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Choosing Surgical Birth:
Personal Choice and Medical Jurisdiction

Alexandria Vasquez
Virginia Commonwealth University
Master's Thesis

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Abstract

This is an exploratory study of women's childbearing decisions and outcomes in non-medically indicated cesarean section childbirths (CS). Focusing on the structure-agency dichotomy, the research is guided by Anthony Giddens' theory of structuration used in the context of the medicalization framework in order to analyze elements of personal choice and medical jurisdiction in childbearing methods. Quantitative analysis of secondary data and a thematic content analysis of Internet forums are conducted in order to analyze women's perceptions of autonomy and constraint in their childbearing decisions and outcomes. The findings suggest that the polarization between second- and third wave feminist critiques on medical intervention in childbirth, and between structure and agency, impede our understanding of the complex phenomenon. Applying structuration theory to the medicalization framework helps to work through this polarization, further lending support to third-way feminism.

Introduction

A cesarean section delivery is the surgical delivery of the fetus through an incision in the abdomen and uterus. In the United States, one out of every three women will undergo a cesarean section delivery, which is twice the number recommended by the World Health Organization's (WHO) estimated projection for developed countries (Declercq et. al., 2006). Though many scholars attempt to explain the rising cesarean section delivery rate, this study focuses on the perceptions of women who undergo cesarean section delivery without medical indication (CS). In exploring this phenomenon, there is a contrasting division within the theoretical and substantive literatures that explain the decision in terms of individual desire, or the dominance of the medical industry and profession. This paper seeks to further explore these arguments and the extent to which each factor influences the other. To aid in resolving this issue, Conrad's theory of medicalization is interpreted through Anthony Giddens' theory of structuration. I argue that utilizing these theories facilitates a better understanding of how women exercise agency in their childbearing decisions, while at the same time attending to the institution of medicine.

There are three reasons to utilize Giddens' theory of structuration to explain medicalization. The first is that many critics commonly utilize medicalization to explain how the institution of medicine gains sovereignty. Although Conrad suggests there are multiple "drivers" of medicalization, including consumers and the pharmaceutical industry, much of the literature on medicalization assumes that the institution of medicine is hegemonic, and that the rise in medicine has occurred primarily at the structural level (Inhorn & Balen, 2002). This is a narrow interpretation of medicalization, and thus a utilization of Giddens' framework is intended to bring attention to both the macro- and micro level processes in Conrad's medicalization framework. Second, because medicalization expands through actions of both the lay public and the medical industry, utilizing Giddens' framework will aid in bridging together the polarization within much of the literature, which suggests that medicalization is the result of either the choice of the individual *or* the intentional strategies of the medical industry and profession. Giddens' theory will enhance Conrad's framework and resolve the disconnection within literature and current theories of childbearing trends by focusing on the combined importance of both structure and agency. Lastly, interpreting the medicalization framework through a theory of structure and agency will impart a richer understanding of the process of the medicalization of childbirth. To

give credence to both aspects of medicalization, this paper explores structure and agency in non-medically indicated cesarean section deliveries (CS hereafter). By focusing on both axes, we can explore a fuller scope of the phenomenon.

The next section provides the rudiments of feminist approaches to the medicalization of childbirth. Through this analysis, it is suggested that second- and third wave perspectives polarize the phenomenon by utilizing certain facets of medicalization, and not fully embracing all of its aspects. Following this summary, a review of the literature on women's decisions to undergo CS is provided in order to highlight how women make decisions in their childbearing practices and the role of the influence of the institution of medicine. This paper illustrates how the medicalization thesis can explain this phenomenon by extracting it from a structure-agency standpoint. Giddens' theory of structuration informs the question of why these women choose a CS delivery, accounting for the aspects of the phenomenon in terms of individual choice as well as medical profession influence and constraint. Following the theoretical overview, research is presented that examines how women perceive their exercise of agency while also reporting pressure and/or influence from healthcare providers in their childbearing decisions and outcomes. The paper concludes by discussing policy implications and directions for future research.

Polarizing Feminist Frameworks

The medicalization of childbirth has been an area of concern for feminists—originating with second-wave feminism's attempt to draw attention to U.S. women's reproductive rights, access and autonomy, predominantly focusing on access to abortion and contraception. Second and third wave feminist debates surrounding childbirth intervention have undertaken another unique dimension less concerned with rights and access, but instead the processes that impact women's birthing methods and outcomes. This section briefly highlights second- and third wave feminist critiques on the medicalization of childbirth in order to better understand the differing positions of these two standpoints, beginning with second wave feminists' structural argument and moving toward third wave feminists' individual agency standpoint. Following this, third-way feminism is introduced as the mediating synthesis of the two, followed by a discussion of the polarizing differences between second- and third wave critiques of childbirth.

Second Wave Critique

Second wave feminists argue that the intervention of medicalized childbirth has led many women to experience more pain, confusion, and ultimately less control over their own birth (Beckett, 2005). Second wave feminists maintain that the pathologization of childbirth has created a rationalized, technocratic order where women's bodies are seen as predictable machines as opposed to natural beings (e.g., Davis-Floyd, 1992; Leavitt, 1984; Reissman, 1983; Rothman, 1982). They further contend that it is not the physical process of labor in and of itself that causes pain, but rather the fear of labor—a theory popularized by obstetrician Grantly Dick-Read's book, *Childbirth Without Fear*. The second wave perspective on childbirth suggests birth is a natural process that should not involve medical intervention (Beckett, 2005). From empirical findings, the second wave perspective suggests childbirth can now be understood “in historical and political terms as a response to the medical profession's pathologization of birth, as well as to the use of technology and application of norms that render birth a ‘high risk’ event” (Beckett 2005). To second wave feminists, the consequences harm all women as it has become customary for any woman to give birth in a hospital setting with unnecessary medical intervention (Childbirth Connection, 2006). Finally, second wave feminists suggest that utilizing medical technologies has further harmed women due to manipulating their perceptions of childbirth as a medical event.

Third Wave Critique

In opposition to the second wave perspective on childbirth, third wave feminism argues that the former perspective idealizes natural childbirth (e.g., Annandale and Clark, 1996; Shapiro, 1998; Talbot, 1999). Third wave feminism responds by insisting that natural childbirth imparts more harm on women physically and psychologically by placing stress and guilt on them to perform without drugs under a very intense and painful procedure. To third wave feminists, natural birth activists campaign for a moralistic birth, which they find problematic. They maintain that morals are not an essential element of the childbearing process, and thus the

valorization of natural childbirth fails to consider childbirth as a burden on women, and not something they have to believe defines their very being. Beckett writes:

The idea that women do (or should) savour, enjoy, or feel empowered by the experience of labour and delivery, they argue, romanticizes women's roles as lifebearers and mothers, and assumes an emotional and physical reality (or posits an emotional and physical norm) that does not exist for many (Beckett, 2005).

Ultimately, childbearing is something women must do if they are to have children, with the exception of adoption and surrogate motherhood arrangements. Men do not bear this burden. Thus to place more stress and emphasis on the empowerment of childbirth is to define women in terms of their reproductive capability.

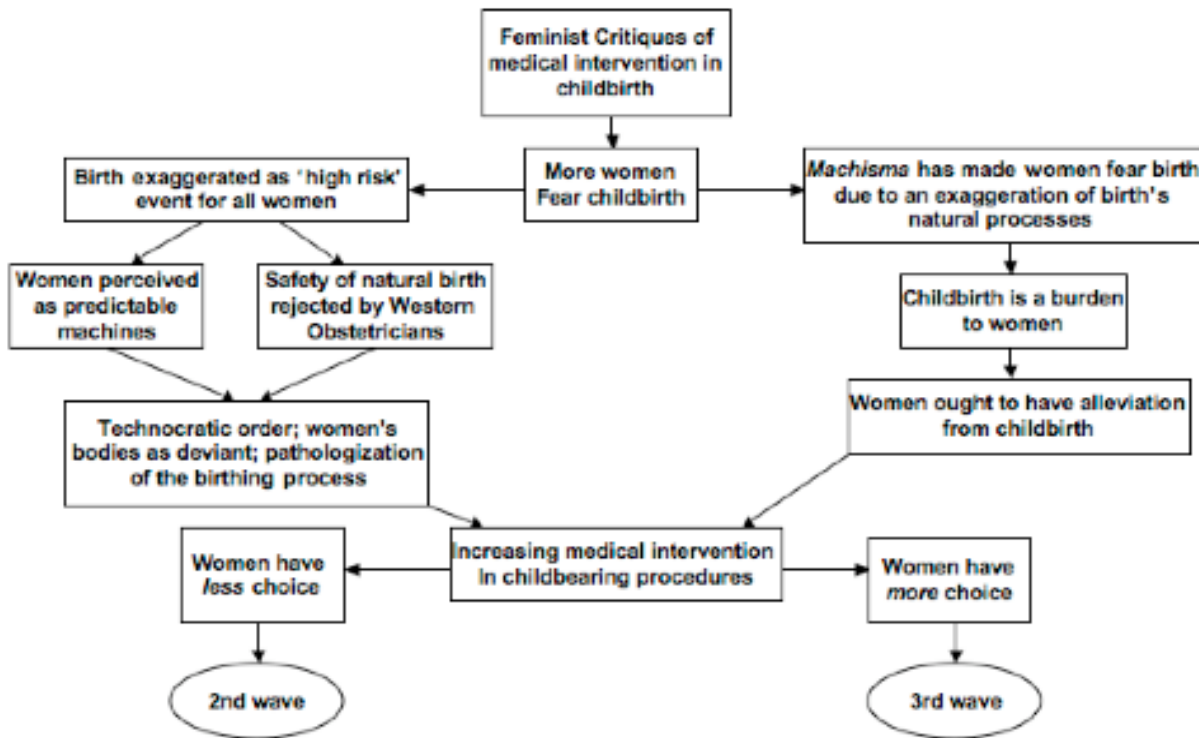
The third wave perspective on childbirth views the natural birth movement as being overly *machisma*—idealizing an aggressive pride in femininity—as it reinforces excessive and unnecessary femininity by emphasizing childbirth as a defining moment in women's lives, a time where women prove to themselves they are an authentic woman (Beckett, 2005 Bergeron, 2007; Frost, et. al., 2006). Third wave feminists argue that this kind of logic is harmful to women—physically and emotionally—when it comes to childbirth. Nina Shapiro further supports this notion when she states, “Isn't it interesting that the movement that's supposedly feminist is the one that insists on women feeling pain?” (Shapiro, 1998). In sum, third wave feminists refute the idea that natural childbirth is the ultimate and best option for women. Instead, they believe medicalized childbirth has proven beneficial for expecting mothers by providing less painful, more manageable, and lower stress births for those who seek out this alternative. In this regard, they contend that a woman should have full autonomy in choosing what mode of childbirth is best for her and her unborn child, and to take away or criticize this right is oppressive rather than feminist.

Third-way Synthesis

Second- and third-wave feminism present two major positions that imply dramatically different perspectives on the relationship between women's desires and non-medically indicated

CS deliveries (See: Figure 1 below). The second wave perspective suggests that these deliveries are the result of the medicalization of childbearing practices and their high incidence implies that women’s laboring process is manipulated by technocratic advances in medicine (Beckett, 2005; Bergeron, 2007; Frost, et. al., 2006). Put differently, the first perspective represents a colonization of women’s bodies by the institutional forces that comprise the medical establishment. The second perspective, representing third wave feminists, admonishes us against romanticizing childbirth and claims that technological assistance helps to reduce the stresses and strains of labor, and hence is not only legitimate, but provides clearly desirable aids to the birthing process (Beckett, 2005; Miles 2007; Shapiro, 1998). Why, these feminists ask, would women go without the modern conveniences that help them to avoid pain, reduce the duration of labor, and provide other technologically inspired comforts?

Figure 1: Second- and third wave feminist critiques of medicalized childbirth



While important in their own right, the two perspectives have polarized the debate on CS deliveries between an emphasis on agency (third wave feminists) and structure (second wave

feminists). The ideological disagreement creates a significant problem, as it directs attention from helping women in need of better solutions to 21st century childbearing problems. Additionally, these perspectives create dilemmas when connecting theory to practice and research because they argue against one another, creating tension where research suggests complex, overlapping explanations. The post-structural feminist perspective of third-way aids in alleviating this tension by approaching the phenomenon from a harmonizing, yet pragmatic standpoint—encompassing both aspects of the debate on medicalized childbirth and aiding in progress toward solutions for a multi-faceted and complex phenomenon. Third-way feminism, which traces back to the Hegelian dialectic, is a theoretical position of understanding the thesis, antithesis, and synthesis in social phenomena (Gray and McPhillips, 2007). In this regard, second wave feminism is the thesis, third wave feminism is the antithesis to the thesis, and third way is currently the synthesis of the two as it incorporates both positions.

Arguably the centrist position, third way feminism can be defined as the infant movement in feminist theory that contributes to the synthesis of structural and individual level processes that influence women. This framework recognizes various social institutions that comprise the larger social structure, as well as women's own agency, reflecting their internalization of external structural influences. These influences are further produced and subsequently influence social structure, eventually again reflexively internalized by the individual. There is no finalized result, but rather results that contribute to the process of social reproduction. The application of third-way to prostitution (Cavalieri, 2011) provides an example of how it can be applied to medicalization. In the process of third-way, women acting on a perceived autonomous desire are also aiding in the (re)production of social phenomena that may have an impact on their very own wellbeing and power. Yet, to also recognize women as genuine subjects acting on their own will has substantive and theoretical significance, as it posits women make decisions for themselves without the acknowledge of external influence. Third way feminism contends that where structure influences women, and where women influence structure, is difficult to differentiate, as it suggests a synthesis through which structure and agency work together in shaping social phenomena.

Because both second- and third wave theories offer significant and powerful contributions, third-way feminism does not attempt to obliterate their positions. Rather, in

removing the warfare of their conflict, third-way feminism extracts the power of each argument and conjoins them together. As Shelley Cavalieri explains:

A middle way between these two opposing theoretical positions must embrace the strength of both models, using each theory to bolster the other in substantive ways. If reconciled, the liberal appreciation for individual experience and the poststructuralist aware of the need for individualized intervention can resolve the flaws of dominance feminism's universalized account. Similarly, reconciling aspects of liberalism and dominance theory permits the use of the class-based analysis of dominance feminism to overcome the liberal failure to provide a cogent description of the social nature of the oppressions... (Cavalieri, 2011)

As Cavalieri contends, both theories aid in alleviating problems within the other, yet they instead interpret the other as being oppositional rather than complementing. Cavalieri argues in her rendition of third-way feminism that women make individual choices, while also conjoining the structural dominance of gender and power. Thus, as women make decisions based upon their own individual desires, they are still influenced by deep-rooted institutionalized notions of gender, which inherently influence their desires.

A third-way approach to medicalized childbirth might examine how women make decisions based upon autonomous desire, while also recognizing the larger institutional influences on these desires. Cavalieri utilizes the individualized element of social phenomena by suggesting that even "agentic action" is oppressive (Cavalieri, 2011). However, unique from other third-way feminist approaches, such as Kathryn Abrams' (1999), which focus on defining agentic actions, Cavalieri removes the debate from variations between agency and structure, and insists on a synthesis of each in order to understand phenomena from a wider perspective. In sum, a synthesis might be more beneficial in understanding the phenomena as many aspects of the debate (Cavalieri terms it "ideological warfare") complement rather than refute. The polarization is also symptomatic of the polarization of agency and structure addressed in Giddens' theory of structuration.

Medicalization Challenged

In addition to the issues previously presented, misreading medicalization has become common in various publications (Inhorn & Balen, 2002; Williams, 1996). Some of these misinterpretations suggest that Conrad's explanation of individuals furthering medicalization as they become more familiar with medicalized knowledge is a flaw within his framework, because it assumes medicalized knowledge precedes individual autonomy. This argument suggests that encouraging medicalization in its entirety would leave out the significance and importance of autonomy—the action taking place in full by the desires of the individual without the dictate of structure or other individuals. Arthur L. Greil suggests that scholars ought to look beyond analyses that give “primacy of place to medical constructions of reality” (Inhorn & Balen, 2002, p. 103). He further writes “Women's options seem limited to either acquiescing to medical metaphors and interpretations or resisting them” when observed within the medicalization framework. Similarly to Greil, others raise the question of whether medicalization addresses individuals' autonomous actions that are separate from medicalized knowledge (Williams, 1996). However, Conrad addresses these when he contends that the medicalization framework does not suggest that individuals play only a passive role in the expansion of medicalization (Conrad, 2007). Rather, individuals and groups as consumers often play major roles in driving medicalization forward.

In the next section, an overview of the literature on why women choose CS delivery is explored. Following this section, an overview of structural/ external reasons are provided, focusing on for-profit hospital monetary gain, and non-medically based decisions provided by healthcare professionals. This overview will bring the focal point to how women's childbearing decisions and outcomes are both products of structure and individual agency.

Undergoing Cesarean Section Delivery Without Medical Indication: Individual Choice and Structural Influence

The National Institute of Health (NIH) defines an elective cesarean section (ECS) delivery as “a caesarean section that is performed on a pregnant woman on the basis of an obstetrical or medical indication or at the request of the pregnant patient” (NIH, 2006). The formal definition misses the reality of non-medically indicated cesarean section deliveries so

prevalent in both academic and popular literature, suggesting that the procedure goes well beyond that prescribed by healthcare providers for women who are not healthy enough to endure a vaginal delivery, women who are undergoing multiple births (twins, triplets, etc.), or women who have undergone a cesarean section previously. Thus, instead of examining ECS deliveries in specific, an analysis of non-medically indicative cesarean section deliveries (CS) will be conducted. The literature suggests a multitude of reasons behind why more women are undergoing CS deliveries. Some women want to schedule their delivery in order to bypass the unexpected oncoming of a natural birth. The literature suggests many women who opt for a CS report more ease in knowing when and where they will deliver their child, and feeling more in control of their labor. Not only do pregnant women often want to schedule their deliveries in advance, but often their doctors do as well. Studies have reported that doctors schedule CS deliveries in advance for reasons that do not benefit a woman and her unborn child, but rather for their personal convenience.

This section explores empirical studies of women's reasoning to undergo CS in order to illuminate how women exercise their agency within the institution of medicine. Literature on women's beliefs about the benefits of CS delivery is pertinent to understanding why women choose surgical birth. Following this review, an outline of the institution of medicine's influences on women's childbearing decisions and outcomes will aid in understanding the complex nature of both agency and structure in this phenomenon.

Choosing Cesarean Section Delivery

Social scientists have focused on why more women are undergoing surgical as opposed to vaginal birth. Some of the research has suggested it is not only the rise in technological advancements in child delivery, but also a growing demand for alternatives to vaginal birth that account for this trend. This section reviews the current literature on why women choose to undergo CS without medical indication. Empirical studies suggest that women actively choose CS delivery for reasons pertaining to their physical and emotional selves, in addition to the physical protection of their unborn child. This section illuminates how women actively choose to undergo a CS, which is an indication of individual desire.

Fear for the self and fetus

Recent studies suggest that women who undergo surgical birth report that the decision was based on the safety of their child (Bryant et. al., 2007; Cheung et. al., 2006; Wax et. al., 2005; Weaver & Stratham, 2005). In addition to these findings, women have reported to be concerned with the harm potentially done to their own bodies during childbirth. This section highlights literature on these issues women's fear for their self and unborn child during childbirth labor.

Saisto and others (2001) studied women in Sweden and reported that they expressed fears of vaginal tearing during childbirth (19 percent), intolerable pain (15 percent), and hemorrhage (three percent). In addition, a study conducted in 1999 suggested women were more concerned about their babies *during* labor, and thus relied more heavily on medical interventions as opposed to their desires expressed prior to birth (Fox and Worts, 1999). The fear of labor pain seems to be one of the major factors contributing to women's choice to undergo a non-medically indicated CS (Cheung et. al., 2006). In the U.S., research suggests that married, white women who give birth in private hospitals are more likely to have a CS than unmarried, non-white women, even though they are less likely to have complications that may lead to surgical delivery. Interestingly, the women of this study attributed their reasons to fear of pain (Wagner 2006). Hofberg and Brockington (2000) describe the fear of vaginal birth, or the pain associated with it, as *tokophobia*. Tokophobia is the fear reported by some women that they will die during childbirth. Hofberg and Brockington conducted a qualitative study in the United Kingdom where they asked 26 women about their fears of childbirth. Out of the 26 women, eight had a fear of childbirth since being young children. Fourteen of the women had tokophobia after a traumatic childbirth experience. In the study, roughly half of the 26 women decided to undergo a CS for their second delivery (Brockington & Hofberg, 2000). Tokophobia can be a very serious mental condition that in severe cases leads to panic attacks, and overall poor social functioning. Although only a minority of women suffers from tokophobia, empirical research has shown that women who opt for a CS attribute their decision to either the fear of pain, or for the health of their child.

Convenience and control

American women who opt for CS delivery report their belief that this type of childbirth will prevent potential complications during the birthing process. Christina Aguilera, an international celebrity, said of her CS, “I didn't want any surprises. Honestly, I didn't want any [vaginal] tearing. I had heard horror stories of women going in and having to have an emergency C-section.” Like Aguilera, many women who opt for a CS not only believe that this mode of childbirth is less complicated than that of vaginal delivery, but also that vaginal childbirth presents more complications and more spontaneous procedures. To them, scheduling a CS is more convenient and less risky than vaginal birth. Cynthia Michaluk argues the concepts of convenience and control are closely related: “Convenience is defined as ‘fitness or suitability, as of place, time; freedom from discomfort, difficulty, or trouble; ease; and accommodation’” (Michaluk, 2009). Although control allows for Michaluk’s definitions of convenience, there is differentiation between freedom to choose CS delivery, and freedom to possess control over one’s childbirth. Some scholars argue that undergoing a CS is taking the control away from the patient and dispersing it among medical staff (Beckett, 2005). If this is the case, why do women believe to exercise more control over their childbirth when they opt for a CS delivery? This section gives an overview of empirical findings that suggest women take an active role in exercising their agency in choosing CS for the purpose of convenience and control.

Several studies have found that women believe CS is more convenient than vaginal birth. In a study of 148 recent mothers in Australia, 53 percent strongly agreed or agreed with the statement “people tend to think of [CS] as a more convenient way to give birth.” This same study found that 44 percent strongly agreed or agreed with the statement “Cesarean section is now seen as a routine way of having a baby” (Walker et. al., 2004). The questionnaire of the recent mothers suggested that roughly over 70% of the respondents agreed that a scheduled CS is an easier way of giving birth due to determining factors of control and convenience (Walker et. al. 2004). Another study reported that 8.3 percent of obstetricians cited convenience as a reason why women choose CS delivery (Wax, 2005). Themes of convenience also serve the purpose of predicting when to give birth to a child, according to ancient folklores. In Thailand, an ancient calendar that predicts good luck is one of the greatest influences on women deciding when to schedule their CS. In China, one woman based her decision to have a CS on a particular date chosen by a fortuneteller, in addition to a date she believed most convenient (Cheung et. al.,

2006). Lo argues that U.S. research may benefit from applying the concept of control in Chinese childbearing practices. She argues that CS deliveries in the U.S. may increase toward the last week of December due to parents attempt to take advantage of tax deductions (Lo, 2003).

Further, convenience and control is still perceived as a luxury for women in particular countries. In Chile, where the CS rate is 60% (roughly double the rate of the U.S.), most women who undergo CS delivery are of lower socioeconomic status (SES). Behague (2002) hypothesizes that women who do not have regular access to technological advancements choose CS delivery because they relate medical technology to high status. In the U.S., study findings suggest that women schedule their CS for the benefit of knowing when- and how they will give birth. Kain's 2009 article on Health.com provides an overview of how she "personalized" her non-medically indicated CS in order to have "more control" over her pregnancy. Ultimately, the specific reasons women opt for a CS differs by country, but many of the reasons have much to do with the desire for control and convenience.

Preserving the body's shape and 'function'

Thus far the literature has suggested women who choose CS without medical reason do so because they fear aspects of vaginal childbirth; and consider CS to be more controlled and convenient over vaginal childbirth. This section reviews literature that suggests women choose CS delivery in order to preserve their body's shape and 'function'. By function, the research suggests women choose CS delivery in order to preserve the anatomical and sexual functioning of their body. This last section concludes the primary reasons why women choose CS without medical indication.

Research has found that some women opt for a CS to preserve the shape and tone of their vagina (NIH State-of-the-Science Conference: Cesarean Delivery on Maternal Request, 2006). It has been recorded since the 18th century that women have been aware of and concerned with the tone of their vagina for the pleasure of their husbands during intercourse (Leavitt, 1986). Historical accounts have suggested it was not uncommon during the 18th through 20th centuries for the female friends, family and neighbors of a laboring woman to discuss the midwife's approach to preserving vaginal tone during childbirth. In addition, Handa's (2006) literature review indicates that numerous studies suggest that women undergo CS in order to maintain

regular intercourse with their partners (NIH State-of-the-Science Conference: Cesarean Delivery on Maternal Request, 2006). Laser Vaginal Rejuvenation (LVR) and abdominoplasty (commonly referred to as “tummy tucks”) are also becoming increasingly popular for women (ASPS, 2007). Particularly noteworthy is the new trend to undergo a “C-tuck,” the dual surgery of CS and abdominoplasty. Also referred to as the ‘Mommy Makeover,’ this trend is increasing according to Roxeanne Guy, President of the American Society of Plastic Surgeons (ASPS). Guy suggests that based on ASPS data, in 2007 there was an 11% increase in Mommy Makeover surgeries (ASPS, 2007). Other researchers hypothesize that some women undergo CS delivery as a means to preserve vaginal tone after childbirth for the sexual pleasure of male partners (Cheung et. al., 2006). Women have also been reported to choose CS in order to retain the function of their rectum, anus, bladder, and vaginal tone for non-sexual related reasons (Cheung et. al., 2006; Hsu, Hwang, & Liao, 2007; Wagner, 2006; Wax et. al., 2005).

Structural Influences

The previous section was an overview of the literature that suggests women choose CS delivery because of their own desires. In this section, the structural influences are outlined in order to depict the rise in the CS delivery rate from a structural standpoint, aiding in understanding how it impacts women who undergo non-medically indicated CS delivery. This section is comprised of three categories pertaining to findings in the literature: (1) pressured and ill-informed; (2) money and medical practice; (3) physician issues.

Pressured and ill-informed

The literature suggests women report feeling pressure from healthcare professionals to undergo CS delivery, in addition to being ill-informed of medical interventions conducted during childbirth. A recent study’s findings report that 25% of expecting mothers felt pressure from healthcare professionals to undergo a cesarean section (Declerq et. al., 2006a). This same study found that 79% of expecting mothers felt they were ill-informed about procedures, such as induced labor, which in some cases led to an emergency CS. Aside from CS delivery pressure,

women of this same study reported feeling pressure to undergo other medical interventions, such as labor induction and epidural (Declerq et. al., 2006a).

Money and medical practice

According to the literature, monetary incentives may play a role in the rising CS delivery rate. Studies suggest hospitals have been found to gain monetary compensation from health insurance companies for CS deliveries over vaginal ones (Berkowitz et al., 1988; Brown, 1996; Childbirth Connection 2006; DeMott & Sandmire, 1999; Dranove & Wehner, 1994; Fraser et al., 1987; Goyert, Bottoms, Treadwell & Nehra, 1989). Studies have also reported that physicians influence women to undergo non-medically indicated cesarean section delivery due to financial incentives. In Taiwan, physicians were found to increase CS delivery during the months following lower salaries (Hu & Tsai, 2002). Provider-related factors have also been influential on the rate of cesarean sections in Thailand. Studies suggest that investor-owned, large bed size, and teaching hospitals have higher CS rates. Researchers have hypothesized Thailand's rising CS rate is due to suiting the needs of hospitals, rather than patients (Berkowitz et al., 1988; Brown, 1996; DeMott & Sandmire, 1999; Dranove & Wehner, 1994; Fraser et al., 1987; Goyert, Bottoms, Treadwell & Nehra, 1989). Additional studies have found that for every \$100 reimbursement for a cesarean section, the rate rose seven percent in the Medicaid population (Gruber, Kim, & Mayzlin, 1999). Researchers of this finding suggest that lower fee differentials between CS and vaginal childbirth under Medicaid than private insurance can explain between one-half and three-quarters of the difference between Medicaid and private CS delivery, concluding that Medicaid reimbursement reductions can cause a change in the treatment of Medicaid patients.

Physician issues

Findings within the literature suggest that the rise in CS deliveries are due to physician schedules, clinical impatience, and the practice of defensive medicine. Some studies suggest that tight scheduling in hospitals creates overwhelming stress among medical doctors. Consequently, scheduling for physicians is of high priority, due to timed office visits, surgeries, and deliveries

throughout the day and night. Recent studies support the hypothesis that doctors schedule CS deliveries to control some of the spontaneity in their work life. One study found that fewer CS deliveries were performed on Sundays, while some doctors scheduled more between 7:30 am and 11 am, and mostly on Tuesdays and Thursdays (Brown, 1996). Other studies have found cesarean deliveries were scheduled less often on weekdays after five pm (Bateman, 2004). Medical doctors have also been found to schedule CS deliveries in order to fit their annual holiday vacation (Johnson 2006). Considering that a CS delivery takes approximately 30 minutes to perform, while a vaginal birth takes an average of 12 hours, scheduling CS deliveries are cost and time effective for hospitals and medical doctors.

In addition to these findings, a recent study by the NIH suggests that the rising rate of cesarean deliveries is due to excessively efficient hospital birthing practices (Zhang et. al., 2010). This study found that doctors were ordering cesarean sections prematurely due to time efficiency. Observations from the study found that doctors were also not waiting for their patients' cervixes to dilate a full 10 centimeters, the recommended dilation for a healthy, vaginal birth. The study also found doctors were ordering emergency cesarean sections after six centimeters of cervix dilation. Additional research suggests that obstetricians are increasingly practicing defensive medicine by ordering excessive testing, using unnecessary medical intervention, and performing CS deliveries. Defensive medicine is defined as medical practice that is not for the best outcome of the patient, but rather to safeguard the physician against malpractice liability. In Italy, for example, regions with high cesarean section rates are believed to be practicing defensive medicine due to some clinics having a 90% rate of surgical deliveries. Italian obstetricians have noted the rate of cesarean section deliveries is due to safety of the woman and baby during labor; however, critics argue the rate is too high to be safe (Serra 2009). Despite the arguable use of defensive medicine and the increasing cesarean section rate, malpractice claims have not decreased among obstetricians (Arulkumaran & Penna, 2003).

Summary

Studies suggest that the medical profession plays a pivotal role in women's childbearing decisions and outcomes. Other studies suggest that women exercise their agency by choosing CS delivery. Because the literature focuses on two facets of this social phenomenon (structural

influence and individual choice) a theoretical framework that accounts for both aspects is needed. This paper suggests that interpreting the medicalization thesis from a structure-agency standpoint is most beneficial for understanding the phenomenon. The following section provides an overview of Conrad's medicalization thesis, followed by Giddens' theory of structuration. Medicalization is then interpreted utilizing Giddens' theory of structuration.

Theoretical Framework

Previous literature suggests that women's birthing experiences are influenced by the medical industry, but that women also play a pivotal role in choosing surgical birth. Feminist perspectives on childbirth support and refute various aspects of these findings, thus making these standpoints insufficient for fully understanding the scope of the phenomenon unless understood from a third-way perspective that synthesizes both feminist positions. A theoretical approach that considers social phenomena at both the structural and individual level may be beneficial in supporting accounting for these findings. This section reviews Conrad's theory of medicalization, supplemented by a structure-agency interpretation of medicalization, provided by Giddens' theory of structuration. Because medicalization has been analyzed from many different standpoints, and is rarely extracted from a structure-agency standpoint, this analysis will be beneficial in guiding further research in addition to joining together previous findings.

Medicalization

Conrad contends medicalization is the process through which otherwise normal human conditions are (1) defined in medical terms, (2) perceived solely as medical issues, (3) and thus become viewed under the medical lens. To Conrad, definition is the most salient factor in the medicalization process. He writes,

The key to medicalization is definition. That is, a problem is defined in medical terms, described using medical language, understood through the adoption of a medical framework, or 'treated' with a medical intervention (Conrad, 2007, p. 5).

For example, when children are perceived to be overly excitable, they become defined as having Attention Deficit Hyperactivity Disorder (ADHD). Therefore, defining conditions in medical terms is a main contribution to the medicalization process. The medicalization of childbirth has been one of the most transformational concerns in the 20th century. Prior to this time, childbirth was largely a holistic, family- and community-oriented endeavor, where midwives and women of the community and family were central to the childbearing process (Leavitt, 1986). Today, however, childbirth has become principally understood as a medical undertaking (Conrad, 2007). The natural and home birth movements led by midwives are recognized socially, but are for the most part on the periphery of common childbirth practices. Defining childbirth in medical terms has therefore played a dramatic role in transforming mainstream childbearing practices into a medical endeavor.

Conrad argues that medicalization does not suddenly occur, but is instead a process (Conrad, 2007). He contends that medicalization is not solely driven by medical entrepreneurs, but also by the lay public and patients, as well as through organizational activities of competing health care professionals. Through this process of medicalizing, multiple actors play a pivotal role in making otherwise social conditions medical. Conrad writes:

The growth of medicalized categories suggests an increase in medicalization, but this growth is not simply a result of medical colonization or moral entrepreneurship. ...The public's tolerance of mild symptoms has decreased, spurring a 'progressive medicalization of physical distress in which uncomfortable body states and isolated symptoms are reclassified as diseases.' Social movements, patient organizations, and individual patients have also been important advocates for medicalization. In recent years corporate entities like the pharmaceutical industry and potential patients as consumers have begun to play more significant roles in medicalization (Conrad, 2007: 6).

The complex process of medicalization involves a number of drivers. Identifying the relevant drivers of the medicalization of childbirth can aid in understanding why women are increasingly undergoing non-medically indicated CS delivery. Patients, patient organizations, women who are publicly pro-CS delivery, pharmaceutical corporations and medical technology companies, and

medical professionals all play a role in medicalizing childbirth.¹ A similar example can be found in the medicalization of masculinity (Conrad, 2007). Conrad writes,

...The medicalization of male aging, baldness, and sexual performance, while currently driven by the medical and pharmaceutical enterprises and accelerated by direct-to-consumer advertising, is also fueled by men's own concerns with their masculine identities, capacities, embodiments, and presentations (Conrad, 2007: 23)

Here, Conrad suggests that the process of medicalization is not only propagated by structural forces, but also by consumers. Women who undergo CS delivery without medical indication provide a similar scenario: While the medical industry heavily influences their childbearing decisions and outcomes, they are also genuinely concerned about vaginal childbirth and make decisions accordingly. Thus it could be argued that the growing trend to undergo CS delivery has as much to do with women's desires as do the changing procedures in childbearing practice.

However, though medicalization includes the lay public and the medical profession as drivers of medicalization, many scholars have utilized medicalization solely to explain social control via the medical industry. These scholars argue that social control is central to medicalization via medical technologies that set the norms for behavior, body, and health; further contending that society adheres to the authority of medicine.² Accordingly, this takes responsibility away from individuals, while simultaneously providing the medical industry more control. Conrad writes, "One social implication of increased medical social control is that more forms of behavior are no longer deemed the responsibility of the individual. That is, when the cause is seen as biological and subject to 'medical excuse,' the individual is no longer considered responsible for the behavior" (Conrad, 2007). Conrad argues that allowing society to have less responsibility has serious social ramifications, such as less attention toward social issues that influence behavior and medical trends. In terms of CS deliveries, some of these ramifications include patients becoming more active in their own treatment, i.e. asking for a CS when it is

¹ There are several advocates for CS without medical indication, but likely the most prominent is Pauline McDonagh Hull.

² The most influential scholars being Michel Foucault, Susan Sontag, Ivan Illich (see: medical imperialism). Though these scholars wrote before Conrad's conceptualization of the medicalization thesis, much of their work is still utilized for research.

medically unnecessary. Conrad argues that patients are becoming more demanding in what they want from their physicians, which demonstrates how society embraces medical intervention. Though social control is an aspect of Conrad's medicalization thesis, it has been widely overused by many scholars. This overuse in the social control aspect of medicalization has led to the obscuration of the process of medicalization.

Conrad notes this problem, and suggests that while the nuances presented in postmodernist interpretations of medicalization are important depending on the context, the medicalization discourse he participates in does not solely focus on this aspect alone:

Medicalization studies, as I and others engage in them, focus especially on the creation, promotion and application of medical categories (and treatments or solutions) to human problems and event; while we are certainly interested in the social control aspects of medicalization, we see them as something that goes beyond, but may include, discourse and subjectivity (Conrad, 2007: 13).

In sum, Conrad contends that the process and expansion of medicalization is complex. Concerns of social control, paternalistic medicine, and the laypublic demanding medicalized treatments are all central issues of medicalization. Although different aspects of medicalization have been addressed, there has not been a clear understanding of how the macro and micro level processes work together to further medicalization. That is to say, though Conrad began the discourse on the process of medicalization, scholars have not proceeded to understand the full scope of this process—instead using only certain elements of the medicalization thesis. Over time, this has led to a polarization in our understanding of the medicalization process. In order to make sense of the literature, medicalization is interpreted through a structure-agency standpoint in the following section.

Applying Structuration to Medicalization

Rarely is a structure-agency standpoint used to explain medicalization, yet its contribution to understanding the medicalization process is an important one. In Anthony Giddens *The Constitution of Society* (1984), he argues that there are two forces simultaneously

occurring that influence social phenomena. These two forces, as he names them, are ‘structure’ and ‘agency.’ To Giddens, structure is the entirety of all social institutions—the social institutions of family, government, gender, class, and so on. He argues that because structure is malleable and constantly being modified, structure ought to be considered in systemic form. That is to say, structure is made up of properties (norms and/or laws), and the only thing bonding structure together is the structuring properties that allow the binding of time-space in social systems. In other words, structure is highly dependent on the moment in time that it exists. Furthermore, Giddens argues that structure is not something external to individuals. He suggests that structure gives meaning and organization to everyday life, but that structure is not in itself pure organization and meaning, so that although structure appears to ‘impede’ on individuals, it does not continue to exist without their embodiment of it (Appelrouth & Edles, 2007). Thus, it is the recursive performances of the past that continually organize structure together in the present. Giddens contends that his conceptualization of structure does not mean that the hierarchical nature of it does not exist, but rather that overt coercion is often times inevident because of the reflexive structure-agency process (Appelrouth & Edles, 2007: 535).

Due to this redefined structure-agency relationship, Giddens challenges the externality of structure to individuals. He argues that although structure does impede on individuals lives, it is not a fixed entity that individuals easily identify and separate their selves from (Giddens and Pierson, 1998). Instead, because they are products of socialization via social structure, their actions are microcosms of structure’s influence in their lives. Giddens draws an analogy to language. He argues that although individuals utilize language in different ways—and language could not exist without their continual usage/dependence upon it—some people may feel put off by those who do not follow its taken-for-granted norms and conventions. That is to say, though language is highly dependent on the time and space that we contextualize it within, it constantly changes; and through these changes individuals notice the taken-for-grantedness of their expectations of how to use it. Put differently, through changes to language individuals come to recognize the arbitrariness of certain conventions; yet simultaneously, language could not exist without continual usage by these very individuals. Consequently, individuals notice the historical existence of structure, and how it changes throughout time due to the intermeshing of the micro and macro processes. It changes because individuals change; it involves because individuals evolve.

Giddens refers to individual agency as the recursive performance of individuals at the micro level. Similar to structure, Giddens suggests that agency is not strictly within individuals. Rather, agency is the blueprint of people's actions. These actions form social structure, which is the conglomerate of individuals' reproduced set of expectations. Giddens writes, "Society only has form, and that form only has effects on people, in so far as structure is produced and reproduced in what people do" (Giddens & Pierson, 1998). Giddens further contends that there is no priority between structure and agency, but that these two concepts are constantly influenced and shaped by one another through reflexive feedback.

Giddens maintains structuration is the recursive performance of human action in the context of social structure that is led by a set of norms, which are different from those of other social structures. As a result, all individual action is to some degree centered upon the respective contextual set of norms under which they occur. He writes,

One of the main propositions of structuration theory is that the rules and resources drawn upon in the production and reproduction of social action are at the same time the means of system reproduction (the duality of structure) (Appelrouth & Edles, 2007: 536)

He further clarifies,

According to structuration theory, the moment of the production of action is also one of reproduction in the context of the day-to-day enactment of social life (Appelrouth & Edles, 2007: 540).

To Giddens, reproductive action at the individual level has an influence on structure at the macro level. He writes, "Structure has no existence independent of the knowledge that agents have about what they do in their day-to-day activity" (Appelrouth & Edles, 2007). Structure does not exist without the routinized aspects of social life—the commonplace of social reproduction. Yet, recursion is also influenced at the micro level by preexisting structural norms and rules. Giddens suggests that social phenomena occurs at both the micro and macro level, as both axes continually and simultaneously influence each other's actions. He argues that the historical importance of human action has transgressed into societies that see past efforts of those

individuals shaping today's social institutions. Thus, although structure is placed within time and space, historical action has worked to establish bases for which the current structure continually maintains.

In applying Giddens' theory of structuration to Conrad's medicalization, there are many ways in which obscurities become clearer. The first is Conrad's argument of how medicalization expands. To Conrad, medicalization occurs through the laypublic, medical profession, and the various interests surrounding the institution of medicine (i.e., the pharmaceutical- and health insurance industry). To Conrad, it is not as though medicine is entirely hegemonic, but rather that as more people gain knowledge of medical technology, they begin to utilize it, thus expanding its prevalence. In terms of women who undergo CS without medical indication, this becomes in line with the literature: As women begin to gain more knowledge of different birthing options, they begin to utilize new technologies. Soon after, non-medically indicated CS deliveries become prevalent as women begin requesting this alternative birthing method.

But while women begin gaining medicalized knowledge and utilizing new medical procedures, they are also influenced by the institution of medicine, which already has its own established rules and norms. For instance, women are gaining the knowledge of CS delivery often through medical staff. Women are persuaded by doctors, and also trust them as authorities in health and medical safety. Giddens would suggest this relationship is confining, yet with a false sense of freedom: "The structural properties of social systems [...] are like the walls of a room from which an individual cannot escape but inside which he or she is able to move around at whim" (Giddens, 1984, p. 174). As women exercise their agency, they are within the confines of the medical industry. The recursive process of women's request for CS delivery, and the medical industry's desire for better efficiency and profit gain *is* medicalization—and further, structuration. Moreover, childbirth today is situated within a historical context: Today's birthing discourse is far more complex and comprehensive than that of the earlier to mid part of the 20th century. Thus, on a final note, second- and third wave perspectives utilized apart from one another can only make sense of portions of the literature, and not the entire scope. Utilizing a structure-agency standpoint alleviates this issue by aiding in comprehensively understanding the rise in non-medical CS deliveries.

...

It is important to fully understand the rise in non-medically indicated CS deliveries. Applying structuration to medicalization is beneficial for guiding further research. It also sheds light on previous findings. From preceding research, it is suggested that women are just as equally influenced by the medical industry, as the medical industry is by them. In Greil's work on infertile women, he argues similarly:

...Infertile women do not respond passively to medical definitions of them but react *actively* and *strategically*; they work the system and try to push medical treatment in the direction they want it to go. *Infertile women are neither passive victims of biomedicine nor uncritical consumers wanting to take advantage of all the available medical technology.* Rather, they are problem solvers, operating creatively within a system they do not control" (emphasis added) (Inhorn & Balen, 2002).

Greil's argument on women exercising their agency in fertility treatments can be applied to women who desire surgical birth and their exercise of agency. In sum, interpreting medicalization through structuration provides a sophisticated understanding of how the macro and micro level processes both play a role in more women choosing CS delivery.

The following section examines how women who undergo CS without medical indication perceive the way in which they exercise their agency for their method of childbirth, in addition to how they perceive the medical profession's influence on their childbearing decisions and outcomes.

Methods

In order to examine women's perceptions in their childbearing decisions and outcomes, a secondary data analysis of the *Listening to Mothers II* data and a quantitative content analysis of Internet support forums for childbirth are conducted. In analyzing these perceptions, women who undergo CS delivery without medical reason are specifically analyzed, as their childbirth method is considered debatable from both the structure- and individual level decision-making process. Examining their childbirth decisions, the study attempts to determine whether their childbirth

was individually chosen, or chosen for them. Doing this aids in understanding the structure versus agency dichotomy, specifically attempting to separate the categories in order to test Giddens' structuration. This section will first begin with the secondary data analysis portion of the research, followed by the content analysis.

Secondary Data Analysis

The secondary data analysis was utilized in order to analyze relationships from the *Listening to Mothers II* data set. Because the research question posits itself around one of two areas of interest—structure, in this case—the secondary data analysis provided insight into how women perceive the institution of medicine influencing their childbearing decisions and outcomes. The analysis allowed me to analyze two key areas:

- The relationship between women who reported pressure for healthcare professionals and their method of childbirth.
- The relationship between women's reported most important source of information on childbearing (self or doctor), and their method of childbirth.

This analysis was beneficial in that it utilized a representative sample of women who have given birth in a hospital setting in 2005. However, the sample did not represent women who had undergone a CS delivery without medical indication, but instead women who underwent both vaginal birth (69.5%) and CS delivery (30.5%), and only 1% for explicit non-medical delivery. However, a benefit of this analysis was that it aided in understanding how women perceive external influences on their mode of delivery, which may have implications for future quantitative analysis on the perceptions of women who undergo CS delivery without medical indication.

Sample and Ethical Considerations

The *Listening to Mothers II* study sample was drawn from the Harris Poll Online (HPOL) panel of over six million active U.S. members. Respondents in this panel were recruited

from a variety of sources, including the HPOL registration website and contracts made with several organizations. Recruitment for the study took place by e-mailing women aged between 18 and 45 from the HPOL panel, inviting them to take part in the Listening to Mothers II survey. The e-mail had a direct link to the survey website, allowing respondents to take the survey at their earliest convenience. Respondents were also allowed to complete some of the survey, and continue the rest at a later time. Once the respondents proceeded to the survey website, however, screenings determined their eligibility. Such screenings included whether or not the women were able to provide information that they had indeed given birth in 2005 and were within the age limit for participation in the survey.

For the telephone sample of the same study, the researchers attempted to broaden their population by be able to collect data from black non-Hispanic and Hispanic women who may not have access to Internet.³ The telephone recruitment was implemented through a list of households with a baby provided by Survey Sampling International. The telephone interviews took place over the course of four weeks, where up to six attempts were made for each household. The interviewers were monitored to ensure that the quality of their interviewing techniques were of sufficient quality. Due to the nature of the subject, the researchers used female interviewers.

To collect data from a more representative sample of the target population (women who gave birth in 2005), the researchers employed a weighting technique. The data were weighted by key demographic variables, as well as the composite variable—the propensity score—intended to be a sign of the respondent’s tendency to be online. Demographic variables used for the weighting procedure included educational attainment, age, race/ethnicity, geographic region, household income, and time lapsed since giving birth, collected from the March 2005 Supplement of the U.S. Census Bureau’s Current Population Survey and national natality data.⁴ The propensity score considered the biases that may arise when conducting research from an online panel.

The researchers for Listening to Mothers II deliberated on the sensitivity of the topic, and thus considered efforts to avoid problems with psychological trauma toward the respondents.

³ Though I find it troublesome they equated Internet access with ethnic/racial background.

⁴ The natality data is the ratio of live births in a particular area to the population of the particular area, and is expressed per 1000 population per year.

The researchers also guaranteed confidentiality to the respondents. Because the researcher is neither interacting with human subjects nor collecting her own data, the study does not meet the criteria for human subjects research, and was therefore exempt from the IRB. Additionally, any identifiers or information linking the data to the participants was not made available to the researcher.

Procedure

The Listening to Mothers II data set provided the data for views toward the structural influences on childbearing decisions and outcomes, while the content analysis of Internet forums on non-medically indicative CS and other childbearing methods served to analyze how women perceive to exercise their agency in childbearing decisions and outcomes, in addition to the structural influences. The purpose of these analyses was to examine the perceptions of individual autonomy and structural limitations in childbearing decisions, as it pertains particularly to women who have undergone or will undergo CS without medical indication. The next section will provide an overview of the secondary data analysis.

Measures and Rationale

The *Listening to Mothers II* data set was utilized in order to conduct analyses on women's perceptions of medical professionals influence on their childbearing decisions and outcomes. This section will begin by giving an overview of the survey instrumentation from the *Listening to Mothers II* data set. Questions within the data set that dealt largely with women's perceptions of pressure from medical staff to undergo forms of medical intervention during childbirth were used. Following this section, a discussion of the analysis plan and hypotheses for the secondary data analysis will be provided. The analysis examined women's perceptions of medical profession influence over their childbearing outcomes. The goal of the secondary data analysis was to determine whether women's perceptions of pressure from medical staff had an influence on the procedure and outcome of their childbirth. To further understand this relationship, women's reports of their most important source of information on childbirth were analyzed against their childbearing outcomes.

Survey Instrument

The *Listening to Mothers II* survey is the primary data collection tool used for analyzing how women perceive the structural impediments and/or influences on their childbearing decisions and outcomes, and was their primary objective for collecting data. The survey recruited mothers who had had given birth in 2005 (N=1,573) through the HPOL Internet base of over 6 million members, and telephone surveys (see: Sample and Ethical Considerations). The subjects for the questionnaire were broken into 13 categories:

- Sample preload and screening
- Prenatal
- Intrapartum
- Birth and cesarean-section specific
- Labor and birth, after birth in the hospital and feeding
- Postpartum II
- Pregnancy and employment history
- Cross-cutting
- Pregnancy history
- Mother Information
- Demographics (phone only)
- Demographics (panel only)
- Interest in follow-up

Many of the questions within the survey were ordinal scale, nominal or dichotomous. For instance, an ordinal scale question would consist of questions such as, *overall, how would you describe your health?* A nominal question would consist of, *where did you give birth?* And a dichotomous question would consist of, *have you ever given birth?* The survey covered a broad range of questions. Because the research interest in the secondary data analysis is how women perceive the structural impediments and/or influences on their childbearing decisions, only the questions pertaining to this topic were analyzed. The questions were of follows:

1. *Did you feel pressure from any health professional to have labor induction?*

- Question is dichotomous, and respondents are to provide 1 for ‘yes’ or 2 for ‘no.’

2. *Did you feel pressure from any health professional to have an epidural?*

- Question is dichotomous, and respondents are to provide 1 for ‘yes’ or 2 for ‘no.’

3. *Did you feel pressure from any health professional to have a cesarean?*

- Question is dichotomous, and respondents are to provide 1 for ‘yes’ or 2 for ‘no.’

4. *Respondent’s most important source of information on pregnancy and childbirth*

- Question is nominal, and respondents are to choose from several categories: ‘Friends & relatives’; ‘Books’; ‘Internet’; ‘Mass media’; ‘Childbirth education class’; ‘A doctor’; ‘A midwife’; ‘Own experiences from previous birth’; and ‘Other’.

Variable number 4 was coded as ‘0’ for respondents that reported *self* as most important source of information, and coded ‘1’ for those who reported “Healthcare Professional”. Because the rest of the variables are dichotomous, they were coded ‘0’ for yes, and ‘1’ for no.

Analysis Plan and Hypotheses

These variables were then tested to examine women’s perceptions of medical professional’s influence in their childbearing decisions and outcomes, beginning with the childbearing outcome variable:⁵

- *The Most recent time you gave birth, was your baby born...?*
 - Question is nominal, and respondents are to provide 1 for ‘vaginally’, 2 for ‘by cesarean’, 8 for ‘not sure’, and 9 for ‘decline to answer’.

Furthering analysis examined women’s reports of pressure to undergo medical intervention during childbirth against their childbirth method outcome. Because some of the variables were

nominal, and some were also manipulated into nominal, chi-square and lambda were utilized. Hypotheses tested were as follows:

1. Women who reported pressure from any health professional to have labor induction will be more likely to have had a cesarean section than those who did not.
2. Women who reported pressure from any health professional to have an epidural will be more likely to have had a cesarean section than those who did not.
3. Women who reported pressure from any health professional to have a cesarean section will be more likely to have had a cesarean section than those who did not.
4. Women who reported their most important source of information to be a doctor underwent a cesarean section delivery.

The goal of the analysis is to examine whether (1) women who reported pressure from healthcare professionals were more likely to undergo a CS delivery; and whether (2) women's reported most important source of information on childbearing was related to their method of childbirth.

The rationale behind the choice of items and data set is due to the fact that this study was conducted specifically for understanding how women who have given birth perceive the medical profession influences their childbearing outcomes and decisions. The researchers conducting the study wanted to examine if women perceived their needs to have been met in the hospital setting during their childbirth. Thus, the usage of this data was for analyzing whether women reported medical staff (what I would consider 'structural') to be of influence in their childbearing decisions and outcomes. In sum, the research question driving this analysis was whether mothers perceive health professionals childbearing methods.

Results

The study explored the influence of health professionals on women's childbearing decisions and outcomes based upon reports by women who gave birth in 2005. Women's reports

of feeling pressure to undergo medical intervention by health professionals, and whether subjects' was reported as the most important source of information on pregnancy were analyzed against whether these women underwent CS delivery. The row percentages and with flagged chi-square significance results for women's perceptions of reported pressure and most important source of information regarding childbirth are presented in Table 1.

Table 1: Percentage Table with Chi-Square Results for Women's Perceptions and Childbirth Outcome

	<i>Childbirth Method</i>					
	<i>Vaginal</i>		<i>C-Section</i>		<i>Total</i>	
	<i>N</i>	<i>%</i>	<i>N</i>	<i>%</i>	<i>N</i>	<i>%</i>
<i>Reported Pressure</i>						
<i>Labor induction*</i>						
Yes	134	79.3	35	20.7	169	100
No	958	68.3	445	31.7	1403	100
<i>Epidural</i>						
Yes	77	68.8	35	31.2	112	100
No	1016	69.5	445	30.5	1461	100
<i>Cesarean Section*</i>						
Yes	24	17.5	113	82.5	137	100
No	1069	74.5	366	25.5	1435	100
<i>Information Source</i>						
Self	938	70.4	395	29.6	1333	100
Healthcare Professional	32	65.3	17	34.7	49	100

*p<.05

The percentage distributions in Table 1 suggest women who reported pressure for induction did not have a higher C-section rate. However, the distribution does suggest that women who reported pressure to undergo labor induction did have a higher vaginal delivery rate, and make up 79.3% of women who reported labor induction pressure. Similarly, women who reported pressure for an epidural did not report undergoing a cesarean section delivery (31.2%) over women who underwent vaginal childbirth and reported pressure to have an epidural (68.8%). However, those who reported pressure to undergo a cesarean section delivery had a much higher rate of cesarean section deliveries, comprising of 82.5% of respondents, as compared to 17.5% of those who reported pressure to undergo a cesarean delivery, but

underwent a vaginal childbirth. Women who rely more on health care professionals have a slightly higher cesarean section rate (34.7%) as opposed to those who reported their selves as the most important source of information (29.6%). However, this relationship is not statistically significant, and relatively few women report physicians as most important source.

Since the study involved categorical data of a random sample of assumed independent variables, the chi-square test of independence was utilized. Categories under *Reported Pressure* and *Information Source* were tested against *Childbirth Method*. Results revealed that the relationship between childbirth method and women's reports of feeling pressure to have labor induction was significant $\chi^2(1, N=1572) = 8.616, p < .05$, critical value = 3.84. The cell residuals suggest that among the respondents, there were fewer women who had a CS and reported feeling pressure to have labor induction than what would be expected ($R = -2.3, p < .05$). However, the overall relationship is very weak ($\phi = .074$). The relationship between childbirth method and women's reports of feeling pressure to undergo an epidural was non-significant $\chi^2 = (1, N=1573) = .031, p > .05$, critical value = 3.84. The relationship between childbirth method and women's reports of feeling pressure to undergo cesarean section delivery was significant $\chi^2 = (1, N=1572) = 1.916E2, p < .05$, critical value = 3.84. However, the overall relationship is weak ($\phi = -.349$). The relationship between childbirth method and information source was non-significant $\chi^2 = (1, N=1382) = .579, p > .05$.

In terms of statistical significance, the overall analysis suggests women who reported feeling pressure from health care professionals were not more likely to undergo a CS delivery. Though reports of pressure to undergo CS delivery and labor induction suggested statistical significance, the overall relationships were very weak to weak. The analysis also suggested that the relationship between women's reported most important source of information and their childbirth method was non-significant. Yet, although statistical significance does not say much about the relationships, the percentage distributions suggested that women who reported pressure to undergo a cesarean section delivery were more likely to have cesarean section childbirth. Interestingly, women who reported pressure to have labor induction and an epidural were more likely to undergo vaginal childbirth over cesarean section women who reported pressure. Lastly, women who reported healthcare professionals as their most important source of information were slightly more likely to undergo cesarean section childbirth over vaginal childbirth. Women who

also reported their selves as the most important source of information on childbirth were slightly more likely to undergo a vaginal childbirth.

Benefits and Limitations

The secondary data analysis provided two main benefits. The first benefit was having a larger sample size that is random, which allowed for better representation of the target population (Babbie, 2010). The second was having access to survey and questionnaire responses without needing to collect data. However, there were limitations to conducting the secondary data analysis. Arguably most important is the validity of the research, as the analysis was unable to analyze women who underwent CS delivery without medical indication. However, it could be argued that it may be difficult to determine the influence of health professionals on women who undergo CS without medical indication, as many women may be undergoing CS delivery with the belief that there is medical reason for the operation when there may not be one. An additional limitation was not having longitudinal data. In terms of the population, the ages and number of births for the respondents are representative of the total number of women who gave birth in 2005 (See Appendix A).

There were also limitations in the data utilized. Since *Listening to Mothers II* is based primarily on online surveys and telephone interviews with respondents, the standardization of the questions might have fostered superficial responses from participants. Earl Babbie argues that surveys cannot measure action, but only self-reports of “recalled past action or of prospective or hypothetical action” (Babbie, 2010). The respondents may have formed an attitude or opinion at the moment the survey or questionnaire was administered, creating artificial data. The respondents may not have been certain during the time of the survey questionnaire whether their childbearing decisions and outcomes were influenced by medical professions or the outcome of their own desires. Superficial answers could have been generated due to respondents considering these questions for the first time. Furthermore, inflexibility of surveys and questionnaires does not allow for modifications during data collection when a new variable becomes important. Lastly, common issues with telephone surveys are that respondents may not feel comfortable

conveying personal beliefs and experiences with the researcher. With such a sensitive subject as childbirth, the data suffers tremendously due to the impersonal approach in data collection.

Content Analysis

Content analysis is the “systematic, objective, quantitative analysis of message characteristics” (Neuendorf, 2002). Some of the methods within content analysis include the careful observation of human interactions; the portrayal of characters in television, movie, theater, and fiction and non-fiction literature; the usage of words in the news and media; the usage of words in political and public speeches; and much more. The utilization of content analysis for this study focused on the careful observation of human interactions through an examination of content on forum websites of women discussing CS without medical indication, paying close attention to women who desire to undergo a CS delivery or have already undergone a CS without medical indication. The interest was in understanding how women perceive the influence of health professionals versus their own agency in their childbearing decisions and outcomes. The content analysis of support-group forum comments allowed for the examination of women’s perceptions based on the assumption that many women who visit and interact on these websites feel a level of comfort in discussing their childbearing experiences because they are in a community of anonymous supporters.

Sample and Ethical Considerations

For the content analysis portion of the research, the study met the ethical requirements of the IRB. Because the websites used in the study were all in the public domain and did not require subscriptions or privileged access to the forums and blogs, the information is public to anyone who accesses these websites. In terms of identifiers, women who use the forums can often engage in online conversation anonymously through “online identities,” also known as “Internet identities,” “Internet personas,” and “virtual persons.” According to Thierry Nabeth’s definition, “A virtual person is a mask defined by its attribute(s), and/or its role(s), and/or its ability(-ies), and/or its acquisition(s). The entity behind the mask, if it exists, is a subject” (Nabeth, 2006). According to this definition, a virtual person creates a ‘mask’ which is often an avatar,

pseudonym, or partial identifier, such as her first name, nickname, or variations of her initials and birth year. In fact, there are many ways in which the subject can create names for an online identity, but it is rare that persons partaking in online community discussions use full name identifiers. If they do, it is often through the social networking site of Facebook.com, or part of an editorial.

Thus, because the research conducted did not analyze conversations on websites that use personal identifiers, the content analysis did not require permission from the IRB.⁶ Furthermore, the Virginia Commonwealth University (VCU) website on human subjects in research defines a human subject as “A living individual about whom an investigator conducting research obtains: data through intervention interaction with the individual or identifiable private information” (VCU Office of Research, 2011). Because the information was not obtained through intervention with the individual, nor was the information collected private, permission through the IRB was not necessary. The information was provided through the public domain, and those who have participated in online, public discourse are doing so with the knowledge that the information they provide is not private.

Measures and Rational

The content analysis explored women’s perceptions of individual choice and doctor-based decisions to undergo non-medically indicative CS childbirth. If properly utilizing structuration, these perceptions should be fluid and overlapping from the researcher’s observations, as structure and agency are continuously and simultaneously being influenced by one another. However, by paying close attention to these two categories of decision-making, the research aims to explore whether there are clear distinctions between these categories, or if indeed Giddens is correct in his assertion of social phenomena. Because content analysis is a broad field of methodology, the first half of the following section will provide an overview of the kind of content analysis conducted. Following this explication, a discussion is provided of how

⁶ See: VCU’s Office of Research downloadable Powerpoint presentation, “How do I determine if my project is ‘human subjects research?’” accessible from the following web address: <http://www.research.vcu.edu/irb/activities.htm>

the data were collected from Internet forums where women discuss their own experiences and opinions on childbirth.

Content Analysis Instrument and Analysis Plan

The sampling method for obtaining the websites used for data collection depended upon Google search results for “Who chose your c-section”. The results yielded website forums and blogs, but some were also online articles. Because the research endeavor is to examine forums specifically due to the nature of the interaction between online identities, Google search results for online articles were discarded. Websites with international web addresses were also discarded in order to have a sample more representative of American mothers.⁷ The websites containing the forums were as follows:

- Pregnancy-info.net
- Whattoexpect.com

The rationale behind using Google’s search engine was to yield online support communities where women were discussing their childbirth among other expecting or current mothers. From the search results, two websites with community forums were chosen. Within these forums, numerous discussion threads on women’s CS decision process were discovered. The content analysis was specifically based on forums found within websites under the search term “elective cesarean section”.⁸ The rationale for searching this term is due to many women using this term to refer to non-medically indicative cesarean sections. Data collection occurred between May 30, 2011 and June 13, 2011. Data collection from Whattoexpect.com included 15 forums threads, whereas Pregnancy-info.net included 12.

⁷ However, women who did participate on the forums were also from other countries, most notably the United Kingdom. Their responses were not discarded because it was not indicated differentiate they were living in the United States or not.

⁸ The Google search for “who chose your c-section” provided the two websites for the content analysis; whereas the search term “elective cesarean section” was conducted once arriving to the websites, and thus yielded specific forums for gathering data.

Lastly, concerns surrounding the utilization of an Internet search engine for conducting social science research may be understood once Google's search engine tactics are more explicit. Because Google uses "PageRank," a link analysis algorithm that gives a numerical weighting to every part of a hyperlinked amount of documents for the intention of measuring its relative value within the specific set, Google's search engine finds the most popular and visited sites for similar and exact searches. However, because Google's algorithms tailor specifically to one's own search inquiries, a Google search was conducted on two personal computers owned by different users, and two university library computers located at Virginia Commonwealth University. All of these searches were done without being logged into any Google accounts, but produced the same two websites within the search results.⁹ A non-probability convenience sample was utilized, thus representativeness is not met for online support forums.

As a guide, Kimberly A. Neuendorf's (2002) *The Content Analysis Guidebook* was utilized. The guidebook served to navigate the process of conducting content analysis research. The study was qualitative due to the coder subjectively classifying the text into a thematic coding scheme through personal interpretation (Hsieh & Shannon, 2005). It was also quantitative in that a thematic coding scheme counted each time a subject referred to the decision making process, thus allowing for exploratory statistical analysis of the data. The content analysis focused on manifest content--what women actually wrote as opposed to what they meant to write. Manifest content captures not the meaning behind the text, but the actual text in itself (Neuendorf, 2002). The unit of analysis was confined to phrases and/or complex sentences of explanations or descriptions of women's perceptions of how they acted on their autonomy during the childbearing method decision-making process, and how they perceived the medical industry to have made decisions for them. The analysis was thematic, as it captured themes found within the text of the authors (Neuendorf, 2002). Furthermore, there was only one variable being measured, which was whether the decision to undergo a non-medically indicative CS was perceived by the subject to be individually chosen or chosen by her doctor. The variable was nominal because it measured only whether or not women perceive their own agency in their childbearing decisions.

Below is a categorization matrix created to make sense of the data:

⁹ The only noticeable differences between searching on different computers were what page of research results the websites appeared on. For instance, one search yielded Whattoexpect.com on the first page of search results, while Pregnancy-info.net was found on the second page of search results.

Table 2: Categorization Matrix of Content Analysis Codes

		Example Key Phrases: Internet identities discussing their CS decision-making process
The decision to undergo a non-medically indicative CS was structurally influenced and/or individually chosen	Individual	<i>The unknowns associated with attempted vaginal births are too numerous and too unnerving for me [...] With a [CS] I feel more in control.</i>
	Doctor	<i>I had a [CS] only because my doctor doesn't do VBAC. Sucks but whatever is best for my baby.</i>
	Combined Decision	<i>My 2nd was 'elective' (in quotations because VBAC was an option for me but my doctor wasn't real gun-ho about it for a couple of reasons so we decided against it and also opted for getting a tubal done at the same time.</i>
	Indeterminate	<i>I also have to add, that I had a [CS] and was worried when people said its major surgery, but I found it no big deal, and that yrs ago, my sister-in-law just had a vaginal birth, a few [months] ago, and is still feeling the after effects of it now</i>

Note: "Indeterminate" is for vague responses about whether the woman had a medically necessary CS and/or whether the decision to undergo a CS was perceived to be chosen by her or her doctor. All women were participating on discussion board about CS without medical indication and similar subject lines (e.g., comparing vaginal to CS delivery).

The method for conducting the content analysis was to first determine the theme of each entry, i.e. perception of who made the decision to undergo CS for a previous or current childbirth; and

second, to count the number of times each theme was reported. In terms of the coding scheme, the coder counted the number of times a woman referred to the decision-making process from a structural or individual level (see: Table 2).

Results

As mentioned above, a simple coding scheme was utilized, first coding the themes, and then counting the number of times each theme was reported. Structuration was supported in the complexity of the distinguishing decision-based categories, as some women were not explicit about their decisions, and some were not specific on whether their CS was medically necessary. Through close observation of ongoing dialogue of particular forum users, however, an understanding about subjects' perception of childbirth decisions occurred. For instance, one user stated that she wanted to have a vaginal birth for her second childbirth due to third and fourth degree tearing during her first, while her doctor opposed this desire and scheduled her CS. It was common for other women to be explicit about their reasoning to undergo a CS without medical indication, and often this was due to stories they had heard from other women about tearing. One user's response:

I am actually quite angry because so many vaginal moms told me to ask for a [CS] because they said they heard it was the easy way out. Also, I am angry at my doctor as he said I wouldn't have any problems with a [CS].

For responses that did not explicitly state who chose the CS delivery, a code of *Indeterminate* was assigned. Indeterminate responses did not capture women's perception of decision-making, but it still could capture overall structural influences on women's perception to delivery by CS. An example of one woman's indeterminate response is of follows: "I suggest [CS]! I am a baby when it comes to pain and my [CS] was a BREEZE!" This mother prefers CS, but does not give details on the decision process. Thus, it cannot be determined whether she perceived her CS to be chosen for her or if she reported to actively choose her own CS. Lending support to structuration theory, the large amount of responses within the *Indeterminate* category

(40.9 percent) suggests that it's inconceivable to understand when agency ends and structural influence begins, as these two categories are continuously influencing one another at every moment.

There were also responses coded under the category *Combined Decision*. One example of a combined decision came from a woman who reported:

My 2nd was "elective" (in quotations because VBAC was an option for me but my doctor wasn't real gun-ho about it for a couple reasons so we decided against it and also opted for getting a tubal done at the same time).

Because there were women who reported their doctor's attempt to influence them in the direction of a CS; used inclusive pronouns; and discussed their own desire or passivity to undergo surgical birth, statements such as the one above were coded under *Combined Decision* as opposed to *Doctor*. However, these excerpts were highly contextual. The entirety of the text by an author was observed in order to determine whether the subjects' statements appear to be perceived as individually- or structurally- based, combined, or indeterminate. A summary of each category's frequency is found below in Table 3.

Table 3: Summary of Category Code Frequencies for Pregnancy-Info.net and Whattoexpect.com CS Forums

Code Categories	Pregnancy-Info.net		Whattoexpect.com	
	Frequency	%	Frequency	%
1. Individual	29	45.3	33	45.2
2. Doctor	6	9.38	10	13.7
3. Combined Decision	1	1.56	2	2.74
4. Indeterminate	28	43.8	28	38.4
Total	64	100	73	100

Values were assigned to each category, ranging from one to four, respectively. The category *Individual* was assigned 1, *Doctor* was assigned 2, *Combined Decision* was assigned 3, and *Indeterminate* was assigned 4. Table 3 summarizes the frequencies of each coded category, where the most common frequencies were for the categories *Individual* (45 percent for each

website) and *Indeterminate* (43.8 percent for Pregnancy-Info.net, and 38.4 for Whattoexpect.com). The category *Doctor* accounted for 9.38 percent for Pregnancy-Info.net, and 13.7 percent for Whattoexpect.com. The category *Combined Decision* had the least frequency, being 1.56 percent for Pregnancy-info.net, and 2.74 percent for Whattoexpect.com.

In terms of exploring women's choice to undergo CS without medical reason, the content analysis yielded five categories, with seven sub categories (See: Table 4). Some of these categories paralleled what was found in the literature (See: *Choosing CS*, page 11); however, the subcategories brought to light that the reported reasons were more complex than what the literature suggests. In addition to women's reasons to choose CS delivery, two categories were created for the category *Doctor* in order to explore women's reports of why their doctor scheduled their CS. The rationale for creating these categories was due to subjects' reports that they had the option for undergoing vaginal delivery, but that their doctor chose CS. Thus, the reports reflect women's perceptions of their delivery being non-medically indicative, and additionally being chosen by their doctors.

Table 4: Reasons individual chose to undergo CS without medical indication as reported in Pregnancy-info.net and Whattoexpect.com

Reported Reasons: <u>Individually Chose CS</u>	<i>Pregnancy-Info.net</i>		<i>Whattoexpect.com</i>	
	Frequency	%	Frequency	%
Fear/ Concerns of Vaginal Birth	21	51.2	13	31.7
External Information/ Delivery Choice	11	26.8	11	26.8
Previously Successful/ Pleasant Cesarean Section	4	9.76	2	9.76
Convenience and Control	2	4.87	8	19.5
No more births after CS	0	0	1	2.44
Unknown/ Insufficient details	5	12.2	6	14.6
<u>Total</u>	<u>41</u>	<u>100</u>	<u>41</u>	<u>100</u>

The content analysis results suggest women report undergoing CS for reasons found within the literature (convenience and control; fear for the self and fetus; and to preserve the body's shape and function).¹⁰ Other reasons paralleled these general themes by expanding into categories on delivery choice and external information; having a previously successful and pleasant cesarean section; and scheduling a CS for her last childbirth due to not having any further children. Some categories within the literature also seem less informed than what was found in the content analysis. For instance, the content analysis found that many women who reported undergoing a CS due to wanting to avoid tearing during vaginal birth expressed this concern more as a fear rather than solely an issue of body preservation, which is not conveyed in the literature. The following sections are an elaboration of the findings presented in Table 4.

Fear/Concerns of Vaginal Birth

This section encompasses three subcategories: *Psychological Reasons*; *Concerns of Vaginal Birth Difficulties*; and *Health and Safety*. *Psychological Reasons* deals largely with women's reports on choosing CS delivery due to panic attacks, Tokophobia, and other related psychological reasons. *Concerns of Vaginal Birth Difficulties* encompasses a spectrum of reports that are concerned, most often, with vaginal tearing, and other related difficulties. The last subcategory, *Health and Safety*, concerns women's reports of choosing CS delivery due to a belief that it is safer and healthier than vaginal birth.

Psychological Reasons

Because psychological reasons are concerned with mental health, it may be debatable whether women who reported choosing CS based on psychological reasons fall outside the realm of non-medically indicative CS delivery. Regardless of this potential quarrel, these reports have been included in the analysis because no indication was given that health care professionals diagnosed their said mental illnesses. Thus, the reports are considered non-medically indicative for this study. The women who reported to have chosen CS due to psychological reasons (n=3)

¹⁰ The sample size is very small. With a larger sample size, there might be reoccurring themes that are not well captured in tables 4 and 5

generally dealt with anxiety over childbirth. One woman stated that she underwent CS childbirth due to extreme anxiety in conjunction with fear: “My reason [to undergo a CS] is because of extreme anxiety and an overwhelming fear of natural birth.” Another woman reported that she had an extreme fear of childbirth, to the extent that she reported to believe she had Tokophobia—the medical diagnosis for this fear. Another woman reported to schedule her CS due to panic attacks:

First, I should mention that I have had one child already by vaginal delivery and this time I opted for a [CS]. I had no medical reason, but I suffer from severe panic attacks and I wanted my delivery to be controlled and quick.

Throughout the forums, women who had been recently sexually attacked were discussing their reasons to undergo CS delivery. Their reports are not included within *Psychological Reasons*, as they had indicated being diagnosed with posttraumatic stress disorder. Other women discussed wanting to undergo CS delivery due to extreme anxiety over childbirth, but their reports were not included as they did not indicate whether they were pregnant and in the process of planning to choose their method of child delivery.

Concerns of Vaginal Birth Difficulties

Many women who reported undergoing a CS due to wanting to avoid tearing during vaginal birth expressed this concern more as a fear (n=12). Thus, it might suggest that these reports had less to do with body preservation, and more to do with fear and the after-effects of vaginal tearing, (E.g., one woman shared her experiences with the after-effects of vaginal birth, including that her bowel movements were excreting from her vagina.) Within the discussion forums, women shared their seemingly horrific experiences with vaginal birth. Some of these women reported that the tearing experienced was more painful than the birth in itself, many providing detailed descriptions of their everyday issues with incontinence. For instance, one woman noted that she had soiled herself many times while at work, which led her to feel humiliated and frustrated. Fewer than a handful of women discussed their developments of anal

fissures and severe bowel incontinence.¹¹ Women who were undergoing medically indicative CS for their current or recent childbirth often provided this level of detail seemingly in support of other's decisions to undergo non-medically indicative CS delivery.

One woman who chose to undergo CS without medical reason said:

I'm glad I don't have to lie screaming in pain as my vag is tore open. And the thought of all the other stuff coming out—afterbirth—just icks me out.

Other women contributing to the conversation discussed the preservation aspect of undergoing CS delivery, suggesting that tearing makes the vagina look like “hamburger meat.” Another woman described vaginal birth as “mutilating” the vagina. Reports of CS childbirth being a better option were also a shared sentiment. One woman reported, “I had a CS and loved it. I will never do vaginal now after seeing how easy a CS is.” Another reported after discussing tearing during a previous vaginal birth, “I would have a section any day over a vaginal birth.” Summing up the sentiment surrounding vaginal and CS delivery, one contributor wrote, “[Name] was essentially writing about me. Many mothers choose CS to avoid perceived difference in pain.”

Health and Safety

Some women reported choosing CS due to health and safety concerns for themselves (n=6), while one woman also included her unborn child in her concerns. This woman reported, “Why would I risk the lives of me and my child to experience natural labor?” Another woman reported, “The bigger the baby, bigger health risks for me.” Most women who reported to have concerns for safety and health reported that their information was provided by external sources, which is covered more extensively in the following category. One instance, for example, involved a woman who sought out the advice of her father, a former obstetrician. She reported that her father told her CS childbirth is best as vaginal birth poses more risks.

¹¹ These responses were not included, as their scheduled CS was medically necessary. However, one woman reported her doctor wanting to still go ahead with a vaginal delivery even after she had fourth degree tearing, developed anal fissures, and had severe bowel incontinence after her first childbirth, which was vaginal.

External Information/ Delivery Choice

Within the category of *External Information/ Delivery Choice*, the subcategories are *Heard or Read CS is Best* and *Doctor Provided Choice*. The first subcategory, *Heard or Read CS is Best* largely deals with women who receive advice and information on CS and vaginal childbirth. Some women report undergoing CS delivery predominantly due to the advice of others, such as family, medical professionals (related or not related to their birthing process), friends, and/or other women. Other sources are disclosed as being from their own research, thus leaving the particular sources ambiguous. The second category, *Doctor Provided Choice*, includes women who were given the choice to undergo CS or vaginal birth, and chose CS.

Heard or Read CS is Best

Some of the contributors to the discussion board noted conducting their own research, consulting medical staff, friends, family, and/or other women on whether to undergo CS childbirth. Most of the responses that fit within the category of *Heard or read CS is Best* (n=8) were also noted in other categories, as their reasoning did not fit into one particular category. (For instance, one woman was consulted by others to undergo a CS delivery to avoid vaginal tear—a fear she expressed as not wanting to undergo.) As mentioned, some women conducted their own research and arrived at the conclusion to undergo CS delivery:

I have heard all the negative remarks, and I did my research, and this I still what I want and will not allow anyone to choose for me.

One woman reported that she was told by an RN (not part of the staff handling her CS) to have a CS. Additionally the RN told her that CS should be the only option for all women because she believes the medical field does not know enough about the dangers of vaginal delivery. Another woman reported to undergo CS based on what she heard from others:

I am actually quite angry because so many vaginal moms told me to ask for a [CS] because they said they heard it was the easy way out. Also, I am angry at my doctor as he said I wouldn't have any problems with a [CS].

As with the response above, some women who chose to undergo CS without medical indication are disappointed and regretful for choosing a mode of delivery they thought would be more beneficial than a vaginal delivery. Another woman shared this same sentiment, "I chose an elective c-section and I regret it. Worst mistake of my life. I would never recommend it personally."

As previously mentioned in *Health and Safety*, one woman reported that she chose CS after consulting her father—a former obstetrician—about childbirth. Her father suggested that she undergo a CS delivery, as it is the superior mode of delivery over vaginal birth—a method she reported poses more risks. One woman reported to have read many celebrity mothers undergo CS delivery, so "it cannot be that bad." Another woman reported that she would recommend CS to any woman after working as a postpartum nurse tech, and witnessing the differences between CS and vaginal mothers in terms of recovery. She reported that many of the women who undergo vaginal birth end up with vaginas that look like "hamburger meat" in their appearance.

Doctor provided Choice

Some women reported to have scheduled their CS due to a previous vaginal birth that was traumatic. In some cases, women reported that their doctors gave them the choice whether to have a CS or vaginal birth [due to vaginal birth after cesarean (VBAC), breech presentation, and size of the fetus or mother] and they chose CS. To use responses from women who have had previous CS deliveries or have a breech presentation is likely controversial; however, their responses were valid as they *perceived* the decision to undergo either vaginal or CS as not being medically indicative. One woman even reported that her doctor insisted she have a VBAC, but she refused. Another woman reported, "Doc gave option, I chose [CS]," as another reported, "I had an ECS. My doc gave me the choice, which I really appreciated."

Some women without medical reason reported asking for a CS to only have their doctors firmly refuse. Some of these women, and others, asked around the forums about particular doctors who will schedule CS without medical indication. Some women responded with details—giving the hospital and doctor’s name where other women ought to seek out services for CS deliveries.

Previously Successful/ Pleasant Cesarean Section

Some women reported to have scheduled their CS due to a previously successful and pleasant cesarean section delivery (n=6). Whether the previous cesarean was medically indicative or not was often unknown. One woman reported to have a previous CS and mentioned, “My doctor didn’t even question my choice.” Another woman reported that her first cesarean section was due to a breech presentation. Though she reported that he doctor suggested she undergo a vaginal birth for her second child, she decided to undergo a CS because she “felt it went so well.”

Control and Convenience

Within the category of *Control and Convenience*, three subcategories were created to further identify different dimensions within women’s reports to undergo CS delivery without medical reason. These three subcategories are *CS for Convenience and/or Control*; *Avoidance of Emergency CS*; and *Family*. *CS for Convenience and/or Control*, captures women directly communicating that their CS was chosen for convenience and/or control of childbirth without providing a specific reason. The subcategory, *Avoidance of Emergency CS*, encapsulates the reports of women who reported to have scheduled a CS in order to avoid a potential emergency CS during attempted vaginal birth. Lastly, the category *Family* represents a category of women who reported choosing CS due to their family’s desires (i.e., significant other). Explications of the findings are found in the following three sections.

CS for convenience and/or control

Some women communicating in the discussion forums reported they chose CS delivery for the purposes of convenience and/or control over their childbirth (n=5). According to these women, scheduling a CS allows for them to know when, where, and how their birth will be conducted. One woman reported, “I am just going to opt for c-section, because it’s more controlled and there are less things that could go wrong.” A common theme among women who opt for CS birth report that the method has less complications and unknowns. Another woman reported, “The unknowns associated with attempted vaginal births are too numerous and too unnerving for me. With a [CS], I feel more in control if that makes sense.” Control over labor, for this woman, means eliminating as many risks possible that are associated with childbirth. Similarly, another woman reported, “Personally, I find c-sections reassuring because of the controlled environment.”

Avoidance of Emergency CS

Some women reported to have scheduled their CS because they wanted to avoid undergoing an emergency CS due to a failed vaginal delivery (n=3). This brings about a curiosity on whether women are becoming more aware of the consequences of giving birth in a hospital setting, and scheduling a CS is their way of responding to it—taking back control in a situation where they may experience much less autonomy. Supporting this idea, one woman insisted that the fourth degree tearing she experienced during her first vaginal birth must have been due to the amount of Pitocin (a drug used in hospitals to induce labor) given to her. Interestingly, her doctor insisted she have a repeat CS, but she declined and gave birth at home with what she reported to be only two-degree tears, which avoided the perennial scar tissue from her previous delivery.

For some of these women, opting for a CS without medical indication would be a better birth plan by bypassing unnecessary complications led on by a failed vaginal birth. These same women reported that the recovery time for an emergency CS would take longer, as the trauma from attempting a vaginal birth, and the surgery from a CS, would be overwhelming. One woman reported, “I just prefer the scheduling of it, less stress for me, and I know I won’t have to push and possibly tear and need a section anyway.” Another woman, who had already experienced the trauma of an emergency CS, reported the following:

I am going to have a planned CS because I had an emergency CS with my son, after 2 days and 6 hours of pushing. He was stuck [...] I don't want to end up with a similar situation!

Some women also reported to have received information from health professionals. For instance, one woman reported to have been informed by several sources—including two obstetrician/gynecologists—that CS deliveries are less traumatic for babies than emergency ones. She reported to have scheduled a CS in order to bypass the possibility of undergoing an emergency one.

Family

Some women reported scheduling a CS for the benefit of their family, and/or advice of their significant others (n=2). The desire to undergo a CS delivery appeared to be for the general convenience for the entire family, and not just the mother. One woman reported:

[Husband] always says how CS is the way to go. Our entire family can be there and avoid waiting for hours on end. He also prefers because my [blood pressure] is out of control by the end of each pregnancy and it is much safer for us.

It is evident from this woman's report that she underwent a CS delivery for the convenience of her husband, and the rest of her family. This is contrary to what was normatively found throughout the content analysis, as most women were concerned about how the childbirth procedure affected them.

No More Births After CS

One woman reported that she scheduled her CS because it was her final childbirth. She reported to have already undergone vaginal birth without complications (n=1). Further information was not provided.

...

In sum, there were different, and often times overlapping, reasons why women chose non-medically indicative CS delivery. Beyond exercising agency, some women were not given the choice to undergo CS, even though they perceived their delivery to not be medically indicative. Table 5 outlines the different categories women reported to have undergone non-medically necessary CS delivery to their contempt. These categories are *VBAC/ Breech Position*, *Size: Mother and/or Fetus*, and *Unknown/ Insufficient Details*. The latter category is not further explored.

Table 5: Reported reasons doctor chose to conduct CS without medical indication for Pregnancy-info.net and Whattoexpect.com

Reported Reasons: Doctor Scheduled CS	<i>Pregnancy-Info.net</i>		<i>Whattoexpect.com</i>	
	Frequency	%	Frequency	%
VBAC/ Breech Position	2	28.6	5	50.0
Size: Mother and/or Fetus	3	42.9	1	10.0
Unknown/ Insufficient details	2	28.6	4	40.0
Total	7	100	10	100

VBAC/ Breech Position

VBAC and breech presentation is believed by a growing population to be medically safe for vaginal birth under particular circumstances. Some of these circumstances include the way in which the fetus is presented (some breech presentations provide mandatory CS delivery), and also the number of prior CS deliveries a woman has already endured. Given these brief explanations, vaginal delivery is believed to be safe for some of circumstances. Some doctors, however, according to the reports of women in the online forums, suggest that their doctor mandated their CS even though they believe the pregnancy to be fit for vaginal delivery (n=7). One woman reported she underwent CS delivery because her “doctor doesn’t do VBAC. Another woman reported:

The doctor on call said I had to have a [CS]. I told her no my doctor said I could deliver vaginally, but she told me it was her decision and I didn't have a say—which I now know was a lie.

Another woman reported, “Even though I probably want three [children] max, it upsets me that the choice has been taken away from me.” This woman was referring to wanting three children, and was upset that her doctor mandated her to have a CS due to breech presentation.

Size: Mother and/or fetus

Women who were mandated to undergo CS delivery due to their own size, or the size of their unborn child, were similarly disappointed that they could not undergo a vaginal delivery they thought was possible (n=4). One woman stated:

My doctor decided to do a [CS] because she didn't think I'd be able to deliver vaginally [...] If I was given the choice I would have delivered naturally.

Other women reported to have undergone a CS delivery due to size, though not all reports indicated that the women was upset or disappointed to have undergone the surgical delivery. One woman even reported that when she found out she was to go undergo a CS delivery due to size, she and her husband immediately high-fived one another and were happy about the doctor's decision. There was a reported case where the mother reported that her doctor scheduled her for a CS, telling her it was medically necessary. Incidentally, she was relieved to go into labor before her scheduled date, and was able to have a vaginal birth free of complications.

Other Findings

Throughout the content analysis data collection phase, conflict in the discussion board threads was apparent. Many of the women who had a CS without medical indication were defensive about their decisions, as many pro-vaginal childbirth advocates (identified usually as

mothers) would enter the CS discussion offering their opinions and advice. One pro-CS poster wrote:

What is your point posting on this thread? The OP called for women who have had c-sections to give encouraging words of advice- not posters who for some reason believe this is a 'bash c-sections' or 'elective c-sections' thread. This is seriously annoying.

Another wrote:

I have had wonderful c-section experiences too and just don't "get" why they are viewed so negatively. If we c-sectioners get put on the defensive, we might need to mention sex after delivery, trampolines and other shallow crap. I would really hate for that to happen.

Though these women, among others, were quick to respond to the pro-vaginal contributors, the opposition continued to voice their opinions. One wrote, "I'm sorry but it just seems kinda vein [sic] to me to put that your baby will have a prettier head if you have a c-section." Some CS mothers and soon-to-be CS mothers would ask pro-vaginal participants to leave the discussion board. In defense of their surgical delivery, some women were quick to report that they had a CS for personal reasons, and no one ought to judge their decisions, "I requested [CS]. And yes, I am a [first time mother]. It was a personal decision."

Benefits and Limitations

Benefits of content analysis of existing data sources include its low cost and unobtrusiveness. For the research purposes of this study, content analysis provided direct examination of the attitudes, opinions, and thoughts of women who have undergone non-medically indicative CS delivery. This aided in understanding the population without having to conduct interviews, and thus not having direct contact with subjects. From this, observations of the sample population's perceptions occurred in online support forums—areas where women arguably feel more comfortable talking about their experiences and opinions due to the anonymity online discussion forums provide.

However, there are also limitations to conducting content analysis. Because this method is descriptive, it did not reveal the underlying motives for women to undergo CS deliveries without medical indication. It could be argued that the content analysis is only able to scratch at the surface—the *perceptions* and not the communication exchange between the doctor and patient that led to a decision. This limitation became clearer during the data analysis phase. While the research endeavor is to analyze the reports of women—their *perceptions*, it does not analyze what happened during the doctor-patient interaction, and what kinds of communication led to the overall decision to undergo surgical birth. Thus, it could be that the influence to undergo surgical delivery was per the influence of multiple actors that the woman did not discuss. Furthermore, when women reported that their doctors gave them a choice to undergo CS or have vaginal delivery, it was indeterminable how much influence the doctor had in their decision to undergo CS. The complexity of the doctor-patient interaction is left to subjects' discussion in the online support forums, and obfuscated from the researcher's analysis. Thus, analysis cannot truly determine whether women's decisions to undergo CS were by their own choice, or the choice of their doctors, without further research methods being implemented. Thus, data analysis made it difficult to determine the structural influences, as they were seldom mentioned for women who chose CS without medical indication. Semantic usage of terms, such as "I chose" or "I wanted to have a c-section" made clear the complexity of understanding the structural and individual decision-making process without detailed narrative on the part of the subject.

Furthermore, utilizing Giddens' term of *structure*, which ought to encompass all different social institutions working collectively to influence social phenomena, the research conducted in this study only examined a representation of one social institution: the medical profession. The doctor cannot account for the entirety of the medical industry, thus the limits to testing Giddens' theory must be understood. Ideally, a more thorough analysis would examine influences from differing social institutions, but also the medical industry as a whole.

Lastly, an additional limitation was not being able to conduct content analyses in online forums that required subscription, thus not being able to analyze data that would have otherwise been beneficial to the research. It is possible that much of the information potentially obtained through subscription holds a deeper level of trust among members, i.e., networking about doctors who schedule CS deliveries without medical reason or thinking pro-vaginal birth advocates can

view and comment in their discussion threads. The task of inter-coder reliability could not be met, as there was only one coder. Validity of studying subjects' *perceptions* of individual- and structural (medical professionals for these purposes) was conducted through manifest content analysis, and the coder created the categories. According to Babbie (2010) manifest content has the benefit of examining surface phenomena, but it suffers by lacking validity, as the code categories can take on differing meanings according to the interpretation of the coder. For example, *individual choice* might mean something different to the coder of this research project than it does to someone else. Thus, although interpretation of the text was not a research task, only one coder was assigned to code the data, which created a disadvantage in the interpretation of the categories used.

Summary and Implications

This study explored reasons why women undergo cesarean section delivery without medical indication, applying structuration to the medicalization framework in order to understand the phenomenon from a structure-agency standpoint. The analysis attempted to bridge together both second- and third wave feminist critiques of medical intervention in childbirth, further lending support to third-way feminism. In this particular instance, however, it is important to recognize that this study *only* attempts to make sense of medical intervention in childbirth that is still considered elective by most of the healthcare industry and lay public. A secondary data analysis and a quantitative content analysis of Internet pregnancy support forums were conducted. The secondary data analysis examined the structural reasons women undergo cesarean delivery, though the sample was not representative of women who underwent the delivery without medical reason, as it included all women who gave birth in 2005. The content analysis served to understand the reasons why women choose to undergo non-medically indicated cesarean delivery, paying particular attention to individual- and structurally perceived reasons.

The first part of the analysis found that women who reported pressure to undergo a cesarean delivery had a much higher rate of cesarean section deliveries. These respondents comprised of 82.5% of the sample population, as compared to 17.5% of those who reported pressure to undergo a cesarean delivery, yet underwent a vaginal childbirth. The findings support

previous research that suggests women report feeling pressure to undergo CS delivery in the hospital setting (Declerq et. al., 2006a). The second part of the analysis found that women who elect to undergo CS delivery without medical indication do so for reasons pertaining to fear or concerns of vaginal birth, desire to control the labor process, and convenience of knowing when and where the delivery will occur. These findings support what is found in the literature. In addition, women in the Internet pregnancy forums made decisions due to influence and planning around their family. They also made decisions based on the information gathered from friends, other mothers, and their own research on childbirth. These findings expand upon the current literature, and shed light on the many differing reasons women perceive CS delivery to be a better birthing method over vaginal delivery.

Based on these findings, it is inconclusive whether the rise in non-medically indicated CS deliveries are due to either the practices of the medical industry or women's own desire for surgical birth (41% indeterminate, and 2% combined decision). Rather, both the medical industry and patients play a role in this trending medical phenomenon. To some degree, this supports structuration theory, yet it is difficult to determine how the decision-making process authentically occurs based on women's perceptions. Nonetheless, structuration aids in understanding how this phenomenon is on the rise: More doctors are accommodating women's desires, while at the same time women are acquiescing to or influenced by healthcare professionals to undergo surgical birth. Another indication of structuration regards the influence from other social institutions on women's decisions to undergo CS childbirth. If "structure" was operationalized beyond healthcare professionals, the content analysis may have yielded additional support for structuration theory. However, the indeterminate findings may also suggest women internalize structure from a multitude of social institutions (family, peers/networks, healthcare industry, etc.).

Thus, implementing either a second- or third wave approach to understanding the rise in non-medical CS deliveries leaves out a holistic understanding of the phenomenon. If one is to choose a second wave approach, s/he leaves out the importance of the individual reasons women choose to undergo CS delivery, further excluding the reality that most women experience feelings of fear and concern over childbirth for legitimate reasons. Women are also concerned with having control over their own labor, which may have more to do with believing the spontaneous oncoming of a vaginal birth in the hospital setting does not provide adequate

control. Supporting this claim, some women reported scheduling a CS in order to bypass a potentially failed vaginal delivery—leading to an emergency cesarean section. Thus, the fear and concerns women report are all too real. Social scientists must understand the experiences of women to be real in and of themselves; and not invalidate them as being illusory or misguided. Understanding the reasons why women choose surgical birth is the first step in alleviating their anxiety-laden perceptions. Simultaneously, utilizing a third wave critique of childbirth leaves out the significance of the structural influences on the rising non-medical CS delivery rate. Overwhelmingly, the literature's findings suggest there are reasons why women undergo CS delivery beyond their own desire. The findings of this study supported those in the literature, such as Declerq's (2006) finding that women feel pressure to undergo medical technology against their own desires. Thus, disregarding the structural reasons in the CS delivery rate fails to fully understand the phenomenon; and is required if considering policy initiatives for lowering the rate to WHO standards.

Through understanding this growing phenomenon from a structure-agency standpoint, social scientists are more qualified to make informed policy recommendations to lessen its occurrence. To begin, this research does not encourage public health policy officials to offer recommendations on what women can or cannot request for their birthing methods. Taking autonomy away from women is not progress from a social-, political-, or medical standpoint. CS delivery is no exception to this rule, and I would challenge others to examine the issues women face as they continue to find balance between medical- and natural approaches to childbirth. From an individual-level standpoint, we should encourage women to seek out information regarding medical intervention in childbirth. Declerq's 2006 analysis suggested women feel ill-informed of the medical interventions administered during childbirth. Thus, non-profit campaigning that provides coherent information regarding medical intervention is most beneficial. This information should be made accessible to all women of all social locations. Information gives power back to women to feel confident in their birthing choices. Further, this campaign should also provide women with information on alternative methods of childbirth, including methods that extend outside the hospital setting. I strongly recommend against policy initiatives that take more choice away from women in their birthing methods.

At the structural level, there are several policy proposals that will dramatically aid in reducing non-medically indicated CS deliveries. The first should aim to establish women's

confidence in giving birth in the hospital setting. In doing this, midwifery needs to be reintroduced into mainstream American health practices. This is not unusual for the Westernized world, as Canada and developed nations throughout Europe utilize both a physician and trained midwife during childbirth. There are many aspects to vaginal birth that healthcare professionals—physicians and physician extenders—have not been trained to conduct. One important technique is preparing before the child's head crowns. The expertise of midwives may reduce tearing and other issues many women perceive to occur with vaginal birth, which will in turn give women more confidence in choosing vaginal delivery. Additionally, midwives serve as the balance between American medical practices and traditional childbearing methods, creating an optimal and holistic environment for birthing women. Incentives to encourage midwifery in mainstream childbearing practices will require legislative power. Most importantly, midwifery should be made available for all women who enter the hospital setting, regardless of social location. Midwives should also be available at for profit and non-profit hospitals. Insurance companies should be able to cover the costs of childbirth care for an obstetrician and midwife. Economists who focus on the healthcare policy should conduct analyses in order for public health policy makers to put forth legislation in the near future.

The emphasis on midwifery combined with American medical practices may reduce the rate of non-medically indicated CS deliveries, but it will not be enough to alleviate other structural issues surrounding the rising CS delivery rate. As the literature suggests, childbearing practices are becoming more concerned with efficiency. Attention must be drawn to this concern by implementing workshops and reoccurring annual training for healthcare professionals. However, the concern over doctors' hectic schedules still remains. Incentives ought to be created for those training in the healthcare profession to remain in non-specialized fields. The need for primary care physicians and obstetricians is increasingly becoming an issue in the United States, as more medical students are moving into specialized fields for increased salaries. Monetary incentive ought to be a policy initiative to get students remaining in primary care roles. In addition, stressing the issue of clinical impatience is imperative. With these combined efforts, the United States will see a decrease in the non-medical CS delivery rate.

Future research ought to examine communication between mothers and their doctors in order to better understand the decision-making process for childbearing methods. Understanding the modes of influence may aid in unraveling how the CS rate can be lowered; and especially for

women who undergo surgical delivery without medical reason. Research that aims to illustrate persuasive, confirming/disconfirming, and appropriate doctor behavior will aid in understanding the decision-making process in childbearing decisions and outcomes. In addition, a development of third-way feminism needs to be conceptualized. Several papers that utilize third-way feminism (Cavalieri, 2011; Grey and McPhillips, 2007) fail to define what it is, and how it can be implemented in understanding social phenomena from a feminist standpoint. It is imperative to understand third-way if we are to discuss a structure-agency approach to feminist critiques on a multitude of poststructural, complex social phenomena that directly affect women--especially when examining women's reproductive autonomy and the growing complexity of the medical industry's influence on women's childbearing decisions and outcomes.

Comparing *Listening to Mothers II* and *Listening to Mothers II Postpartum* Results to U.S. National Birth Records

To more accurately reflect the target population, *Listening to Mothers II* and *Listening to Mothers II Postpartum* data were weighted by key demographic variables, as well as by a composite variable known as a propensity score, intended to reflect a respondent's propensity to be online. Additional information about this methodology, which has been validated by Harris Interactive, is available in appendices to the *Listening to Mothers II* and *New Mothers Speak Out* reports, available at www.childbirthconnection.org/listeningtomothers/. The table below compares demographic and childbirth-related results from the weighted data of the two surveys to a comparable national population derived from birth certificate data from 2005, the year when the survey participants gave birth. All three columns describe women 18 to 45 years of age who gave birth to a single baby in a U.S. hospital in 2005.

Data Item	<i>Listening to Mothers II</i> (2005) n=1,573	<i>Listening to Mothers II</i> <i>Postpartum</i> (2005) n=903	Singleton hospital births to women 18-45 (2005) n=3,821,309
Birth attendant			
Doctor	92%	92%	92%
Midwife	8%	8%	8%
Mother's race/ethnicity			
White non-Hispanic	63%	66%	55%
Black non-Hispanic	12%	11%	14%
Hispanic	21%	18%	24%
Asian and other	4%	4%	7%
Mother's age			
18-24	28%	25%	34%
25-29	27%	28%	28%
30-34	25%	27%	24%
35-39	14%	15%	12%
40+	6%	6%	3%
Number of times has given birth			
1	33%	39%	39%
2	38%	35%	33%
3+	29%	26%	28%
Mother's education			
High school or less	44%	41%	49%*
Some college	28%	30%	24%*
College and post-graduate	28%	29%	27%*
Method of birth			
Vaginal	68%	69%	71%
Vaginal, vacuum extraction or forceps	6%	7%	7%
Vaginal birth after cesarean	2%	2%	1%*
Cesarean	32%	31%	29%
Primary cesarean	16%	17%	18%*
Repeat cesarean	16%	14%	12%*

*Official national estimate not available. Education and method of birth were measured differently in states that revised their birth certificate (1,141,738 singleton, hospital births to 18 to 45 year olds) compared to states that had not revised their birth certificates (2,640,319 singleton, hospital births to 18 to 45 year olds). Above figures with asterisks represent estimated rates combining revised and unrevised states for education, VBAC, primary and repeat cesareans weighted by population in states with and without revised birth certificates.

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