CHAPTER SEVEN

ELECTIVE CAESAREAN SECTION OR CAESAREAN BY CHOICE

Let the vexed rejoice in the house of the one in travail!
As the Bearing one gives birth,
May the Mother of the child bring forth by herself!
(Meltzer, 1981)

7.1 Introduction:

The performance of caesarean birth in present medico-social domain is more attributed to non-medical reasons rather than medical one. Such phenomenon of women choosing to deliver by caesarean section in the absence of any medical indication is most popularly known as caesarean by choice. Caesarean delivery on maternal request (commonly known as CDMR) is a medically unnecessary caesarean section, where the conduct of childbirth through caesarean intervention is requested by pregnant mother.

An analysis of the secondary data in the earlier chapters brought out various factors leading to the conduct of c-section intervention during childbirth. The analysis also indicated that there is substantially high incidence of c-section delivery among socio-economically advanced sections of the society. But how in a changing socio-economic realm of the society leads to preference for c-section delivery? Hence, for a better understanding
of the phenomenon an empirical study has been carried out in the city of Kolkata.

The study, on the one hand, focuses on the aspect of medicalisation from institutional perspective and on the other, it also tries to explore the preference of medical intervention from the point of view of women. The previous chapter highlighted on the medicalisation aspect of caesarean delivery form provider’s perspective or supply side of the phenomenon. The aim of this chapter is to explore the context of medicalisation and attitude towards caesarean delivery from client’s perspective or demand side of the phenomenon. Noteworthy to mention that, as women are living longer and having fewer children and as childbirth becomes safer for women and their babies, quality of life issues related to childbirth become more important. At the same time, women are having an increased say in obstetric decision-making unlike in the past which could possibly influence the decision on c-section delivery as well.

Moving away from the conventional indicators that explain the reasons for high caesarean intervention, this chapter takes up the central issue of factors that result in decision making for caesarean delivery in a family set-up. The important questions that arise in this context are:

a. How do we understand the concept of maternal request for caesarean delivery?

b. How different circumstances that lead to decision making for caesarean intervention can be explained?
c. How the context of power and autonomy during childbirth can be explained?

The information base for this chapter also comes from the qualitative field study conducted in the city of Kolkata, West Bengal. The field study includes in-depth interviews with the doctors and case studies of women who had caesarean birth within a fortnight.

The city of Kolkata, witnessed a combination of social and economic development coupled with growing privatization in health care and increased institutionalized births. It is a place where people from rural as well as other urban or semi-urban places come for seeking health care. Hence, we get a mixed profile of patients in both public and private hospitals. The study aimed to collect information from women who had come for delivery to the hospitals (all total 8 hospitals have been covered of which 4 are private).

The case studies elucidate some interesting aspects of mechanism for the preference for caesarean delivery. Worth mentioning that the sample size for the case studies is small, therefore generalizing the information is beyond the scope of this study. However, we can throw light on some interesting aspects regarding the preference for caesarean childbirth and the decision making process for the preference.

The chapter is divided into three sections. In the first section, a theoretical review of the current debates on caesarean delivery on maternal request has been presented. In the next section, an analytical depiction of the
circumstances that leads to preference for caesarean section is presented. This section is divided into two sub-sections viz. attitudes towards motherhood and medical intervention and decision making in childbirth. The economic consequences of caesarean childbirth have been described in third section followed by discussion.

7.1.1 Caesarean delivery on maternal request: A Review

Over the last several years, as caesarean deliveries have grown increasingly common, there has been a great deal of public and professional interest in the phenomenon of woman ‘choosing’ to deliver by caesarean section in the absence of any specific medication. The issue has sparked intense debate, as it raises question about the nature of autonomy in birth. The main argument in the field of Medical Sociology is what could be the possible explanation for the higher rate of caesarean childbirth in both developed as well as developing countries. While some studies focus on purely medical aspect of caesarean childbirth (Baskett and McMillen, 1998; Cai et al, 1998). At the same time, it is also believed that the increasing trend of cesarean delivery in the developed countries attributes to the increasing demand from patients and informed decision making (Ash and Okah, 1997; Potter et al. 2001).

Earlier, the idea of a woman undergoing a caesarean section was met with trepidation. But today, it is a different story with an increasing number of women preferring caesarean section as the mode of delivery rather than normal one. Even as we observe a trend towards natural births in U.S and
European countries, in India, at least in the urban centres of some states like Kerala, West Bengal and Andhra Pradesh, more women are resorting to c-section. A c-section, which was earlier performed only in emergency, is now being seen as a convenient form of delivery from both doctor’s perspective and woman’s perspective.

The believe that many women opt for caesarean section delivery without any medical indication prevailing in society for many years, though increased rampantly in current time in many parts of world. A recent data shows that in United Kingdom, 7 percent of all the caesarean delivery was by women’s preference (NCHS, 2006). However, unfortunately, little is known regarding the current scenario of c-section delivery by choice in developing countries particularly in India. Although, some field based studies focusing in this aspect, rare is known nationally.

Interesting to note that, the preferences for requesting caesarean section not always purely based on women. A number of combinations of factors plays important role. Among these, one important factor, obviously, is the preference from doctor. Many of the times, doctor plays key role in generating demand in women and their family members. The current chapter therefore tries to throw light on two aspects such as preference by woman and her family members for caesarean delivery and doctor’s preference behind the performance of this medical procedure.
Recently, a movement has begun to gather momentum that argues in favour of a pregnant woman’s right to choose to deliver by caesarean instead of undergoing a trial of labour. Supporters of this intervention argue that the safety of modern caesarean delivery has reached a point such that it is time to reevaluate its merits compared with the risks of trial of labour, both for mother and foetus (Bernstein, 2002).

Earlier, where c-sections were only done in cases of prolonged labour, foetal distress, uterine rupture, any placental problems or other emergencies, today they are being carried out even without adequate medical reason. Doctors, many times give examples of patients opting for a c-section in order to deliver a child in some auspicious day or time. But most of the time it is not clear whether the decision to perform c-section is purely a woman’s choice or a preference from doctor or her family members.

Studies have clearly indicated the interplay of family members, relatives etc in the decision making on c-section (Mould et al. 1996). In many cases, relatives play an important role in this decision (Mould et al. 1996). The reasons behind such phenomenon are complex and involve social, cultural and economic aspects. Some studies cited a number of factors that leads to the demand for this surgical procedure such as i) fear of pain in labour, ii) uncertainty of outcome and fear of emergency intervention such as forceps, iii) fear of foetal distress in labour, iv) fear of future sexual dysfunction or pelvic prolapse, v) convenience and vi) religious factors (Behague et al. 2002).
Therefore, the operational pathway in which, the decision making process for caesarean delivery takes place is a complex phenomenon. In general, the emphasis was on the doctor and the health facility but it is important that the decision making within family is also considered appropriately. Moreover, it is important to consider this issue based on feminist argument of use of technology in reproduction and childbirth in the context of medicalisation of society.

7.2 Circumstances that lead to decision to perform caesarean section:

Interviews with the women who have given birth by c-section provides information on the mechanism of decision making for the caesarean childbirth both at the health facility level and at the family level and elucidate the factors for such preference. Literature suggests that a number of socio-economic factors most of the time trigger the demand for this medical intervention. It has been found from the interviews that women with high educational attainment preferred caesarean childbirth than normal birth. Although, it has been noticed that risk aversion mechanism or fear of labour pain are important factors for preferring c-section birth than other factors. Moreover, the decision to have a child or importance of pregnancy in a family does matter in case of women’s preference of mode of delivery.

7.2.1. Birthing experience and attitudes towards motherhood:

A woman, because of her physiological capacity, is capable of bearing children. Through the act of carrying a child in her womb and giving birth, a
woman attains ‘motherhood’ (Krishnaraj, 2010). The personal meaning of motherhood for every woman springs out a variety of personal experiences and responses to familial circumstances and social pressure. Moreover, the very basic factor which curtails or enhances the personal meaning is that reproduction is not entirely a personal affair. In view of the fact that, a major aspect of a woman’s role is reproduction, mothering has continued to be basics to women’s lives as well as the organization of family, and is fundamental to the genesis of the ideology about women. Family, kin, neighbours and social groups of which women are a part influence their reproductive behaviour, their decision to have child or even their preference of mode of delivery. In addition, family background and atmosphere, size of the family, status of woman in her family, attitude towards son-preference and other family pressures play a part in shaping women’s views on motherhood and childbirth (Pande, 2000). The question had been asked to them as what is their attitude of being a mother and the experience of childbirth.

“To become a mother is one of the greatest responsibilities and a pride for woman. I wanted a child at any cost. In my in-law’s family my husband is the only son. Therefore, it was very important to have a male child. I am very proud that I became a mother. Although, I had lots of problem in my pregnancy and delivery, but the joy of becoming a mother is more than any pain. During pregnancy I developed high BP. Doctor told me that normal delivery could be possible. But I and my husband did not want to take any chance for this precious birth. We told doctor to perform caesarean and save the child at any cost”.
This has been the experience of a graduate who is working in a sub-urban primary school and with better economic background. She had an immense desire for children. When I interviewed her, she had caesarean two days before. In her words, ‘this is my first child and I am so happy that I am a mother now’.

While, motherhood is precious for women but for some it is job which they have to perform failing which their role in family will be questioned. In another case, the urge for son made the woman go for fourth pregnancy after three daughters. Soon after her secondary examination, she was married at age of eighteen. She came from lower middle class families with five sisters. She associates motherhood with responsibilities rather than joy. “My husband’s family is very big. I have four sister-in-laws and my husband is eldest. So you can imagine how much there is a desire for son. I wanted to get operated immediately after the second child. But nobody allowed me to go for that. I am very much thankful to God that he blessed me a male child this time. During delivery my labour pain was not started properly and doctor advised to go for caesarean. My mother-in-law and my husband told me that I should not take any chance. Therefore, I had my third c-section”.

Thus, in general, the women were having a mixed view on motherhood and the childbirth. For some, the child is a gift from God, to be loved and cherished. For some it was a matter of responsibility and getting proper place in a family set-up. Hence, the decision for pregnancy, childbirth is perhaps a complex phenomenon and depends on number of aspects such as woman’s
own attitude on motherhood, desire for having a child, family need for getting a child.

### 7.2.2. Decision making in childbirth

Although, it is true that in many cases of caesarean delivery where doctor advised for surgical procedure, patient or her family members also generate their own opinion which ultimately result in c-section delivery. The following sections deals with three major pathways of decision making; i) maternal request for caesarean delivery, ii) Family member’s decision and iii) Doctor’s motivation for mode of delivery which is discussed in the following section:

#### 7.2.2.1 Maternal request for c-section

Caesarean sections performed without medical necessity are commonly known as caesarean section by demand or maternal request caesarean sections. The belief that many women are demanding caesarean sections in the absence of clinical indications has been prevalent for many years (Jane et.al. 2007). Caesarean delivery on maternal request is defined as a primary caesarean delivery done on the request of the mother in the absence of any medical or obstetric indication (Minkoff, 2003 in Robin Kalish). Although, many times, this preference involve several other preferences for a woman’s family members or husband.
The current section deals with aspect of preference for caesarean option by a woman to deliver her child. Interesting to point out that, the demand for a medical intervention or caesarean can be purely woman’s own preference or many time familial decisions made by husband or mother-in-law. In my field study an attempt has been made to elicit the information of how the decision making takes place in a family and also in the birth place of a child. The case studies bring out the aspect of decision making for on caesarean delivery based on the experiences of women who had caesarean birth. However, it may be pointed out that it is hard to differentiate between demand purely by woman and demand influenced by the family members or doctor. Most of the time it is an interplay within a family set-up.

*Reasons for preferring caesarean as mode of delivery:* 

In the field study, I have come across some interesting findings of c-section delivery on maternal choice. It has been found from the field study that the request for caesarean delivery comes due to some important reasons such as: 

i) Fear of pain in labour 

ii) Fear of foetal distress in labour 

iii) Religious factors 

iv) Dependency and trust on doctor 

Details of the factors supported by the case studies are discussed bellow:
i) Fear of pain in labour

One of the most important causes for requesting caesarean is fear of pain or apprehension during delivery. Avoiding pain during delivery has become more common among the pregnant mother. In current scenario, the technological advances have turn out to be a major decisive mechanism to avoid pain during labour. In many instances mothers do no longer want to bear the massive pain. The fear for labour pain could arise because of woman’s previous experience or fear could also induced in woman through comments made by health professionals, family members or friends.

As we see in one of the cases, the preference was due to fear of pain in last pregnancy. She already had child by normal delivery and experienced unbelievable pain during the childbirth. In her words.

“It was a horrendous delivery…in the end it was forceps delivery, and it was very traumatic. In less than a year after that I discovered I had a prolapse, and I went to see the doctor and he said it was a bladder prolapse. He also assured me it was nothing at all to do with giving birth, but….I can only think that all that squeezing and pushing must have done it…and then when I became pregnant with the second child, all I could think of was going through all that again…..therefore…I just requested doctor to perform the caesarean….now I am happy that my child is also ok…..”

Women who had experienced previous vaginal deliveries felt that the pain of labour can be avoided only through surgical intervention. They also
believed that caesarean is a painless way to give birth, although, none of them were aware about the post operative pain.

On the other hand, in some cases the fear of pain can be due to neighborhood effect. For another woman the preference for c-section delivery motivated by her friend, who suffered a lot due to normal delivery. She delivered her male child by c-section. She didn’t have any health problem. But she had the fear of normal birth.

In her words...

“I have seen people suffering from heavy pain during childbirth. Oh my God…that is really painful. When I came to hospital, doctor told me that I can deliver my child normally. But I didn’t agree with that. I told doctor please you do operation and save my male child. At the time of delivery I was unable to get labour pain. And time was over. So doctor performed caesarean delivery. I am so happy. My child is safe and I am also ok”.

Although, she is from low income family and school final pass but she had the preference for caesarean so much, she requested doctor that she will deliver her child through caesarean section only.

Another respondent Parna (name changed, age: 22 yrs) who is a school teacher by profession, was very much in favour of c-section. She belongs to high economic strata and her husband was a businessman. She heard that giving birth normally is a painful and harmful to the baby. According to her, “…how I formed the opinion of giving birth was really through my sister and my
mother, talking to them, and I remember particularly my mother saying how painful the normal delivery. She told that if she was given the option to have a caesarean she would definitely go for that. But at that time this procedure was not that popular and highly developed, which is not in my case. In my case we went to a good Gynaecologist in the city and did not hesitate to pay for this surgery as we both wanted our child delivered safely”.

Thus it is clear that not only the women from educated and economically advance section of the society prefer c-section but even women from poor uneducated families also prefer surgical intervention to have a painless child birth.

ii) Fear of foetal distress in labour:

In many cases mothers want c-section as this is safe procedure for the child. The opinion is formed sometimes due to late pregnancy and also due to previous pregnancy failure such as miscarriage or still birth. One of my respondents Sunita (name changed, 38 yrs), shared her experience with me regarding her first pregnancy after nine years of marriage. Sunita is having a master degree and belongs to better economic background. She found caesarean delivery as safer procedure than normal birth for high age mother like her. In her words, “I am 38 years old and did not have any child for last nine years after my marriage. We visited a famous Gynaecologist who suggested me to go for caesarean birth. I also had a fear that my child will suffer in this late pregnancy or in delivery. So why to take chance? Then I and my husband decided to go for c-section just to save the life of my child. I have read things where I have heard that it’s better
for the baby, to have a caesarean; they are not getting squashed all the way along the birth canal. And I also have heard that it’s relatively easy surgery in respect of the baby”.

In India, caesarean section is widely perceived as safer than vaginal birth for babies. Any risk associated to caesarean section are usually minimized and described as risks to the mother.

“I just felt the caesarean was safer for the baby …..although the risks to me were it was going to take longer to get over and all the rest of it, the risk of infection and stuff like that. But I still felt that, that at least the baby will be safe. I knew I could recover all that, because, I was quite fit and a healthy person. Now I am happy to see that my baby boy is ok”. (Chobi Mahato, 25 Yrs.)

The fear of foetal distress and loss of child make a huge tension for family members. In the decision making process, family members play important roles which sometime motivate woman to opt for medical intervention. As in the case of Lata (already discussed in previous section), the pressure from in-law’s family and her own family for male child through a safe procedure triggered off for caesarean section.

iii) Religious factors.

Another major reason for caesarean delivery is the desire to give birth in auspicious time or on some special day. In a country like India, where religion and religious believes have an important bearing on many decisions, desiring childbirth on an auspicious day is highly possible. In the study, two
respondents wanted to ask for caesarean section to have some control over the timing of the birth, but both cases the request was turned down by the hospital staffs. Aparna and her family members, especially her mother-in-law wanted a child on Saturday morning in a special star combination. Though, doctor did not agree with this as her labour induction4 was not started. It has also been noticed from the voices of women that preference for having birth on some special day for religious and cultural reasons are common in many instances.

\textit{iv) Dependency on doctor:}

Trust is clearly a significant aspect of maternity care for many women. According to Gilson (2003) trust in health care institution can be defined as dependency in relationships that occur in the context of inequality such as that between health care provider and patient. Most of the women interviewed emphasized on the fact that they trusted their doctors implicitly, not just in terms of their clinical expertise but also as a care giver during pregnancy and delivery. One of my respondents shared her experience with her Gynaecologist in the following way.

“I feel more comfortable being in the care of a specialist obstetrician as well. And my doctor is the head of the department of the hospital and a professor. He is someone who is specialized and done more than 15 years of research and practice in this field. I knew that whatever decision he took for my child it was right. We trusted

\footnote{Labour Induction: This is a procedure where labour pain starts normally}
him implicitly. And you know when he did the surgery it was so painless and without any complication”.

Moreover, women would never question their obstetrician’s advice as there exists common notion of medical world being more knowledgeable and thus powerful. This relationship between knowledge and power addressed by French Philosopher Foucault who argued that, over the time, the medical power is a disciplinary power that provides guideline about how patients should understand, regulate and experience their bodies (Foucault, 1975).

But, on the other hand, the dependency may be caused due to medical emergency rather than preference of women. As we take the case of Rajyashri, the delivery of her child was in medical emergency. Rajyashri (name changed), aged 29 years was from lower middle income family delivered her premature female child after nine years of marriage. She had some problem in getting pregnant. She was under the treatment of Sr. Gynaecologist. After a laparoscopy she was able to bear child. At the time of delivery she faced major problems. On the last month of pregnancy she was in danger. She immediately admitted to the hospital and doctors decided to perform c-section. According to the doctor, she had to undergo c-section otherwise both the lives would be in danger.
In her words,

“Doctor saved our lives. I am so happy. I know that without c-section delivery it was not possible to see the face of my child, although I was not informed about the c-section”.

If we look into the case of Mina (name changed), the caesarean was performed to save the child. Mina had been advised to undergo c-section because of breech presentation of child. According to her,

“C-section is safe mainly for baby. And during emergency it is important to save the life of child. Today there are so many options so that we don’t have to worry.”

It is a common traditional belief that, caesarean delivery is a life saving procedure for the neonates in most of the cases. And moreover, strong believe on medical technology and knowledge of doctor it is hard for patient or her family members to go against medical set-up.

7.2.2.2. Role of family in decision making:

Pregnancy and delivery are not entirely a personal celebration but family, kin, neighbours and social groups of which women are a part influence their decision making in all the from selecting hospital to type of delivery and care. From the voices of the case studies it appears that once woman become pregnant, family members make several decisions on their behalf on issues of sex of the child, type of hospital to be sought, type of delivery to be conducted etc. The preference for any surgical procedure by family members mainly involved preference from a woman’s husband or her mother-in-law. The
preference can occur mainly due to avoid child death during delivery (in most cases male child) or number of religious factors especially by mother-in-law.

As discussed in previous section, Lata’s family members created pressure directly or indirectly to have a male child. Moreover, during delivery of the child they even supported doctor’s advice to go for surgical intervention as they did not want to take any chance. While on the other hand, in Sunita’s case her family members especially her husband and mother-in-law supported her preference for caesarean section. During her pregnancy when they visited Gynaecologist she told the doctor that she wants a caesarean considering her age. Before that, with her family members particularly her mother-in-law and husband supported her preference. She was of the opinion that as she is much educated her family members supported her voice.

Nonetheless, it is important to say that the decision making process in a family depends on number of factors such as education, family background, economic condition, views on sex preference.

**7.2.2.3. Doctor’s motivation behind the decision making**

The preference for such surgical intervention may be gaining additional support among physicians for medico-legal reasons, as doctors are more frequently being sued for failure to perform a caesarean in case of any emergency (Bernstein, 2002).
It is often argued that, the decision to perform a surgical intervention mainly motivated by a doctor rather than the patient. The complex negotiation between medical professional and patient interaction are often understood and analysed from the prism of power. In many cases, demand for caesarean delivery largely dominated by preference from doctor with or without any medical reason. The doctor’s interest determined the choice of c-section most often (Mishra and Ramanathan, 2002). The physician factors that affect c-section decision include physician practice styles (Goyert et. al. 1989), the obstetrician’s clinical attitude and fear of litigation (Belizan et al. 1991), the physician’s convenience (De Regt et al. 1986) and more importantly the economic incentives.

One of my respondents narrated her experience of caesarean childbirth in a following manner. “I preferred caesarean birth than painful normal birth when my doctor showed me the problems that we could face during normal birth procedure. He is so famous and experienced we even never thought of going against him. But actually he was right. He knows better than us in case of medical procedure”. She delivered her child by c-section.

Nonetheless, it is important to mention that, in the arena of medical technology doctor has the power to decide over most of the confounding medical issues. Sometimes, doctor believes that caesarean delivery promotes the overall health and welfare of the women and her child than the normal birth. Therefore, in this situation when patients come to visit for pregnancy
and delivery, doctors brief them about the benefits of c-section. And finally patients also agree to go for the procedure.

This norm was often reinforced in the women’s individual interactions with their obstetricians both in the antenatal period and during and birth. Women described that interactions with doctors continually during pregnancy firms up opinion and fear on women’s bodies. For instance, some women were told during pregnancy that their pelvic might be too small, or that there babies might be too big or in a wrong position. However, their views also reflected obstetric ideology, where birth is understood as always potentially risky and catastrophic phenomenon. May Lee and Kirkman’s (2007) analysis of caesarean discourse showed that the contemporary medical discourse centred on the assertion that “more women need caesareans today than ever before” and the vaginal birth was inherently risky and unpredictable while caesarean birth was safe and predictable.

7.2.2.4 What a doctor will do when a woman request for caesarean section?

The counter argument about how should physicians respond to or counsel patients who request for caesarean delivery has been a central theme for medical sociology for decades? Is performing caesarean delivery on maternal request consistent with good professional medial practice? Should patient choice caesarean delivery be routinely offered to all pregnant women? A number of ethical questions arrive when we talk about maternal request for caesarean delivery.
Their exist arguments in the field of obstetric and gynaecology for and against the maternal request elective caesarean section. According to the obstetricians, women will continue to come forward and request for this intervention when, in their own assessment, the benefit of the procedure outweighs its risks. The American College of Obstetricians and Gynaecologists (ACOG, 2008), in annual committee report suggested that a physician who believes elective caesarean delivery is in the best interests of the mother and her foetus is ethically justified in performing the procedure.

During my field study, I asked a renowned Gynaecologist regarding this phenomenon he opined that “education among mothers has increased mainly in urban areas. They are well aware about their health. I think an informed patient should be granted caesarean childbirth”. Some obstetricians thought that many of the women did not truly want a caesarean section but saw this as the only way to guaranty the safety of the baby or to avoid their previous frightening experience.

7.3 Economic consequences of caesarean delivery

A number of studies commonly noticed a higher incidence of caesarean deliveries in private hospitals compared to public sector hospitals. This suggests that non-medical factors such as economic gain and pressures of private practice may motivate doctors to perform surgical deliveries. The incidence of caesarean deliveries in Brazil was found to be strongly associated with the occurrence of delivery in the private hospitals as opposed to a public
facility (Chacham and Perpetuo, 1998). The analysis of secondary data based on NFHS (III) suggests that, there is an increasing picture of caesarean child birth in India mostly in private health facilities rather than public health facilities. This probably could points towards unhealthy practices prevailing in private health care for profit motive. Analysis of the data indicates that states like West Bengal, Andhra Pradesh, Goa, Kerala, the caesarean births in private health facilities are more than 40 percent. Perhaps, most of the cities, the caesarean delivery is high due to higher incidence of births in private hospitals (Surekha, 2008).

During the field study, I have asked my respondents regarding the amount given as user charges for c-section. Interesting to see that, the cost for c-section in most of cases is above 30,000 Indian rupees. Moreover, in high-quality hospitals the cost raises up to Rs. 60,000. Including the cost of medicine, the total costs increase upto nearly one lakh. Ankita, who delivered her child in a nursing home, spent almost Rs. 85,000 When asked her and her husband, regarding the economic burden to family, her husband opined that “we are powerless in front of the medical world. If we want a safe delivery of child we have to bear the cost. I know this cost we have spent is too much and it exceeds our capacity but we don’t have any choice”. Another woman from middle income family delivered her child in private nursing home opined that “in current times any surgery in good hospital or nursing home need huge amount. In my case we did not have any choice as my doctor suggested me to undergo c-section. You
In the world of medical consumerism, the person may have no choice but to undergo such burden.

7.4 Discussion:

The question of caesarean section by choice (that is caesarean delivery in the absence of medical necessity) has been immensely debated by the medical sociologist in recent years. The field study unveils some important aspect of preference for caesarean delivery from both doctor and women perspective. It can be concluded from the case study that there is an increasing demand from women for this medical intervention. Among the 20 cases it was found that, 8 women preferred caesarean birth during their delivery. In many societies in world obstetricians have had increasing requests from women or their family members to conduct delivery by caesarean section for personal rather than medical reason (Christilaw, 2006).

It is often argued that women’s socio-economic standing decide their decision making power within household. Analysis of the secondary data suggest that women with high educational background and standard of living are more likely to undergo c-section. But the case studies divulge some interesting aspects where women with both high and low socio-economic profile prefer c-section. Probably, risk aversion mechanism or fears of labour pain are important factors for preferring c-section birth than other factors.
But the main concern arrive in the case of caesarean by choice is how far the women have been informed regarding the risks and benefits of this surgical procedure. In the medical domain a physician has an obligation to present all relevant medical data to the patient to help her make a decision that is in her interest (Christilaw, 2006). This should be part of a process of open dialogue between patient and the doctor. But such discussion does not seem to take place in the case of India.

Rethinking feminist ideologies of caesarean childbirth and medical hegemony:

A careful examination of the data leads to rethink whether the feminist critique of medicalisation have the explanatory potential to the specific issue of women’s choice of mode of delivery. The feminist argue that the use of technology on women’s health mainly paralyzed women’s autonomy or decision making power. But in the current study it appears that in case of women choosing to deliver by caesarean does not necessarily a medical control but is also their own choice. In the process, the medicalisation of society is also undergoing changes in recent years particularly in childbirth.

Power and Autonomy in childbirth:

Over the last several years, as caesarean deliveries have grown increasingly common, there has been a great deal of public and professional interest in the phenomenon of women choosing to deliver by caesarean section in the absence of any specific medical indication. The issue has sparked intense conversation, as it raises a new question about the nature of autonomy in
birth in both developed as well as developing countries. In March, 2006, the National Institute of Health (Maryland) convened a panel of independent experts at a State-of-the-Science Conference to assess the available scientific evidence relevant to understand the trends in the use of caesarean delivery, the short and long term benefits, risks to mothers and babies and the ethical issues surrounding performing a so-called ‘caesarean delivery on maternal request’. The panel concluded that there was insufficient evidence to issue a recommendation concerning the relative safety of planned vaginal and caesarean births as well as women’s autonomy in birth. Autonomy, is defined as the right to self govern and act freely in accordance with a self chosen plan (Beauchamp and Childress, 2001). A woman’s experience of her caesarean birth and perception of the event, are influenced by multiple complex factors. Therefore, the reasons for which the caesarean was performed is entrenched with her cultural values, her beliefs and anticipations of the birth, possible traumatic events in her life, available social support and also her personal sense of control (Cummings, 1988; Cranley, 1983; Marut and Mercer, 1979; Sheppard-McLain, 1985) in Nicette Jukelevics.

In India, undoubtedly, the decision on c-section birth is not purely taken by the women alone but includes her family members, relatives etc and more importantly influenced by the advice of doctor. As in the case of Suman we see that she and her husband opt for caesarean as she was too aged to give birth. But this medical concern actually came from her doctor who insisted
her to opt for caesarean. So, the difference between woman’s demand and preference from doctor is thin and hard to distinguish.

However, by approaching childbirth in medical terms, pregnancy becomes an illness for which childbirth is the cure and both become the property of medical professionals. Therefore, success in childbirth is judged in terms of measurable outcomes and women seem to accept it in many instances based on the field work data. Assessing the dichotomy between the professional medical discourse explained in the previous chapter and women’s experience provides vital clues on the medical establishment’s infatuation with caesarean section on maternal request. The medical establishment’s interest in accepting the request from women for c-section merely confirms the belief that this procedure is undertaken without any hesitation. Women are thus, invited to exercise unlimited autonomy within the limited range of choices presented to them by the medical profession.

7.5 Summary:

The objective of current chapter is to explore the reason for opting caesarean birth by women. More specifically, the chapter deals with context of medicalisation and attitude towards caesarean delivery from client’s perspective or demand side of the phenomenon.

The tone of voices of women who had caesarean births it can be understood that, within society, the advent of technology has resulted in a change in women’s perceptions of pregnancy, birth and motherhood.
Therefore, the decision to undergo delivery with the help of medical intervention is even most of the time motivate by the perception of benevolent effect of medicine and technology. Moreover, familial decision plays important role in women’s lives in all stages of pregnancy and childbirth. Furthermore, it has also been noticed that not only the women from educated and economically advance section of the society prefer c-section but even women from poor uneducated families also prefer surgical intervention to have a painless child birth.