Snow 1994; Wajcman 1994). Some believe that
technology is neutral and value-free and can be used or abused. The development and application of reproductive technologies is creating contradictory possibilities for women (Gupta, 2000). Such technologies, while allowing the exercise of individual reproductive rights and offering ‘choice’ of motherhood to some women, have at the same time the potential to take away rights and choices for decision making from other women (Gupta 2000). In general, it is not often women who are in control of matters affecting their own health. Pregnant women are especially seen as being incapable of taking responsible decisions on behalf of themselves and their foetuses.

Historically pregnancy and childbirth have sometimes been difficult and risky experiences for women. It is often argued that it is because of the medicalisation of reproduction that women stand a much better chance of experiencing a healthy and uncomplicated childbirth. The criticism was on the degree and extent of this medicalisation than medicalisation itself. Today many people believe it is irresponsible to give birth outside a hospital. There have been cases in some of the western countries to consider women who consider home deliveries to be convicted for child-abuse (Gupta, 2000).

Radical Eco-feminists like Sazz Blog (2005) argued that when reproduction is medicalised a woman’s experience of pregnancy and childbirth is no longer her own. It becomes a technological business, with procedures and equipment that she doesn’t know how to use or is not authorised to use and therefore she is pacified. Because these procedures and pieces of technology have become central to the reproductive process, and
because she lacks the necessary knowledge and training to use these tools, her own experiences and plans are frequently disregarded because she is thought not to understand reproduction (Oakely 1997).

The debate on how far technology enhances women’s autonomy or goes against it, and under what condition, becomes even more complex. The introduction of reproductive technologies, affects women more strongly than men (Gupta, 2000). It is true that the technology of birth control and new development in reproductive technology helped women to enhance their autonomy. Sen (1994) argues that, ‘the lingering, legitimate fear of childbirth may have hampered women’s objections to the routine use of invasive technologies which shift the basis of obstetric decision-making from prospective clinical observations to the printout on foetal monitor’. Therefore, question arises whether medicalisation, in spite of having life saving technologies for maternal health, has made pregnancy and childbirth as complicated medical processes than natural experiences for a woman?

2.3.3.3 Is technological intervention bad for women’s health always?

General notion of the feminists always place technological intervention in treating women health problem in a negative manner. But it is true that in a country like India, where majority of women lacks proper health care, technological assistance help them to combat with health problems. In this regard, scientific invention of new reproductive technologies such as access to safe abortion, contraceptive technology, infertility treatment, (IVF or In-Vitro
Fertilisation) which are commonly known as New Reproductive Technologies (NRT) are being considered as better way to combat issues relating to women health. In the past, high population growth was considered as a serious problem for a developing country like India. But with the invention of family planning measures and contraceptive technologies it became manageable for India to control the population growth. Therefore, feminists (Stanworth, 1987, Petchesky, 1987) and Lynda Birke, Susan Himmelweit and Gail Vines (1990) welcome these technologies as scientific and technological progress which ensure women’s right to reproductive choice, looking upon women as active agents rather than passive victims.

2.4 Discussion

The debate on the medicalisation of human body and its likely impact on society are rich and wide. Both medical sociologists and feminists have their own contributions to this debate although each of them viewed the issue in their own different perspectives. Although the Foucault writing on power was one of the pioneering works on this issue, the passionate writings of Ivan Illich has added further dimensions to this debate. He strongly believed that human health is totally captured by the modern medicine and considered that the contemporary scientific medicine undermined people’s health than improving it. He also brought out the possible side-effects of medical treatment and the diminishing ability of people in dealing with their own health care. This generated a serious debate on the medicalisation of health and a strong view that has emerged is that the social life and social problems
have become more and more medicalised with the modern medicine and technology.

As against this orthodox view, a more sympathetic view emerged with the writings of Foucault. Unlike those who assert the orthodox medicalisation critiques, Foucauldian perspectives argue, that it is impossible to remove power from members of the medical profession and hand it over to patients. According to the notion, power is not a possession of social groups, but is relational, a strategy which is invested in and transmitted through all social groups. It does not necessarily mean that Foucault and his followers would necessarily accept the notion of contemporary form of medicine with great influence on human bodies. Contrary to this Foucault also considered that the society is medicalised in a profound way. At the same time, although medicalisation tries to administer bodies of citizens, it also tries to promote good health and productivity.

On the other hand, feminists brought in another aspect of the medicalisation of life by analysing how it related to women specifically. In relation to the medicalisation of reproduction, they tended to emphasize that power did not only pertain to the asymmetrical relations between the doctor and the lay persons, but that it had to do with the unequal power relations between women and men.

The development and use of reproductive technologies contributes further to the medicalisation of women’s life. Despite its profound positive
aspect in attaining higher levels of women’s reproductive health, it reflects a new problem for women in terms of power and autonomy. According to the feminist thoughts, these new reproductive technologies enhance patriarchal control over women’s reproduction and is closely linked to the control over women’s sexuality, the control over women’s productive or labour power, property and other economic resources, control over women’s mobility and also control over her decision making and access to health care (Gupta, 2000).

The recent studies on increasing caesarean section deliveries indicate that there has been significant increase in demand from women in seeking caesarean section intervention than purely motivated from the institutional side. Therefore, for a better understanding of the underlying issues, there is a need to integrate the traditional debate with the modern changes in the realm of socio-economic transformation of the society. This could possibly help in deducing a correct judgment on the advantages and disadvantages of health technologies and its intervention in human life. The study, therefore, will be an attempt to frame the possible interlinkages between increasing technological intervention during childbirth (more specifically the caesarean section delivery) and the determinants for the increasing trend both from the institutional aspect and socio-economic determinants. The institutional factor is mainly attributed to the increasing medicalisation of health of individual, which includes the institutional delivery. On the other hand, the socio-economic factors are mainly contributable to the demand for caesarean delivery from women of reproductive age group. Emphasis will also be made to examine the context of increasing trend in caesarean delivery with the
traditional debate on the theoretical aspect. Therefore, on the one hand, the present study will focus on the current issues on increasing medical intervention on childbirth; while on the other hand, it will be able to emphasize the demand aspect from women’s perspective for this medical intervention.

2.5 Summary:

The current chapter discusses theoretical debate over medicalisation of human body from different perspectives in medical sociology and feminist methodology. The theories of medicalisation and health are broadly classified into three major groups. The orthodox medicalisation critique, dominated by Illich’s notion on health and illness, mainly focused on medical dominance over human health. The second criticism on medicalisation by Foucault and his followers follow the perspective of power and medical dominance. The third wave of debate concentrates on feminist’s argument over male involvement and dominance over female health.

In sum, the medicalisation debates bring out some interesting aspects of medical technology that affect human beings constantly in an effort to keep good health. While the debate as such is successful in depicting the problem from a completely institutional angle, it has not largely touched upon the changing socio-economic environment in the society and the increasing instances of considerable demand from the population at large in seeking these technologies for various reasons. Perhaps, the debate gives a good picture of medicalisation only from institutional perspective.