CHAPTER SIX

CAESAREAN DELIVERY – THE CONTEXT OF MEDICALISATION

“Technology accelerates our progress, but that is often only a progress towards acceleration”

Aldous Huxley

6.1 Introduction

The previous chapters discussed the current scenario of caesarean childbirth in India and states based on the available information. Analysis of NFHS data in different rounds provides information on the current level of caesarean delivery in different states in India. The role of medical or risk factors, socio-economic factors and institutional factors responsible for c-section childbirth was analysed within the larger context of medicalisation framework. However, the available information on c-section delivery in the country was highly limited and no further analysis was possible to understand the mechanism of decision making either within the health facilities or within the household in choosing caesarean delivery. Such analyses are vital to understand the motives for the increasing c-section delivery in India and to suggest policy measures.

Often the reasons for such growing incidence of medical intervention at childbirth are uncertain. There often exists debate in medical sociology regarding the causing factors of caesarean intervention. From medical
perspective, maternal characteristics such as age, complications during pregnancy, multiple gestation, late babies, and low birth weight have been greatly associated with increased rates in caesarean delivery (Burns et.al. 1995). Apart from the patient related factors, economic motives from hospitals and insurance companies also appear to shape the decision of performing caesareans (Burns et. al. 1995; Gregory et. al. 1999).

But in a micro perspective, the decision to perform surgical intervention involves interplay of different factors, institutional as well as familial decision. The institutional factors include growing medical intervention during pregnancy and delivery, reliance on technological intervention during childbirth among medical professionals.

The current chapter will throw light on these aspects of medicalisation of childbirth from institutional angle by drawing examples from in-depth interviews of medical professionals. Moreover, what are the motivational factors that lead to preference for such medical intervention will also be discussed in this chapter. Another important aspect of medicalisation of childbirth is the changing relationship between doctors and their patients. Hence, the current discussion also explains how the perception of doctors and their patients on the role of medical profession on illness changes with time. The chapter is divided into three sections. In the first section an attempt has been made to underline the concept of medicalisation in society and incidence of childbirth. The second section deals with relationship between medicalisation and growing incidence of caesarean births by drawing
examples from in-depth interviews. In this section, the perceptions of doctors both on medical intervention during childbirth and current scenario of caesarean section has been examined. It also presents a narration on different factors leading to decision to perform caesarean birth. The third section focuses on discussion on the role of *power* in medical profession and patient-doctor relationship within this context.

**6.2 Medicalisation of Childbirth - The context of caesarean delivery**

Medicalisation of human body in general has received a lot of attention both theoretically and empirically in the last few decades. The medicalisation as a process of social phenomenon encompasses the pathway of dealing with disease in terms of a medical model and individualized aetiology (Zola, 1972). In recent times, most of the women’s experience of childbearing both in developed as well as developing countries is medicalised, as birth takes place predominantly in a hospital or in the presence of a doctor. Hence, the act of birth is surrounded by all of the symbols of the medical profession and all that it stands for – science, power and knowledge (Einion, 2003).

The medicalisation of childbirth can essentially be broken down into a process which has led to childbirth becoming a medical event rather than a social one and, therefore, embraced with a negotiation of power balance between the medical world and the human society. The review of the literature has brought out some interesting aspects of increasing c-section intervention and medicalisation debate in the field of medical sociology. A
number of studies that have been reviewed mainly focused their attention towards over medicalisation of childbirth as the cause of increasing trend of caesarean delivery. They have also focused on the aspect that the institution of medicine has undergone major changes in its social organization with the advent of managed care, the power mechanism of medical professional and lay human society.

One of the current examples of this negotiation between medical dominance and patient informed choice is the debate over increasing caesarean childbirth. The growing reliance on medical technology by the doctors for simple remedial issues has become a concern in present times which also can be noticed in case of maternal health. The doctor’s power over their patients on the decision to perform any surgical procedure during delivery of child many a times depends on a number of factors. These factors are medical emergencies, economic motive and attitude towards technological intervention. The current chapter, therefore, attempts to focus on such issues behind the performance of caesarean procedure during childbirth from the point of view of medical professionals. In doing so, firstly the discussion will focus on the perceptions and attitude of the medical professionals towards preference for caesarean intervention during childbirth.

6.2.1. *View of Medical professionals towards caesarean intervention*

Medical interventions in childbirth, including c-section are many often carried out for medical emergency. Normally caesarean section is recommended
when vaginal delivery might pose a risk to mother or baby. Some of the conditions that may require birth by a caesarean section include breech or transverse presentation of the baby, placenta praevia or maternal conditions (such as high blood pressure or high age). In this regard some studies in public health and medical sociology suggest that, the increase in complications during pregnancy and delivery in many cases contributes to the increase of caesarean childbirth (Cai et al, 1998, POST, 2002).

Nevertheless, some researchers believe that the rate of caesarean birth is increasing due to profit motive of private hospitals and nursing homes. The increasing scenario of this medical intervention in urban areas and private hospitals creates suspicion about the efficacy of this procedure without any medical emergencies. Hence, it is true that with the advances in anaesthetic services and improved surgical techniques, the morbidity and mortality of this medical intervention have come down considerably. This has, indeed, wrongly, emboldened obstetricians to perform more and more caesarean section, even in cases not warranting medical emergencies. Point to be noted here is that, this over-relying on technological intervention has been defined by many medical sociologists as medicalisation of society which can be viewed from institutional angle of medical profession and, on the other hand, from lay human society. The current study, therefore, is an attempt to understand the perception of medical professionals on the aspect of caesarean intervention during delivery and what other factors that affect the decision to perform this other than medical emergencies.
The field study consists of in-depth interviews with the Gynaecologists in different health facilities for a better understanding of the process of medical intervention during childbirth. Altogether, eight interviews have been conducted, of which four are drawn from public hospitals and four from private health facilities in Kolkata. The first part of the discussion focuses on the views of doctors towards this medical intervention from both private as well as public health facilities.

6.2.1.1 Perception among the doctors from public health facilities:

West Bengal is also experiencing an increasing trend in caesarean childbirth over the last few years, particularly in private health facilities. The analysis of NFHS data showed that nearly half of the deliveries are taking place by c-section in many private hospitals raising concern of maternal health scenario. The interviews with the doctors focus initially on the explanation towards such trend. Therefore, in the interviews, doctors are asked whether they agree on the increasing c-section in West Bengal. They have also been asked to elicit possible explanations for such trend. Doctors are also asked about the effect of growing privatization in health care and increasing caesarean delivery.

A majority of the doctors were of the opinion that there is an increase in the proportion of caesarean childbirth. However, there are disagreements among them on the factors contributing to the increase. On the one hand, doctors emphasized medical factors for the current increase, at the same time,
some doctors preferring social and economic factors responsible for the increase. It has been noticed from the interviews that doctors from public health facilities mainly stressed on medical reasons for such an increasing scenario of caesarean childbirth. Doctors were also asked about their opinion on the growing privatization of health care and its impact on caesarean delivery. The opinions among the doctors from different health care facilities have been analysed in the following section.

The doctors from public health facilities uniformly were of the opinion that the performance of c-section increases due to medical complication and necessity. A senior gynaecologist emphasised the medical reason for the increase of c-section childbirth. “Yes I am aware that c-section is increasing but that is due to increasing medical complication”, the doctor remarked. Another senior gynecologist and obstetrician also stressed the medical causes for the increasing c-section births. The doctor emphasised the factors such as, pregnancy at higher ages, sedentary lifestyle and obesity as medical causes of increasing c-section in recent times. Pregnancy in higher ages may cause a number of anomalies to the foetus such as intrauterine growth retardation, distress or breech presentation. Therefore, for better outcome in delivery and to save lives of mother and baby doctor has to perform caesarean delivery.

On the other hand, acceptance of medical technologies to combat with any kind of emergencies and complication had increased in the past few years as part of improvement of scientific knowledge. According to another gynaecologist, “Surgery is performed by doctors when they believe it is
clinically justified and in accordance with accepted medical practice. And I think that as medical technologies are improving day by day it has the capability to prevent maternal and child death and hence, caesarean delivery is increasing and not due to merely money making”.

As already pointed out, doctors from public hospitals mainly stressed on medical complication as the major cause behind the increasing scenario of c-section; they disagree with profit motive of private hospitals for such a situation. A doctor from public hospital argued that “there is no question of money making. Today c-section is increasing because of medical complications such as high age, obesity, complications during pregnancy. Doctors know better than anybody else as to what to do in critical condition of mother. We have to perform c-section to save mother’s and baby’s lives”.

The above excerpt of interviews are all from public hospital doctors and it is somewhat clear that they are more likely to be of the opinion that the caesarean section is increasing only due to increasing pregnancy complications and not due to merely money making of the health care providers. Moreover, according to them medical technologies should be used only based on doctor’s preference mainly in cases of emergencies.

6.2.1.2 Perception among the doctors from private health facilities:

Doctors from private health facilities are also of the opinion that the current scenario of caesarean childbirth is increasing in West Bengal. But they have mostly stressed on social and economic factors for such a trend. Moreover,
according to them, the social and economic development in the state has
grounded to the hospitalized births mainly in urban areas and increasing use of
medical technologies during childbirth. The most important factor that has
been highlighted by the doctors is education of women and late marriage.
Senior gynaecologists, Apex Institute of Medical Sciences were of the view
that, “education among mothers has increased mainly in urban areas. They
are well aware of their health needs. I think an informed patient should be
granted caesarean childbirth”. Another Gynaecologist from a private nursing
home was of the opinion that “patients are educated and well informed. I
discuss with them the risks and benefits of caesarean section versus normal
vaginal delivery. In present situation doctors don’t want to take chance”.

C-sections are usually reserved for cases in which vaginal birth could
put the mother’s or baby’s lives at risk. But there is a sea change in this
outlook, and the procedure is now considered to be safer than a normal
delivery. “No one wants to take chances; even doctors want to be more
cautious. In most vaginal deliveries, some element of risk is involved’ says
Gynaecologists at Ballygaunge Maternity Home. Another important factor for
increasing caesarean births is attributable to the changing socio-economic
realm of the society. “We have improved medical technologies and we should
use it. Women, too have become a lot more comfortable with having a c-
section, and many prefer it to natural birth”. The concept of medicalised birth
rather than normal birth gradually is taking place in society due to improved
technologies and better outcome in pregnancy and delivery. Although, it is
not clearly justified in medical literature that c-sections are no riskier than normal births. A number of literatures pointed out that both mother and babies are at risk when a woman gives birth by c-section because of major abdominal surgery. Women’s demand or preferences for such a delivery and sometimes doctor’s fear of malpractice have also been listed as important causes for growing caesarean births.

Another important factor is giving birth on some auspicious day. To quote a doctor from private hospital, “More and more women are requesting an elective caesarean, either for the sake of convenience in timing of birth or in hopes of avoiding pain during labour”.

Hence, in most of the cases it is not very easy for doctors to take the decision for surgery as they have to convince their patient about the benefit and risks of caesarean births. Pediatrician from Woodlands Nursing Home clearly mentioned that “women have been increasingly choosing caesarean section for reasons such as avoidance of labour pain, and many a times we warn them about possible medical consequences about this surgical intervention. But in present times, public perception of caesarean section has seen a swing from a failure of obstetric care to being safe for mother and child. And hence, this procedure is gaining importance day by day”.

On the other hand, patient or health care provider convenience, legal concerns of the health care provider, business oriented private hospitals and nursing homes, the scenario is also changing. According to a gynaecologist, in
some cases doctors feel more vulnerable to malpractice lawsuits if something were to go wrong during a vaginal birth and caesareans are seen as a safer alternative where the physician has more control.

Studies in medical sociology point towards the fact that, medical practice in current times has taken control over a large part of the society. While analyzing the interviews of the health professionals it can be conclusively said that reliance on medicine and medical technologies have increased over the past few years. In the next section a discussion on different factors behind the performance of c-section has been presented.

6.2.2 Factors of medicalisation

The possible factors that facilitate medicalisation process in society have been identified by various medical sociologists and social analysts. Foremost among these, on the ‘supply’ side is the prestige and power of medical profession. It is well known that the medical profession gained great influence and authority in the first half of twentieth century, attaining both professional dominance (Friedson, 1970) as well as cultural authority (Starr, 1982 cited in Conrad, 2004). Hence, professional dominance and medical monopolization gave medicinal jurisdiction over the so called ‘health’ or ‘illness’ (Friedson, 1970). Studies of problem ranging from childbirth (Wertz and Wertz, 1989) to child abuse and the rise of behavioural paediatrics (Pfohl, 1977 and Halpern, 1990 cited in Conrad, 2004) all profess some kind of intra-professional explanation for the rise of medical dominance.
On the ‘demand’ side of medicalisation, there has been a growth in consumer demand for medical solutions. According to Busky and Borus (1995) the public tolerance for mild symptoms and benign problems has decreased, spurring a progressive medicalisation of physical distress in which uncomfortable body states and isolated symptoms are usually classified as ‘disease’. On the other hand, patients have become more knowledgeable, demanding and critical of medical care prompting towards a new phenomenon of medical consumerism. Moreover, important changes have occurred in health care in the last centuries, especially the increased corporatization of health care (Light, 2000). According to Light the concept of ‘countervailing power’ emerged to describe the changing power balance among the medical profession and related social institutions. As other arena of health care this shift in power balance also has noticed in reproductive technologies where negotiation for a surgical procedure used during childbirth follow a tow-directional line which has been discussed in the last part of this discussion. However, the Current chapter explicates the supply side of medicalisation induced by the power of medical professionals. A discussion on how different factors motivate doctors to perform a caesarean section other than medical emergencies has been discussed. In the analysis only names of the hospitals have been given.
6.2.3 How risks, benefit and liability issue impact the recommendations for the mode of birth?

1) **Risk aversion mechanism:** The most debated and discussed cause for preference of caesarean delivery is perhaps the risk aversion among medical professionals. Today, this medical intervention has received a lot of attention among obstetricians and gynaecologists for a safer mode of delivering the child and to avoid maternal mortality. In the interview question was asked as to why doctors feel caesarean is safe. An obstetrician from private nursing home opined that ‘I feel today we have modern technology and all the medical gadgets which can help in easy surgery. So why to take chance? We should tell our patient to undergo this surgery rather than suffering’. As discussed earlier, there always has been a difference in the opinion among the doctors from public and private hospitals. A doctor from public hospital stressed more on growing health problems as risk for caesarean birth. In his opinion ‘women are getting more and more health problems due to sedentary life style and high age at marriage. Therefore, many a times they are at high risk of pregnancy and come to us at last minute. As we can not take chance of failure in delivery and have to perform caesarean section’. Another doctor from the same hospital emphasized on the fact that “if already a high-risk patient comes to us just at the last hour we can’t do anything except performing c-section”.

It is well known a fact that surgical intervention during delivery of child is usually performed to ensure safety of mother and child under conditions of obstetric complications. Although, it is under doubt that in such cases how far women have been intimated or informed about the surgical procedure and related risks before delivery. If doctors advise for c-section delivery due to medical emergency then there is no choice left to patient or her family member.

2) C-section for medical convenience: There is evidence to suggest that medical intervention in childbirth, including caesarean section, are sometimes, carried out for reasons such as convenience for the medical practitioner rather than the medical need of the woman concerned. A doctor from a nursing home clearly mentioned that, in her clinic many a times caesarean delivery is performed based on availability of medical staff such as anesthesiologists, general surgeon. She stated that, “this is a major surgical procedure which needs a number of medical staff, anesthesologists, pediatrician and other specialists. Many a times it is impossible to get them all at a particular time but we can’t wait for long time when the expectant mother is having labour pain. We just take decision to perform surgery”. The main factor behind this is too much reliance on medical technology which has gained immense importance in the last decade with a tremendous improvement in medical technology.

Although, it has been noticed that the concept of medical convenience for the performance of c-section, dominated among the opinion of the doctors
from private health facilities. When I asked about this to a doctor from public hospital he simply disagreed with the fact and told that, the preference of this surgical procedure is due to medical convenience can be noticed in small nursing homes or private hospitals but in public hospital this situation is rare as public hospitals have large number of specialists and doctors.

3) **Anxiety and Fear of litigation**: Fear of litigation or anxiety among the medical profession is an underlying factor in intervention rates in childbirth generally. Because, if there are problems associated with the birth and doctor is not able to handle then he may be sued for that (Churchill, 1997). Therefore, doctors feel more vulnerable to malpractice lawsuits if something were to be wrong during a vaginal birth and caesareans are seen as a safer alternative because the physician has more control. A doctor from public hospital stressed on the fact that in current times doctors from private hospitals or nursing homes have the risk of getting unnecessary troubles if they fail to perform successful surgery. Because, according to him, if a caesarean is carried out, any resulting problems (including death of mother and baby) are considered to be a normal risk of operation. He also stated that “there have been occasions where an obstetrician has been manhandled for a poor outcome and blamed needlessly for not having performed a caesarean section”. Hence, medical professionals prefer caesarean intervention rather than risky normal delivery. Therefore, it is argued that defensive medicine is responsible for the high caesarean section rate in private practices in the case of western countries.
4) **Technological management of labour:** One of the important aspects for the increasing rate of caesarean delivery is the technological management of labour. In the arena of medico-technological improvement, doctors and other health professionals frequently use technology in managing labour. Evidence suggests that, this introduction and use of technology had changed the milieu, whereby, earlier management of labour and reproduction by female midwives shifted to male dominated skilled delivery.

According to lady gynecologists from a nursing home, “with the improvement of medical technology we detect the problems much earlier and more easily. The cardiogram of the unborn child can be monitored. Decreased blood supply or an odd position or any other small problem can easily be detected. During delivery of a woman through caesarean section we extensively look in all these matter very professionally. And moreover, patient as well as doctor wants to be on the safer side”.

5) **Consultant’s preference and prestige issue:** The different rates of caesarean section between countries, region, hospitals and individual consultants have been blamed on the failure to establish basic principles regarding technological intervention during childbirth. In a medical institution, it is important issue for gynaecologists and obstetrician to maintain their prestige (Burns et.al. 1995). According to a gynaecologist and obstetrician, doctors don’t want to take chance which will spoil their good name. Therefore, in any case, whether it is in emergency or not, they straightaway go for technological intervention. It appears that individual
physician characteristics do influence caesarean section rates significantly, including factors such as place of medical education and place of practicing.

In the decision making for performance of caesarean delivery the above causes play role in different combinations. Following is an excerpt from the case study in which the decision for c-section was taken based on mainly doctor’s preference.

Namita (name changed, 27 yrs) had delivered her female child by c-section in Apex Institute of Medical Sciences. It is a private health care complex (popularly known as hospitex). She delivered her child under the supervision of famous gynaecologist. She is MA in English and school teacher by profession. She is from a good income family.

In her words…

“When I realized that I am pregnant I immediately went to a doctor in my locality with my husband. But doctor referred me to go to the Apex and visit the Doctor, famous gynaecologist. We went for check-up in his chamber. He told me that as I am 27 years old may be I may encounter some problems during delivery. Therefore, it is better for me to undergo c-section. He also suggested that as we both are employed there is no money constraint. I also thought over this matter and decided for c-section. This procedure is safer than normal delivery which is very painful and also safe for my child. And we didn’t want take any chance for our only child. My husband also insisted me to go for a c-section. And in this hospital, the facilities are also very good. Yes, we paid a good amount of money but that is negligible before the happiness”.
Many women would not question a doctor’s authority; particularly they are told that the treatment they are receiving is in the best interest of their soon-to-be born baby. Furthermore, a few women would be willing to take responsibility for their decisions when the impression they get from the medical practitioners is that they will ‘wash their hands’ off if they do not comply with medical advice (Churchill, 1997).

6.2.3.1 The decision making process in childbirth

The recommendation for the mode of delivery whether it is normal or surgical entails a number of factors that necessitate an in-depth understanding. In current medico-social domain where health care has become more consumerised, interviews with the doctors depict a picture of negotiation of mode of delivery between professional medical world and patient’s family. It is evident from the discussion with the medical professionals that performance of caesarean delivery does not always necessarily depend on medical emergencies. Rather it is an interplay between doctors and their patients on the notion of possible risk and benefits from this medical intervention.

6.3 Discussion

Reasons for c-sections range from life-threatening emergencies to simple convenience to threats of malpractice. The most important institutional factor which trigger the rate of c-section is growing reliance on technological intervention during childbirth which actually is an outcome of medicalisation.
of society. The current chapter elucidates different factors behind the preference for c-section procedure rather than the medical one.

Interviews with the Gynaecologists enlightened on some important issues. Firstly, all of them agreed on the issue of increasing caesarean childbirth, though factors for such increase are different. Secondly, there exists disagreement on the factors for such an increase. Doctors from public hospitals stressed on medical factors for the current scenario. Whereas, doctors from private health facilities were of the opinion that social and economic factors are more important for the increasing c-section birth.

The Gynaecologists were asked to describe medical causes of c-section delivery. The major causes that were reported by the doctors are high maternal age, obesity of mother, breech presentation of baby. Pregnancy in high age may cause a number of anomalies to the foetus such as intrauterine growth retardation, distress or breech presentation. In such cases doctors have to perform c-section to save both the lives of mother and child. Existing body of research also reveals the fact that medical intervention is more or less justified under certain circumstances such as breech presentation, dystocia, previous caesarean section and suspected fetal compromise (Baskett and McMillen, 1998).

Reasons for performing caesarean delivery vary among the opinions of doctors. Some doctors indicated pregnancy in later age, breech presentation and obesity of mother trigger caesarean childbirth, whereas, others emphasize
on previous c-section delivery, unbearable pain as important factor for c-section. The main aspect of the performance of this surgical intervention lies on the interplay of power and decision making process in medical world.

6.3.1 Power in childbirth: The medicalisation of women’s bodies established childbirth as a specialized field where only doctors have appropriate knowledge. The debate on the notion that the medical profession possesses superior knowledge in matters relating to childbirth prevailed in many societies in the west.

The debate over increasing medical technology since many years reign in western medical sociology, though, none had focused in the context of developing countries like India. The increasing scenario of caesarean childbirth in many states in India in current times perhaps indicates towards growing use of medical use during child birth in mostly private hospitals and some public hospitals. Is that power in medical profession matters? Or there could be a demand from women for the use of technology in childbirth. But what factors lead to such an intervention is not clear. The study therefore, tries to focus on the factors behind the use of medical intervention during childbirth from the point of view of medical professionals mainly the gynaecologists and obstetricians.

Now the question that comes to mind is what do we mean by power in medical profession? According to Churchill (1997), power is an important element in the differing experiences and expectations of the medical
profession and women as receivers of maternity care. Studies have shown that, perhaps there could be an unequal relationship between the two, in which doctors still hold the power. Women are expected to be passive in the labour room, with insufficient information to make choices about their health care. The technological management of childbirth also enables doctors to extend power over other professional groups within the hospital hierarchy. Because, when the decision is made to use technology to deliver a child, most of the time control is taken out of the hands of everyone except the obstetrician. This condition perhaps clearly depicts the concept of orthodox medicalisation whereby, medical profession hampers individual’s autonomy and social life and social problems become more and more medicalised, or viewed through the prism of scientific medicine as disease.

As already discussed in the review of literature, the theoretical debates in literature on the contributing factors of such medical intervention mainly focus on two aspects - motivated by health care professionals and demand evaluated from women. Most of the studies emphasised the role of health-care institutions in augmenting the c-section delivery. However, the changes taking place within the family and community and its likely consequences on c-section delivery has not received adequate attention. Moreover, the negotiation for performing a surgical intervention between medical professional community and lay society is another important arena of discussion.
6.3.2 The patient-doctor relationship

One of the examples of medicalisation of health is patient-doctor interaction in the negotiation of health care. Over the past few years, as medicine world has undergone tremendous changes, the evolution of society from health care to health consumerism also made its foot prints. Gain, in a micro perspective, the interaction of women and obstetricians on the experiences and outcomes are very different. Women and medical profession, it has been argued, have a qualitatively different view and experience of childbirth (Nettleton, 2006).

Graham and Oakley (1986) have described different frames of reference between doctors and women which refer to an ideology, i.e. a system of values and attitudes through which pregnancy and childbirth can be viewed. The main aspect of medicalisation from institutional angle is ‘doctor knows best’ which implies the idea that reproduction is a specialist subject about which doctors are the experts. A further dimension of this reference in which, women are typified as patient and care during pregnancy and childbirth referred to management of labour concise the idea of medicalisation from a societal angle. Analysis of the in-depth interviews with the gynaecologists portrays the context of medicalisation from purely institutional angle. A common notion about women as a patient and use of technical intervention during childbirth, hitherto, points towards power in medical profession.
6.3.3 Consequences of c-section delivery

In current times, caesarean section as live saving mechanism for mother and her child has gained immense importance in the field of medical sciences. Performing caesarean for breech presentation, premature babies, preventing HIV transmission is justified under certain medical consideration. According to senior gynaecologist, BNR Hospital, caesarean can be life saving in very high risk cases, although it involves a number of risks to mother and baby if performed inappropriately. Doctor’s opinion varied considerably regarding the consequences of c-section. Doctors mostly pointed towards physiological consequences of both mother and child. Though, it is difficult to unearth the magnitude of various pros and cons of emergency c-section and c-section on demand or elective c-section. Following are some consequences listed by the doctors:

6.3.4 Economic consequences:

One of the most important non-medical consequences is economic problems faced by patient and her family. In the era of medical consumerism, health care cost is increasing day by day in both developed as well as developing countries. Studies suggest that, women not only from higher income families demand for c-section, but a considerable proportion of women from middle income families or sometimes from lower income families too prefer for this medical intervention. But what could be the reason for this is not clear. It is possible that, fear of substandard care is behind many poor women’s
preferences for a c-section. On the other hand, educated women from middle income families are much conscious of their health and child health. Therefore, paying for healthcare sometimes becomes more important than its cost. According to a gynaecologist and obstetrician of BNR hospital “C-sections have longer stays in the hospital which is costly in many private hospitals”.

The high rate of c-section delivery in the private health facilities clearly indicates a point towards profit motive of the health care facilities behind the performance of such medical intervention. The financial factors lead to increases in the caesarean section rate and may act against the best care being given to pregnant women. In most of the cases c-section required high cost in addition to medicines and a long hospital stay. It has been noticed from the case studies that, women who delivered their child in private hospitals had to pay a substantial amount of money to the health facilities. Because, where payment is involved in health care it is more lucrative for the doctor to perform a caesarean as it can be done in a shorter time than a normal delivery and hence, the doctor will be paid more (Francome. C. 1990). There exists an increasing consumerism in health care which affected women’s health. A number of studies point that wealthier and insured groups of the population suffer higher rate of caesarean section than their lower socio-economic counterparts (Stafford et.al. 1993, Keeler and Brodie, 1993). This suggests that profit has become a valid indicator for caesarean section rather than medical need or concern for the woman involved. Moreover, faith on modern
technology and medical dominance works hand in hand in the society. But who will benefit from this milieu of medical market, a woman or health care facilities? Many a times this surgical procedure creates huge financial burden on patient and her family. In urban set-up like Kolkata, currently in any good private hospital or nursing home the cost of c-section is above Rs.50,000/-. But there could hardly be any secondary estimate on which policy for maternal health development can be modified.

6.4 Summary

The main objective of this chapter is to explain the aspects of medicalisation of childbirth from institutional angle by drawing examples from in-depth interviews with the gynaecologists. It also discusses the motivational factors that lead to preference for such medical intervention in an urban context. The overall idea we get from the conversation with the medical professionals is that there exists a dependence on medical technologies for childbirth for various reasons. This scenario perhaps shows us the context of medicalisation of health which entails the argument put forward by Foucault (1977) or an medical profession. From this perspective, medical power may be viewed as the underlying resource by which diseases and illnesses are identified and dealt with. In the course of medicalisation of human health, the exercise of power by medical professionals in the field of medicine and body politics creates a disciplinary apparatus that operates through manipulation, subjugation and regulation of bodies.
However, it is important to mention here that increasing use of medical technologies during childbirth is not only a decisive mechanism of health professionals but also an accepted notion in society which entails interplay of power and decision making in a larger context. Analysis of the case studies explains that, risk aversion mechanism works in many cases regarding the acceptance of c-section, which will be discussed in the next chapter.