Caesarean sections on request: Perceptions and positions (1996-2008)

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This thesis is the result of my own work. It does not exceed the word limit set by the Degree Committee.

Abstract

This thesis examines perceptions of caesarean sections on request from the mid-1990s to 2008, and in particular the meaning of the term and how this mode of delivery has affected doctors' practice, as well as the opinions of expectant mothers. Within the field of obstetrics, caesareans on request represent a highly relevant issue, not only because a quarter of all births are currently by caesarean delivery. However, despite its relevance, this topic has not yet been the subject of substantial academic research.

Caesareans on maternal request refer to caesareans with no clinical indications and thus no obvious medical justification – this fact in particular has stirred the medical world as well as evoking disputes among pregnant women. By exploring the views of medical professionals and mothers-to-be, this thesis uses an interdisciplinary approach, combining aspects of medical history and the social sciences. Furthermore, it goes beyond the clinical perspective by researching popular scientific publications, such as advice books and even debates on online forums.

The phenomenon of caesareans on request suggests a change in indications, as well as a shift from caesarean delivery as an emergency intervention to a viable option. It involves an interaction between patient autonomy, risk assessment and prevention; furthermore, obstetric behaviour and changes in medical attitudes have played their part in providing the grounds for making maternal choice possible.

Contents

List of illustrations

List of abbreviations

DGGG Deutsche Gesellschaft für Gynäkologie und Geburtshilfe [German Association for Gynaecology and Obstetrics]

ECV External cephalic version

FIGO Fédération Internationale de Gynécologie et Obstétrique [International Federation of Gynaecology and Obstetrics]

NICE National Institute for Clinical Excellence

WHO World Health Organisation

Statement of copyright

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1 Introduction

My thesis is about childbirth and, in particular, caesarean section (CS) on request. This mode of delivery not only represents an example of patient autonomy, but also demonstrates what has changed in childbirth issues, especially during the years 1996 to 2008. The topic introduces the theme by providing information from an interdisciplinary selection of sources. It also gives special attention to caesareans on request in first-time mothers. Moreover, I have tried to focus on internet forum debates, since discussions seemed authentic, and this section represents an opportunity to compare findings with a more practical environment.

What is it about in particular? The main theme is a contemporary mode of delivery, caesarean sections on request. Caesarean sections have existed for a long time but what is new is a shift in responsibility and changes in decisions about how to give birth. That is, medical laypersons who have gained influence and participated in medical decisions no longer leave the assessment exclusively to doctors. I also analyse the various reactions of individuals concerning caesareans on request, as well as the resulting positions and statements.

What comes to mind upon hearing the words "caesarean section on request"? The listener will probably think of surgery and women who choose this route of delivery for no medical reason but instead, as the term implies, on request. This encompasses one controversy of caesareans by choice – babies are born via an artificial, surgically created birth opening, and mothers-to-be (instead of doctors) decide on the medical procedure to be used. However, the issue of caesareans on request is far too complex to be

summarised in a few sentences. Mothers and obstetricians are two groups who are particularly involved in this topic and the related debates; these participants are fundamentally different, representing laypersons and medical professionals. They are united by the issue of childbirth. How they think about caesareans on request and how they approach this mode of delivery will be explored in this thesis.

1.1 A brief note on the issue

In the field of obstetrics, caesarean sections on request represent a widely discussed and controversial topic.[1] In the mid-1990s, this (at the time) new mode of delivery started hitting the headlines of journals and magazines. Since then, it has received constant attention. Representing a subtype of the elective caesarean section, the "request" caesarean no longer requires any medical indications. The decision depends solely on a maternal request. Thus, caesareans on request became a further example of pre-existing debates on patient autonomy and self-governance.

As the debates developed, discussions on issues relating to caesareans were no longer restricted to obstetrics. The involvement of maternal choice and other (e.g., psychological) indications resulted in other academic fields, such as psychology, anthropology and social studies, also contributing to the debates. In general, issues of childbirth seem to stir up emotions. The nonmedical public informed itself by consulting (parenting) magazines, newspapers or popular scientific advice books. Internet information portals and online discussion boards became an important

[1] Terminology: caesarean (section) on request, request caesarean (cf. Bewley/Cockburn 2002) and caesarean by choice all refer to the same phenomenon. These terms are used synonymously in this thesis, in order to avoid redundancies in style.

influence, as they spread opinions quickly and are accessed by a broad audience.

1.2 Aims and approach

A great deal can be said about caesarean sections on request. Some opinions have already been mentioned. The purpose of this thesis is to develop an understanding of what is actually meant by "caesareans on request," including opinions and discussions resulting from misconceptions and clashes of statements. Various perspectives and approaches exist for exploring the issue. Moreover, there must be a reason why caesareans on request have become so popular in the media. In this context, this thesis will furthermore enquire as to whether caesareans on request are a temporary fashion or whether they are the next step in the development of obstetrics.

Overall, this thesis aims to deliver a comprehensive approach to caesarean sections on request, involving their main participants: obstetricians and expectant mothers. Resolving issues with regard to the increasing caesarean rates has never been a goal of this thesis (and I doubt that it could be achieved through my analyses).

This thesis looks into publications about caesarean sections on request from between 1996 and 2008 (approximately). The time span of this thesis is based on the time when discussions about caesarean sections on request first arose. Of course, the disputes did not stop after 2008, but I had to draw the line at a particular date that corresponded to my research period.

This thesis analyses opinions regarding this mode of delivery and provides an overview of how it is represented in debates. In the context of the characteristics assigned to this mode of delivery, the project furthermore

evaluates which topics and contrasting views have played a major role in these disputes. From the participants' (i.e., obstetricians and expectant mothers) perspective, gathering information not only helps to form an opinion, but also to reach a decision. However, the actual percentage of pure caesareans on request – i.e., caesareans for no medical reason – is rather low. Nevertheless, this small percentage has provoked heated debates. What is the actual controversy surrounding request caesareans?

1.2.1 Academic discipline

The thesis belongs to the discipline of medical history, and in particular history being close to everyday life (which is particularly expressed in the chapter on internet discussion boards). It concentrates on the description and reconstruction of the development of caesarean sections on request, including identification of key events. Thus, it is mainly a historical account (which is strengthened by using the past tense). The method of discourse analysis adapts well to historical topics.

The issue of caesarean delivery on request is assigned to medicine and healthcare. Technical publications in particular contained many medical terms, such that the topic might best be understood by those with a background in the health professions. I had in mind to address medical historians as well as medical professionals (especially obstetricians) with an interest in childbirth. The field of history was included in the account of the development of caesareans on request, one of my goals being to reconstruct what had changed over the years regarding this mode of delivery.

As for expecting women and mothers, it is unlikely that this thesis would be able to answer their particular questions. For example, internet

forums were only examined for their contribution to the historical description of how caesareans on request were discussed. However, in general, everyone who would like to learn about this mode of delivery might like to have a closer look at this publication which is meant to be an introduction to caesareans on request because it also contains general information.

1.3 Research questions and hypotheses

How are caesareans on request perceived by doctors and expectant mothers? Are there any differences? What is so controversial about this mode of delivery?

We put forward four hypotheses:

1. Caesareans experienced a shift from emergency interventions to surgery by choice.

This hypothesis concerns medical advances in particular, as they allowed a better assessment of the risks of caesarean sections. Consequently, obstetric practice changed, which had an effect on indication catalogues. Moreover, for the first time, psychological reasons became acceptable justification for the performance of surgery. Indications are important with regard to the study of caesareans on request, because they provided reasons for surgery and, for the persons involved (doctors and mothers), served as a justification at the same time. Moreover, changes in caesarean section indications made it possible to schedule surgery in advance (a characteristic of caesareans on request), as these indications were extended.

2. Caesareans on request are preventative surgery.

A striking characteristic of caesareans on request is the lack of medical indications. In addition, the mother's choice and her request for surgery play a role. There is no clinical justification for

caesareans on request, and thus we can assume that the surgery is performed for preventative reasons only. Decisions are based on the myth that, in theory, risks could occur during vaginal delivery, and that they should be bypassed by performing a caesarean.

3. The change in attitudes towards risk represents another precondition for caesarean sections on request.

This refers (partially) to the broader context of precautions and control, which women experience during pregnancy (e.g., routine check-ups, ultrasounds and birth preparation classes). Due to medico-technological progress, it was believed that risks were being kept under control. Caesareans on request are predictable and can be planned; they not only address modern society's need for safety, but also reflect this attitude.

4. Attitudes towards childbirth and modes of delivery have also changed.

Without a shift in perceptions of vaginal delivery and changes in childbirth paradigms, requesting caesarean delivery would probably not have become an option. Vaginal birth was previously viewed as the standard birth mode and thus it was not questioned. However, when caesareans began to entail fewer risks, the potential implications of vaginal delivery were simultaneously noted and debated.

1.4 Methods

1.4.1 Discourse analysis and its application

This is an interdisciplinary thesis, combining medical history and socio-cultural studies. I previously applied discourse analysis in my Masters dissertation, and thus I was acquainted with this research method. Because of this, and because of the aim to deliver a historical overview about caesareans on request, I opted to use this methodology again, which allowed the combination of medical and nonmedical references and thus an interdisciplinary application. Discourse analysis was an ideal method to study the actual meaning of statements.

In addition, I aimed to avoid expressing a subjective position myself, and discourse analysis allowed a neutral view of debates. It did not support a particular position or judgement. It was therefore a good method to get to know different views and to grasp their meaning; this was particularly helpful regarding internet forum discussions, which at first sight could seem confusing because they contained a lot of statements.[2] By applying discourse analysis, I could identify key statements.

I refer to discourse analysis in order to develop an understanding of the participants' attitudes. A discourse, in this case, comprises a set of statements and is thus different from a dispute or a discussion. As regards putting this method into practice, I looked into statements and the goals of texts, reconstructed their meaning and set them in the context of the overall debate. This method involves more than just the interpretation of texts; it allows statements to be isolated and information to be gathered about contributors and their motives and aims. This helped to reconstruct a more

[2] Furthermore, forum contributions were often written as a spontaneous reaction and hence without being proof-read.

detailed impression of discussions, taking into account the background and intentions of participants. As discourse analysis allows comparisons of a variety of perspectives, as an approach to the topic of this thesis, it includes not only the medical perspective but also more general opinions (such as women's personal experiences, laypersons' statements and caesareans on request in popular science). Discourse analysis is therefore ideal for interdisciplinary research, as it is detached from any specific topic or discipline.

Starting with the question of what was described by the term "caesarean section on request" and, connected to this, why this mode of delivery caused controversies, the next step was gathering and then structuring information, in order to build a "corpus".[3] I wanted to deliver a chronological overview; the listing of events, I thought, would make it easier to grasp the phenomenon and to understand its developments. I also aimed to provide as many details as possible. As soon as the structure of the project was clear, I collected further material to learn more about the context.[4] In the publication itself, I wanted to answer various questions, addressing general issues as well as more particular aspects. Moreover, I included internet discussion boards as a new means of communication and topic of analysis at the same time. Discourse analysis, in the end, also aims to raise interest and to initiate curiosity[5] with regard to the audience, so that they want to learn more about a phenomenon by themselves.

[3] Landwehr 2008, p. 102.
[4] This step is indeed called "context analysis", according to Landwehr 2008, pp. 105.
[5] Landwehr 2008, p. 13.

1.4.2 Comparative studies

At times, this thesis will compare the British perspective to the German view. I believe that involving another country is beneficial in terms of understanding positions and attitudes. Historically, Britain has been associated with offering obstetricians a wider scope of action, when compared to Germany.[6] Both nations have a current caesarean rate of about 30%, but attitudes towards this mode of delivery could differ substantially. A similar caesarean rate, therefore, does not mean that there are similarities in how the phenomenon is perceived. However, the participants were usually not aware of any cultural differences, as this thesis shows.

Hence, in addition to English sources, this thesis also analyses German publications (I have a command of both languages, which was another reason for undertaking a comparison). One advantage of intercultural research is that a substantial amount of material can be consulted, although the German references in this thesis often refer to international publications and therefore English texts (but not vice versa) or have been translated into English and republished. Due to this overlap, the actual comparison of both states will play a minor role. Moreover, the use of German sources confirms that caesareans on request are frequently discussed in various countries, instead of being limited to a particular nation.

[6] Lehmann 2006, p. 239.

1.4.3 Impact and perception of risks

Industry and society were no longer producing goods but risks.[7] This is how German sociologist Beck summarised the "risk society" in his book of the same name. However, Beck's approach focused on the entire society and not necessarily on the individual, and he also emphasised that the risks were a result of the development of society. Beck created the term "risk society" in the 1990s.[8] "Risk society" referred to a profound development: the industrial society's shift to modern age. According to Beck's theory, risk society replaced the former systems of classes and social statuses.[9] In this context, nature was no longer perceived as a given phenomenon (at best being controlled by the moods of gods), but because of her unpredictability declared as a potential threat by the risk society.[10]

Simultaneously, society found itself incapable of controlling those risks. Relating to the definition of risks, Beck's concept of the risk term was not meant to have a flexible meaning.[11]

Kommentar: In footnote 5, is is not clear why "Caesarean" was capitalised; this has been changed to lower-case. Please also check the use of the abbreviation "c-section" in the footnote.

What made these risks special was, according to Beck himself, that they originated from society itself because, once again, members of the society constructed what should be named and perceived as dangerous.[12] Therefore, the danger itself was not seen as threatening, but its dissemination and the many discussions about it. That is why society became aware of the risks.

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[7] Lemke 2007, p. 51.
[8] In the same decade, the term "caesarean section on request" came into being, i.e. this type of caesarean became popular in the mid-1990s, mostly because celebrities had chosen this mode of delivery. There is, however, no scientific proven evidence of a connection between the terms "risk society" and "caesarean on request" although the requested c-section can be understood as a method of coping with risks.
[9] Beck 1986, p. 7.
[10] Beck 1986, p. 9.
[11] Lemke 2007, p. 51.
[12] Beck 1986, p. 218.

Moreover, within the risk society, the individual was no longer part of a traditional social ranking.[13] Since old social bonds and conventions ceased to exist, the individual person – in the context of this publication, the expecting woman - found herself compelled to acquire new behavioural patterns. Upon doing this, she was continuously exposed to outer influences. Hence, the risk society perceived itself as being permanently confronted with non-predictable situations that made risk assessment necessary.[14] Normally, these states referred to events affecting the entire society, such as unemployment. Therefore, society felt the need to distinguish between safety and threat. It subsequently learnt to assess and make decisions so that they would contain minor risks and consequences (from the viewpoint of the person who made the decision).

Furthermore, the possibility of risks becoming everyday phenomena contained the danger of them being perceived as a usual matter of course that was no longer paid attention to.

[13] Beck 1986, p. 206.
[14] Lemke 2007, p. 51.

1.5 Initial associations with caesareans on request

When the media disclosed the names of several celebrities who had opted for a caesarean without a medical reason, general interest arose regarding this mode of delivery. Has abdominal delivery become a fashion? Since then, when talking about caesarean sections on request, names such as pop singer Britney Spears or top model Claudia Schiffer have been referred to; however, it was footballer's wife Victoria Beckham who grabbed the headlines, being the first celebrity to be known to have opted for a caesarean by choice, on a particular date that fitted in with her husband's football schedule.[15]

However, there are other attributes of caesareans on request which are not connected to particular persons. These range from a "quick, pain-free and scheduled birth" to the convenience for doctors of bypassing long, unpredictable deliveries. In this context, litigation is often spoken of, as vaginal birth could lead to considerable long-term implications for the mother or her baby (birth defects), although these complications are rare. In spite of these facts, caesareans on request faced a great deal of criticism. Occasionally, they were compared to cosmetic surgery.[16] Talking about aesthetic operations or learning about them from the mass media was no longer a taboo. It was probably due to this change in attitudes that women struggled less with having surgery done, according to perinatologist Marsden Wagner (2000).[17] Request caesareans and cosmetic surgery both depend solely on the patient's choice. Medical reasons are subordinate to the goal of

[15] Markus 2006, p. 17.
[16] See, for instance, Wagner 2000, Maasen 2005.
[17] Wagner 2000, p. 1679.

achieving a particular body image. However, for caesareans on request, the responsibility extends to a second person, namely the unborn baby.

As regards the decrease in morbidity and mortality rates, many obstetricians have stated that the risks of abdominal delivery have become easier to assess and that, to an extent, safety can be ensured by a caesarean birth. In addition, the potential risks of vaginal delivery must be considered.[18] Medical publications often point out the technological advances in caesareans in order to justify caesarean sections on request.

Some publications have furthermore reflected on whether caesareans by choice could represent an alternative to vaginal birth, but considering that, at the beginning of the 21st century, the proportion of caesareans on request was rather low – only about 7 % of all deliveries[19] – this suggestion could hardly be confirmed.

In addition, although obstetricians view the performance of caesarean sections as routine surgery, at this point in time, caesareans on request were still far from being morally accepted. Even among mothers, opting voluntarily for an abdominal birth was not always well regarded; caesareans by choice appeared to be an avoidance of the method of delivery that nature had intended, that is, vaginal birth. Thus, caesareans on request suggested to critics that both mothers and obstetricians were opting for "an easy way out." Historically speaking, vaginal delivery has always represented a "natural birth" and "spontaneous childbirth," while caesarean operations were considered as *ultima ratio*. They were only performed when all possible methods of vaginal birth had failed.

[18] Schneider 2008, p. 36. Hohlfeld (2001, p. 115) reported a different rate for a particular London hospital ("an overall section rate of 10.6 per cent, about three-quarters of all elective procedures were in response to maternal request." However, the proportion of elective caesareans is not mentioned).
[19] NICE 2004, p. 37.

1.5.1 A brief history

In the past, when asepsis and antisepsis were unknown to mankind, but also at the beginning of the 20th century, the decision to perform a caesarean symbolised the decision between life and death – of the mother, the baby, or both. Whether or not caesarean surgery was appropriate was the doctor's decision. A great deal has happened since then; medicine and technology have been developing steadily. Caesareans still involved risks, but the assessment of these risks had become more reliable and they had generally decreased. Having reduced the hazards of abdominal delivery, it became easier to decide in favour of caesareans. Today, caesarean births represent a substantial proportion of the general birth rate. They are anything but unusual or rare. With these medical advances in mind, attitudes towards caesareans have experienced a shift. Abdominal deliveries are no longer viewed solely as life-saving emergency surgery. This change resulted firstly in a rise in elective caesareans and later paved the way for caesarean sections by choice.

Frequently, abdominal delivery is planned in advance; so-called "primary caesareans" involve pre-empting the onset of labour.[20] At the same time as this development, medical indications were extended and a more liberal policy was applied that allowed broader interpretations. Due to their frequency, caesareans became routine surgery. However, due to their growth, the increasing caesarean rates were criticised, even among obstetricians and other medical practitioners. One consequence was the World Health Organisation's (WHO) "Fortaleza Declaration" (1985), which

[20] There are primary (or elective) and secondary caesareans. While primary sections are planned in advance and performed before the onset of labour, secondary caesareans are decided upon during the actual birth. These are emergency interventions.

recommended that the percentage of caesareans should not exceed 10 to 15%; a higher rate would no longer offer any benefits.[21]

However, while the risks of caesarean delivery were reported to have reduced, the possible threats relating to vaginal birth came to the attention of medicine, mothers and the media.[22] An article by London obstetricians Raghad Al-Mufti, Andrew McCarthy and Nicholas Fisk – a key text in debates and also with regard to this thesis – evoked a large number of various reactions. The authors questioned other obstetricians about their (or their partner's) preferred mode of delivery, if they had a choice, and 31% opted for a caesarean section, even with a trouble-free pregnancy. This was a surprising result, and moreover, it followed on from pre-existing discussions about patient autonomy by questioning whether a caesarean should be offered to any pregnant woman as an alternative to vaginal birth, promoting the notion that the mode of delivery should be decided upon by the expectant mother.

Based on the survey by Al-Mufti, McCarthy and Fisk about preferred modes of birth, this thesis reconstructs statements and developments concerning caesarean sections on request. Due to the fact that maternal decision-making is the crucial element in caesarean delivery, which was once initiated by doctors only, caesareans underwent a shift to become surgery on request, and rapidly became a widely discussed novelty in obstetrics.

Of course, debates on caesarean sections on request did not arise solely because of this survey. However, it was the first of its kind to introduce the topic frankly – although in 1996, there was a lack of terms regarding this

[21] WHO 1985, pp. 436-437.
[22] Husslein (2001) refers to possible implications, such as the loss of sexual drive as a consequence of birth injuries, loss of oxygen to the fetus during labour and emergency caesareans (Arch Gynecol Obstet 265, p. 171).

subtype of primary caesareans, but the authors provided a detailed paraphrase of the procedure. Nonetheless, the results of the study influenced both the content of the debate and the representation of caesareans on request, which confirmed the special status of the article by Al-Mufti *et al.* They showed the shift to surgery as a service in the context of patient choice and at the same time challenged existing ways of thinking by assessing patient autonomy in a different way. Moreover (and according to the conclusions of the study), the authors explained that caesareans on request were already being performed, at least among obstetricians and their relatives.

However, this development meant more than just a superficial trend in obstetrics, based on medico-technological advances: narrowing risks and aimed at providing control and safety. Thus, ensuring plannability by referring to patient autonomy and informed consent appeared to provide safety, in the view of expectant mothers and doctors. Later in the course of the debates, the question arose of whether or not (taking into account medical advances) caesareans on request could represent a contemporary way to give birth. This would mean a further development of childbirth, based on the principles of modern obstetrics.

However, debates about caesareans on request stir up emotional responses. Particularly in modern times, in which it is common to strive for safety, any issues regarding planning and preparation for birth are more relevant than ever.[23] The changes in the view of caesarean births reflect a society that is very precise in the calculation of risks and their acceptance. Thus, the impact of caesarean sections on request on childbirth has not lost its relevance, even today.

[23] Paterson-Brown 1998, p. 463.

1.6 Outline

As regards the structure of this thesis, Chapter 2 focuses on the survey by Al-Mufti, McCarthy and Fisk. This, however, was based on a publication by the Department of Health (DoH), *Changing Childbirth*, which promoted maternal rights. Al-Mufti *et al.* resumed this concept of choice and applied it to modes of delivery. They also gave a broad impression of caesareans on request and indicated possible reasons for maternal choice. This chapter also traces how their study was received and the role it played in the subsequent course of discussions. In order to provide insight into childbirth practices at the time, a sub-chapter will consider the main issues of obstetric routines and preparation for childbirth.

Chapter 3 introduces what high-level medical institutions had to say about caesareans on request, namely the *Fédération Internationale de Gynécologie et Obstétrique* (International Federation of Gynaecology and Obstetrics, FIGO), the *National Institute for Clinical Excellence* (NICE) and the *Deutsche Gesellschaft für Gynäkologie und Geburtshilfe* (DGGG, German Association for Gynaecology and Obstetrics). Their position on and understanding of caesareans on request could differ notably. The views of these institutions could, in addition, have an impact on the debate. This chapter also provides some background information about the organisations and their approaches to the topic.

Popular themes in the debates on caesareans on request are presented in Chapter 4. During the course of the discussions, the main issues became clear; many disputes were about changes in obstetric behaviour, which were not yet reflected in indication catalogues. Moreover, indications for caesareans at that time were no longer sufficient, because they considered only clinical reasons. However, as patient autonomy gained

influence and because some mothers referred to their previous birth experiences and emotions, psychological indications were finally included in the catalogues. This chapter deals with risk and prevention and therefore also looks into obstetricians' fears of malpractice suits.

The way in which popular science (in this case, represented by advice books) has approached caesareans on request is studied in Chapter 5. This chapter starts with some words about motherhood, which may help to understand how expectant mothers view themselves in their new role. The main part of this chapter, however, focuses on sources of information about childbirth issues, provided by popular scientific authors. There is a broad variety of advice books available, and approaches to caesareans on request could vary greatly. This chapter examines a pregnancy report book by Naomi Wolf (2002), a subjective discussion by Theresia Jong and Gabriele Kemmler (2003) and a photographic book by Caroline Oblasser, Ulrike Ebner and Gudrun Wesp (2007).

Chapter 6 presents an approach that differs from the textual analyses which characterise the thesis up to this point. This chapter explores conversations on Internet discussion boards (forums) and thus dives into peer exchange and the concerns of expectant women. It complements Chapter 5 because it evaluates the practical side of advice books, questioning what is relevant to women according to their thoughts. Moreover, it shows that topics relating to childbirth lead to very emotional debates.

Chapter 7 offers a short break from this stream of information. On the one hand, it is meant as a recap, revisiting what has been said thus far. On the other hand, it brings together the previous statements and views, in order to proceed to the review of the hypotheses in Chapter 8.

Chapter 9 puts forward the conclusions.

1.7 Contribution and originality

Although caesareans on request are still a newsworthy topic, the literature about this mode of delivery is rather scarce, compared to references about childbirth in general. In medical textbooks and articles, as well as popular scientific publications, caesareans on request are often discussed in combination with general statements about abdominal delivery. Therefore, this thesis aims to isolate the issue of caesareans on request from its general caesarean context, as the medically unnecessary caesarean is certainly a phenomenon that is worthy of recognition on its own. After all, various publications speak of a "trend,"[24] which implies interest in the topic.

Research thus far has focused in particular on medical aspects, such as surgical progress and a decrease in mortality and morbidity, while noting the rising caesarean rates and questioning the reasons for this increase in abdominal births. The content and goals of discussions play a minor role when researching caesarean issues. Furthermore, the medical literature rarely involves the maternal perspective; in most cases, mothers' views are only reproduced as part of statistical data in surveys or other quantitative analyses.[25] Popular scientific advice books, on the other hand, allow women to voice their experiences, but because of their nonmedical target group, these references often lack appropriate evidence.

One special feature of this thesis is the inclusion of Internet sources in the form of discussion forums. There has not yet been a project about caesarean sections on request that has studied the Internet as a means of communication regarding childbirth as intensely as this thesis. Online discussion boards can have a significant impact on the formation of opinions,

[24] For example, Bopp 2003, p. 25.
[25] For instance, Johnson/Slade 2002.

which should not be underestimated. In addition, conversations on forums reveal a great deal about women's experiences and their way of thinking.

This is why this thesis puts together the views of both obstetricians and mothers. It treats both groups equally and reconstructs an overall impression of caesareans on request and the most influential debates. By focusing on risk and decision-making, it also shows how childbirth and safety relate to one another in contemporary obstetrics and that the way in which doctors and mothers communicate plays a role in how they view and experience caesarean sections.

1.8 Subject limitations

Caesarean sections on request and the views of obstetrics and pregnant women are already comprehensive topics in themselves. Many other aspects could be derived from them, all worthy of further discussion – but this project has to stop at some point.

What must be left out? I decided not to focus on specific gender issues (i.e., comparing statements by female and male speakers, as well as exploring their authority in debates and in clinical practice) and also not to seek a deeper insight into the role of midwives in caesarean on request debates. Midwifery in Britain and Germany would have constituted an issue in itself, which would have exceeded the outline of this thesis. In addition, I would probably have to consider other medical professions which also deal with aspects of childbirth, such as anaesthesia, neonatology, paediatrics, internal medicine, etc.

Furthermore, I did not take into account any aspects of the social and ethnic backgrounds of the participants (mothers or medical professionals).

The same applied to cultural minorities – the only exception is English journalist Naomi Wolf, who experienced her pregnancy in the United States.

I also excluded studies on multiple pregnancies and most articles on malposition, because these conditions are accepted indications for an elective caesarean section.

Whether there is a relation between caesareans on request and cosmetic surgery, in terms of medical needs, constituted another topic that was not included in this thesis; there were in particular German publications on this issues, but overall, material for comparison would have been scarce.

2 A letter to the editor and its consequences

Central to this chapter is a publication which not only presented caesarean sections on request as a new topic in 1996, but which also inspired many debates on this mode of delivery: the study by London obstetricians Raghad Al Mufti, Andrew McCarthy and Nicholas Fisk. Their survey challenged existing paradigms of childbirth and patient choice and became a key publication regarding caesareans on request. The German lawyer and ethicist Nora Markus thought that the study was exemplary and groundbreaking in terms of the debates,[26] and obstetrician Hans Ludwig emphasised that the survey, in his view, marked the beginning of debates about caesareans by choice.[27]

To start with, this chapter introduces the actual article, in order to proceed to follow-up publications and discussions which resulted from the survey. One of the authors in particular – Nicholas Fisk – continued working with the ideas of the study, which received a variety of responses from the medical world.

This chapter progresses by setting the topic of caesareans on request in the context of obstetric practice towards the end of the 20th century. The pre-existing discussions about medicalisation and the impact of technology on issues of childbirth were still in progress. Controversies about caesareans on request in relation to these matters represented the beginning of further intense debate.

[26] Markus 2006, p. 57.
[27] Ludwig 2001, p. 121.

2.1 A key text? Al-Mufti, McCarthy and Fisk and their study in The Lancet

In 1996, a letter to the editor published in *The Lancet* attracted the attention of obstetricians. Published under the headline *Obstetricians' personal choice and mode of delivery*, London-based obstetricians Raghad Al-Mufti, Andrew McCarthy and Nicholas Fisk reported that, according to their survey, some women would consider opting for a caesarean section without any medical justification, if it was up to them to decide on the mode of delivery.[28] According to this letter, Al-Mufti *et al.* were concerned about the scope and interpretation of patient choice. Being able to opt for a particular mode of birth was introduced by the authors as an example of the practical application of patient autonomy, in order to study the relation between caesarean sections on request and patients' decision-making.

Upon introducing the topic, Al-Mufti and his colleagues emphasised that the term "patient choice" had become a catchphrase which had caught the attention of those outside the medical world as well as medical practitioners. In the field of obstetrics, this had been initiated by *Changing Childbirth*, which inspired the survey's obstetric theme. Bearing the results of their study in mind, the authors reflected on the possible role that caesareans on request might play in the future with regard to issues of childbirth.

[28] Al-Mufti/McCarthy/Fisk 1996, p. 544.

2.1.2 Changing childbirth by *Changing Childbirth*?

Changing Childbirth[29] – which viewed the voices of pregnant women as an essential part of contemporary obstetrics and thus stressed expectant women's right to involvement in birth planning – is an official document, published by the DoH. For this reason, it embodies a certain authority and significance. The concept of choice it promoted prompted reflections; for instance, consultant obstetrician Mary Anderson remarked in her critical acclaim that the time had come for changes in obstetric practice. If women were fully informed, they would be able to make appropriate choices.[30]

Nevertheless, *Changing Childbirth* advocated low-technology deliveries[31] – the opposite approach to Al-Mufti *et al.* Both studies consider whether obstetrics should make full use of birth technologies, as is the case in caesareans on request. Last but not least, the theory of "consumer choice" described the patient as someone making use of (medical) services; the previously passive patient, who depended on the doctor's recommendations, had transformed into an active consumer.[32] However, this is why critics of the report, such as William Dunlop – speaking for the Royal College of Obstetricians and Gynaecologists (RCOG) – remarked that it would be difficult to transfer the approach of *Changing Childbirth* into obstetric practice. The report was too general, and smaller health centres lacked the necessary capacities. Moreover, *Changing Childbirth* was not based on acclaimed research standards and was therefore only a recommendation.[33] In a way, this also applied to caesarean sections on request, as they too require certain preconditions.

[29] Department of Health 1993a, p. 27.
[30] Anderson 1993, pp. 1071-1072.
[31] Department of Health 1993a, p. 27.
[32] Hardey 2001, p. 389.
[33] Dunlop 1993, pp. 1072-1073.

The term "caesarean section on request" (or any similar name) had not yet appeared; Al-Mufti, McCarthy and Fisk spoke of a "maternal request for elective caesarean section" when describing the phenomenon. They stated that the increase in abdominal deliveries could be explained by something other than the assumption that obstetricians recommended primary caesareans too quickly. It should also be considered that doctors themselves could opt for a caesarean birth, and hence "request caesareans" already existed. It is necessary to reconsider the breakdown of statistical data about caesareans. The term that later became accepted, i.e., "caesarean on request" had not been established at this point in the discussion, when the phenomenon was still evolving.

The authors presented further details about the increase in the rate of caesarean sections and the results of their survey. This was based on a fictional case of an uncomplicated pregnancy, and participants were asked which mode of delivery they would prefer and why. According to the data, 31% of the interviewed obstetricians would choose voluntary caesarean surgery for themselves or their partner, even when the pregnancy was free of complications.[34] In this way, the interviewees showed significant open-mindedness in terms of abdominal delivery. Al-Mufti and his colleagues concluded that, because of their medical training, obstetricians were aware of the risks that might accompany a vaginal birth. The reasons for their choice corresponded to the possible implications of vaginal delivery: most of the interviewees wanted to avoid birth injuries and long-term sequelae, which might impair sexual activity. Fear for the baby was also mentioned, e.g., due to a loss of oxygen during childbirth. In a fictional case of a risky pregnancy (e.g., the baby is breech), even more obstetricians chose to have a

[34] Al-Mufti/McCarthy/Fisk 1996, p. 544.

caesarean.[35] Therefore, Al-Mufti, McCarthy and Fisk identified anxiety as a major reason for requesting a caesarean delivery. Moreover, decision-making was based on fears relating to a future event; thus, the women took precautions by choosing surgery.

Moreover, Al-Mufti *et al.* suggested that consultations would reflect the personal attitudes of doctors. In any case, research should explore whether opting for a caesarean without medical indications could become an integral part of counselling.[36] Obviously, this mode of delivery was already an available choice for doctors, and thus it made sense to offer it to other expectant mothers, who did not have a medical background.

2.1.3 The popularisation of the survey – the choice of medium determines the focus

Another relevant choice of a different kind was made by the authors by submitting their letter to the editor of *The Lancet*. Choosing this renowned and popular journal certainly helped to attract readers to the survey by Al-Mufti, McCarthy and Fisk. As a letter to the editor is limited in length, they had to restrict their contribution to the most striking findings, but their publication still had an impact. In addition, other medical professions apart from obstetrics were attracted by the journal's general medical theme. Professor of Midwifery Rosemary Mander, who looked into the research by Al-Mufti and his colleagues in her monograph on caesarean sections in 2007, called the study "famous, or perhaps infamous."[37] Analyses were overly superficial and generalised – Al-Mufti *et al.* considered preventive caesareans, which Mander did not want to grasp. As Al-Mufti and his

[35] Al-Mufti/McCarthy/Fisk 1996, p. 544.
[36] Al-Mufti/McCarthy/Fisk 1996, p. 544.
[37] Mander 2007, p. 107.

colleagues referred to no actual complicated cases but only theoretical ones, there was no real threat and thus prophylactic surgery was questionable in her view.[38] In particular, Mander observed that, by writing a letter to the editor and mentioning their own study, instead of referring to any particular article in *The Lancet*, Al-Mufti, McCarthy and Fisk had succeeded in outwitting the peer review process. The plan had worked, as Mander summarised: "minimal detail and data were able to be provided, while maximum publicity was obtained."[39] Was publicity the actual goal of the three obstetricians? Mander, however, was the only person to voice such thoughts.

The complete study was nevertheless published one year later in the *European Journal of Obstetrics and Gynecology and Reproductive Biology (EJOG)*.[40] This was not announced in *The Lancet*, and so one can hardly presume that Al-Mufti and his colleagues used *The Lancet* for promotional purposes. In the *EJOG*, Al-Mufti *et al.* addressed an exclusive audience, i.e., experts in the field of obstetrics. This may be one reason why the detailed version of the survey did not attain the popularity of the letter in *The Lancet*.

The study's actual title (cf. *EJOG*) was *Survey of obstetricians' personal preference and discretionary practice*. Thus, it was obvious that the findings should refer to modes of delivery. In addition, the project consisted of two surveys of obstetricians. The first was about Down's Syndrome, which was discussed in a relatively short section.[41] It elaborated on the idea that prenatal diagnostic tests were of substantial relevance to doctors.[42] However, the authors did not explain whether they saw any relation between Down's

[38] Mander 2007, p. 103.
[39] Mander 2007, p. 107.
[40] Al-Mufti/McCarthy/Fisk 1997, pp. 1-4.
[41] This was, however, not relevant in terms of this thesis and is thus mentioned only for completeness.
[42] Al-Mufti/McCarthy/Fisk 1997, p. 1.

Syndrome screenings and modes of delivery, nor did they state what had led to the "observations" they mentioned in the article and which had initiated the survey. In addition, it was not clear to the reader whether the statements about Down's Syndrome were resumed in the article's conclusions, and therefore in the context of discussions about patient choice.

Nevertheless, the main purpose of the article was to analyse obstetricians' personal choices. But why obstetricians? Patient autonomy, explained the authors, had gained greater relevance, particularly after the publication of *Changing Childbirth*, which entitled expectant mothers to self-governance. In previous times, mothers' voices had played a rather subordinate role, while obstetricians made full use of the available facilities and treatments of their profession. Moreover, in the words of Al-Mufti, McCarthy and Fisk, they were the best-informed professional group as regards issues of pregnancy and birth.[43] For this reason, obstetricians had expert status and their opinions may be considered to be trend-setting. In the end, self-determination requires information. Last but not least, the study questioned whether or not the results of the survey applied to other pregnant women as well, i.e., women without a medical background.

Al-Mufti, McCarthy and Fisk stated clearly that obstetrics was undergoing a change of attitude, and they implied that this development would soon extend to aspects of patient autonomy. An increase in the rate of caesareans, moreover, was already being reflected in obstetric practice. However, the active participation of mothers-to-be in deciding upon the mode of delivery was a new concept.

[43] Al-Mufti/McCarthy/Fisk 1997, p. 3.

2.1.4 Some facts about the study

The authors focused on a group of 282 obstetricians located in South London and reported a 73% return rate (206 interviewees).[44] Al-Mufti and his colleagues were aware that the findings, provided by a small and region-specific group, could not be considered representative. Therefore, they emphasised that their analyses were purely hypothetical.[45]

Out of these 206 obstetricians, 88% would opt for a caesarean on request, mostly out of fear of birth injuries. Al-Mufti *et al.* concluded that many of the interviewees favoured caesareans on request because, as obstetricians, they knew about the risks of vaginal delivery. They were in a position to assess the different modes of delivery realistically.[46] Hence, they knew that, for instance, antibiotics and thrombosis prophylaxis help to decrease the morbidity and mortality rates of caesareans. Furthermore, epidurals allow surgery to be experienced under full consciousness – like a vaginal birth – due to partial numbness.

While obstetricians seemed to have the choice to opt for caesareans on request, the next logical step was to offer this option to all patients. Doctors will probably have already referred to this mode of delivery during consultations, when discussing the benefits of caesareans with their patients. In theory, any consultation could be influenced by the obstetrician's personal attitude.[47] According to the publication, caesarean sections on request would add another aspect to the critique of the increase in caesarean rates. An initial explanation was that obstetricians recommended caesareans even in low-risk pregnancies. However, the study by Al-Mufti, McCarthy and Fisk

[44] Al-Mufti/McCarthy/Fisk 1997, p. 2.
[45] Al-Mufti/McCarthy/Fisk 1997, p. 3.
[46] Al-Mufti/McCarthy/Fisk 1997, pp. 2-3.
[47] Al-Mufti/McCarthy/Fisk 1997, p. 4.

demonstrated that women themselves may well have asked to have the surgery performed.

2.1.5 Critical acclaim for the study

The study by Al-Mufti and his colleagues contained a great deal of information about attitudes towards patient choice and decision-making. At the same time, they made several statements regarding caesareans on request in particular, although "discovering" a thitherto unclassified mode of delivery was not an initial aim of their survey – after all, they could not have foreseen the interviewees' answers, or that caesareans on request would receive any attention at all, or the content of forthcoming debates.

Nevertheless, the question of whether a voluntary (i.e., not medically justified) caesarean section was acceptable became part of pre-existing discussions about the reasons for the overall increase in abdominal births. The publication by Al-Mufti *et al.*, which concerned a possible extension of patient autonomy, also had an impact on later debates on request caesareans.

The authors revealed that caesarean sections without medical indications were already being performed, but were restricted to doctors, and more specifically, to obstetricians.[48] The existence of request caesareans, therefore, was beyond the knowledge of expectant mothers who did not belong to a medical profession (or who were not related to an obstetrician). Hence, this mode of delivery was presented as an option that was not available to every woman. However, the authors' perceptions were based solely on their own survey (although it should be remarked that at that point,

[48] Al-Mufti/McCarthy/Fisk 1997, p. 3.

there were basically no other information sources available regarding caesareans on request).

As caesareans on request were no longer just a theory, they also appeared in statistical data on caesareans in general, and this information augmented the authors' results. These data, therefore, needed new analyses and detailed breakdowns, in order to establish the percentage of caesareans on maternal request. Due to its nature as voluntary surgery, caesareans on request represented another interpretation of patient choice. Patient autonomy, as Al-Mufti *et al.* explained, had created a new age: the "era of patient choice,"[49] in which *Changing Childbirth* had a share, as it granted pregnant women the right to create a comprehensive birth plan.

Moreover, the interviewees were basically aiming to avoid potential sequelae of vaginal delivery in advance, e.g., a long labour or injury to the birth canal. Caesareans on request seemed to be an opportunity to minimise these risks. The other reasons also indicated that medical impairments played a major role in risk assessment – long-term consequences such as stress incontinence, loss of sexual drive, fear that something might happen to the baby during labour and birth and a guarantee that the birth will take place on the due date. It appears that only medical aspects were important to the obstetricians who were interviewed.

In their findings, Al-Mufti *et al.* linked the concept of patient choice to informed consent. They deduced that, because of their training and practical experience, obstetricians represented the best-informed group in terms of issues of childbirth.[50] More information accompanied a better overview of the decision-making process and possible options; the decisions made by the

[49] Al-Mufti/McCarthy/Fisk 1996, p. 544.
[50] Al-Mufti/McCarthy/Fisk 1997, p. 3.

obstetricians were in fact different from those made by other patients, Al-Mufti, McCarthy and Fisk claimed. However, the authors did not verify these assumptions, but surmised that they fit the results of their survey. Nonetheless, the question arose of what medical laypersons would decide if they knew about all of the available options.

The article allowed two hypotheses to be deduced with regard to the medical status represented by the interviewed obstetricians: first of all, the doctors' expert knowledge involved a large amount of information. Second, they could make use of their profession in order to access opportunities that were not available to "regular" expectant mothers (those with no medical background). Both aspects are connected with one another; without medical status, there was no access to certain treatments, but knowing about them requires one to be informed. This, however, was not connected with patient autonomy.

The controversy that was mentioned by the authors towards the end of their study referred to a lesser extent to the existence of caesareans on request but rather to their possible interpretation as an alternative to vaginal delivery or as an additional choice in the context of applied patient autonomy. Thus far, "childbirth" had been seen as equal to "vaginal delivery," and this equation had not been challenged but merely communicated during the pregnancy period. Due to the suggestions of Al-Mufti, McCarthy and Fisk, vaginal birth was not only linked to certain risks but also seen as being "outdated." It still maintained an unchallenged supremacy as the standard mode of delivery.

2.2 Further reception and first controversies resulting from the study

Follow-up articles with contributions from Fisk discussed some of the survey's statements in further detail. These articles put the topic into a more interdisciplinary context, by including issues from the social sciences, with the aim of addressing other disciplines, which did indeed join the discussion. Articles which referred to the study by Al-Mufti *et al.* also indicated that obstetrics was in the middle of creating new structures with regard to decision-making and risk assessment – and considering caesarean delivery as an option.

In collaboration with consultant obstetrician Sara Paterson-Brown, Nicholas Fisk published another article about patient choice in 1997. In this, the authors asked directly whether caesareans on request should become a general option, and thereby challenged the history of vaginal delivery as synonymous with childbirth.[51] Paterson-Brown and Fisk reasoned that the awareness of the long-term impact of vaginal birth had brought forth an increase in relative medical indications, in order to bypass genital birth trauma. Consequently, there was a rise in caesareans, as well as a new group of indicators: psychological reasons, such as a fear of childbirth because of a previous negative birth experience or maternal choice, reflected this development. In addition, the obstetric profession had also undergone changes, in terms of reduced practical training, which resulted in junior obstetricians finding it hard to manage complicated births, such as vaginal breech deliveries.[52] Decision-making in favour of caesareans was, as Paterson-Brown and Fisk emphasised, justified, due to this lack of professional experience. Moreover, young doctors were already trained

[51] Paterson-Brown/Fisk 1997, p. 351.
[52] Paterson-Brown/Fisk 1997, p. 353.

under the condition of a high caesarean rate, which often seemed "normal" to them.

Should, however, a situation arise in which a woman asks for a caesarean, the authors advocated that the wish should be granted, provided that she was aware of all of the risks:

> *It is the mother who is going to have to live with the consequences of such a choice. She should be respected and her choice, as long as it is fully informed, granted.*[53]

Not only did this suggestion promote the necessity of risk assessment but, above all, it advocated a shift in responsibility and decision-making from the obstetrician to the pregnant woman, or from the expert to the medical layperson.

Only a few months later, Paterson-Brown added another angle to the debate. She reflected on informed consent and explored the way in which doctors should respond to mothers' requests for caesarean sections. This was published in the *British Journal of Obstetrics and Gynaecology (BJOG)* as a controversial article for discussion (the opposite view was represented by obstetricians Olubusola Amu, Sasha Rajendran and Ibrahim Bolaji). Paterson-Brown stated clearly that the woman's choice should be respected. References to further shifts in the recent development of obstetrics, such as technological progress and the revision of attitudes, served as grounds for her argumentation.[54] These led to changes, meaning that the traditional hegemony of vaginal birth, which had for a long time been promoted as the only and "right" way to give birth, was now being questioned. There was clinical evidence that caesareans were safer, and thus perceptions of vaginal

[53] Paterson-Brown/Fisk 1997, p. 354.
[54] Paterson-Brown 1998, p. 463.

delivery, as well as attitudes towards surgical birth, had changed. Last but not least, during pregnancy and with regard to other treatments, there are many choices available to expectant mothers.[55]

Obstetrician Hans Ludwig shared this opinion. Women had many options in childbirth, ranging from water births to epidurals, so why not include caesarean delivery as a preferred mode of delivery? Caesareans on request, for Ludwig, were just another option.[56]

Rosemary Mander, who reviewed Paterson-Brown's article in 2007, focused on her argumentation. She was right to wonder about Paterson-Brown's promotion of informed consent while at the same time admitting that medical research at the time could not yet refer to any long-term evidence, which, in Mander's view, was an obviously paradoxical statement. In addition, Mander thought that Paterson-Brown's publication was "overused" because of its popularity.[57]

The opposing view of Amu *et al.* should be noted, as it was published together with Paterson-Brown's statements. First, Amu, Rajendran and Bolaji confirmed the existence of request caesareans, and then admitted that they presented a challenge not only for obstetric practitioners but also for ethical values.[58] In the past, elective caesareans were sometimes suggested when the woman had suffered a traumatic birth and feared another vaginal birth.[59] However, if a pregnant woman could now opt for a caesarean section, this would mean that any possible risk of birth trauma – or, more specifically, situations in which perineal injury might occur – should be avoided in advance, which implies decision-making for preventative reasons. In addition,

[55] Paterson-Brown 1998, p. 463.
[56] Ludwig 2001, p. 121.
[57] Mander 2007, p. 101.
[58] Amu/Rajendran/Bolaji 1998, p. 463.
[59] Amu/Rajendran/Bolaji 1998, p. 464.

it had emerged that doctors themselves represented one major consumer group that tended towards caesarean births.[60]

Amu *et al.* questioned whether women were fully informed when they had to make a decision. Ill-informed decisions could potentially be "irrational" or spontaneous, and moreover, the women had to rely on the information provided. As mentioned in Al-Mufti *et al.,* obstetricians could have an influence on decision-making by suggesting their own attitudes. However, in any case, as Amu and colleagues argued, it is necessary to protect the woman from making a decision that she may well regret at a later point. In line with Paterson-Brown, Amu *et al.* respected the general concept of patient choice. However, they added that the mother's request should not be the only determinant of a caesarean section.[61]

A later survey by Nicholas Fisk, Sara Paterson-Brown and Christina Cotzias (2000) confirmed the assumption of the 1996 study that many obstetricians would respect maternal requests. However, informed consent and risk assessment were once again rated as preconditions by the interviewees.[62] In another article, Fisk (2001) presumed that patient choice would gain greater influence, and he predicted an overall caesarean rate of 50% in the 21st century.[63] The predictability of caesarean sections was probably the reason that this mode of delivery was increasingly being considered by expectant mothers and obstetricians, and long-term studies further confirmed the safety of this mode of delivery. However, at the time, Fisk thought it too early to offer caesareans as a matter of routine to every

[60] Gerary/Wilshin/Persaud *et al.* 1998, p. 1177.
[61] Amu/Rajendran/Bolaji 1998, p. 464.
[62] Fisk/Paterson-Brown/Cotzias 2000, p. 16.
[63] Fisk 2001, p. 30.

pregnant woman, due to the lack of clinical evidence,[64] which to an extent contradicted the approach of the 1996 study.

2.3 Al-Mufti, McCarthy and Fisk and their impact on Germany

In comparison to the stir caused by the survey by Al-Mufti, McCarthy and Fisk from 1996 onwards, Germany appeared to be left behind. No national debates on caesareans on request were initiated, which would have responded directly to the publication by Al-Mufti and his colleagues. The fact that there were no national discussions, however, did not mean that obstetricians in Germany had not learned about the topic. Nicholas Fisk, for instance, was invited to participate in a "State of the Art" conference in 2000, which was held in Zürich, Switzerland. The German-speaking world had noticed that there was a new mode of delivery termed caesarean sections on request. However, for debates, the English language and the English-speaking international context was preferred. Swiss obstetrician Peter Hohlfeld, for instance, quoted the survey by Al-Mufti *et al.* in his publication, which was written in English.[65] If a paper was written in English, the international academic language of researchers, it stood a better chance of being recognised; at the same time, international debates were often trend-setting and predominant.

If Al-Mufti *et al.* assumed the hegemony of vaginal delivery, this would also apply to their survey. In an unpublished essay, master's student and medical historian Elselijn Kingma (2005) spoke of the study as a "powerful

[64] Fisk 2001, p. 29.
[65] Hohlfeld 2001, p. 115.

argument in the hands of supporting women's choice regarding her mode of delivery."[66] She also referred to the article's uniqueness.

However, it was not until 2003 that a similar study was ready for publication in Germany. Medical doctors Rita Schmutzler, Maike Herlyn-Elger, Kerstin Rhiem *et al.* had also focused on regional practices, and questioned obstetricians in the small area of Westfalen-Lippe.[67] The publication was in German, was much shorter overall (just one page) and was printed in the obstetric journal *Frauenarzt*. The feedback that the authors received did not compare to the study by Al-Mufti, McCarthy and Fisk: only 7% of the German obstetricians would choose a caesarean birth. Nonetheless, the participants indicated a fear of labour pain as the main reason for wanting a caesarean section on request, followed by pelvic floor implications and previous emotional birth trauma, with answers ranging from 55 to 67%. Maintaining one's sexual drive and plannability (a particular birth date) fell behind, but still reached 18%.[68]

This study, however, did not receive a great deal of attention. In 2006, it was quoted by obstetrician Volker Lehmann, who summarised the overall findings.[69] However, in general, it was only the study by Al-Mufti, McCarthy and Fisk which had an impact on the debates and started them off.

[66] Kingma 2005, p. 6.
[67] Schmutzler/Herleyn-Elger/Rhiem *et al.* 2003, p. 632.
[68] Schmutzler/Herleyn-Elger/Rhiem *et al.* 2003, p. 632.
[69] Lehmann 2006, p. 242.

2.4 Caesarean sections on request and their relation to obstetric practice at the time

It may help to know about the obstetric context – practice and routines – at the time when Al-Mufti, McCarthy and Fisk presented their statements and received their first feedback on the topic of caesareans on request. Prevention and the avoidance of risk were not new to obstetrics; they had an important meaning right from the beginning of a woman's pregnancy. When the survey by Al-Mufti *et al.* was published, control had already become a vital part of birth preparation. Moreover, expectant mothers were no longer left on their own to gather information about pregnancy and childbirth. They could access handouts or popular scientific books, and from the turn of the century onwards, Internet sources on aspects of medicine were also booming. With the Internet at their disposal, mothers-to-be could consult innumerous resources and find answers to any question.[70]

In addition, women experienced regular medical care: obstetricians (or midwives)[71] looked after them, who had committed themselves to providing the best possible standard of medical care. Each stage of pregnancy was allocated detailed guidelines in terms of check-ups, in order to assure that risks were minimised.[72] The most important thing was to identify any complications in time. Although screenings always had a "voluntary" attribute, many women considered them to be necessary for themselves and their unborn babies. Learning in advance about any problems signified that they were in charge of possible risks.[73] This applied specifically to prenatal

[70] For example, NHS 2007, The Pregnancy Book, pp. 2-3.
[71] This thesis focuses on obstetric care. Of course, midwives play an important role in pregnancy issues, but this would deserve a project of its own, due to the extra references.
[72] NICE 2008, pp. 10-11.
[73] Schindele 1995, p. 14.

examinations, which could either evaluate the probability of having a disabled baby (screenings) or give a clear diagnosis (diagnostic tests).[74]

2.4.1 Concepts of preparation – it is all about planning

Caesareans on request fitted in well with this concept of prevention. Close-knit supervision demonstrated that obstetrics no longer left anything to chance. Monitoring started during the family planning stage, through recommending a healthy lifestyle during pregnancy, including controlling the pregnant woman's eating habits, etc.[75] It seemed that striving for healthiness and wellbeing extended to the postpartum period as well. Women knew about available screenings and that they were entitled to have them performed. Pregnancy, therefore, was no longer a state that could be experienced in a light-hearted or untroubled fashion. Regular check-ups – seven to 10 consultations and examinations,[76] as well as one ultrasound screening[77] – provided structure. Files such as the "National Maternity Record" (or, in Germany, the "Mutterpass"[78]) condensed the course of pregnancy into compact data, including serological tests, the predicted date of birth and the baby's position in the womb. All of these results were filed, standardised and instantly accessible for medical consultants, particularly those which were relevant to the expected birth outcome.[79]

[74] http://www.nctpregnancyandbabycare.com/info-centre/decisions/view-85 (retrieved 29.03.2010).
[75] NHS 2007, pp. 8-16.
[76] NICE 2008, p. 14.
[77] NICE 2008, p. 28.
[78] A record to be kept with the woman which lists the results of all of her check-ups, cf. http://www.frauenaerzte-im-netz.de/de_schwangerenvorsorge-mutterschaftsrichtlinien_168.html (retrieved 05.05.2009).
[79] NICE 2008, p. 14.

Antenatal classes were offered in the last term of pregnancy, e.g., by the National Health Service (NHS; free) or the National Childbirth Trust.[80] Similarly, in Germany, such classes were offered by midwives or hospitals (costs were usually covered by health insurance companies).[81] Healthcare structures once again stressed that these classes were voluntary, although at the same time they were promoted as an opportunity to meet up with "peers," i.e., other mothers-to-be, and to demystify the birth process together, in order to lessen any potential anxiety.[82] Birth preparation classes rarely took caesarean delivery into account. Instead, they focused on vaginal birth, which still represented the expected (standard) mode of delivery. Caesareans, in contrast, were considered as an intervention that was performed when a vaginal birth was not possible. They were not introduced as an alternative option.

Although they committed themselves to regular check-ups, expectant mothers were free to work out their own birth plans. The purpose of a birth plan is to work through the birth event and, by doing so, to overcome any fears.[83] There are no particular instructions about what the plan should comprise, but the NHS provides checklists.[84] These references can be partially transferred to caesarean deliveries as well; for instance, whether the woman would like painkillers postpartum. However, there are no guarantees that a birth plan will be adhered to. In the event of an emergency intervention, birth plans are no longer feasible.

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[80] http://www.nct.org.uk/in-your-area/course-finder/courses-parents-to-be/antenatal-standard (retrieved 10.06.2009).
[81] http://www.frauenaerzte-im-netz.de/de_geburtsvorbereitung_86.html (retrieved 05.05.2009). Germany's health system is not state-controlled, like the NHS; women are either privately or publicly insured, with "public" insurance referring to statutory health insurance. There are a variety of health insurance companies.
[82] http://www.nhs.uk/Planners/pregnancycareplanner/Pages/Antenatalclasses.aspx (retrieved 28.07.2010).
[83] NICE 2007, p. 9.
[84] http://www.qms.nhs.uk/services/Maternity/Birth%20Plans.aspx (retrieved 16.06.2009).

2.4.2 Acceptance of monitoring routines

Strikingly, medical disciplines did not criticise their own check-up routines. In fact, the social sciences were concerned with the contemporary role of the "modern woman." They stood up against escalating control and increasing birth technologies which, in their view, had gained influence.

German sociologist Eva Schindele (1995) stressed in her general approach to contemporary pregnancy and birth issues that although obstetricians performed prenatal check-ups for prophylactic reasons, the same doctors also suggested that pregnancy entails risks. This representation influenced perceptions of pregnancy[85] and birth. Knowledge about risks coexists alongside anticipation regarding the baby: expectant mothers are happy and concerned at the same time. According to Schindele, obstetricians had reduced birth preparation to screenings and other medical aspects, an observation that was confirmed by the survey by Al-Mufti, McCarthy and Fisk. As Schindele further explained, obstetrics relies on statistics and stressing the probability of complications in empirical data. Doctors put these data into practice by taking charge of medical and technological equipment, which makes them seem trustworthy from the women's point of view.[86]

Mothers' own uncertainty leads them to seek medical help. Obstetricians represent an institution; they are viewed as experts in pregnancy and childbirth.[87] Schindele described the relationship between obstetrics and pregnant women, including patient autonomy, as a special one, which was to an extent applicable to caesarean sections on request: upon approaching doctors, women already have specific expectations and

[85] Schindele 1995, p. 13.
[86] Schindele 1995, p. 13.
[87] Schindele 1995, p. 51.

ideas about the course of their pregnancy and their birth experience. Under these terms, caesareans on request would signify no more than an advanced step forward for existing precautions in the context of pregnancy check-ups.

However, the concept of letting the mother have a say in choosing a caesarean delivery was not new. In *The Experience of Childbirth*, which was published in 1978, social anthropologist Sheila Kitzinger pointed out that patients are not automatically powerless when facing a caesarean birth. Their influence was, however, limited, and normally only possible under the conditions of a planned caesarean, for instance, regarding anaesthesia (whether general or epidural) or whether the newborn should be monitored at the neonatal ward.[88] However, Kitzinger also stressed that decision-making required the person to be informed. Discussions about the necessity of the surgery should also be made possible by consultants. Kitzinger demonstrated an unbiased attitude towards abdominal delivery. Caesareans are also a birth experience which leads to partners becoming parents (the "challenges of parenthood will become even more important than the challenge of birth").[89]

While Kitzinger advocated a fairly moderate and balanced opinion, anthropologist Emily Martin (1985) concentrated on unnecessary interventions. In her view, these involved an unjustified use of technology. However, unlike Schindele, Martin also mentioned caesarean sections; she was aware that this mode of delivery had received a great deal of criticism.

Martin assumed that obstetricians referred by default to the decreasing risk of caesarean delivery which was due to technological advances.[90] Thus, indications used to justify caesareans were often a cheap excuse.

[88] Kitzinger 1978, p. 284.
[89] Kitzinger 1978, p. 284.
[90] Martin 1992, p. 79.

Nevertheless, she agreed that abdominal delivery would benefit doctors, by helping them to escape litigation.[91] In contrast, hospitals were able to increase their fees, as caesareans were more expensive than vaginal births – an aspect that followed on from the findings of Liane Clark *et al.*, who had previously analysed the costs of vaginal and caesarean deliveries.[92] According to Emily Martin, it would therefore be fatal if prophylactic caesareans became accepted.[93]

Martin, thus, anticipated two important issues with regard to future discussions on caesareans on request: defensive medicine, an attitude that ranks prevention and the avoidance of risks as very high priorities, and rising costs in the context of health economy, due to discrepancies in the charges for vaginal and caesarean deliveries.

In 1985, Martin had already noted that medicine and technological advances had taken control of the birth process. Women frequently reported that they felt alienated in their own bodies, and that they no longer considered that their body was a part of themselves.[94] Martin explained that these feelings could, on the one hand, result from the loss of control and, on the other hand, from intrapartal medication. However, this "separation of the self and the body" was more intense when the woman had experienced a caesarean section.[95] In these cases, there was also a visible separation due to the drapes that were put up around the woman's chest.

Furthermore, Martin raised the point that the psychological meaning of birth was not fully considered (which also became an issue in later request

[91] Martin 1992, p. 82.
[92] Clark *et al.* 1991. The authors calculated that the cost of caesareans, even for elective surgery, were generally higher than those of vaginal births. Furthermore, the cost of postpartum care (hospital stay, postnatal examinations) played a substantial role, as usually, the duration of postnatal stay was longer after a caesarean delivery (p. 520).
[93] Martin 1992, p. 150.
[94] Martin 1992, p. 79.
[95] Martin 1992, p. 82.

caesarean controversies; these obviously summarised many aspects of debates on abdominal delivery in general). Her theories were supported by sociologist Ann Oakley, who also stressed that caesarean births impeded attachment and breastfeeding (both of which are believed to be helpful for successful bonding), as the mother – when recovering from anaesthesia – is unable to care for her newborn immediately.[96]

The social sciences also continued to raise psychological issues in the context of caesarean sections, as regards caesareans on request in particular. In the further course of debates on childbirth routines, various disciplines and perspectives came together. Expectant mothers found themselves occupying their contemporary role as emancipated women, but in an environment that was characterised by technology and a clinically constructed version of pregnancy and childbirth, which confronted them with concepts of prevention and risk assessment – to the point of opting for their mode of delivery.

[96] Oakley 1993, p. 132.

2.5 Clinically approved childbirth

The clinical approach to childbirth differs, of course, from that of the social sciences. The medical perspective restricts itself to clinical evidence and statistical research and has great confidence in advances and progress in the field. Once again, it helps to be familiar with the contemporary context of the mid-1990s, in order to gain a better understanding of the study by Al-Mufti, McCarthy and Fisk.

In the beginning of the 1990s and therefore long before the survey by Al-Mufti *et al.*, the idea of performing caesarean sections on maternal request was not yet an issue. Technology, however, was gaining a greater influence over childbirth, and caesarean surgery began to play a major role in obstetric debates. Doctors noted that the rate of caesareans – in particular, elective caesareans – was rising substantially, and that there was a need for explanations. From the medical perspective, advances in technology had made the operation safer, thereby reducing morbidity and mortality. Caesareans, therefore, were seen less as a potentially fatal hazard, and more as a realistic option when the risks of childbirth had been assessed.[97] The rise in elective caesarean deliveries in particular represented the shift from a life-saving emergency intervention to planned surgery. However, in 1987, the assumption remained that caesarean sections could have a negative effect on intellectual development of the baby.[98]

Technological progress, however, was also accompanied by a change in perceptions of previous standards. Although the decrease in risks relating to caesareans was generally viewed as a sign of beneficial progress, these

[97] Ludwig 2001, p. 122.
[98] Hall 1987, p. 201.

new childbirth technologies[99] had the potential to be detrimental to mothers, who often experienced a caesarean delivery as a loss of control. In this regard, doctors were either viewed as being subordinate to technology or exercising power by applying these new technologies and deciding on the route of delivery.[100] Women did not always feel comfortable with childbirth routines. Not only the loss of active involvement in the birth event, but also trouble in postpartum bonding with the baby could be hard to cope with.[101] Social scientists once again emphasised the psychological meaning of childbirth.

2.5.1 The impact of medical risks

Risks and their assessment should be a key aspect of caesareans on request. Risk, in general, does not mean that something will (in any event) occur, but that it may (or is likely to) happen. Thus, there is no guarantee that the anticipated danger will occur.[102] No-one can say with certainty that a women will suffer from long-term consequences after a vaginal delivery.

In the context of technology taking over childbirth, so-called "defensive medicine" became a popular term which has been linked to elective caesareans. It is a new obstetric behaviour which has been heavily criticised but has nonetheless become successful. A broader interpretation of relative indications was used in publications – e.g., maternal age, malpresentation – to justify planned caesareans.[103] Instead of undergoing a trial labour and

[99] This also includes standards such as electronic fetal monitoring (EFM).
[100] Martin 1992, p. 64.
[101] Postpartum standards were not affected by improved surgical techniques. Women still had to recover from anaesthesia, and even if they had local anaesthesia, such as an epidural, the baby underwent a check-up first, instead of being handed to the mother immediately.
[102] Adam/van Loon 2000, p. 2.
[103] Berryman/Thorpe/Windridge 1995, p. 180. There was, however, no medical evidence of why older mothers would benefit from caesarean births, as the increasing age of

monitoring potential risks, abdominal births were arranged in advance. Hence, while the percentage of elective caesareans was increasing, fewer emergency operations had to be performed. However, as the necessity of such a high number of planned surgeries was doubted, allegations of prophylactic and defensive attitudes arose. Critics claimed that obstetricians wanted to avoid malpractice suits. As they were afraid of medical accidents, which could lead to severe birth defects, they advised elective caesareans. However, as a further result, the number of opportunities to practise obstetric skills during vaginal deliveries decreased.

As a subtype of elective caesareans, repeat sections were also considered to influence the overall rise in rates.[104] In spite of the promotion of VBAC (vaginal birth after caesarean), the old saying "once a caesarean, always a caesarean" was still present in the minds of many obstetricians.[105] Last but not least, comparative research into modes of delivery showed that abdominal deliveries could benefit hospitals economically, which may have led to the promotion of caesarean births. In comparison with vaginal deliveries, caesarean sections were more expensive for patients.

The increasing rate of elective caesareans may have influenced the idea of caesareans on request, which were sometimes even referred to as "elective caesareans on request."[106] Both were planned in advance, although the main differences are the person making the decision (elective caesarean: doctor; caesarean on request: pregnant woman) and the fact that caesareans on request are performed in the absence of medical justification.

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primigravidae was still a new topic in the 1990s and no representative studies had yet been carried out.

[104] Roberts *et al.* 1994.

[105] These words have been traced back to American obstetrician Edwin Cragin, who first said them in 1916. Dürig/Schneider 2001, p. 66.

[106] For instance, Paterson-Brown 1998, p. 462.

2.5.2 On to caesareans and childbirth

Obstetricians Iain Chalmers, Murray Enkin and Marc Keirse did not judge the caesarean section rate in their compendium on obstetrics,[107] a fact that probably contributed to the general attitude towards surgical delivery. The two volumes of *Effective Care in Pregnancy and Childbirth* as well as their summary, *A Guide to Effective Care in Pregnancy and Childbirth*,[108] were published in 1989. Although Chalmers *et al*. noted the rising percentage of caesarean births, they stated that many surgeries were performed for good reasons, i.e., under life-threatening conditions. However, indications of dystocia[109] and fetal distress in particular are not always clear, and so doctors have to decide on each case individually. Doctors tended to perform a caesarean, thereby opting for a safe route, rather than dealing with further uncertainty.[110] However, whether or not this broader interpretation of relative indications and the resulting change in attitudes constituted a new phenomenon was not studied in more detail by the authors.

Overall, the textbooks by Chalmers *et al.* were well received, and they fulfilled the expectation of becoming a standard reference in obstetrics.[111] However, as they discussed the field of obstetrics in general, the sections on caesarean delivery were kept short and refrained from promoting an opinion. Instead, the authors focused on medical aspects, such as anaesthesia and surgical techniques, in order to create guidance. Thus, *Effective Care in Pregnancy and Childbirth* became indispensable for general obstetrics, but

[107] Paintin 1990, p. 967.
[108] Chalmers *et al.* (eds.) 1989 and Chalmers *et al.* 1989.
[109] Dystocia means that labour does not progress, cf. Mander 2007, p. 44.
[110] Chalmers *et al.* 1989, p. 256.
[111] "Probably the most important book in obstetrics to appear this century and its value to the profession will be profound and long lasting" (Paintin 1990, p. 967). This refers to the two-volume edition. Much more important than Paintin's praise was that, for the first time, a book combined international studies and research activities. In short, Chalmers, Enkin and Keirse presented a comprehensive database on obstetrics in the past and present, which was completely unique at the time.

with regard to debates on caesarean sections on request, it did not play a major role.

Almost simultaneously, the obstetric profession started to research the risks of vaginal births. At this point, it is worth mentioning that these projects did not yet have the purpose of promoting particular routes of delivery. Allen *et al.*, for instance, assessed the long-term effects of vaginal birth on the pelvic floor. They concluded that a prolonged second stage of labour, as well as a heavy baby, may cause a prolapsed womb or incontinence, in connection with (partial) denervation. Surprising as it may seem from today's perspective, they did not recommend preventive caesarean sections – which were not even mentioned – but rather an episiotomy or the use of forceps to shorten the second stage of labour.[112] Thus, in the early stages of research on the implications of vaginal births, there was no link to caesarean deliveries, let alone request caesareans.

2.5.3 On to safety and reliability

In contrast to Allen *et al.*, the study by Lilford and colleagues illustrated that, first, statistics would show a lower percentage of maternal deaths if only healthy women were considered.[113] In other words, they excluded all women with pre-existing medical conditions, as antenatal complications generally increased the risk of these conditions and could become dangerous during labour. Second, Lilford *et al.* questioned whether, in these problematic cases, an elective caesarean section might be beneficial. Depending on the circumstances – e.g., breech position – a planned caesarean could lead to a

[112] "(...) and the shortening of a long active second stage by an episiotomy or even forceps has merit in as much as these practices minimise the risk of denervation damage of the pelvic floor" (Allen *et al.* 1990, p. 778).
[113] Lilford *et al.* 1990, p. 883.

better outcome than a failed trial labour. However, the authors claimed that there was no justification for performing a caesarean solely for prophylactic reasons and stated that the choice between the options of a "possible failed trial of delivery" or an "elective Caesarean [sic]" was always hard to make.[114]

This study demonstrated that although caesarean deliveries were often associated with increased risk – especially in terms of mortality – compared to vaginal births, a caesarean could be a better option under certain circumstances and when the woman is healthy. This opinion may have contributed to the development that, only a few years later, elective caesareans were performed more routinely. In any case, vaginal delivery was indirectly shown to be a route that should no longer be followed at any price.

A connection between elective, prophylactic caesareans and the avoidance of litigation, however, had not yet been made officially. However, in the rare event that publications explored the threat of malpractice suits, it was found that the field of obstetrics was on a state of alert, although not considerably affected.[115] Changes in legislation were considered to make it easier to take action, even if medical evidence was not always clear.[116] Consequently, "defensive medicine"[117] and risk assessment in advance were advocated, meaning that doctors tended to perform medical action preventively and on time, rather than letting events get out of control. It was often assumed that, after a failed trial of labour, caesareans could have

[114] Lilford *et al.* 1990, p. 891.
[115] Vincent 1991, p. 390.
[116] For instance, Clements (1991) explained that the new legal aid system was now calculated on the basis of the plaintiff's income – in obstetrics, the plaintiff was the newborn – and no longer on the resources of his or her parents. As a result of not having to worry about financial aid, it might become easier for parents to decide in favour of a lawsuit (p. 423).
[117] Clements 1991, p. 424.

prevented major birth defects, and thus saved the obstetrician from being sued.[118]

2.6 Caesarean sections: A global view

With regard to high-ranking associations in the field of health policy, there is one key institution: the supranational WHO. The longer the debate continued about whether an ideal caesarean rate existed and how it could be achieved, the more important became a WHO paper which was published in 1985, named *Appropriate Technology for Birth* (or *Fortaleza Declaration*, after the Brazilian venue at which it was written). In later debates in particular, this paper was assigned a major role by critics of caesarean delivery, as it states clearly:

> *There is no justification to have a caesarean section rate of higher than 10-15%.*[119]

This statement became the most popular quotation of the entire Declaration and a key phrase in many discussions about caesarean sections on request. Although the methods with which this figure was generated have often been questioned (as well as the content of the entire publication), the validity of the paper was confirmed by the previously mentioned acclaimed work by Chalmers, Enkin and Keirse (1989).[120]

Obstetrician Wendy Savage, for instance, referred to the WHO statement and built her argumentation on the passage about caesarean delivery. She agreed that the caesarean rate was too high. Combining research about the impact of obstetric technology and the increase in

[118] Vincent *et al.* 1991.
[119] WHO 1985, p. 436.
[120] Beverly Chalmers (no relation to Iain Chalmers) 1992, pp. 709-10.

abdominal births, Savage arrived at the conclusion that the main reason for the increase in the caesarean rate was obstetricians' anxiety. The fear of malpractice suits, often accompanied by a lack of professional experience, promoted elective caesareans. This trend, as Savage summarised in a later publication co-authored with sociologist Colin Francome, initially arose in the United States and then reached Europe.[121]

Thus, the purpose of regular check-ups for mother and fetus was not only to recognise abnormalities in time; these examinations also promoted risk awareness. For this reason, Savage referred to the Modern Age as the "monitoring period," in which childbirth was no longer viewed as a natural event but as an illness which must be controlled.[122] Clinical advances resulted in a change in doctors' attitudes. Obstetricians no longer disapproved of caesareans, because the safety of the surgery had improved.[123] However, because of their trust in medico-technological equipment, obstetricians also lost faith in their own expertise and became passive followers of technology.[124]

In this study, as well as in her articles with Francome, Savage concluded that these developments were characteristic of Western society. She conceded, however, that exceptions existed, such as the Netherlands and Sweden, which are renowned for the standards of their midwifery.[125] If childbirth becomes a midwifery issue once again, caesarean rates would not only decrease, but health services would also save a substantial amount of money, according to Savage and Francome.[126]

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[121] Francome/Savage 1993, SocSci, p. 1199. A shorter version of their study, which discusses the situation in Britain in particular, was published in *BJOG* in the same year.
[122] Savage 1992, p. 182.
[123] Savage 1992, p. 177.
[124] "In essence they have become the slaves, not the masters" (Savage 1992, p. 182).
[125] Savage 1992, p. 185.
[126] Savage/Francome 1993, p. 495.

2.7 Almost in the headlines – caesarean sections on request in theory

In 1993, the possible existence of caesareans on maternal request was brought up for the first time. In a *BJOG* commentary, which was a direct reply to Colin Francome and Wendy Savage, obstetrician Geoffrey Chamberlain agreed that certain attitudes towards childbirth (e.g., elective caesareans because of malposition), which had come from the United States, were already being implemented by some doctors from the United Kingdom. Nevertheless, Chamberlain argued against a limitation of caesareans, as recommended by the WHO, illustrating that a fixed rate would only make sense if it was a means to achieve a specific goal. In terms of defensive medicine and malpractice suits, he emphasised that another aspect – for which he could not yet provide a term – had not been fully considered: thus far, research into the reasons for the increased caesarean rate had excluded maternal wishes or, in his own words, "the woman's own wishes."[127]

The situation which Chamberlain described corresponded to later approaches to caesareans on request. Although he restricted his explanations to multiparous women,[128] he stated that the wishes of any woman who preferred a voluntary caesarean section, e.g., due to previous negative experiences of childbirth, should be respected. Therefore, elective caesareans were not always initiated by doctors, but requested by pregnant woman as well. Research into the phenomenon of women's concerns and expectations, instead of a focus on litigation, would be necessary to ensure that limited caesarean section rates are appropriate.[129]

[127] Chamberlain 1993, p. 403.
[128] A woman who already has two or more experiences of childbirth.
[129] Chamberlain 1993, p. 404.

Thus, Chamberlain realised that the liberal use of indications for caesarean sections would not represent the last step in the development of caesarean deliveries. The next step, which had possibly already been taken, meant transferring decision-making power to the expectant mother.

In 1996, the study by Al-Mufti, McCarthy and Fisk finally took up Chamberlain's considerations and proceeded to the next stage of caesarean delivery. However, obstetrician Peter Hohlfeld (2001) stated that caesareans on request were not a totally new concept in obstetrics. He was sure that they (or at least the concept) existed before they were made public by Al-Mufti *et al.*, although their study helped to make this mode of delivery a topic for discussion.[130] The fact that maternal request caesareans were not talked about derived from moral aspects; although they may have been performed, caesareans on request were considered to be unethical. Hohlfeld suggested that the actual reasons for maternal requests were hidden behind relative indications. Al-Mufti, McCarthy and Fisk had thus broken a taboo and made it possible to discuss caesareans on request.

Apart from caesarean sections on request and the increasing influence of expectant mothers on the decision-making process, risk assessment and risk tolerance also received more attention. As we can learn from the description of society at the end of the 20th century, planning events long in advance and making them as predictable as possible had become much more important. Obviously, caesareans on request matched better than vaginal delivery with this concept. Vaginal birth, which had previously been recognised as "natural" (meaning as nature intended) was now associated with dangers and unclear outcomes. Thus, there was a shift in medical

[130] Hohlfeld 2001, p. 115.

attitudes – reflected by the increase in caesarean surgeries – as well as a change with regard to perceptions of childbirth and modes of delivery.

2.8 Summary

In 1996, a previously unknown mode of delivery caused a stir in obstetrics – caesarean sections on request, explicitly mentioned for the first time in an article by obstetricians Al-Mufti, McCarthy and Fisk. Their names, as well as their survey, gained popularity in the context of caesarean sections on request, a topic of debate initiated by their publication. Inspired by the *Changing Childbirth* report, published in 1993 by the DoH, Al-Mufti *et al.* extended the concept of patient choice, as mentioned in the DoH document, to the expectant mother, who should be able to opt for her preferred mode of delivery. As a result, the survey by Al-Mufti and colleagues showed that a substantial percentage of the interviewed obstetricians would choose a caesarean delivery – for no medical reason, but by maternal request. However, in addition, it transpired that this option was already available to obstetricians. As professionals in their field, the doctors had noted the risks of vaginal childbirth, and safety for the baby and the mother was their top priority. This meant seeking out low mortality and morbidity rates, as found in caesarean deliveries. Moreover, the obstetricians expressed concerns about postpartum sexual attractiveness and the intactness of their birth canal.

The obstetricians represented experts in their clinical field; thus, Al-Mufti *et al.* wondered whether "everyday women" would make a similar choice. If so, every pregnant woman should have the chance to have her preferred mode of delivery. Supported by medical evidence of the time and under particular conditions, caesarean sections were viewed as low-risk

surgery and, with regard to morbidity and mortality, even comparable to vaginal births. One of the authors, Fisk, continued to discuss the topic in further publications.

Fisk and his colleague Paterson-Brown objected, for instance, to the fact that vaginal delivery was synonymous with "childbirth" and viewed as the "common" mode of delivery. Giving birth vaginally (and thus as nature intended) was the standard that should be achieved. Fisk and Paterson-Brown did not comply with this hegemony, particularly when considering the possibilities of modern birth technologies, because the risks of vaginal delivery were often ignored. In particular, long-term implications for the pelvic floor, but also psychological trauma after a long and painful labour, are possible sequelae. Caesarean sections, in contrast, were no longer viewed as dangerous, and the rise in planned surgeries shows that caesareans shed their image of being an emergency intervention only. They became easier to plan and to predict, as well as an integral part of contemporary obstetric training. Due to the latest developments in obstetrics and patient autonomy, it was justified to allow mothers-to-be to decide on their mode of delivery.

In a controversial issue of *BJOG*, Paterson-Brown delivered further thoughts about caesarean sections on request and stated that they reflected a modern, dynamic and risk-sensitive society. Precaution and risk assessment were already routine aspects of to pregnancy care, so why exclude childbirth from this? In Paterson-Brown's view, this did not make sense. However, ethical issues were evident, in terms of doctors' responsibility. Obstetricians hesitated over whether or not they should perform an intervention without medical justification. However, Paterson-Brown explained that this happened only because vaginal delivery had been

socially constructed as the only and "right" way to give birth. For a long time, women took this for granted, but they began to question established paradigms. Moreover, a cooperative relationship between patients and doctors had become appropriate, as patients – expectant mothers – knew their rights.

The counter-argument to that of Paterson-Brown was put forward by Amu *et al.*, who focused on ethical conflicts. Women could be mentally manipulated in their decision-making, e.g., by obstetricians who suggest a caesarean section. Expectant mothers should never feel pressurised or later regret their decision. Research and development at the time showed no signs that patient choice could be the sole determinant regarding the mode of delivery, and moreover, advocates of caesareans on request often neglected to state that vaginal birth could also be a positive experience.

Responses to this debate identified that the theme of caesareans on request contained substantial potential for further discussions. Replies were, as expected, mixed, and indicated that a consensus was out of reach. The first key topics became clear, such as the question of what the term "birth experience" should comprise and the current position of caesareans on request in relation to their becoming an alternative mode of delivery.

In Germany, the study by Al-Mufti, McCarthy and Fisk did not cause immediate debate. In 2003, Schmutzler *et al.* proposed a similar approach; they too explored obstetricians' personal preferences for childbirth and found that the majority of their interviewees would opt for caesareans on request, in order to avoid labour pain, pelvic floor damage and follow-up trauma (if they had already given birth). However, this study did not become popular in the

international context of the debate, probably because it was published in German.

When Al-Mufti *et al.* published their study, childbirth routines at the time were undergoing revisions (*Changing Childbirth*) and were criticised for being medicalised and dominated by technology. Caesarean sections on request fitted in with this theme, because they encompassed further aspects of modern birth medicine.

Prevention had become routine, and the "monitoring age" had become more than just a saying. Mothers-to-be and the clinical professions were accustomed to these conditions; this was one reason why birth technologies were heavily criticised from outside of the field of medicine, by the social sciences. Pregnancy and childbirth were subjected to plans and standards, which suggested to women that everything was voluntary. However, participation levels were high; the peer pressure was hard to escape (and check-ups were perceived as normal, integral parts of pregnancy care). Therefore, criticising caesarean sections on request meant simultaneously criticising contemporary birth routines.

Due to the increased predictability of caesarean sections, thanks to advanced surgical techniques and overall clinical progress, obstetricians began to prefer elective caesareans to emergency ones, as the latter were still associated with higher risks. This behaviour involved a different perception of caesareans, which were released from their former image of being reserved for emergency and life-threatening cases only. Expectant mothers, however, had to become accustomed to this shift in circumstances, and to some extent, they felt controlled and restricted by the monitoring process. Their feelings were documented by the social sciences.

Doctors started to embrace planned surgeries, and the term "defensive medicine" found its way into the field of obstetrics. This clinical attitude tried to avoid risks in advance (in this case, the unpredictability of vaginal birth) in order to protect doctors from malpractice suits. Medical textbooks supported this behaviour. The comprisal by Chalmers *et al.* (1989) recommended opting for a caesarean section if a vaginal delivery might turn out to be complicated. As the view of caesareans changed, the safety of vaginal births was questioned. These issues were brought up in comparisons of modes of delivery. Caesareans had generated, particularly in terms of morbidity and mortality, an argument in favour of abdominal childbirth. The increase in caesareans, however, called critics' attention to the WHO publication of 1985, in which the WHO argued against surpassing a caesarean rate of 15%. There were no medical benefits beyond this percentage, and too many caesareans were thought of as unnecessary. The so-called *Fortaleza Declaration* continued to play an important role in further debates about caesareans on request, particularly because most Western countries had already exceeded the recommended level of 15%. In addition, many indications suggested that the caesarean delivery rate would continue to increase. In fact, the debates surrounding caesareans on request had only just begun!

3 Caesarean sections on request from a high-level perspective

This chapter concerns statements made by high-level organisations – namely FIGO, NICE and the DGGG – regarding caesarean sections on request. Thus, relevant publications by these three associations will be introduced and discussed, and necessary background information will be provided in sub-chapters. This chapter concludes with a comparison of the views of the three organisations.

Caesareans on request had just started hitting the headlines as part of obstetrics-themed debates, when the topic began to detach itself from the purely medical perspective. Discussions became independent of the context of *Changing Childbirth* (however, this never explicitly enquired into the choice of a mode of delivery) and the study by Al-Mufti, McCarthy and Fisk. Debates on caesarean sections on request were (in the mid-1990s) an issue in their own right and were soon adopted by interdisciplinary approaches.

Attempts to explore caesareans on request, to define them or to explain what they could potentially mean did not just spark discussions, but arose constantly and repeatedly during the course of debates. Statements made by high-level organisations attracted particular attention and had a certain impact on debates. Both international and national associations were respected as authorities because of their knowledge and often outstanding reputation, as they were usually known for guidelines on other medical issues as well. Institutions strived to achieve objective representations. In their publications in particular, they wanted to work against probable uncertainties, defining their position and giving practical advice. Thus, obstetricians had something they could fall back on, as well as a basis for making and justifying

decisions. With regard to caesareans on request, publications by FIGO, NICE and the DGGG had an influence on debates, the latter two focusing on national discussions.

3.1 Official bodies: Who are they and whom do they serve?

When analysing the publications of "high-level institutions" such as FIGO, NICE or the DGGG, we should consider their target demographics as well as their scope of action and influence. Last but not least, their competence could be limited to particular regions or nations, which as a consequence may affect the content of their statements.

FIGO is an international organisation of obstetricians. Thus, they must gather together the various opinions of the nations of all of their members, in order to be fully representative. However, this also means that FIGO's statements are rather general. They cannot consider the opinions of individual persons or health systems. NICE and the DGGG are different, as these two organisations operate on a national basis. NICE is affiliated to the NHS, although it can act independently of their recommendations. However, as the NHS represents a state service, NICE is also a public organ and therefore has to stay within the boundaries and budget of the state-organised NHS.

The DGGG, however, is a privately registered association of obstetricians, founded in 1885. They also perform research, often working closely with the German DoH. In collaboration with the *Berufsverband der Frauenärzte* (BVF, the Professional Association of Gynaecologists), the DGGG publishes its monthly journal *Frauenarzt* (The Gynaecologist).[131]

[131] http://www.dggg.de/ueber-die-dggg/frauenarzt/ (retrieved 28.03.2010).

Similarly to NICE, the recommendations of the DGGG are not compulsory, and are meant as guidelines only. In 2008, the DGGG published a detailed paper on caesarean sections on request.

All three can influence obstetric behaviour and attitudes, as these institutions have barely any competitors. They embody a hegemonic position, which stands for authority on the one hand and for competence and expert knowledge on the other.[132] Overall, FIGO, NICE and the DGGG did not differ considerably in terms of their target audience. First and foremost, they address obstetric practice and the relevant medical professions within this group. Due to the medical terms and vocabulary used in these publications, alongside the very specific topic of caesareans on request, it is unlikely that medical laypersons would have considered accessing these specialist papers, as they require expert knowledge. However, in general, the publications were available to anyone who was interested in them.

[132] For example, the Royal College of Obstetricians and Gynaecologists (RCOG) had not yet published its own statement regarding caesareans on request but instead referred to the NICE guidance as well as to international debates. http://www.rcog.org.uk/womens-health/clinical-guidance/non-rcog-guidelines (retrieved 26.03.2010).

3.2 An ethical approach: FIGO

The FIGO paper on caesarean sections for nonmedical reasons (1998) referred more or less exclusively to ethical considerations. Similarly to the WHO's *Fortaleza Declaration* of 1985, caesareans on request constituted only one of many topics discussed in the guidelines, ranging from stem cell research to abortion. However, FIGO made the first official statement by a professional body on caesarean sections on request.[133] Although their argumentation did not comprise more than one A4 page, the Federation stated clearly that they did not support "caesarean delivery for nonmedical reasons," for in FIGO's view, such surgery represented an unethical procedure. Any caesarean remained a hazardous surgery, while a vaginal birth meant fewer risks. By making doctors rather than expectant mothers responsible for the rise in caesareans on request and the new attitude among obstetricians, doctors were advised to rethink their practice and, in the first place, to provide information to pregnant women, e.g., via counselling.[134] This guidance was reprinted in the *International Journal of Gynecology & Obstetrics* in 1999[135] and initiated further debates about patient choice in connection with childbirth.

FIGO obviously regretted that all previous attempts to control the rise in caesarean deliveries had been "disappointing."[136] They also expressed that they did not support the "excessive"[137] increase. Strikingly, FIGO communicated their statements on behalf of all doctors, the "medical profession throughout the world."[138] They therefore viewed themselves as

[133] FIGO 1998, p. 72.
[134] FIGO 1998, pp. 72-73.
[135] FIGO 1999, pp. 317-322.
[136] FIGO 1998, p.72.
[137] FIGO 1998, p. 73.
[138] FIGO 1998, p.72.

the voice of obstetrics, which furthermore suggested that there was a homogenous opinion on caesareans on request. However, they could only refer to the views of their members. The term "for nonmedical reasons," as used by FIGO, implies that they did not see any medical justification for caesareans on request and therefore that asking for this mode of delivery was unsubstantiated and consequently unnecessary. Due to this lack of medical evidence and justification, FIGO were forced to declare caesareans on request to be an unethical procedure.

3.2.1 FIGO's position and influence

This opinion was both unexpected and surprising, as it was an official statement by an international professional body, which did not reflect obstetric practice and the substantial caesarean rate. FIGO's critical remarks, however, did not focus on the surgery itself, but rather on the use of abdominal surgery and its availability at the mother's request. Risks did still exist; that was why FIGO appealed to doctors to handle requests with care. The fact that caesareans presented the safest route in most emergency cases was not denied by the Federation.

As an association for obstetricians, FIGO also wanted to remind doctors of their medical ethos, and the healing goals of the medical profession (a conflict that was also recognised by Sara Paterson-Brown in 1997).[139] Doctors should heal instead of inflicting injuries on their patients – from FIGO's perspective, caesareans on request presented such an injury, once again because of the lack of medical justification. As no considerable medical evidence or other proof existed in favour of caesareans, compared to

[139] Paterson-Brown 1998, p. 463.

vaginal births, FIGO stressed that the patient's will should and would count only to an extent in this case. From a medical perspective, it was irresponsible to let expectant mothers decide on something without clinical evidence and support. Thus, FIGO criticised obstetric practice; however, they also reserved the right to reconsider their opinion should further evidence arise.

FIGO's discussion of caesareans on request as "caesarean delivery for nonmedical reasons" became widely recognised and accepted among clinicians. Its dissemination certainly contributed to this fact, as the *FIGO Committee Report* was quoted in various publications on request caesareans. However, it is important to note that FIGO presented caesarean sections with no medical justification as surgery that was initiated by obstetricians for reasons of medical safety. Thus in 2004, the NICE guidance on caesarean deliveries produced another definition, which included an explicit reference to the expectant mother's role: "caesarean section on maternal request." This publication stated clearly that it was the mother who was considering a caesarean birth and approached the consultant with her request.

Obviously, FIGO had some idea of which topics would become popular concerning caesarean sections on request. In 2006 and based on the FIGO statement, obstetrician Jan Elizabeth Christilaw enquired as to how the debates had developed subsequently.[140] Technology in connection with childbirth was a substantial issue; Christilaw said that doctors probably trusted technological advances too much. Despite the progress which had been made, caesareans still bore risks and their safety could not yet be guaranteed, and so regarding this issue, nothing had changed since the

[140] Christilaw 2006, p. 262.

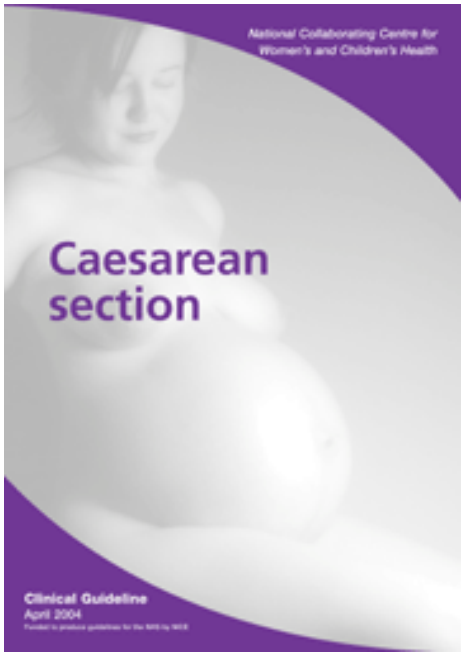
FIGO report. Christilaw explained that the phenomenon of "caesarean section on request" combined technology, ethics and patient autonomy, as well as broader social topics such as feminism and cultural and media influences. This variety of backgrounds and approaches alone added complexity to the topic and contributed to controversies.[141]

3.3 NICE – patient choice, but with a reason

NICE published two guidelines on caesarean sections, *Intrapartum Care* (2007) and *Caesarean Section* (2004). The target audience of *Intrapartum Care* in particular was NHS personnel, working in maternity wards or family planning centres; people who, because of their professions, were in close contact with pregnant women. However, for *Caesarean Section*, expectant mothers were also invited to consult the guidelines.[142]

[141] Christilaw 2006, pp. 264-268.
[142] NICE 2004, p. 2. *Intrapartum Care* lacked an introduction along these lines.

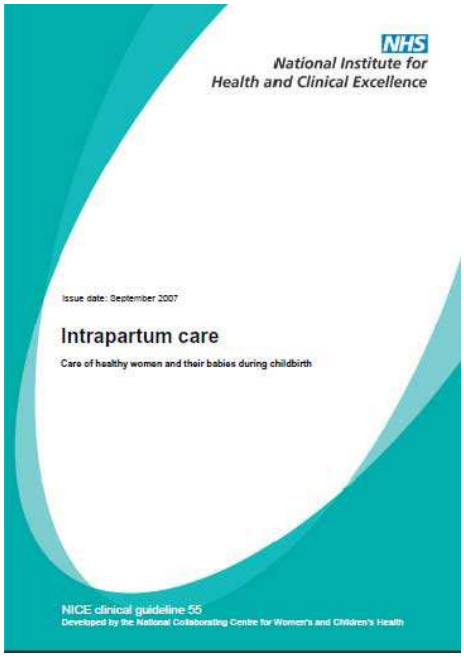
Strikingly and in contrast to *Intrapartum Care*, *Caesarean Section* used a cover picture; this showed a pregnant woman smiling at the baby in her belly.



(Image 1: Cover of Caesarean Section by NICE, 2004)

Possibly because of the caesarean theme, the picture alluded to the idea that the baby would be born by caesarean section.

The cover of *Intrapartum Care* featured the usual plain NICE design.



(Image 2: Cover of Intrapartum Care by NICE, 2007)

Both guidelines featured a similar structure, which was divided into topical and chronological (a succession of diagnostic and surgical routines) sections. With regard to the content, NICE provided advice on how to act in particular situations. Due to the clear structure, the guidelines also served as a reference. However, medical laypersons may have encountered problems understanding the publications, in spite of the glossary and the list of abbreviations, because clinical terms were used frequently and confidently. Moreover, the writing style of *Intrapartum Care* and *Caesarean Section* was rather neutral and unemotional. The sentences were short and the guidelines did not contain any illustrations. They also excluded particular at-risk pregnancies, such as women with gestational diabetes, multiparous women,

preterm labour, etc.[143] Furthermore, the reader was never addressed directly (which can also occur in popular scientific advice books) – pregnant women were spoken of as "the woman" or simply "she," although the guidelines simultaneously stressed the concept of woman-centred care.[144]

In *Caesarean Section*, NICE stated their goal as being to inform, instead of comparing the benefits and disadvantages of clinical practice.[145] In addition, the guidelines were not compulsory but only recommendations; they aimed to support the decision-making process.

3.3.1 *Intrapartum Care* versus *Caesarean Section*

Intrapartum Care explained how to care for expectant mothers from the moment they arrived at the hospital until childbirth. These guidelines centred round a vaginal hospital delivery and in the table of contents, the text distinguished between complication-free and complicated labour and mentioned caesarean delivery only briefly,[146] by recommending the other NICE publication, *Caesarean Section*, for further reference. According to *Intrapartum Care*, "caesarean section should be advised if vaginal birth is not possible"[147]; thus, vaginal delivery was presented as the mode of delivery to strive for. Caesareans on request did not exist, according to *Intrapartum Care*.

Nevertheless, *Caesarean Section* was indeed more detailed. There were two versions of these guidelines – a quick reference and the guidance in full – which came out around the same time, on the 14 and 26 April

[143] NICE 2007, p. 5.
[144] NICE 2007, p. 7.
[145] NICE 2004, pp. 1-2.
[146] NICE 2007, p. 4.
[147] NICE 2007, p. 53.

2004.[148] Discussions about *Caesarean Section* in this thesis will refer to the full text only; the quick reference guide contained excerpts of the more detailed version, re-arranged into diagrams to provide a quick overview.

On behalf of NICE, these guidelines were elaborated by the *National Collaborating Centre for Women's and Children's Health* (NCC-WCH). Their work was supported by a panel of caesarean-related medical professionals (such as obstetricians, midwives, anaesthesiologists and neonatal consultants), as well as members of the *Guideline Development Group* (GDG) who provided experience in publishing guidance.[149]

3.3.2 "Maternal request for caesarean section" – a NICE approach

The NICE guidance in *Caesarean Section* was popular among certain researchers before it was even published in 2004. For instance, medical journalist Jane Feinmann – who knew that the guidelines were still being finalised – looked forward to *Caesarean Section* and was eager to learn about NICE's position with regard to caesareans on request.[150] She had evaluated a rate of 5% of maternal request caesareans and was therefore curious with regard to how NICE would assess this mode of delivery. Moreover, rumours about the guidance had spread to Germany. Medical doctor and psychologist Beate Schücking hoped that NICE would particularly emphasise the risks of caesarean delivery and state that it was a risky operation (in order to scare women away, as Schücking did not support caesareans on request). In Schücking's article, it also seemed that the guidance was meant to be published mainly for expectant mothers.[151]

[148] An updated version is planned for release in October 2011.
[149] NICE 2004, p. 2.
[150] Feinmann 2002, p. 774.
[151] Schücking 2004, p. 29.

However, ultimately, *Caesarean Section* presented a different approach. Both Feinmann and Schücking focused on caesareans on request in particular and probably expected NICE to do so as well – but the guidance was relatively broad.

In the publication *Caesarean Section*, NICE introduced this mode of delivery in detail but concentrated on the overall aspects of abdominal delivery. The guidelines discussed indication catalogues as well as when decision-making should take place and how women should be prepared for surgery. The text even included recommendations for neonatal care.[152] The chapter about elective caesarean delivery listed "maternal request for caesarean section" as a possible indication.[153]

A definition of "maternal request" was not given – obviously, NICE viewed it as being self-explanatory. However, other indications for elective caesareans were also not explained in more detail. NICE probably assumed that its audience was familiar with terms such as breech position and gestational diabetes. Thus, NICE maintained its consistent structure and use of sub-chapters, although it indicated possible reasons for maternal requests from the pregnant woman's point of view. These were based on "19 observational studies"[154] which had been conducted in various countries. According to these studies, for Britain, Sweden and Australia, the average proportion of caesareans on maternal request was 6%. Many women had referred to their negative experiences of previous deliveries (vaginal deliveries or attempts to give birth vaginally); thus, they were afraid of undergoing vaginal childbirth again. For these women, caesareans meant a

[152] NICE 2004, pp. 1-2.
[153] NICE 2004, pp. 37-38.
[154] NICE 2004, p. 37.

mode of delivery containing reduced risks, while vaginal birth symbolised a natural event (the mode of delivery given by nature).[155]

3.3.2.1 Background information: The study by Hildingsson et al. (a source for NICE)

In order to estimate the percentage of caesareans on request, the study by Hildingsson *et al.* (2002)[156] – mentioned above together with similar projects – was used as a major source by NICE. There was a good reason for this, because this survey by the Swedish research group was the first to try to find out about actual caesarean on request rates. This study helps to understand NICE's approach as well as their recommendations, as this study served as a basis for NICE's guidance.

Medical researchers Ingegerd Hildingsson, Ingela Rådestad, Christine Rubertsson and Ulla Waldenström focused their study on the question of why women would opt for an abdominal delivery. One of their findings was that the percentage of caesareans was actually fairly low. This study was the first of its kind to investigate the percentage of caesareans on request, which was why NICE included it in their guidance. According to Hildingsson *et al.*, 8.2% of the women interviewed in Swedish maternity wards would choose a caesarean delivery in theory.[157] However, the authors did not explore how many surgeries had actually taken place. Thus, NICE referred to the situation in Sweden, as well as to fictional events, as none of the women questioned had actually given birth yet.

However, representative studies on caesarean sections on request did not exist in 2002. For this reason, Hildingsson and her colleagues quoted the study by Al-Mufti *et al.*, in order to provide other (theoretical) data for better

[155] NICE 2004, p. 37.
[156] Hildingsson *et al.* 2002, pp. 618-623.
[157] Hildingsson *et al.* 2002, p. 618.

comparison. In the end, the conclusions of the Swedish researchers were more interesting, as they indicated reasons for maternal requests. Hence, traumatic previous experiences of birth or pregnancy (such as a miscarriage) and also general fears of vaginal delivery were the main reasons why women chose caesareans.[158] It was less clear whether there were any connections to modern attitudes and changes in society, in that women now dared to speak about their concerns – or whether their attitudes towards childbirth had changed and made them more cautious and critical. Hildingsson *et al.* noted the medical aspect of abdominal surgery and revealed a connection to psychosocial issues, such as women's feelings and expectations. They concluded from their information that mothers-to-be were not only concerned about the birth event itself, but also about a variety of possible risks, and that they started to worry during pregnancy.[159] I have deduced from the results of Hildingsson and her fellow researchers that, according to the reasons mentioned by expectant mothers, a preventive caesarean section (i.e., a requested one) results from worries about the unborn child, as well as from the mother's aim to avoid repeating previous experiences from other childbirth situations (if applicable) right from the beginning.

NICE adopted the part about the mother's psychological wellbeing in particular, and thus recommended further consultations, in order to find out more about possible hidden fears.

[158] Hildingsson *et al.* 2002, pp. 621-622.
[159] Hildingsson *et al.* 2002, p. 622.

3.3.3 Caesarean sections on request as portrayed by NICE

NICE limited its statements on caesareans on request to the fear of labour and explained that this affected an estimated proportion of 6 to 8% of mothers-to-be. If a mother was considering a caesarean delivery, this could reflect that she felt uneasy about giving birth, suggested NICE.[160] For this reason, consultants should analyse individual cases, in order to explore particular reasons for maternal requests. Moreover, counselling makes it possible to overcome fears, as well as to get a second opinion. NICE had calculated that, by reducing overall caesarean rates, the NHS would save a substantial amount of money – a welcome side effect.[161] In 2008, the *Telegraph* journalist Julia Llewellyn Smith even postulated that NICE's statements on caesareans on request actually aimed to decrease caesarean rates by emphasising how and where costs could be considerably reduced.[162] Llewellyn Smith explored who ultimately determined a mother's birth plan, as many mothers found that, in practice, they were sometimes useless because medical professionals and institutions had their own "plans" (i.e., routines). In this context, NICE was mentioned as interfering with women's decisions.

Moreover, studies expressed doubts that surgeries (because caesareans on request lack medical justification) were desired by the women, who were probably just uncertain. Rather than agreeing to caesareans, doctors should counsel their patients. NICE admitted, however, that there was not yet any evidence of the positive effects of counselling, i.e., women who abandon their wish for a caesarean and pursue a trial of labour

[160] NICE 2004, p. 37.
[161] NICE 2004, p. 38.
[162] Llewellyn Smith 2008, Telegraph (25.05.08).

instead.[163] Nevertheless, counselling would in any case entail the provision of information, as well as helping women to realise what they actually want in giving birth.

The *Caesarean Section* guidance given by NICE introduced caesareans on request as a separate topic. However, this mode of delivery was presented as only one of various possible indications and was briefly dealt with in no more than two pages. Categorising caesareans on request – or expressing the request – further suggested that NICE did not accept a request as sufficient indication on its own. They stated themselves that a maternal request would not be sufficient to justify surgery,[164] probably because the previously mentioned indications (such as multiple pregnancies, breech position or placenta praevia) have a clear clinical background supported by medical evidence, which did not apply to maternal requests. Thus, NICE's argumentation focused on counselling and a bigger scope of action and interpretation. However, the Institute did not seem to consider that the cost of these consultations may also be high.

Therefore, the question arises of whether or not NICE really aimed to be objective in their guidelines. One obvious goal was to encourage expectant mothers to rethink their decision and to reconsider vaginal delivery. Implicitly, women's decision-making was doubted or not taken seriously. NICE expressed that a substantial proportion of maternal requests for caesareans arose in order to bypass the uncertainties of vaginal delivery. Caesareans on request, as stated in the guidance, were closely connected to the fear of childbirth, and this uneasiness signified uncertainty, which women wanted to overcome by opting for caesareans.

[163] NICE 2004, p. 38.
[164] NICE 2004, p. 17.

3.4 Guidelines in Germany – the DGGG paper

The DGGG statement entitled "Absolute und relative Indikationen zur Sectio caesarea und zur Frage der so genannten Sectio auf Wunsch" [Absolute and relative indications for caesarean sections as well as for the so-called caesarean on request] was the result of the DGGG's collaboration with the *Arbeitsgruppe Medizinrecht* (AG MedR, the Study Group for Medical Laws) and became effective in August 2008. The title implied that caesarean sections on request represented one main aspect of the publication. It was obvious that the DGGG aimed to define what exactly the term "caesarean on request" included, as well as to explain the preconditions for this mode of delivery. According to the introduction, which described contemporary developments in obstetrics and particularly with regard to surgical delivery, the subject of caesareans on request required official statements and clear positions.

In the view of the DGGG, safety was the crucial factor that had made it possible for expectant mothers to request caesarean deliveries. Thanks to progress in obstetrics and medical technology in general, caesarean routines had become more reliable and less dangerous. Patients benefited from these developments; in terms of maternal morbidity, the risks involved in planned caesareans were, at the time, comparable to those of vaginal delivery.[165] The DGGG even stressed that the overall danger could even be higher in vaginal births.[166] Nonetheless, the DGGG did not support the attitude that caesarean sections and vaginal deliveries should be considered equal (without giving particular reasons).[167] However, in terms of medical aspects and thus

[165] DGGG 2008, p. 7.
[166] DGGG 2008, p. 6. Risks for the baby were particularly low after week 39 of the pregnancy because her/his respiratory system had matured, according to the DGGG paper.
[167] DGGG 2008, p. 23.

particularly with regard to safety, caesareans had caught up with vaginal births.

What exactly did the DGGG mean by these statements? According to the paper, the possible consequences of caesareans had become easier to predict and to assess. At the same time, and because of the increased safety of abdominal delivery, the risks of vaginal birth had gained more attention. Postpartum incontinence in particular was mentioned frequently in this context.[168] The need for predictability – mothers-to-be wanted to be sure what to expect when giving birth - and information had generally increased among pregnant women as well as obstetricians. Obstetrics, according to the DGGG, had become the medical field facing the largest amount of litigation cases. Moreover, the influence of patient choice had increased.[169] Women as well as doctors had become more aware that (vaginal) birth entailed certain risks; this also contributed to the rise of caesarean on request debates. In order to elaborate on the relationships between patient choice and changes in obstetric practice as regards maternal requests, the DGGG referred to the study by Al-Mufti, McCarthy and Fisk.[170] This was still well-known in Germany.

[168] DGGG 2008, p. 5.
[169] DGGG 2008, p. 4.
[170] DGGG 2008, p. 1.

3.4.1 Caesarean sections on request according to the DGGG

The DGGG viewed caesareans on request as a separate, independent mode of delivery, which of course belonged to the overall "family" of caesarean surgery. However, one aspect differed significantly from the terms used by FIGO or NICE: according to the DGGG, a "real" caesarean on request contained neither medical nor psychological indications. Thus, only organisational reasons remained, such as "fixing a particular place and date of birth in advance."[171] Reasons could include fitting in with anniversaries or signs of the zodiac, or to adjust the time of the surgery to fit the partner's (the father of the baby) timetable, according to the DGGG.[172]

This view was different from that of other institutions, and the DGGG's understanding became even clearer when synonyms such as "caesarean by contract" or "caesarean out of courtesy" appeared in the paper. Caesareans on request had little connection with indication catalogues, the DGGG implied; they resulted instead from a service contract between the mother-to-be and her obstetrician.[173] More precisely, a "caesarean section on request" involved a particular date of birth **chosen by the mother-to-be** as its sole determinant, with no medical or other justification. In practice, this variant of the elective caesarean seldom occurred and, as explored by the DGGG, often confused with planned caesareans for psychological reasons. These, however, were recognised as relative indications by the DGGG.[174]

[171] "Zeit und Ort der Entbindung [sollen] im Voraus fest bestimmbar [sein]" (DGGG 2008, p. 4).
[172] DGGG 2008, p. 4.
[173] DGGG 2008, p. 4.
[174] DGGG 2008, p. 3.

3.4.2 Defensive medicine and caesareans on request

Moreover, preventive caesareans were also viewed as a relative indication by the DGGG, as they were often justified by previous experiences. "Defensive medicine" was only applied under certain circumstances, especially if obstetricians had more experience with caesareans than vaginal deliveries. In such cases, doctors would demonstrate responsibility by performing the routine they knew best, in accordance with their skills. The DGGG provided another similar example: shift changes can be stressful, and on night shifts, fewer personnel are available for emergencies. Such situations (and possible lawsuits if things went wrong) could be avoided through scheduled caesareans.[175]

The DGGG's considerations were unique. They referred repeatedly to court verdicts and the current legal situation in Germany. Hence, requests for caesareans were also supported by the right to self-determination, which formed part of German constitutional law. As doctors and women mutually agreed on the surgery, caesareans on request did not entail a criminal assault.[176] However, expressing such a request was not sufficient on its own, but became an accepted reason if the woman was fully informed.[177] On the other hand, obstetricians were not obliged to suggest caesareans on request or to raise the topic, as long as the pregnancy was uncomplicated. The *Bundesgerichtshof* (BGH, Federal Court of Justice – Germany's highest court for civil cases) had already made this decision.[178] Thus, the DGGG's argumentation differed substantially from that of FIGO, who, 10 years ago, had worried about injuries being inflicted. While NICE reflected upon NHS

[175] DGGG 2008, p. 3.
[176] DGGG 2008, p. 9.
[177] DGGG 2008, p. 8.
[178] DGGG 2008, p. 7.

budgets and cutting medically unjustified surgeries, the DGGG came up with a medico-legal approach.

3.4.3 The DGGG statements in a nutshell

Strikingly, the DGGG's approach to caesarean sections on request was much more detailed and less critical than the publications by NICE and FIGO. The DGGG viewed caesareans on request as the next step forward, which had resulted from contemporary medico-technical developments, combined with a shift in the attitudes of doctors and women towards childbirth and risk. These changes were reflected in the involvement of mothers-to-be in decision-making as well as in the revision of indications: previously, medical indications alone had played a role in decision-making, but psychological issues began to be considered as well.

Nevertheless, the DGGG's paper was not intended as a general recommendation for caesareans on request in any case; they should not be understood as an alternative to vaginal delivery. However, no explanation was provided for why caesareans and vaginal birth were not treated equally, particularly because the DGGG had said that caesareans were as safe as vaginal delivery, with risks to the baby even being lower than in vaginal births. Overall, the risks involved in caesareans were mentioned only briefly, as were the medical aspects. The DGGG focused on organisational and formal predispositions. In 2003, German lawyer Rudolf Ratzel explained the legal framework of the DGGG's paper and attitude (2003). He concluded that caesareans on request were justified and supported by personal and patient rights, which applied to Germany. Moreover, prevention was beneficial for the

wellbeing of the unborn child as well, whose state was also considered during the decision-making process.[179]

As regards ethical issues, caesareans on request, from the DGGG's perspective, did not aim to heal an actual disease (which is the goal of medicine). However, as caesareans on request are preventative surgery, complications which may otherwise occur could be avoided.[180] This justified the performance of caesareans on request to an extent because they avoided theoretical emergencies.

3.5 Reception of caesareans on request by official bodies

First, official bodies aimed to approach and define the phenomenon of caesarean sections on request. As they were a new mode of delivery at the time (or at least one that had not yet been talked about), publications recognised the need for detailed descriptions. Caesareans on request were categorised as a variant of elective caesarean sections and abdominal deliveries, as they represented a surgical procedure. This procedure, however, was performed without an obvious medical need, which was why FIGO, for instance, did not support caesareans on request. Surgery was asked for by the expectant mother; this differentiated caesareans on request from other elective caesareans.

Last but not least, papers aimed to offer practical guidance in terms of obstetric behaviour by recommending how doctors should react to maternal requests. The advice did not focus on clinical therapies or surgical techniques; the institutions had recognised that psychological and emotional aspects in particular played major roles in decision-making, from the mother's

[179] Ratzel 2003, p. 603.
[180] DGGG 2008, p. 9.

perspective. Thus, the guidelines concentrated instead on ethical considerations, such as how doctors should react to requests in order to uphold their responsibility and act morally at the same time. FIGO covered the widest scope when discussing such issues, because of its internationality. Obstetrician Volker Lehmann (2006) explained FIGO's rejection of caesareans on request by referring to their global responsibility and membership.[181]

NICE stayed within the borders of a particular health system, namely the NHS; it had to consider budgeting, as well as other aspects of national health policy. Its actions were thus constricted to the framework given by the NHS.

3.6 Caesareans on request – reception and perceptions

FIGO stressed the interaction between medical and ethical aspects of caesareans on request. At the same time, they assumed that moral and ethical issues would become increasingly important as discussions progressed. Indeed, further evidence and findings were anticipated. The "unethical" aspect of caesareans on request was obvious – the lack of medical necessity, which meant, from FIGO's perspective, that this mode of delivery was not justified.

However, why had caesareans on request been allowed? FIGO suggested that obstetric behaviour had undergone a shift in attitudes. It had only been a matter of time until indications were adjusted, reflecting these new practices and debates. Nevertheless, when agreeing to caesareans on request, obstetricians also accepted risks which had not yet been fully

[181] Lehmann 2006, p. 243.

explored, such as the long-term implications of caesareans. At the same time, however, they bypassed other risks which were already known, e.g., the consequences of vaginal delivery (e.g., birth injuries).

NICE not only mentioned that indications had changed, but also included "maternal request" in their list of relative indications. Ignoring this newly arisen mode of delivery was no longer an option, as it had become too important, particularly with regard to issues of patient autonomy and obstetric advances. NICE had realised that caesareans on request existed in obstetric practice. Providing advice and guidance was their way of participating in the debates.

The DGGG also knew about the shift in obstetrics, but this German association produced a statement of approval and detailed explanations. This made it hard for critics to argue against caesareans on request. At the same time, the DGGG paper contained the fewest gaps and instead referred to all of the relevant aspects of caesareans on request.

As regards the classification of caesarean sections on request, while FIGO mentioned only briefly that they were medically unnecessary (which was also recognised by NICE and the DGGG), the DGGG compared them to other types of caesarean (emergency and elective) and concluded that they represented a mode of delivery in their own right and that maternal requests constituted an approved indication. For NICE, however, a maternal request was only one of many possible relative indications, which was not valid on its own but would require a second opinion. NICE obviously wanted to be sure that no unnecessary surgeries would be performed. The DGGG saw no problem with agreeing to maternal requests, as long as certain conditions – including the woman's consent – were met. Thus, caesareans on request

were more "mature" in Germany, more detached from other types of caesarean and probably easier to achieve.[182]

Did the mother's opinion play a role? FIGO did not mention why mothers-to-be would opt for a caesarean birth, but they indirectly blamed obstetricians for their current attitudes and practice, which had become less critical towards surgical births. NICE and the DGGG identified (like Al-Mufti, McCarthy and Fisk did in 1996) a fear of childbirth (labour pain but also fear for the baby) and low self-confidence in general as the main reasons. These were often paired with risk awareness, particularly with regard to postpartal implications such as trouble healing and the impairment of future sexual activities, which were associated with vaginal birth.

Ethical issues played a major role in FIGO's paper; moral issues provided the grounds for further reflections on obstetric behaviour and decision-making. NICE did not refer to the ethical components of caesareans on request, and they also did not compare them to vaginal deliveries, as FIGO and the DGGG did. Although none of the institutions wanted caesareans on request to be an alternative to vaginal birth, the DGGG at least stated that, in terms of risks, both modes of delivery were fairly equal.

Caesarean Section by NICE was intended to be a clinical reference and thus was structured like one, providing important medical information. The DGGG statement contained clinical issues too, but its overall content was more general than detailed. Their collaboration with AG MedR allowed the DGGG to provide a grounded opinion on legal issues as well, and particularly medical malpractice legislation and defensive medicine. This was an important aspect in comparison with NICE and not least the NHS: German hospitals had a bigger scope of action, as they were less state-controlled.

[182] This will be further discussed in Chapter 6, which is about debates on Internet forums.

How important was information? FIGO, NICE and the DGGG stressed that decision-making could not take place without information. While FIGO once again excluded the patient-doctor relationship, the DGGG recommended that, in general, "the weaker the indication, the more detailed the information"[183] which should be provided by medical professionals, comprising obstetricians as well as counsellors and midwives. The DGGG stated that doctors should preferably provide the information, without giving a reason, but probably because they would perform the surgery.

By publishing their statements and opinions in the form of guidance – which applied to FIGO as well as to NICE and the DGGG – long-term validity was achieved; a temporary phenomenon would not need detailed guidelines. However, implicitly, the institutions confirmed that they took the existence of caesareans on request seriously and that this mode of delivery was far from being a temporary fashion, which had already caused numerous debates.

In the international context, FIGO was well-known, as it had members from various nations and operated worldwide. NICE and the DGGG did not have much impact outside their home countries, apart from the aforementioned announcement by medical doctor Beate Schücking, who was looking forward to the *Caesarean Section* guidance (2004).

In spite of the DGGG's lack of international popularity, they are fairly well-known and respected in Germany, because of their expertise. Lawyer Nora Markus explained in 2006 that DGGG guidelines were often considered when indication catalogues were compared to lists of services by health insurance companies, in order to check whether invoices were justified.[184] Most health insurance companies adopted the DGGG lists.

[183] DGGG 2008, p. 13.
[184] Markus 2006, p. 50.

3.7 Summary

At this time, discussions about caesarean sections on request were finally recognised by high-level institutes. FIGO, an international federation of obstetricians, published a statement in 1998 on elective caesareans without medical justification and communicated a critical position. Specifically, they reminded their fellow obstetricians of their ethical responsibility, which meant that, in FIGO's view, surgery without medical indications was immoral. FIGO showed a certain degree of open-mindedness as well, in terms of expecting further medical findings, as research was still in progress. At that time, however, no clear evidence existed in favour of caesareans on request and their long-term benefits or disadvantages. Thus, FIGO held on to vaginal delivery, which they declared to be the safest way to give birth.

FIGO addressed its members as well as other obstetricians. Moreover, it was an international organisation. NICE, on the other hand, had a regional influence in Britain and the NHS. Their guidelines on caesarean sections had a broader target group (anyone who was interested). In addition to clinical descriptions, NICE included ethical as well as economic issues in their guidance, the latter reflecting the institute's dependency on the NHS and its (budgetary) restrictions.

Intrapartum Care by NICE (2007) only briefly discussed caesarean sections as a way of giving birth. This publication concentrated on complication-free vaginal deliveries. As caesareans constituted an unexpected situation, they were not included in the description of the standard delivery process and were mentioned separately. Caesareans on request were not listed at all. However, they had already been discussed in NICE's other guidance text on abdominal delivery, *Caesarean Section*, which

exclusively concerned caesarean birth. In this work, NICE explored caesarean delivery in detail, from diagnosis to performance and aftercare. Maternal request was viewed as one of various indications. According to NICE, a request alone was not enough to justify surgery; there should be other convincing indications as well. In addition, NICE did not provide a definition of caesareans on request, but instead quoted some studies in which mothers spoke about the reasons why they had requested surgery. As the fear of childbirth ranked high on the scale, NICE suggested counselling to overcome anxiety and encourage rethinking so that a vaginal delivery could at least be attempted. Last but not least, and in terms of restricted NHS budgets, vaginal births are less expensive than surgeries, particularly when they lack medical indications. NICE obviously had to abide by NHS regulations; however, they did not reveal whether counselling expenses were actually cheaper than granting requests for caesareans.

The statement of the DGGG, published in 2008 and thus 10 years after FIGO's statement, partially contrasted with NICE's views. The DGGG emphasised the safety and predictability of caesarean deliveries and particularly of those on request, as the topic of the paper. Despite this argumentation, they stressed that caesareans on request were not equal to vaginal deliveries, meaning that they should not replace vaginal births. Nevertheless, when mentioning vaginal births, the DGGG focused on their risks and implications, as well as the possibility of malpractice suits, which were a growing problem in the field of obstetrics. Patient choice was an approved indication for caesareans on request, as long as the mother could be considered to be well-informed.

The publications of high-level organisation were widely received. They also attracted special attention and contributed to debates. Nonetheless, sometimes the statements of organisational bodies applied to their respective nation and healthcare system only.

4 Controversies and main themes: Caesarean sections on request in the headlines

This chapter concerns the main issues in debates about caesareans on request. It comprises medical and medical-themed discussions and thus complements the previous chapters; however, as the debates develop, this chapter gives a deeper insight into the issue of caesareans on request, which is one of its aims. Moreover, it identifies the major topics of discourses in order to clarify why a patient would choose to undergo surgery and what was so controversial about requesting a caesarean.

The introductory part of this chapter also provides basic information which I thought may be helpful with regard to understanding the content of debates and subsequent inquiries into the reasons for caesareans. Thus, there will be an introduction to caesarean indications and how they changed in order to facilitate doctors' agreement to maternal requests. The characteristics of caesareans on request which are studied in this chapter are all linked to each other and interact. These characteristics form the main part of this chapter.

Risk awareness and changes in the perception of childbirth also constitute an issue, as they have contributed to the understanding of caesarean deliveries as preventive surgery. This issue, as well as shifts in the concept of patient autonomy, will be studied in subsequent sub-chapters. This chapter closes with an approach to women's reasons for choosing a caesarean delivery, which simultaneously leads on to Chapter 5.

4.1 From FIGO, NICE and the DGGG to the broader medical debate

Statements by high-level organisations, introduced in the previous chapter, suggest the real subject matter of debates on caesarean sections on request. Generally, however, there was another basic problem, which exceeded the contents of papers, as it was never mentioned: no common-sense definition of "caesarean section on request" existed. While FIGO, NICE and the DGGG basically ignored this fact or chose their own terms such as "caesarean on maternal request,"[185] when Gossman *et al.* researched the definitions of caesareans on request in 2006, they concluded that the lack of a general definition could evoke misconceptions.[186] Various terms were in use, such as "caesarean by choice" (CSBC)[187] and "woman actively seeking a caesarean."[188] These definitions or circumscriptions of the phenomenon emphasised that the mother-to-be was the person behind the decision, and that she was actively involved. As regards their contents, the definitions differed with regard to the scope of medical indications as well as their perception of nonmedical indications. The shift to psychological indications was not clearly defined, which influenced caesarean rates and statistics.

Actual clinical reasons for caesareans on request could be hard to reconstruct. According to obstetrician Peter Hohlfeld (2001), doctors as well as women often referred to "pseudo" indications, in order to conceal their true intentions, either because the indications would not have been sufficient to

[185] NICE 2004, p. 39.
[186] Gossman *et al.* 2006, p. 1506.
[187] Christilaw 2006, p. 262.
[188] Mander 2007, p. 99.

perform surgery or because women were ashamed of opting for a caesarean.[189]

In order to clarify the situation, a knowledge of the differences and common characteristics of elective caesareans and caesareans on request is helpful. The most striking issue was the lack of medical indications with regard to caesareans on request, as well as the fact that surgery was planned in advance and requested by the mother-to-be. Nora Markus added correctly that there was no difference in terms of surgical techniques between elective and request caesareans.[190] As these two types of caesarean were performed in an identical manner, differences could only arise regarding other aspects – namely medical indications, which were replaced by a maternal request. However, as the clinical performance was the same, critical remarks concerning caesarean delivery in general could be easily transferred to caesareans on request, e.g., statements on mortality and morbidity. Thus, critics who remarked that there were still no long-term studies on caesareans referred in fact to studies on caesareans on request exclusively. Such studies were obviously not yet available, because discussions had only recently arisen and debates were still in progress.

The debates also referred to statements on caesarean delivery in general, which had already been published, in order to explore medical and psychological issues associated with this mode of delivery and apply them to caesareans on request. It could therefore be proven that caesareans entailed less risk in comparison to earlier days.[191] The risks (i.e., morbidity and mortality) were now comparable to those of vaginal delivery, and thus

[189] Hohlfeld 2001, p. 115.
[190] Markus 2006, p. 103.
[191] Ludwig 2001, p. 122.

caesareans had caught up.[192] Therefore, differences could only occur with regard to aspects beyond medical evidence, i.e., relative indications in particular but also obstetric attitudes. Both were hard to measure.

4.2 Types of indications for caesarean sections

The conditions for a caesarean were fulfilled if one or more approved indications were identified. In cases in which these indications were found, caesarean intervention was considered to be medically justified. It was the obstetrician's duty to identify indications and arrange, when approved indications were found, for the surgery. Indications for caesarean delivery could be absolute (life-threatening conditions for mother, baby or both) or relative (birth may turn out to be risky).[193] In cases of relative indications, doctors conducted risk assessments to judge whether a vaginal birth was still possible. With absolute indications, because the situation was considered to be life-threatening, caesareans were obligatory and doctors had to decide quickly.[194]

This was different for relative indications, which were applied to elective surgeries. In colloquial terms, they were also referred to as "weak indications," thereby questioning the obstetrician's decision and implying that surgery may not always be necessary.[195] Relative indications showed a high degree of flexibility and could be interpreted very broadly and generally. The idea of caesareans on request certainly benefited from this aspect. As caesareans on request represented planned surgery, they clearly belonged to the category of elective caesareans with relative medical indications.

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[192] Al-Mufti *et al.* 1996, p. 544.
[193] Dudenhausen 2001, p. 80.
[194] DGGG 2008, p. 3.
[195] DGGG 2008, p. 3.

The life-saving attributes of emergency caesareans could not be ignored, which was why this type of caesarean was not focused on by critics. Emergency surgeries were accepted because the circumstances could not be changed. On the contrary, the necessity of emergency interventions was often stressed, in order to recall the original and alleged (for some critics) function of caesareans: to save lives.[196] In this context, obstetrician Joachim Dudenhausen in 2001 explored the notion that emergency caesareans had also undergone changes. The wellbeing of the unborn child had begun to play an important role as well, which had not been automatically the case in previous times.[197] Emergency caesareans saved lives; thus, they were useful and, because of clear medical indications, always justified.[198] They were not targeted by critics.

4.2.1 Relative indications, elective caesareans and their relation to caesareans on request

What was the issue with planned caesareans? They are, as we have learned thus far, based on relative indications. Towards the end of the 20th century, the safety of caesarean sections increased. The study by Al-Mufti, McCarthy and Fisk (1996) compare their risks with those of vaginal delivery, stating that they were similar in terms of complications. This argument allowed caesarean delivery to challenge vaginal birth – the traditional mode of delivery – in terms of risks and sequelae. For many obstetricians, the increased predictability of caesareans was reason enough to opt for a caesarean delivery when trouble could be expected.

[196] Hillan 1996, p. 123.
[197] Dudenhausen 2001, p. 80.
[198] Lobel 2007, p. 2227.

How did debates reflect the shift in indications, which focused particularly on relative indications? In the beginning, the increasing use of relative indications was discussed independently of caesareans on request. Obstetrician Hans Ludwig (2001) identified a publication by his colleague Peter Husslein, written in 1998, in which Husslein recognised the decreasing use of absolute indications.[199] At the same time, this marked the shift from elective caesareans to surgeries on request – in Ludwig's view, the last possible step in the extension of caesarean indications had been taken.[200] In the same year (1998), Chris Wilkinson *et al.* concluded in their study that obstetricians relied on not only one, but multiple indications, in order to be safe when deciding upon a caesarean delivery.[201] The authors concentrated on a particular Scottish maternity ward. However, when a variety of indications applied, it was hard to reconstruct the actual main reason for surgery (which could affect the statistics).[202]

With regard to indication catalogues, Susan Meikle *et al.* found that first-time mothers formed a large proportion of those having planned caesareans (2005).[203] Once again, this obstetric practice may have been reflected in the increase in caesarean rates. In this context, the rise in specific relative indications, such as malpresentation and bleeding during pregnancy, was striking.[204] Meikle and her colleagues further recognised that attempts at a trial of labour (vaginal delivery) had decreased, as had the use of particular techniques, such as ECV (external cephalic version – trying to turn a breech baby into the right position in the womb). Instead, caesareans

[199] Ludwig 2001, p. 122.
[200] Ludwig 2001, p. 122.
[201] Wilkinson *et al.* 1998, p. 45.
[202] Wilkinson *et al.* 1998, p. 45.
[203] Meikle *et al.* 2005, p. 751.
[204] Meikle *et al.* 2005, p. 754.

were performed.[205] This suggested the use of surgery for preventative reasons, with the aim of bypassing certain complications before they could even occur – a condition that applied to caesareans on request as well.

In 2002, obstetrician Andree Faridi *et al.* (2002) questioned whether there were connections between prevention, caesarean rates and recent changes in indications (in the particular context of postnatal anal incontinence). Their findings clarified that relative indications had broadened.[206] Knowledge about caesareans had obviously increased and other, less apparent factors such as patient choice and postpartum considerations had played a role in recent developments. Compared to previous times, maintaining the lowest possible caesarean rate was no longer a sign of the quality of maternity wards.[207] "Prevention" had a medical component and was thus, for Faridi *et al.*, different from "on request."[208] Childbirth was no longer approached in an unbiased manner, which was also reflected in an increased need for doctors to be safe.

Did this have an effect on mothers-to-be as well? In 2002, obstetrician Jane Feinmann noted that the safety-related aspects of caesarean sections led to women trusting this mode of delivery.[209] The interaction between caesareans and safety were, however, ambivalent. As medical interventions – which were generally accepted – had increased, they were no longer perceived as unusual. It was rather a matter of course that doctors seized the possibility to prevent complications in time.[210] This attitude resulted in a further rise in interventions as well as interventions becoming associated with

[205] Meikle *et al.* 2005, p. 754.
[206] Faridi *et al.* 2002, p. 42.
[207] Faridi *et al:* 2002, p. 42.
[208] Faridi *et al.* 2002, p. 48.
[209] Feinmann 2002, p. 774.
[210] Johanson *et al.* 2002, p. 892.

safety. Medical doctors Richard Johanson *et al.* spoke of "blame and claim" in the context of the communication of safety and predictability (2002).[211] Rosemary Mander (2007), however, referred to the fact that "safety" had many dimensions which were influenced by a certain perspective.[212] In obstetrics, medicine and technology stood for safety (and control); thus, they had a considerable impact on obstetric practice.[213]

The view of sociologists Clarissa Schwarz and Beate Schücking in 2004 was more critical; they did not deny the impact of medicalisation on childbirth (2004). Medicalisation, in their view, was substantially increasing and therefore childbirth had become more and more controlled by technology. Schwarz and Schücking therefore asked what was left of "normal" childbirth (meaning vaginal delivery).[214] The link between caesareans and safety was reported to be an illusion. In another publication in the same year, Schücking claimed that caesareans on request in particular meant that mothers-to-be agreed to a variety of risks.[215] The presentation of caesareans as safe, routine surgery reflected that technology had taken over childbirth. To an extent, Schücking and Schwarz resumed Marjorie Tew's approach of 1998 (but did not refer to it explicitly), in which the author tried to establish a connection between technological advances and safety.

With the rise of caesareans in mind, statistician Tew focused on the medicalisation of delivery and, by researching statistical data on mortality, morbidity and modes of delivery, aimed to explore whether or not hospital births were really beneficial. Although her monograph was not exclusively on caesarean delivery, surgery played a role in Tew's study of the impact of

[211] Johanson *et al.* 2002, p. 894.
[212] Mander 2007, p. 106.
[213] Johanson *et al.* 2002, p. 892.
[214] Schwarz/Schücking 2004, p. 1.
[215] Schücking 2004, no page given in this publication.

technology on childbirth. She was, however, particularly critical towards birth technology, including abdominal delivery.

Through interpreting statistical data, Tew emphasised that caesareans always involved higher risks than vaginal birth, which was generally the safer option.[216] Furthermore, Tew concluded that safety signified an increased use of technology, referring implicitly to the conflict between "nature" and "technology" with regard to childbirth: being pregnant and giving birth are not an illness, and thus childbirth should not be medically controlled.[217] Parents often confronted doctors with unrealistic expectations, which relied to a great extent on technology – these parents wanted to be guaranteed a healthy baby. Doctors felt pressurised, and were already suffering as a result of reduced practical training, as well as a fear of litigation.[218] The more technology dominated childbirth, the less attention was paid to the nature of childbirth and safety, as Tew recognised.

4.3 From changes in the perception of vaginal delivery to preventive medicine

Vaginal birth, which was viewed as the standard way to give birth for a long time and which, for this reason, was not critically questioned, was suddenly viewed as risky, hard to control and associated with long-term sequelae. What did this mean? The relevant debates referred to the main themes which were discussed by Al-Mufti, McCarthy and Fisk in 1996. Studies focused particularly on implications for the pelvic floor, which were said to be avoided by caesareans. However, evidence at the time suggested that it was not only the mode of delivery – in this case, vaginal birth – which

[216] Tew 1998, p. 165.
[217] Tew 1998, p. 244.
[218] Tew 1998, p. 244.

could lead to temporary postpartal incontinence. As regards this matter, Wijma *et al.* (2003) found that both pregnancy and vaginal childbirth impaired the functionality of the pelvic floor. To what extent each factor was responsible had not yet been identified. Six months postpartum, however, incontinence became less severe or no longer occurred. However, every other symptom was likely to last and become chronic.[219] The reason lay in changes in the tissue and muscles.[220]

The impact of the mode of delivery was therefore not clarified, as Dolan *et al.* further reported (2003). They looked into the long-term sequelae of delivery and pregnancy.[221] Regardless of the mode of delivery, the risk of developing stress incontinence was higher when symptoms of incontinence occurred during pregnancy.[222] The relation between incontinence and the mode of delivery was further explored by Fitzpatrick *et al.*, who also carried out research into operative vaginal delivery (2003). They found that a mother who underwent a forceps delivery had a higher risk of developing anal incontinence.[223] They noted that the sequelae of vaginal births were discussed frequently and also in comparison with caesareans on request.[224] Women often mentioned severe implications as their reason for choosing a caesarean delivery.[225]

It would therefore make sense for caesareans on request to prevent severe injuries – under risk assessment – which would have long-term effects on the patient's physical wellbeing, as well as on other aspects of everyday life. Preventive sections, for instance, in the context of breech

[219] Wijma *et al.* 2003, p. 658.
[220] Wijma *et al.* 2003, pp. 661-662.
[221] Dolan *et al.* 2003, p. 1108.
[222] Dolan *et al.* 2003, p. 1113.
[223] Fitzpatrick *et al.* 2003, p. 427.
[224] Fitzpatrick *et al.* 2003, p. 424.
[225] Fitzpatrick *et al.* 2003, p. 427.

babies, had already gained acceptance. Medical evidence existed, and recommending caesareans in the context of relative indications had been approved.[226] The RCOG also supported caesareans in the case of breech babies because, in this context, planned surgeries decreased perinatal mortality and adverse outcomes in general.[227] Obstetrician Burke took the next step and suggested that caesareans might present an alternative to vaginal breech delivery, because of their safety.[228] This view was partially modified by Villar *et al.* (2008), who agreed that caesareans reduced fetal mortality rates with babies in the breech position.[229] However, they also concluded in their comparative study on vaginal delivery and caesarean sections that caesareans still generally result in higher mortality rates.[230] Nevertheless, Villar *et al.* did not deny that the rate of caesareans had risen. One significant reason for this was that obstetricians feared litigation. Could this be viewed as another reason for paving the way to caesarean sections by choice and encouraging doctors to agree to maternal requests?

4.3.1 Prevention and litigation

A variety of aspects interacted in order for caesareans on request to appear in debates and obstetric practice;[231] first, we shall examine changes in indications. These amendments were extensions and adaptations rather than outright changes, meaning that certain indications never became void but that new, further indications were included in catalogues. Caesarean delivery experienced a shift from being an emergency intervention to planned

[226] Markus 2006, p. 52.
[227] RCOG 2006, p. 2.
[228] Burke 2006, p. 970.
[229] Villar *et al.* 2008, p. 6.
[230] Villar *et al.* 2008, p. 1.
[231] Smith *et al.* 2003, p. 1779.

surgery. Professor of Midwifery Edith Hillan assumed that these changes were major indicators which contributed to the rise of caesareans (1996) and probably to more planned surgeries. Their biggest impact, however, was that litigation also increased, and that doctors feared malpractice suits, Hillan explained. A vicious circle emerged, as obstetricians no longer gained a broad experience of guiding deliveries, because their training was restructured, and so they could not acquire particular practical skills, such as guiding complicated births.[232] Although Hillan did not explore caesareans on request specifically, she nevertheless alluded to the idea by emphasising the extension of relative medical indications.

How real was the threat of malpractice suits? Jenny Gamble – another Professor of Midwifery – *et al.* (2007) found that not only women but also obstetricians feared childbirth, the latter because of the litigation involved. The authors linked this fear to the rise in caesarean deliveries performed for preventative purposes. Doctors felt uneasy about certain aspects of childbirth, such as the lack of predictability, and thus tended to favour clinical interventions.[233] Interestingly, Gamble and her team identified that "medical norms"[234] (i.e., doctors' attitudes and practice which reflect the national health system) determined and influenced obstetric practice. These norms determined the quality of maternity care as well as obstetric training and how litigation was dealt with by the law.[235]

All lawsuits had to be taken seriously because they could damage a hospital's and a doctor's reputation and lead to financial losses.[236] As previously mentioned, obstetricians were aware of defensive medicine, a

[232] Hillan 1996, p. 121.
[233] Gamble *et al.* 2007, p. 338.
[234] Gamble *et al.* 2007, p. 338.
[235] Gamble *et al.* 2007, p. 339.
[236] Bopp 2003, p. 27.

doctors' practice which opts for the course with the fewest risks.[237] The perception of the risk involved had also changed, with caesareans becoming safer. In theory (and according to RCOG, 2009), risks are everywhere, because they represent the possibility that danger could occur.[238] However, risks are taken regardless if they are expected to bring about more benefits than disadvantages, which is crucial for explaining why women opted for caesareans and why obstetricians agreed to requests.

4.3.1.1 Practice of defensive medicine

Defensive medicine has been a recurring topic in debates about caesareans on request, and it was said to be a pseudo reason, which allows medical institutions to charge higher fees than for an uncomplicated vaginal delivery. Thus, an obvious connection was made between elective caesareans, defensive medicine and financial implications. Although caesareans involved higher costs (which were reimbursed by healthcare services and insurance companies), at the same time, hospitals avoided potential lawsuits and claims for compensation. Anthropologist Sheila Kitzinger (2006) compared the general issue of giving birth in the 21st century to a precise timetable that must be adhered to; if not, there are clinical methods of intervention, such as inducing labour. Caesareans, of course, presented one "solution" for fulfilling plans.[239] According to Kitzinger, the heavy use of technology led to this development; she advocated natural childbirth, i.e., minimising the use of technology and interventions. However,

[237] Markus 2006, p. 39.
[238] RCOG 2008, no page numbers given.
[239] Kitzinger 2006, pp. 34-35.

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women agree to caesareans because they feel that ignoring their consultants' recommendations might become dangerous for the baby.[240]

4.3.1.2 Risk avoidance for financial reasons

Health sociologist Helen Churchill (1997) was not convinced by the presumption that the increasing performance of caesarean sections was all about risk avoidance. In her view, preventive practice meant no more than exploiting insurance companies and being greedy for gain. Churchill confirmed that caesareans were more expensive than vaginal births, because of staffing expenses and the technology needed. Thus, planned caesareans (and, at a later date, those on request) represented a "lucrative" source of finance for hospitals, which often purchased the latest technology. These monetary expenses had to be paid off, Churchill explained.[241] Costs were shifted to patients and healthcare services. Obstetricians had therefore found an opportunity to increase their income with minimum effort.

Hospitals and birth wards, rather than mothers-to-be had to take into account financial issues. Nora Markus indicated that many hospitals in Germany had to budget their expenses by maintaining their quality at the same time.[242] Hospitals often had to cut back, particularly with respect to personnel and working hours, and the staffing of wards was also affected by this, so staff were only able to provide minimal time for their patients.

Financial discrepancies between vaginal deliveries and caesareans provoked many critical remarks and led to suggestions that the charges should be reviewed. With profit-making in mind, some obstetricians were probably more likely to agree to maternal requests. Several approaches were

[240] Kitzinger 2006, p. 111.
[241] Churchill 1997, p. 63.
[242] Markus 2006, p. 41.

used to explore this phenomenon. Obstetrician Peter Hohlfeld (2001) proposed equal charges for vaginal births and caesarean deliveries. This would lessen financial greed and the prejudice against defensive medicine.[243] If vaginal births and caesareans were on the same financial level, this could lead to fairer and more objective decision-making. The suggestion by Ian MacKenzie, a researcher in the field of obstetrics, that mothers-to-be should bear at least some of the costs would also disburden health insurance companies of some charges.[244] The idea behind proposals such as this was probably to discourage women from undergoing caesareans by choice, because fewer caesareans would at least lead to a stagnation of caesarean rates.

Obstetrician Jane Feinmann emphasised that unnecessary surgeries should be avoided to spare the NHS high expenses.[245] However, what is meant by "unnecessary" interventions? German obstetrician Volker Lehmann arrived at the conclusion that every indication was justified and valid and thus that there was no such thing as "unnecessary" or "too many" caesareans. He alluded to caesarean rates, including surgeries on request.[246] Within the scope of the NHS, keeping expenses under control and staying within budget was a substantial issue; thus, it is surprising that similar considerations regarding the reduction of costs existed in Germany. Health policies in Germany were fairly liberal. Nevertheless, the idea of charging women for the costs of request caesareans, with the aim of better controlling expenses, was a topic of debate.[247] According to obstetrician Thomas Szucs, the costs of vaginal delivery compared to those of caesarean sections were not that

[243] Hohlfeld 2001, p. 117.
[244] MacKenzie 1999, p. 1070.
[245] Feinmann 2002, p. 774.
[246] Lehmann 2006, p. 242.
[247] Hamburger Abendblatt (17.05.2004).

different any more, as soon as any preparations were included, such as the provision of personnel and other capacities. Thus far, examples of charges had always been based on uncomplicated vaginal births versus caesareans.[248] Moreover, even VBAC did not necessarily lead to lower costs than a caesarean delivery, and any unforeseen events could be even more expensive.[249] Hence, taking into account failed trials of labour, the cost of caesareans did not seem to be that high any more.[250] Thus, charges for planned caesareans, including caesareans on request, were foreseeable, in contrast to vaginal deliveries, which were still associated with unpredictable outcomes.

Obviously, it also might have been easier for privately insured women to be granted a caesarean on request. Markus explained that there was the status of private health insurance on the one hand, with hospitals being paid better for private patients.[251] Taking into account budgeting and a shortage of staffing, doctors probably had their reasons for performing caesarean delivery on request.

There were other approaches which aimed to relativise or contradict the notion that caesarean sections were motivated by financial incentives.[252] In their comparative study on obstetric habits in eight European countries, Habiba *et al.*, members of the Reproductive Sciences Section of the University of Leicester, found that caesarean rates did not result from being associated with a "source of capital," but rather from the fact that patient choice had gained importance (which applied to the United Kingdom and

[248] Szucs 2001, p. 40.
[249] Szucs 2001, p. 41.
[250] Schneider 2008, p. 40.
[251] Markus 2006, p. 41-42.
[252] Habiba *et al.* 2006, pp. 651-652.

Germany in particular[253]), as well as the general fear of risks by both mothers-to-be and doctors.[254]

4.3.1.3 Clinical advances and their impact on obstetric behaviour

Last but not least, the revision of indications was based on several issues. Medicalisation and the impact of technology had gained influence and had become approved and recognised elements of obstetrics. Technological advances promised safety and predictability. There were clear arguments in favour of caesareans, as the risks involved had become foreseeable and more readily assessed. This applied to elective surgery as well to caesareans on request, which were performed in the same way.

However, indications did not reflect that clinical advances had resulted in changes in obstetric practice: obstetricians had adapted to their new situation, which did not happen without due consideration, as shown by the numerous discussions on caesarean indications. Even though obstetric attitudes underwent changes, indications remained unchanged at first. They were unable to catch up with new practices – doctors were able to adopt new techniques instantly, but the modification of indications depended on the approval of various participants – such as professional associations – and not individuals.

Another issue lay in the change in childbirth routines. British sociologist Ann Oakley referred to routine birth inductions in the 1960s and 1970s.[255] However, in the following decade, home births were suggested as the ideal way of giving birth and therefore something a mother-to-be should

[253] Habiba *et al.* 2006, p. 649.
[254] Habiba *et al.* 2006, p. 653.
[255] Oakley 1993, p. 59.

strive for. Home births were advocated for instance by social anthropologist Sheila Kitzinger.[256] Therefore, caesareans on request could probably also represent a similar development: a contemporary way of giving birth.

In 2006, obstetricians Robin Kalish *et al.* addressed the problem that caesarean indications involved a certain scope of action because of the discrepancy between clinical possibilities and their content, according to their wording. Kalish *et al.* noted that actual indications for caesareans were no longer sufficient. Indications contained a "grey zone": they did not explicitly refer to the option of maternal requests, but particularly with regard to increasing caesarean rates, patient choice could not be ignored, as it was already a current issue in obstetrics. In their article on "Decision-making about caesarean delivery," the authors explored the meaning of risk assessment and decision-making, linking both aspects to each other.[257] According to Kalish *et al.*, no representative studies existed on how mothers-to-be reached their decision about how to deliver.

In addition, there was the general question of whether (and to what extent) expectant mothers should be involved in decision-making and who should make the ultimate decision.[258] The authors recommended rethinking current indication catalogues and considering individual cases, which would begin a new direction in obstetrics.[259] Of course, it was not the goal of indications to make caesareans on request possible. However, obstetricians recognised that caesareans deserved further consideration, due to contemporary clinical progress. As the risks had become less dangerous, it was possible to involve expectant mothers in the decision-making process.

[256] Kitzinger, Sheila (1978). *The Experience of Childbirth*. Harmondsworth: Penguin.
[257] Kalish *et al.* 2006, pp. 883-884.
[258] Kalish *et al.* 2006, p. 883.
[259] Kalish *et al.* 2006, pp. 883-884.

4.4 Patient autonomy and psychosocial issues

Last but not least, indication catalogues were ready for revision, especially as regards a particular category, which included psychological reasons. Caesareans on request were not only associated with medical issues such as labour pains or injuries, but also psychological aspects, e.g., the fear of childbirth. This approach also involved emotional issues. New childbirth technologies and changes in obstetric practice in order to initiate caesareans resulted in a different perception of surgical delivery. On the one hand, this development was reflected in the fact that caesareans became routine surgery; on the other hand, patient autonomy attracted further attention. Expectant mothers were aware of their rights and communicated them to doctors. Geoffrey Anderson (2004) described these changes as "consumer demand versus service supply" in the *British Medical Journal*.[260]

Patient choice was already a major issue in the findings of Al-Mufti, McCarthy and Fisk, when they discussed the possibilities of a maternal request as an indication and offering all women the option of a caesarean delivery.[261] As regards this topic, the controversies did not change during the course of the debates, and Al-Mufti *et al.* probably had a different version of patient choice in mind compared to the suggestions of *Changing Childbirth*.

In 1997, sociologist Helen Churchill looked into the existing understanding of patient autonomy, aiming to prevent caesarean rates from increasing further. Churchill advised that women should obtain as much information about childbirth as possible, and she claimed at the same time that the support provided by medical professionals did not make women sufficiently aware of the risks of caesarean birth. Mothers-to-be also felt

[260] Anderson 2004, p. 697.
[261] Al-Mufti/McCarthy/Fisk 1996, p. 544.

unsafe if their main medical contact person changed during pregnancy; thus, Churchill proposed assigning women a single, trustworthy person who was familiar with their records. Justifying caesarean sections too easily was, in Churchill's opinion, not what *Changing Childbirth* had meant when it discussed patient choice.[262]

Nevertheless, Churchill stated clearly that it was not possible for women to make a mature decision without being substantially informed, while obstetrician Peter Hohlfeld (2001) noted that patient autonomy had gained more attention and influence. Many obstetricians respected the woman's will and its impact on issues of childbirth. It was no longer the consultant alone who decided on how the baby would be delivered.[263] Moreover, medicine in general offered many choices to patients, and Hohlfeld provocatively added that informed consent was not necessary for a vaginal birth, which was obviously the standard mode of delivery – so why the uproar regarding caesareans on request?[264] Having the choice between a variety of treatments was apparently a characteristic of the contemporary patient. Obstetrician Peter Husslein (2001) also confirmed that the concept of choice formed part of obstetric practice and that doctors must be aware of this. Husslein stated that patient autonomy was a consequence of contemporary clinical practice. Similarly to consultant Sara Peterson-Brown (1997), he suggested that different routes of delivery reflected society at the turn of the century.[265] Risks were no longer ignored or taken for granted. Husslein even

[262] Churchill 1997, p. 159.
[263] Hohlfeld 2001, p. 116.
[264] Hohlfeld 2001, pp. 116-117.
[265] Husslein 2001, p. 172.

proposed that sequelae and other implications had previously not been talked about.[266]

However, with regard to new approaches to caesarean sections, critical remarks about a lack of information were made repeatedly despite these medical advances. Perinatologist Marsden Wagner (2000), a supporter of FIGO's argumentation, investigated the possible consequences of patient autonomy for the obstetric profession and also for society. Childbirth had become dominated by medicine and technology and, as a result, was viewed more as a pathological state than a natural event.[267] Vaginal delivery was a natural consequence of pregnancy, and this fact should be accepted. Caesareans on request represented a surgical procedure; they were simply unnecessary and, as Wager reflected, the next step may well be that, for instance, breast augmentation would be granted just as easily. Wagner compared caesareans on request to cosmetic surgery because, in his view, there was no medical need for either.

Wagner concluded that technology did not mean progress. Although medicine benefited from machines, these advantages were often overrated. However, doctors would favour technology over the unpredictability of natural events. As an advocate of midwifery, Wagner claimed that its influence was about to decrease.[268] Pointing out the contrasting attitudes of midwifery and obstetrics with regard to technology, he also explained that midwives were trained to master particularly difficult birthing situations, instead of relying on technology. Breech presentation, for example, is just a "variation of the

[266] Husslein 2001, pp. 170-171.
[267] Wagner 2000, p. 1679.
[268] Wagner 2000, p. 1679.

normal," but from the perspective of obstetrics, it is a "pathological condition."[269]

For doctors, caesareans presented a comfortable solution for dealing with complications. However, the image of caesareans as being comfortable and beneficial for the mother and her baby could not withstand reality. Quoting the FIGO statement, Wagner agreed that the benefits of prophylactic caesareans could not yet be proven. Moreover, the information which was provided was based on theoretical rather than practical approaches and preselected; it was probably also influenced by consultants' own opinions and thus biased.[270] The right to choose involved the right to unbiased information as well. Caesareans on request only benefited doctors who could fit surgery into their shift plans and who needed to detract from their lack of experience with regard to difficult vaginal births.[271]

According to Wagner, caesareans on request broadened the pre-existing gap between midwifery and obstetrics and also between societies: surgeries on request were generally unavailable in developing countries, which simply could not afford such costs. Caesareans on request therefore represented industrial nations and hence created (further) social differences.[272] “Choice” should not be allowed to escalate; Wagner discussed the situation in Brazil, with caesarean rates above 75% – which, in his opinion, should not be the aim.

Consultants Susan Bewley and Jane Cockburn also doubted that obstetricians as well as women would consider all of the aspects of caesarean sections and their risks, particularly with regard to request

[269] Wagner 2000, p. 1679.
[270] Wagner 2000, p. 1678.
[271] Wagner 2000, p. 1678.
[272] Wagner 2000, p. 1679.

caesareans. Their twofold approach to the "unethics" and "unfacts" of request caesareans" was published in 2002. By referring to "powerful"[273] discussions and controversies, they claimed that caesareans on request were decided upon (and granted) too easily by both parties (doctors and women) and that decision-making was often based on the benefits only, which may not necessarily be true. Every expectant mother wishes for a healthy baby, and caesareans may at first sight seem to be the optimal choice. However, if they really were the best option, the authors deduced, they would be offered routinely.[274] Furthermore, "choice" was, according to Bewley and Cockburn, used as a rhetoric device, in order to promote the false belief that mothers-to-be could influence decisions. In fact, they were guided by what the doctors thought would present the best route of delivery.[275]

The second part, "unfacts," commented on the medical advantages of caesareans on request. Once again, Bewley and Cockburn attempted to refute (or at least question) their technological benefits. Pelvic floor problems, for instance, which could lead to stress incontinence, are related to pregnancy (the pressure of the baby's head against the pelvis and cervix) rather than labour and vaginal birth. Hence, there is no guarantee that a caesarean on request would avoid them.[276] As regards sexuality after childbirth, the possible occurrence of perineal trauma and its sequelae was not denied, but the authors suggested that self-esteem should not come from vaginal integrity alone. Feeling insecure about labour and childbirth was viewed as a normal state during pregnancy; caesareans on request would

[273] Bewley/Cockburn 2002, p. 593.
[274] Bewley/Cockburn 2002, p. 593.
[275] Bewley/Cockburn 2002, p. 594.
[276] Bewley/Cockburn 2002, p. 598.

only provide a superficial solution, while consultations could help to deal with anxieties.[277]

Bewley and Cockburn stood up against caesareans on request. Their articles were therefore accused of being biased and promoting "unfacts" by other obstetricians, such as the fact that failed trials of labour had been excluded, and that they could also lead to caesareans. Preventative caesareans would avoid this right from the beginning and, furthermore, emergency caesareans still entailed higher risks than elective surgery. Therefore, emergency interventions should probably also be bypassed by planning surgery in time.[278]

4.5 Why caesareans on request? Motives

Why do doctors agree to maternal requests, and were Al-Mufti, McCarthy and Fisk right that it was all about feeling safe? Indications referred to the application of new technology and recent advances in obstetrics. An examination of obstetric behaviour, however, revealed that fear was a significant issue, e.g., with regard to litigation. For women, making use of patient choice seemed at a glance to express self-confidence to the outside world; it indicated that the woman was well-informed and had planned for a certain childbirth experience. However, an inquiry into the reasons why women opted for caesareans and why obstetricians did not reject requests showed that anxiety played an important role as well.

Marsden Wagner criticised obstetric attitudes but did not deliver further arguments in order to strengthen his own position. Thus, social scientists Helen Statham and Jane Weaver (2001) thought that his reflections were too

[277] Bewley/Cockburn 2001, p. 599.
[278] Danielian/Nikolau 2003, p. 784.

general and seized the opportunity to refer to their own findings. According to their study, all modes of delivery were perceived ambiguously. Vaginal delivery was both "natural and desirable" and "natural and hazardous" at the same time. Caesareans, however, were generally associated with safety, according to the women questioned by Statham and Weaver.[279] Nonetheless, the same women also stated that they did not feel fully informed, meaning that insecurities and information gaps existed when they made their decisions. However, even at this stage, the women obviously dared to make a decision. Was it the superordinate desire to have a healthy baby which made pregnant women agree to take risks? Obstetricians Pham and Crowther (2003) shared this opinion and added that expectant mothers also ranked a self-determined birth experience as a high priority, as well as an individualised environment in which to give birth.[280] Utility scores[281] for birth expectations differed between women and doctors.[282] Specifically, women felt uncomfortable regarding the long-term implications of childbirth.[283]

Medical researchers Wing Hung Tam, Dominic Tak Sing Lee, Helen Fung Kum Chiu *et al.* (2003) addressed these considerations about emotional issues and general birth expectations in comparison with actual outcomes. They investigated the ways in which mothers coped with caesareans or other unexpected delivery routes and found that counselling before childbirth had no impact on the women's feelings in terms of unplanned (or, as they called it, "suboptimal"[284]) outcomes because "it failed

[279] Statham/Weaver 2001, p. 645.
[280] Pham/Crowther 2003, p. 121.
[281] In this case, these comprised checklists and questionnaires, as well as findings deduced from the above.
[282] Pham/Crowther 2003, p. 125.
[283] Pham/Crowther 2003, p. 126.
[284] Wing Hung/Tak Sing Lee/Fung Kum Chiu *et al.* 2003, p. 857.

to show the effect expected."[285] Nonetheless, counselling made sense according to the authors, as it helped to learn about communication with patients.[286]

In many cases, the women themselves were not fully satisfied with their active involvement in decision-making. In such cases, factors other than the level of information played a role. Previous birth experiences, for instance, had a substantial impact on how decision-making was approached, as explained by obstetrician Moffat *et al.*[287] Furthermore, this research group noted that the media had a relatively low impact.[288] Instead, women worried about their unborn children, and wanted nothing more than a safe arrival.[289] During the decision-making stage, they also changed their minds fairly often regarding the birth plans.[290] The mothers-to-be also stated that information provided by consultants was too general, which also encouraged their feelings of unease about their decision.[291]

Health psychologist Clare Emmett *et al.* (2006) found that women actively gathered further information only because they felt the need to do so. Additional findings confirmed that expectant mothers did not always feel comfortable with their role as decision-makers and actually wished for a more extensive patient education. As supplementary resources, they consulted the Internet, advice books and their peers (other pregnant women).[292] Women felt respected by obstetricians with regard to issues of patient choice. The

[285] Wing Hung/Tak Sing Lee/Fung Kum Chiu *et al.* 2003, p. 858.
[286] Wing Hung/Tak Sing Lee/Fung Kum Chiu *et al.* 2003, p. 858.
[287] Moffat/Bell/Porter *et al.* 2006, p. 90.
[288] Moffat/Bell/Porter *et al.* 2006, p. 87.
[289] Moffat/Bell/Porter *et al.* 2006, p. 91.
[290] Moffat/Bell/Porter *et al.* 2006, p. 89.
[291] Moffat/Bell/Porter *et al.* 2006, p. 91.
[292] Emmett/Shaw/Montgomery *et al.* 2006, p. 1440.

level of information the women received, however, depended on the consultant.[293]

Emmett *et al.* also realised the importance of information and that women had difficulty making decisions; being informed came as a relief. However, at the same time, they knew that they could have an impact on decisions. In addition to their goals, the emotional state of the mothers-to-be was also relevant. When comparing modes of delivery, the psychological and emotional aspects of childbirth gained increasing levels of attention. This was particularly because previous experiences of childbirth (e.g., birth trauma) also had an impact on decision-making, and were considered as psychological indications for caesareans. Social scientists alluded to aspects such as these, which played a role in debates among mothers as well as in popular scientific advice books.

What is the meaning behind the event of childbirth? Sociologist Beate Schücking looked into this question and concluded that childbirth had a particular meaning for mothers-to-be in the context of their plans for the future as a woman and a mother. Schücking thus presumed that childbirth represented a key experience which affected a woman's self-confidence and future relationships.[294] She furthermore emphasised that vaginal birth had psychological advantages; in her view, this was the "real" birth event because it was experienced actively by the mother. As regards caesareans, women often felt that they had failed at giving and controlling birth. Abdominal delivery could therefore lead to depression.[295]

In her discourse, Schücking did not distinguish between emergency and planned caesareans, particularly with regard to the arising issue of

[293] Emmett/Shaw/Montgomery *et al.* 2006, p. 1442.
[294] Schücking 2001, p. 194.
[295] Schücking 2004, no page numbers given.

caesarean sections on request and their consequences for the perception of childbirth. Schücking's explanations were, overall, too general; in her view, all variants of caesareans entailed the same substantial risks. Professor of Nursing Ulla Waldenström (2001) referred explicitly to the distinction between elective and emergency caesareans.[296] However, in spite of this, negative experiences should be respected. They could affect relationships as well as future family planning. Postpartal depression could have implications for bonding with the newborn as well.[297]

Health psychologists Marci Lobel and Robyn Stein DeLuca confirmed in their study that planned caesareans involved fewer psychological sequelae in comparison with emergency surgeries, because in cases of elective caesareans, women had time to become accustomed to the situation. Unfortunately, once again, most of the studies did not distinguish between feelings after emergency and planned caesareans and those on request, as the authors noted.[298] Studies have also produced different results concerning the question of whether or not there is a connection between the development of depression and the mode of delivery.[299] However, why do caesareans have negative connotations? They have been reported to be stressful and, moreover, some women fear surgery and are intimidated by the environment, i.e., they feel uncomfortable in the theatre. In addition, some women felt uneasy about the unexpected nature of the situation – they thought that they had lost control and that their initial birth plans had suddenly became void.[300] Lobel and Stein DeLuca furthermore emphasised that it was a "cultural norm" that "normal birth" was associated with vaginal

[296] Waldenström 2001, p. 197.
[297] Waldenström 2001, p. 196.
[298] Lobel/Stein DeLuca 2007, p. 2274.
[299] Lobel/Stein DeLuca 2007, p. 2275.
[300] Lobel/Stein DeLuca 2007, pp. 2276-2277.

delivery.[301] Expectations and control were rated highly and thus played an important role in birth preparations.

However, the authors believed that women cannot always remember the birth event in full or that they tend to idealise it afterwards. Therefore, "retrospective methods" should be questioned because such answers cannot reconstruct in a reliable way what really happened.[302] Questions about caesareans were no more uncommon when Lobel and Stein DeLuca published their study; they also assumed that the rise in caesarean deliveries meant that they were no longer stigmatised or considered "abnormal" (meaning rare or unusual).[303] Their study addressed the complexity of the issues behind caesarean deliveries, but also showed that perceptions with regard to the phenomenon of childbirth had undergone changes. As women's experiences were examined as well, obstetricians began to get a better understanding of the emotional state of expectant mothers.

Obstetrician Peter Hohlfeld was also convinced that decision-making was based mostly on previous experiences.[304] Studies on the process of decision-making, however, did not consider whether mothers were well-informed.[305] Sometimes, it seemed that they did not know much about caesarean birth, its procedure and risks, but that they nevertheless requested one.[306] The following two chapters will introduce several information sources which women use to gather information and exchange opinions with their peers, outside of pregnancy care and clinical consultancies.

[301] Lobel/Stein DeLuca 2007, p. 2277.
[302] Lobel/Stein DeLuca 2007, p. 2278.
[303] Lobel/Stein DeLuca 2007, p. 2279.
[304] Hohlfeld 2001, p. 116.
[305] Gamble *et al.* 2007, 332.
[306] Gamble *et al.* 2007, 332.

4.6 Summary

At this time, overall caesarean section rates had risen, which drew people's attention. The number of emergency caesareans, however, decreased, while there was an increase in planned surgeries. Advances in medicine and technology led to this development, as caesareans entailed fewer risks. Thus, instead of waiting for unforeseen events to occur, caesareans were more often scheduled in advance, in order to bypass any risks in a timely and certain manner.

While debates on caesareans on request proceeded, their main topics and controversies were revealed. Discussions concentrated on changes in indication catalogues in particular, and in the context of exploring the reasons for this development, on increasing caesarean rates and the medicalisation of childbirth.

Obstetric practice was quick to apply new techniques and therapies. However, indication catalogues remained unchanged at first. However, as the changes persisted (caesarean rates were still increasing, as was the rate of elective surgeries), it was only a matter of time before the indications were extended. The meaning of indication catalogues was significant. If at least one approved indication was given, caesarean surgery was "legalised" and its performance could be justified as well as clinically proven, e.g., by medical diagnoses. For doctors, this meant safety. However, because caesareans on request could not be explained clinically, it was hard to explain the reasons for surgery. The challenge was to avert a risky situation; the difficulty was that the risky situation had not yet occurred. This meant that – at the point at which the decision was to be made – the danger existed in theory only. In addition, it was not "guaranteed" that the risks would actually occur. Hence,

opting for a caesarean section nevertheless could only be done in the context of prevention and based on a fictional risky situation.

With regard to caesareans on request, it emerged that the indication catalogues at the time were insufficient. Fear of childbirth and of unknown situations in general was not considered as an indication. However, because of clinical advances, which led to fewer risks, it was necessary to adapt the indications. Psychological aspects were included, and mothers-to-be could refer to their emotional state when requesting a caesarean delivery: the woman's choice became a recognised indication and decision-making power could be transferred to her under certain conditions (e.g., with informed consent). Mothers indicated that they thought about their future physical as well as psychological state when considering caesarean birth. Doctors, in turn, were particularly afraid of malpractice suits. Self-protection, therefore, was an important reason for caesareans on request – on both sides.

From a financial viewpoint, indications played a role in invoicing clinical services. Usually, only caesareans given for approved (i.e., included in indication catalogues) reasons were reimbursed by healthcare services or insurance companies.

Developments in obstetrics, as well as the extension of indications for caesareans led to further changes in the perception of childbirth. Medico-technological progress promised safety and control, which matched the modern age. Vaginal delivery could not catch up. Consequently, the risks of vaginal delivery became the focus of attention, particularly when compared to caesareans. The long-term implications of both vaginal and abdominal delivery, however, had not yet been fully researched. Nevertheless, caesareans were associated with safety, especially with regard to litigation,

which was feared by doctors, as the number of malpractice suits in obstetrics had increased. Planning caesareans for preventive reasons was often considered by critics as an example of defensive medicine. This was because caesarean sections had preventive characteristics; they avoided certain implications of vaginal delivery in advance. However, in spite of this, caesareans were not risk-free. Mothers-to-be as well as doctors, however, persevered, as according to individual risk assessments and in their own personal view, the benefits of caesareans, in comparison to vaginal delivery and its disadvantages, were in the lead.

5 Communicating caesareans on request to women – popular scientific advice books

Central to this chapter are popular scientific approaches to caesarean sections on request, represented by advice books on pregnancy and childbirth. These aim to communicate aspects of caesarean delivery to their target group – pregnant women. Eventually, participants and authors outside of the medical field became aware of the changes taking place in obstetrics and recognised debates on a new mode of delivery. Advice books serve as information sources, as women actively consult them.

This chapter, however, starts by addressing a different issue – motherhood. At the time in question, expectant mothers consulted advice books because they felt unsure about their role and their future as a mother, and because they wanted to learn more about their pregnancy and about giving birth. The women also linked certain expectations to being a mother, which may have influenced their perceptions of childbirth.

The sub-chapter following this section begins by introducing a selection of advice books and referring to their structure and goals. The way in which advice books viewed themselves was also an issue with regard to their function of supporting their readership by providing advice and information. The main part of the chapter focuses on how advice books approached the issue of caesareans on request and how it was presented to their readers. In this context, the main themes of popular scientific publications as well as what they identified as being the major characteristics of caesareans on request played a role. This will be illustrated by a cross-section of advice books and a discussion of their common features.

To finish, this chapter examines selected publications in more detail. These publications were built on autobiographic details from their authors' experience. These advice books differ in their approach and writing style. The evaluation of these publications furthermore leads on to the next chapter, which will take another look at experiences of childbirth, but from a different angle.

5.1 Thoughts on becoming a mother

Becoming a mother changes a woman's life. Mothering intertwines social and biological events and is, moreover, exclusive to women.[307] However, the image of motherhood depends on the culture in which the woman lives. In order to understand how pregnant women may have understood and used advice books, this sub-chapter introduces the social context of motherhood, which is something that women anticipate with mixed feelings (as shown by the activity of seeking advice). Therefore, did views on motherhood influence matters relating to childbirth, and was responsibility already an issue during the antenatal stage? This chapter will explore the potential connection between opting for a specific mode of delivery (due to maternal responsibility) and a certain idea of motherhood in terms of childbirth.

[307] Katz Rothman 2007, p. 74.

5.1.1 Motherhood – a female fate?

Motherhood is something that women look forward to on the one hand, but on the other hand, it is an unknown state (for first-time mothers) which will change their self-perception as a woman. At the time in question, mothers also needed to redefine their role in society. This applied to the birth event itself, which signified a mix of happiness (expectations) and anxiety.

The automatic view of a woman as a potential mother reflected the fact that motherhood was first and foremost a social and cultural construction. Conceptions of motherhood accompanied certain expectations of women, as British sociologist Julie Kent explained (2000).[308] Often, the biological fact that women are able to have children was sufficient to justify their role as a mother. The desire to become a mother, furthermore, was linked to the woman reaching adult status.[309] In industrial societies in particular, such as Britain and Germany, motherhood was mostly characterised by the relationship between the mother and her child. Therefore, mothering always involved at least two persons. In this context, there were two angles from which motherhood could be viewed: the social perception of motherhood and how mothers viewed themselves. In addition, two main themes seemed to characterise the state of being a mother, which were consequently quoted on many occasions (for instance, by sociologist Christine Everingham, 1994): responsibility and restrictions. These characteristics refer to the theory that motherhood entails a loss of autonomy and individuality.[310]

[308] Kent 2000, p. 104.
[309] Kent 2000, p. 110.
[310] Everingham 1994, p. 34.

5.1.2 When does motherhood begin?

Furthermore, the idea of motherhood and therefore the image of the "good mother" was characterised by steady changes, as outlined by Kent (2000). The influences on these changes were manifold. As regards childbirth, they ranged from changing cultural values to medical developments. For instance, it seemed that the social passage[311] to motherhood was beginning earlier in the woman's life and that the responsibility for the (future) child began during pregnancy, as discussed in Chapter 2 with regard to pregnancy care. The pregnant woman was advised to monitor her eating and lifestyle behaviours for the sake of the health of the baby. She learned about folic acid intake and that screenings might detect any possible risks in time. These are topics which appeared in almost every advice book on pregnancy and childbirth. As a result, the mother-to-be may have experienced her maternal identity long before giving birth. Being a "good mother" could not set in too early; this was communicated through many studies which stated that the mother had sole responsibility for the future wellbeing of the growing child.[312] However, this self-perception was influenced by society: not only by a certain pregnancy care model, but most of all by an idea that saw childbearing as the fulfilment of womanhood. Hence, when a woman accepted this belief, she may also have respected the prescriptions of medical professionals, hoping that they would help her to have a healthy baby. She may also have studied what was recommended to her by advice books.

Julie Kent even spoke of the idealisation of motherhood and a "loss of identity" and individuality when the fetus' needs became more important than

[311] "Social passage" in this context means the point in time when an expectant mother is viewed and treated by society as a mother, for instance regarding responsibility for her unborn child.
[312] Kent 2000, p. 108 (this researcher discusses the theories of bonding by John Bowlby).

those of the pregnant woman herself.[313] The contradiction of possible self-fulfilment and the subordination to "experts" such as obstetricians or popular scientific publications could lead to inner conflict. It does not seem surprising that this kind of "prenatal responsibility" also applied to the actual childbirth. Responsibility for the baby was linked to the avoidance of risks,[314] and women deliberately accepted restrictions during pregnancy in order to be a "good" mother right from the beginning. Women who did their best to ensure for their unborn child a risk-free and safe pregnancy may also be more likely to request a caesarean and to assess the risks of vaginal versus abdominal birth. Pregnancy, as Kent summed up, could in these cases be seen as a biologically and culturally acceptable state. However, in terms of childbirth, there have always been debates regarding what may be the preferred mode of delivery and the necessity of medical treatments, and so cultural influences became clear.[315]

5.1.3 Good mothering

The mother's responsibilities become even more noticeable after childbirth, when they have established their role as the primary carer. Julie Kent emphasised that the image of motherhood was always the result of a social construct and the cultural environment, and that the way in which the baby was cared for was therefore also derived from cultural influences.[316] Mothers were confronted not only with their own expectations but also with external pressure. In her practical, everyday life, a mother had to deal with maternal duties and patterns, which distinguished her from other women. In

[313] Kent 2000, p. 106.
[314] It is, however, unclear what exactly is meant by minimising risks from the woman's perspective – it probably involves as little medical intervention as possible.
[315] Kent 2000, p. 105.
[316] Kent 2000, p. 104.

society, motherhood was associated with no longer being able to act autonomously, dependence and (self-)sacrifice, but also with what was called "natural, maternal instincts."[317] These instincts often served as a basis for a woman's need to devote herself to her offspring. On the other hand, this interaction between instincts and trained behaviour in response to the child's needs was contradictory. It stressed, however, the cultural dependence of the motherhood ideal and that the passage to motherhood is complex and diverse. Nevertheless, women also transferred these characteristics of motherhood to future generations and set them down in theories.

5.2 Beyond consultancies: Pregnant women's views

Upon researching medical opinions, I noted that very little research had thus far been performed on women's perspectives. In fact, most articles about caesarean sections on request approached the issue exclusively from the clinical angle, although it was stated that doctors approved of patient choice when approached by requests for caesareans.[318] This respect for women's autonomy implied that responsibility had shifted from doctors to patients. However, at the same time, interest in the views of pregnant women was low. However, the importance of their opinions, not only in order to reconstruct debates but also to understand their motives and the phenomenon of caesareans on request, is obvious.

Of the medical publications that could be found which included statements from expectant mothers, most were based on surveys, which were carried out using questionnaires or, in rare cases, interviews.[319] However, these studies were usually derived from prepared material that was

[317] Kent 2000, p. 104.
[318] Hohlfeld 2001, p. 116.
[319] For instance, Moffat/Bell/Porter *et al.* 2007, pp. 86-93.

evaluated using statistical data. These publications, moreover, were retrospective, i.e., the women had to reconstruct what they remembered of the birth event and sometimes how they had experienced pregnancy. Memories, however, could be incomplete or differ from the women's actual feelings at the time (childbirth is said to be a very emotional event, and it is always possible to idealise or simply forget things afterwards;[320] in addition, the women were often drugged, e.g., with painkillers, or felt exhausted). The research themes usually focused on women's views about obstetric issues (e.g., risk assessment).[321]

Specific cases were sometimes discussed separately in these publications, but no studies included discussions among women or showed how they exchanged their opinions. Did clinicians and medical researchers lack any interest in nonmedical opinions? In Chapter 3, we found that doctors trust evidence-based medicine and that they rely on its proven aspects. In terms of expectant mothers, it is impossible to deduce any evidence-based statements from their concerns, at least with the methods used in clinical trials. Thus, the criteria for accessing women's views must differ, and they would produce evidence of a different kind, i.e., with no tables or similar quantitative statistics.

My approach to developing an understanding of women's views was to find out about their preferred means of communication. Emmett and Shaw *et al.* remarked that publicly available sources, such as advice books and Internet platforms, were popular among expectant mothers wishing to fill gaps in their knowledge outside of medical consultancies.[322] For researchers, however, these tools provided insights into communication among expectant

[320] Lobel/Stein DeLuca 2007, p. 2278.
[321] For instance, Turner/Young/Solomon *et al.* 2008.
[322] Emmett/Shaw/Montgomery *et al.* 2006, p. 1440.

mothers, which is why I decided to study both popular scientific books and online discussion boards.

5.2.1 For pregnant women only: Sources of advice

In these additional sources (advice books and Internet discussion boards), practitioners become minor characters and women seem to act differently from how they behave in conversations with obstetricians or upon having to assess medical evidence in questionnaires. Among other mothers, women can act as experts, by providing their experiences and knowledge. This is one of the major differences between medical publications and alternative, more popular science-based information sources.

Both popular scientific books and discussion forums aim to assist women, to help them to understand certain situations (in this case, what happens during pregnancy and childbirth) and, to a certain extent, in decision-making. Advice books, for instance, can contain checklists to prepare expectant mothers when they are approaching their hospital stay.[323] Like Internet discussion boards, they mimic face-to-face conversations by addressing their readers directly. One significant difference is, however, that advice books are normally written by experts – journalists or authors with a medical background – and available for purchase, while Internet forums provide space in which everyone is invited to participate (thus, platforms are more homogeneous) and which are free. Let us take a closer look at advice books before shifting to the more complex subject of online communities.

[323] Bopp 2003, pp. 64-67.

5.3 At a glance: Popular scientific advice books

There is a wide variety of advice books on childbirth in English- and German-speaking areas. Their purpose is to educate and assist their readers (usually expectant mothers or women in the stage of family planning). As advice books aim to address every woman, regardless of her educational and social background, they are written in a comprehensible, sometimes colloquial style that tries to avoid clinical terms by limiting their use and making them easy to understand. Instead of carrying out their own research, they basically recap the main characteristics and statements of medical discourses, but in a simplified and sometimes incomplete manner, sometimes without indicating their sources.[324] Hence, compared to Chapter 3, this section contains nothing new about medical perceptions and clinical evidence regarding caesarean sections on request. Footnotes and bibliographies are rarely found in advice books. Practical hints[325] and first-hand reports (extracts from interviews)[326] complete the popular scientific perception of childbirth.

However, popular scientific literature is qualified only to a limited extent for use in research into caesarean sections on request in the context of this thesis. Most of these publications concentrate in equal parts on pregnancy and childbirth, with the latter focusing on vaginal delivery. Thus, caesareans on request present only a minor issue in advice books, as just one of many topics which are discussed. Starting with pregnancy, the books finish with the postpartum stage, without leaving much room to introduce the

[324] Upon discussing caesareans on request, Heil (2008) introduced "a British study" that had shown a relation between caesarean sections and stillbirth in subsequent pregnancies (p. 85). Although no source was mentioned, she was clearly referring to Smith/Pell/Dobbie (2003).
[325] Parker-Littler 2008, p. 212.
[326] de Jong/Kemmler 2003, pp. 24-26.

varieties of caesarean birth.[327] Nevertheless, risks in general and their assessment were not neglected in advice books. At the same time, expectant mothers received detailed information about risky behaviour, such as smoking or consuming alcoholic drinks, and dietary recommendations, as well as information about the meaning of antenatal care and screenings.[328]

A similar body of advice literature was dedicated to childbirth itself, with the length and detail of these sub-chapters being comparable to the chapters about pregnancy – at least, as far as vaginal delivery was concerned. The reader could learn about, for instance, what she would need in her hospital luggage (often another checklist), the first signs of labour and the different stages of childbirth, as well as about immediate postnatal care.[329] Caesarean sections, however, were often dealt with only marginally and in a quick and concise way.

5.3.1 A broad variety of opinions

The selection of references for this chapter provides a cross-section of German- and English-speaking advice books. In terms of publications written in English, there were also many books available on the British market which originally came from the United States, i.e., written by American authors. I did not consider them for this chapter, because they usually refer to the culture and health policy of the United States and address the English readership only because of the common language.

[327] *Your Birth Year*, published by the NCT, even starts with a young girl (who later becomes the expectant mother) being born and her transition to adulthood, followed by her becoming a mother and experiencing her first year with the baby, which the authors call "babymoon" (obviously a modified version of "honeymoon," which compares life with a newborn to the happiness of being just married). NCT 2004, table of contents (no page numbers).
[328] Stoppard 2008, pp. 174, 184.
[329] NHS *The Pregnancy Book* 2007, pp. 89-100.

5.3.2 The popular scientific view of childbirth in advice books

There is a broad choice of advice books competing for the reader's favour. In addition to revised and newly edited versions of well-established titles, a variety of new books on pregnancy and birth had been put on the market over the past few years. Expectant mothers were spoilt for choice – and publications were often similar. This applied not only to their contents, which addressed the most common aspects of motherhood, but also to their front covers, which used to depict young mothers with their (dormant) newborns, or women in an advanced stage of pregnancy (or, at least, looking unmistakably pregnant) and smiling at the reader. Pregnancy, as these visual aids tried to communicate, is a happy and visible state. Moreover, after childbirth – as signified by other covers – mother and baby continued to be one entity, cuddled up to each other. With regard to English and German advice books, there were no differences in the themes of their front covers. English publications, however, could portray mothers of various ethnic origins, e.g., the NHS *Pregnancy Book* (2007).

The actual content also sometimes contained illustrations or photographs, in order to support visually what had been explained or to simply accompany the text. Once again, English publications presented women from different ethnic backgrounds, whereas German advice books only depicted persons (mothers, babies, doctors) of Caucasian origins.[330] The people shown should, it seemed, represent a cross-section of the country's inhabitants.

More common characteristics of advice books, regardless of the language they had been published in, could be found in the style of writing,

[330] For instance, Bopp 2003, or, more obviously, Oblasser/Ebner/Wesp 2007. Of the 162 mothers they photographed for their book, all were white.

which was rather colloquial. The authors avoided complex language and reproduced medical terms and actions using simplified descriptions.[331] Moreover, readers were often addressed directly, as they would in a dialogue or face-to-face conversation. This created mutual trust – which, in turn, explained the use of informal language. With almost no exceptions, the authors of popular scientific advice books on childbirth were women; the fact that they were of the same sex as the reader probably added to their credibility and trustworthiness.[332] Case studies were another device which was used to approach the reader, e.g., in the publication by Theresia de Jong and Gabriele Kemmler.[333] By learning about another woman's experiences, readers could identify with her and therefore with the book. At the same time, case studies helped to explain concepts more fully.

However, as regards the actual voices of women, advice books disseminated the opinions of their authors. Expectant mothers contributed through qualitative approaches such as interviews, reports about their experiences and questionnaires,[334] but only in the form of extracts, and their views were restricted to passages which agreed with the author's views. Thus, although advice books criticised obstetricians for trying to influence their patients and stated that women's concerns played a minor role in medical publications or that the information provided was incomplete, the authors of these books followed similar patterns. Last but not least, advice books did not tell the reader a great deal about how women perceived caesareans on request.

[331] For instance, de Jong/Kemmler 2003, throughout the book.
[332] Since this assumption has not yet been researched, there is no evidence.
[333] de Jong/Kemmler 2003.
[334] For instance, Oblasser *et al.* 2007.

5.4 Self-perceptions of advice books

Advice books promised to provide comprehensive education and information, which would exceed the standard provision of information and even go beyond everything a woman's "best friend would dare talk about."[335] In addition, they represented "wisdom, insight and expertise."[336] Even the free of charge *Pregnancy Book* could rely on the reputation of its publisher, the NHS.

Renowned authors, such as obstetrician Miriam Stoppard – who was praised on the front cover as "the UK's most trusted parenting expert"[337] – backed up first-hand experience with their names. Obviously, the "expert" title resulted from Stoppard's medical training and also from the popularity of her books, which claimed to be bestsellers and thus made Stoppard herself popular.[338] However, there was no actual explanation of the term "expert" by the publisher or author. Moreover, her pregnancy book was subtitled as the *Childbirth Bible*, alluding to the Christian Bible. Once again, this evokes trust; the Bible represents an institution and, with regard to the Christian faith, no other book could replace it. Stoppard's advice book was intended to convey a similar aura, and it uses the authority and popularity of the Bible for its own purposes. As regards the message, everything an expectant mother would need to know was contained in this book. Some of Stoppard's books on early childhood education and infant healthcare were also translated into German

[335] Cf. Heil 2008; front cover: "Was Ihnen Schwangerschaftsratgeber nicht verraten und die beste Freundin sich nicht zu sagen traut" [What pregnancy advice books would not tell you and your best friend would not dare to speak of].
[336] Parker-Littler 2008, front cover.
[337] Stoppard 2008, front cover.
[338] Other publications by Stoppard basically cover all of the themes which are of interest to new parents. They include, for instance, children's healthcare, early childhood development, baby sign language and, focusing on female healthcare, the menopause.

and became popular in Germany as well, in spite of the fact that Stoppard referred to experiences which had occurred in Britain.[339]

"How scars on belly and soul can heal"[340]: this is what the advice book by the two German journalists de Jong and Kemmler aimed to help with. Both authors gave birth by emergency caesarean and experienced their births as traumatic; however, their purpose was not to share their own stories but to assist other women in overcoming their negative experiences of caesareans (and therefore birth). The subtitle suggests that caesareans leave another, invisible scar on the mother's soul, affecting her emotions and feelings. In accordance with the title, the cover showed a mother and her baby with their eyes closed and – as a smiling woman would have been discordant with the topic – this mother looked contemplative and serious.

Emotions were also addressed in the photographic book by Austrian authors Caroline Oblasser and Ulrike Ebner, assisted by photographer Gudrun Wesp (2007). The front cover used a palette of reddish colours, which contrasted with a faceless mother, pictured in black and white, holding her baby. She nearly disappeared due to the dominance of the various shades of red. This publication aimed to warn women about caesareans by depicting caesarean scars and therefore putting these visible "leftovers" at the centre of attention.

[339] One possible explanation for the popularity of Stoppard's books in Germany is that babycare and prenatal care, e.g., tips regarding maternal nutrition and fitness, could be applied to Germany as well, and that the chapter regarding caesarean delivery was restricted to explaining caesarean routines and what happens in the theatre, as well as mentioning indications and risks. All of these aspects were similar, if not the same (surgical methods) in Germany.
[340] "Wie Narben an Bauch und Seele heilen können."

5.5 On request? Advice books and their general approach to caesarean delivery

Chapters which focused exclusively on caesarean sections on request, and which went beyond noting the existence of this mode of delivery, represented a minority in most advice books. Caesarean delivery in general, however, was not ignored, although it was introduced only for the sake of completeness. For this reason, advice books used to stress that abdominal delivery involved higher risks, compared to vaginal birth. There was one exception: German medical journalist Annette Bopp[341] dedicated her monograph exclusively to caesareans on request and introduced them on the back cover as an "alternative way of delivering a child!"[342] (including the exclamation mark). Consequently, Bopp neglected emergency caesareans, and also caesareans planned by the obstetrician.

Advice books sometimes presented abdominal delivery as only a marginal idea. As in medical debates, vaginal birth was viewed as the standard mode of delivery; the NHS *Pregnancy Book* supported this attitude. Nearly all of the sections of the chapter about childbirth were devoted to vaginal delivery, and the stages of spontaneous birth were explained in detail.[343] Caesareans on request were not even mentioned, but the publication distinguished between emergency and elective surgeries.[344] However, caesareans were generally introduced as heavy abdominal surgery, which was only performed under medical indications (they will "only be performed where there is a real clinical need for this type of delivery").[345]

[341] Bopp actually has a medical background, cf. Bopp 2003, front page flap (no page number) "About the author."
[342] "Eine Alternative, um ein Kind auf die Welt zu bringen!" Bopp 2003, back cover.
[343] NHS 2007, p. 90.
[344] NHS 2007, p. 102.
[345] NHS 2007, p. 101.

The NHS publication furthermore ignored the benefits and disadvantages of all modes of delivery.

Thus, the NHS *Pregnancy Book* did not discuss any new discoveries in terms of caesarean delivery, but instead listed the well-established, well-known risks. While caesareans were not given much attention, the readers learned all the more about vaginal delivery.

Your Birth Year by the National Child Trust (NCT) took a somewhat different view. The NCT claimed that caesareans were a "now common surgery,"[346] referring to their routine performance. Compared to other advice books, the NCT publication approached decision-making from the opposite angle, questioning what would happen if a woman refused a caesarean birth.[347] By doing so, the authors obviously implied that caesareans were suggested and initiated by doctors. Moreover, no clear answer was provided.

The NCT did not focus on caesareans on request, but discussed risk and safety issues. They stressed the safety of vaginal birth ("about four times [safer than caesareans]") but also remarked that – as regards both types of delivery – it was unlikely that major implications would occur in the modern age. Mothers should, however, be aware that surgery would leave a scar on their belly and that their babies could suffer from respiration distress.[348] Thus, the NCT supported the avoidance of unnecessary caesareans.

As regards caesareans on request, the authors did not provide their own opinion, but argued that even among obstetricians, various attitudes existed. Therefore, the mother may be offered a second opinion; this recommendation of the NCT alluded to the fact that getting a doctor to consent to requests was not easy. Nevertheless, the NCT stated that

[346] NCT 2004, p. 134.
[347] NCT 2004, p. 134.
[348] NCT 2004, p. 135.

psychological reasons would qualify as medical indications and thus justify caesareans on request.[349]

Although caesareans on request were mentioned, the NCT discussed them in a short section and not in full detail. Compared to other advice books, it is striking that the NCT were so reserved with their own opinion. Midwife Catharine Parker-Littler chose a similar approach to developing an understanding of caesareans on request (2008). Her advice book was based on a question-answer format, and Parker-Littler introduced herself as an expert because of her profession. Throughout the book, she refers to her practical experience.

The passage about caesarean sections focused specifically on elective caesareans. Parker-Littler referred to caesareans on request only briefly, and judged them to be "drastic decision."[350] She defined them as caesareans without a medical indication, which were performed only because the mother-to-be feared vaginal birth. Parker-Littler furthermore explained that caesareans involved abdominal surgery and as such included many risks. Thus, women were advised to overcome their fears rather than choosing surgery. Caesareans should be considered as the last resort only. Parker-Littler was against a policy that offered the choice to opt for a caesarean birth.[351]

Although Parker-Littler referred to the phenomenon of caesareans on request, she described this mode of delivery in such a way as to emphasise the lack of medical necessity and clinical indications. Thus, she questioned indirectly whether caesareans on request were justified. Moreover, Parker-

[349] NCT 2004, p. 136.
[350] Parker-Littler 2008, p. 207.
[351] Parker-Littler 2008, p. 207.

Littler seemed to understate psychological issues by limiting the reasons for maternal requests to anxiety about childbirth.

Advice books often indicated and highlighted the risks of caesareans – it was rare for them to miss out such aspects. The discussion of surgery routines was intended to inform the readers, but at the same time it could be daunting to learn too much about clinical issues. This is how consultant Miriam Stoppard introduced her reflections on caesarean delivery, by explaining the routine preparations for surgery, as well as the performance of caesarean sections. In her view, abdominal delivery was restricted to cases where it was impossible to give birth vaginally; thus, Stoppard did not take into account caesareans on request. Her attitude towards this mode of delivery was consequently that "some women also ask for caesareans as they believe they are easier and they feel more in control."[352] Following this statement, she listed the possible risks of surgical delivery, as well as approved indications for caesareans.

Checklists were popular in advice books, because they reproduced facts that seemed important in a concise way. They also made readers think by allowing them to reflect upon each item. The impression of closeness to the reader could, moreover, be created by fostering a trusting relationship. Journalist Alexandra Heil (2008) used this device to suggest mutual trust. Her advice book promised to go beyond the information given by other childbirth-themed publications, as well as to reveal secrets which the reader would learn nowhere else. The changes resulting from pregnancy and motherhood were the main issues dealt with in Heil's book. It consisted of questions and answers, all devised by the author. As the questions were posed in the first person, a dialogue was mimicked.

[352] Stoppard 2008, p. 308.

Heil's advice book includes a short section about caesareans on request. In her view, they were a trend, and the reason behind this choice was to bypass labour pain. "Can I avoid labour pain by having a caesarean?" was the question that marked the paragraph.[353] This implied that caesareans were chosen because of convenience and fear, and Heil's further illustrations to explain why some mothers-to-be chose abdominal delivery reinforced this suggestion. A choice of birth date and physical integrity also played important roles, according to Heil.[354] She admitted that caesareans on request were frequently discussed, and she furthermore assumed that all obstetricians thought that all planned caesareans deliberately interfered with nature by delivering a premature baby. Moreover, Heil stated that recovery took longer and babies were weaker, due to the effects of a caesarean on their respiratory system. Such babies probably were weaker, because "elective caesarean babies" were generally younger and thus smaller.

However, according to Heil, caesareans (in general – she did not restrict her views to request surgeries) entailed too many long-term risks, which disqualified them as an alternative to vaginal birth. Heil wanted caesareans to be performed only in emergencies, and failed to discuss various types of caesarean.

[353] Heil 2008, p. 84.
[354] Heil 2008, p. 84.

5.6 Caesarean sections on request in more detail

5.6.1 Advice and information

However, there were advice books which looked into caesareans on request in more detail, although they were rare. The topic may have been too exclusive, and did not apply to all mothers-to-be, in contrast to topics associated with pregnancy.[355] German-speaking publications led the way in terms of presenting caesareans on request in more detail. As regards their content, advice books which aimed to support decision-making were distinguished from those aiming to comfort mothers who had gone through an unexpected caesarean.

Medical journalist Annette Bopp (2003) viewed caesareans on request on the same level as vaginal birth, and her publication was dedicated to caesareans by choice. She identified them as a trend[356] and described in detail how the surgery was performed, in order to provide expectant mothers with as much information as possible. A paradigm shift had occurred in obstetrics, which – according to Bopp – could no longer be denied. Caesareans were no longer unusual, but had become routine surgery in Germany as well as in many other countries. As more caesareans were being performed, their overall proportion of births had risen.[357] The major reasons for surgery were to avoid litigation, as well as general risk awareness and women making use of the concept of patient choice.[358]

Bopp delivered a comprehensive approach to the main issues of caesareans on request, which focused on introducing this mode of delivery

[355] In this context, the "problem" occurred again that many publications in the English language were meant for the United States market.
[356] Bopp 2003, p. 21.
[357] Bopp 2003, p. 9.
[358] Bopp 2003, p. 33.

and decision-making. She provided "food for thought" and discussed caesareans on request from various angles, such as the historical development of surgical delivery and its clinical status in other countries. Today, there is still no other source which is comparable to Bopp's publication regarding a detailed description of caesarean sections on request in the context of popular science and advice; usually, only advice books on vaginal delivery are as detailed. Bopp provided extensive information on caesareans on request, from preparations for hospitalisation to aftercare.

Her publication was fairly one-dimensional, because the topic of caesareans on request formed the majority of the text. However, Bopp created a balance with regard to the overall market of pregnancy advice books. The more information there was about caesareans on request, the more likely it was that prejudice could be defeated.

One-sided and biased from another angle was the opinion of journalist Theresia Maria de Jong and Gabriele Kemmler, a pedagogue. They too discussed caesarean delivery, but in a more general manner than Bopp and with a focus on emergency caesareans as well as mothers' emotional wellbeing postpartum. Their publication merged the general characteristics of advice books (recommendations, advice, information) and the authors' views, which resulted from their personal experience.

The authors, who were both mothers who – according to their own statements – suffered as a result of unexpected caesareans, approached this mode of delivery from a rather subjective perspective. This was justified, however, because their book aimed to help other mothers to overcome "caesarean traumas." One chapter was devoted to caesarean sections on

request.[359] De Jong and Kemmler criticised caesareans in general, which is why they did not have a positive view of caesareans on request. These were viewed as a "threat to the future of childbirth" and only assigned a positive role in relation to their life-saving function.

De Jong and Kemmler assumed that the increase in surgery had happened only because of the goal of maximising profits, since obstetricians would take into account the fact that caesareans evoke trauma. Caesareans prevented women from experiencing "real" childbirth (again, this stands for "vaginal birth") and thus led to negative side effects, such as making it hard for the mother to bond with her baby. The authors furthermore portrayed caesarean sections as a reflection of power structures with regard to the patient-doctor relationship and clinical predominance. Obstetricians were aiming to redefine female attitudes towards childbirth by increasing surgery rates. According to the authors, caesareans did not equal "giving birth," as they claimed that caesareans prevented women from experiencing childbirth.[360] Ultimately, they warned, with caesareans becoming a lifestyle choice, the society of the future would suffer specific consequences, such as the idea that the development of artificial wombs would finally succeed.[361]

[359] de Jong/Kemmler 2003, pp. 106-114.
[360] de Jong/Kemmler 2003, p. 112.
[361] de Jong/Kemmler 2003, p. 114.

5.6.2 An attempt to link caesareans on request to the trauma of an unwanted emergency caesarean

As regards caesareans on request, de Jong and Kemmler claimed that they addressed women's anxiety and fears; thus, caesareans by choice had identified a vulnerable point in pregnancy and birth preparation. Allowing mothers-to-be to opt for surgery equalled a redefinition of childbirth, an idea that de Jong and Kemmler were not willing to support. Suddenly, vaginal delivery had become stigmatised and was associated with risks, and instead of the "natural" aspects of childbirth – including women discovering their own power and relying on their instincts – medicalisation, control and technology had taken over.[362] Women's perceptions, moreover, had already adapted to this new image of delivery so that, as de Jong and Kemmler explained, they requested caesareans for reasons of patient autonomy, as well as to ensure a predictable birth event. At the same time, obstetricians and women ignored the risks: according to de Jong and Kemmler, practice at the time contradicted society's general attitude of risk-awareness.[363]

Furthermore, the authors introduced psychosocial aspects alongside medical issues, e.g., they stated that the risks inherent in caesareans were four to 12 times higher than those of vaginal delivery, but they did not explain what risks they referred to, nor did they provide evidence anywhere in their book. It was also assumed that caesareans constituted dangerous surgery.[364] According to de Jong and Kemmler, caesareans were therefore not only life-saving, but also life-threatening. Once again, their explanations lacked evidence.

[362] de Jong/Kemmler 2003, pp. 106-107.
[363] de Jong/Kemmler 2003, p. 107.
[364] de Jong/Kemmler 2003, p. 108.

Furthermore, they included a report in the chapter on caesareans on request in which a mother retold her caesarean experience. She appeared to be distressed, and her sutures had trouble healing.[365] However, at no point did the authors reveal what type of caesarean this mother had. Although this chapter concerns caesareans on request, the report could also apply to any other caesarean variant.

In the discussion later in the book, caesareans on request were termed "Rolls Royce birth," implying that they are an unnecessary indulgence. It was also denied by de Jong and Kemmler that they were safer than vaginal delivery.[366] With regard to the reasons for maternal requests, the authors suggested that women were influenced by consultants' attitudes and an overall lack of information.[367] Furthermore, instead of supporting the women's self-confidence in delivering vaginally, obstetricians would point out the dangers of spontaneous childbirth, not least because of financial incentives and their own fear of lawsuits. De Jong and Kemmler also indicated that expectant mothers made use of "informed consence [sic]"[368]; caesareans on request belong to this conception. Uniquely, and by repeatedly mixing medical and psychological theories, they stated that victims of sexual abuse might prefer caesareans – de Jong and Kemmler presumed that these women could overcome their trauma by "therapy"[369] (a word chosen by the authors), which should consist of vaginal birth. This hypothesis could not be found in any other source.

[365] de Jong/Kemmler 2003, pp. 108-109.
[366] de Jong/Kemmler 2003, p. 110.
[367] de Jong/Kemmler 2003, p. 120.
[368] de Jong/Kemmler 2003, p. 112.
[369] de Jong/Kemmler 2003, p. 112.

5.6.3 Another angle of experience – semibiographical publications

Personal components of advice books added another perspective; some authors willingly included biographical details of their pregnancy and used them as a main theme.[370] The authors shared their personal experiences with their readership (Naomi Wolf used this approach to deliver a comprehensive report of her pregnancy).[371] Sometimes, additional information is given which is helpful to mothers-to-be. If the author's own story was not at the centre of the publication, it may still have been the reason why the book was written. This type of advice book also aimed to inform and assist women in overcoming distressing experiences or to support them right from the beginning in case they face unforeseen events. Such support had often been unavailable to the authors themselves during their own pregnancy, and this method recreated a basis of trust, as they attempted to provide a comforting presence to the reader.

[370] A similar, much abbreviated version of this type of biographical approach can also be found on Internet discussion boards. Cf. Chapter 5.
[371] Wolf 2002.

5.6.4 The "journey to motherhood" of Naomi Wolf

5.6.4.1 A different cultural angle

English journalist Naomi Wolf brought together several aspects of giving birth and experience pregnancy; she had readers participate in her pregnancy and at the same time provided reports of other women in her "journey toward childbirth"[372] (2002). Her biographical publication *Misconceptions* showed how cultural perceptions change when one moves to a different country and becomes familiar with another culture. In her case, Wolf had moved from England to the United States. The moment her cultural environment changed, Wolf noted the differences. British habits, which had previously been taken for granted and seemed normal to her, were now compared to American standards, which she experienced as being new. This was particularly striking when she became pregnant – pregnancy care and birth preparation differed substantially from British standards.

Wolf discussed these differences in her book while narrating the course of her own pregnancy. Therefore, she did not intend to write a standard popular scientific advice book, discussing the usual pregnancy themes. The biographical style and the fact that Wolf did not address the readers directly (as other advice books often do) made her publication stand out.

Furthermore, Wolf wanted to familiarise fellow American mothers with British childbirth habits (and vice versa), and in pursuit of this goal, she compared the two countries a great deal. Thus, her readers learned how pregnancy issues were dealt with in Britain, and they were also informed

[372] Wolf 2002, p. 127.

about doctors' attitudes and women's emotions. Wolf used her own pregnancy as a central theme and as a link between the two countries, which worked well in terms of the readability and structure of her book. In addition, she provided a great deal of "food for thought" by questioning contemporary routines.

However, comparison was not the only goal of Wolf's publication. She considered it more important to talk about topics relating to pregnancy, as being pregnant meant finding oneself in a new and uncertain situation. Wolf expressed her thoughts and worries as an expectant mother, and she aimed to inform other women about what childbirth could involve, particularly with regard to communication with medical professionals. Other women should be prepared for all possible eventualities, as well as encouraged to question current birth paradigms and routines.

Wolf therefore delivered a different approach to childbirth issues, which was what made her publication unique. Moreover, she aimed to provide a complete account of the experience of pregnancy by studying "the hidden truths behind giving birth in the developed world today."[373] She aimed to prevent misconceptions which could cause unexpected situations. Thus, she attempted to fill the gaps and prepare other mothers-to-be for events they had not yet considered, as well as to build their self-confidence. In Wolf's opinion, consultants often do not fully inform women and thus communicate a one-sided image of childbirth, focusing on only the joyful aspects of motherhood.[374] Childbirth was always linked to how to cope with

[373] Wolf 2002, p. 1.
[374] Wolf 2002, pp. 2-3.

pain and anxiety, but often, labour pain was trivialised or downplayed as being a "normal event."[375]

Wolf's perspective on childbirth issues in the NHS was presented from a distance, not only geographically but also regarding her experience. She restricted her analyses to medico-social approaches and therefore needed to include accounts by women who had given birth under NHS standards, as Wolf herself could not refer to her own experiences in this situation. Her perceptions not only referred to general opportunities for women, but also to particular issues, such as the necessity of monitoring.

Britain therefore had a particular childbirth profile, as Wolf made clear in her analyses. The first – and in her view probably most apparent – aspect was the opportunity to have a home birth (instead of hospital delivery) and the greater impact of patient choice in Britain. Moreover, British hospitals were less insistent on fetal and maternal monitoring, although this was a topic of debate in many critical approaches to NHS standards. Thus, Wolf's different perceptions seemed unusual in this context (although her observations expressed that there was a higher level of medicalisation and the application of technology in the United States). The two countries had fairly similar caesarean rates, which were perceived as being high in British publications, but Wolf remarked that in the United States, obstetricians would intervene earlier and produce higher caesarean rates than her British colleagues.[376] Hence, when it came to comparison, Wolf saw American habits as strange, while she perceived the standards of her home country as the normal state.

[375] Wolf 2002, pp. 158-159.
[376] Wolf 2002, p. 136.

5.6.4.2 Caesareans on request from another perspective

When discussing caesarean delivery, Wolf assigned caesareans on request to the United States rather than Britain. She was aware of the fierce debates in her home country, but had noticed that American doctors would often convince women to opt for caesareans, referring to sexual activity after childbirth and the need to preserve a "honeymoon vagina."[377] Wolf found her assumption that mothers lacked full information confirmed, which caused them to approach childbirth in too naïve a manner; they trusted in doctors' experience instead of in themselves. Moreover, Wolf addressed an approach which was, in fact, different between the two countries: explicit promotion of caesarean sections by doctors.

Other statements by Wolf regarding surgical delivery did not differ much from the information provided by standard advice books, and here, Wolf preferred to rely on her secondary sources. She emphasised that caesareans still represented a surgical procedure and that the "routine" attribute had a rather trivialising effect.[378] Wolf concluded that caesareans and vaginal delivery simply could not be compared because they remained too different. In this section of her book, she emphasised the medical information she had consulted.[379]

Nevertheless, Wolf deduced from debates on caesarean sections that women were interested in following their rights and choosing a mode of delivery. Patient autonomy, however, made sense only when the patient was fully informed.[380] Wolf herself had actually opted for a midwife-run birth centre, but in the end had delivered by emergency caesarean. She reiterated

[377] Wolf 2002, p. 149.
[378] Wolf 2002, p. 149.
[379] Wolf 2002, p. 150.
[380] Wolf 2002, p. 154.

that both types of delivery – technology-oriented hospital birth and "natural" vaginal delivery – had their benefits and disadvantages. Combining the emotional support of vaginal birth with the medical safety provided by caesareans would produce a "birthing revolution."[381] More striking, however, was Wolf's reference to hospital delivery as the "traditional way," a label often reserved for vaginal birth.

The readers accompanied Wolf on her journey to becoming a mother. They experienced how her attitude changed and her own experiences, including the disillusionment after her actual childbirth experience differed from her expectations. Can childbirth be planned, other than by caesarean on request? This characteristic at least was assigned to this mode of delivery by advice books.

5.6.5 Visualising caesareans on request

As regards the influence of personal experience in publications and standing out from the crowd of childbirth literature, linguist Caroline Oblasser and pedagogue Ulrike Ebner chose another path to disseminating their opinion (2007).[382] With the aid of photographer Gudrun Wesp, they portrayed the scars of 162 mothers who had given birth by caesarean. The scars that remained after surgery had attracted hardly any attention outside of clinical circles. Although they had never officially been a taboo, scars were not talked about publicly, explained the authors. Moreover, post-surgical images always used to show a "happy mother and baby" team. With the increase in caesarean births and caesarean sections on maternal request in the mid-1990s, the scar had been assigned a double meaning: it expressed both

[381] Wolf 2002, p. 172.
[382] Oblasser/Ebner/Wesp 2007.

physical and emotional injury and therefore affected the body as well as the soul.

This new depiction of caesareans did not shy away from exposing bodies or including medical images in popular scientific publications. The photographic book by Oblasser *et al.* focused exclusively on scars from caesareans and showed them as they were, not sugar-coated but as the remains of the surgery. It linked the disciplines of the arts, social sciences and obstetrics, and aimed to present its photographic material both realistically and aesthetically. As the mothers portrayed were also interviewed (but their faces never shown), caesareans were represented as being more than just a mode of delivery.

Right from the beginning, the authors made clear what they thought about caesarean sections and particularly those on request; in their opinion, most surgeries were unnecessary and only performed due to financial incentives, then presented as a "birth event."[383] Thus, women suffered after having had a caesarean delivery, and there was practically no understanding for surgeries on request. Oblasser, Ebner and Wesp delivered a very critical and subjective examination of the topic, as was their intention. The book resulted from the authors' own experiences of unwanted caesareans.[384] This self-financed project[385] was an attempt to help them to overcome their trauma, but was also intended to address other mothers and anyone who was interested in learning more about a different and visual approach to caesarean delivery.

In support of their findings, Oblasser *et al.* used a varied overall approach, including magazine excerpts and third-party articles (exclusively

[383] Oblasser/Ebner/Wesp 2007, p. 25.
[384] Oblasser/Ebner/Wesp 2007, p. 481.
[385] Oblasser/Ebner/Wesp 2007, p. 481.

written for their publication) in their book. Although they addressed mothers, they obviously did not want to create another standard reference on childbirth, and so they left out any pregnancy issues and advice sections. Instead, they focused on caesarean birth and one of its long-term consequences, the scar.

The photographs comprised the main body of the book, along with the mothers' statements.[386] The description of the scars by the mothers could differ depending on how the reader perceived the photographs – the book therefore addressed body image issues as well. Although each caesarean is performed in the same way, the postoperative scars are different and unique. There were two levels of intimacy in the book (although not explicitly mentioned by Oblasser *et al.*): the visible scar on the body and the invisible memories of the childbirth event.

As regards caesareans on request, the authors stated that, among the 162 mothers they interviewed, five had requested a caesarean (3%).[387] This confirmed that the percentage of caesarean sections on maternal request was lower than was probably expected (around 4 to 8% of all caesareans). Overall, the benefits of caesarean delivery were mentioned nowhere in the book; the authors restricted themselves to mentioning the advantage that emergency caesareans save lives. Thus, the publication showed a rather one-dimensional image of caesarean sections and, last but not least, not a favourable one.

[386] Oblasser/Ebner/Wesp 2007, pp. 65-207.
[387] Oblasser/Ebner/Wesp 2007, p. 217.

5.7 Controversies and main issues

5.7.1 General observations

Advice books recognised that caesareans on request had become an issue, and they referred to this mode of delivery and to shifts in obstetric practice, hoping to find an answer to why the rate of caesarean deliveries had risen substantially. The approach of advice books, however, meant that patient choice as a topic and influence on caesarean sections was generally neglected. From the perspective of advice books, patient autonomy had to stand behind obstetricians' goals; according to this, the patient-doctor relationship was unbalanced. Furthermore, advice books presented medical advances as either dangerous (due to the authors' anti-caesarean attitude) or progressive and thus beneficial (open-minded towards caesareans), which could influence the opinions of their readers. The view of caesareans shifted between a generally sceptical attitude with regard to modern society (which, in the view of some authors, preferred to avoid risks instead of challenging them and trusting in the "natural"[388] course of events) and the recognition of obstetric progress, which had resulted in the availability of caesareans on request, involving safety and predictability. However, it was not always made clear whether reflections such as these were the personal opinions of the authors of advice books or reproduced from their sources.

Cultural aspects were not explicitly mentioned or emphasised in advice books – except for Naomi Wolf's pregnancy report, because she lived abroad. As a matter of course, publications referred to the country of the language in which they were written and where they had initially been

[388] In this case, as nature intended.

published. Thus, there was no need to point out any national specificities. Advice books therefore expressed implicitly that they contained linguistic (the language they were published in) as well as regional limits.

However, the detailed descriptions contained in advice books in the German language suggested that it was less difficult to have a request for a caesarean granted in Germany. As a result, mothers-to-be were in need of information and support. In the English-speaking advice literature, caesareans were sometimes presented as something that was reserved for particular situations only and depended on doctors' approval, which – in addition – was hard to achieve.

Although discussions on medical aspects were mostly descriptive, advice books put effort into informing and educating their readers about shifts in the use and popularity of caesareans. In this case, they did not restrict themselves to reviewing the reasons that had been mentioned in medical publications, but linked these statements to psychological or psychosocial arguments. Some authors of advice books assumed that obstetricians were increasingly recommending caesareans to pregnant women, thus initiating surgery, often for profit-making purposes and preventative reasons (avoiding malpractice suits). Obstetrics had become a lucrative occupation, as claimed by advice books; the income of hospitals increased and the fears of expectant mothers regarding childbirth were tackled.

Advice books that did not support the idea of caesareans on request often stated that some women had experienced childbirth as a trauma. However, these were often mothers who had undergone an emergency caesarean (a fact which was, however, mentioned in the books). The strategy of advice books was to transfer these negative experiences to

caesarean sections in general, therefore neglecting to mention that emergency situations were always delicate and often threatening, as they involved an unexpected outcome. The approach of certain advice books was contrary to publications which favoured caesareans on request.

This concept also worked the other way around, aiming to evoke the fear of caesareans (instead of vaginal delivery), and therefore stressing the risks and implications of the surgery. The same advice books also referred to childbirth as a natural event represented by vaginal birth. Hence, they communicated that this had been the usual, accepted way to give birth for centuries, which was why vaginal delivery should not be questioned.

5.7.2 Approaches, statements and opinions

Popular scientific advice books presented the issue of caesareans on request in many dimensions. First, caesareans on request were recognised as an existent mode of delivery. On rare occasions, they were ignored completely – this kind of advice book focused on uncomplicated vaginal births instead. In general, vaginal delivery was communicated as the standard mode of delivery by the advice literature, which is reminiscent of Sara Paterson-Brown's belief that vaginal birth embodied the traditional mode of delivery.[389] On the other hand, advice books emphasised that caesareans would challenge this hegemony, not only because of increasing caesarean rates. Moreover, surgical delivery was obviously supported by some medical professionals.

Advice books gave caesarean birth a critical reception by repeatedly emphasising their benefits and disadvantages. Although sections on

[389] Paterson-Brown 1998, p. 463.

caesareans and maternal request were kept short, there was always enough space for a comparison to vaginal delivery. With regard to caesareans on request in particular, it seemed that their justification was repeatedly questioned, because critics expressed doubts concerning their safety and pointed out their disadvantages. On many occasions, these considerations took into account only one particular position, that of the author.

Several authors thus implicitly warned against choosing a caesarean delivery, not only by emphasising the risks and implications or pointing out that maternal requests were hard to put forward and not granted easily, but also especially with regard to the strict indications to which obstetricians adhered. Did advice books want to discourage mothers-to-be? Those women who had opted for a caesarean birth were supposed to have done so because of convenience and anxiety. Implicitly, advice books alluded to irresponsibility as well, questioning how mothers could expose their unborn child to the stress of surgery, its dangers and unknown sequelae.

However, at the same time, caesareans on request were also viewed as an option, although usually suggested by doctors. Advice books therefore suggested that women did indeed opt for an abdominal delivery – but often only because of insecurities that had been evoked and fostered by obstetricians. According to this theory and as mentioned above, doctors alone were responsible for caesareans on request, in the view of some advice books. The women were not responsible, as patient choice ultimately signified no more than a pathetic excuse for clinicians to save their skin. Hence, obstetricians transferred their understanding of choice to the patients which meant that they suggested the treatments they favoured.

5.7.3 The glamorous side of caesareans on request: Celebrities

However, it was not only anxiety that was assigned to women who opted for a caesarean delivery. There was another aspect, as mentioned by Oblasser *et al.*: celebrities who had a caesarean section on request. This made this mode of delivery seem glamorous, as it evoked associations with the world of fame, celebrity and a certain lifestyle. Everyone knows the names of singer Britney Spears, model Claudia Schiffer and footballer's wife Victoria Beckham.[390] They, and probably many other celebrity mothers, not only opted for a caesarean, but also chose exclusive private clinics as their place of birth, which were both expensive and luxurious.[391] However, advice books could not prove that celebrity mothers did in fact influence the decision-making of "everyday mothers." However, media reports as well as the media interest in caesareans on request suggested that celebrities were at least partially responsible for the overall increase in caesareans. Once again, advice books did not bother to find evidence, and they did not even mention any actual or estimated rates of caesareans on request. In addition, the introduction of media articles further nourished the already critical attitude of some popular scientific authors, questioning once more whether caesareans on request made sense.

Reports about celebrities supported the assumption that mothers chose a caesarean delivery mostly for superficial reasons, and thus in the absence of indications. Instead of worrying about their unborn child, they were thought only to care about their postpartum appearance. Advice books had a reason for mentioning celebrity reports – these mothers popularised the issue of caesareans on request, and there were probably "ordinary"

[390] Oblasser/Ebner/Wesp 2007, pp. 47, 49.
[391] Oblasser/Ebner/Wesp 2007, p. 47.

women who heard of this mode of delivery only because they followed the press. In addition, once they had given birth, these celebrity women seemed to shed their "baby pounds" (the weight gained during pregnancy) faster than "everyday" mothers. It appeared that celebrities were back in shape within a couple of weeks, while "ordinary" mothers recognised the traces that pregnancy had left on their bodies, such as stretch marks.[392] These "leftovers" were sometimes seen by women as "disfigurements,"[393] and thus new mothers also wanted to tone their bodies as quickly as possible. Thus, according to the *Telegraph*, celebrities had a specific influence on the behaviour of ordinary women.[394]

5.7.4 Investigating the reasons

Among the authors of advice books, opponents and advocates of caesareans on request could be found. Their presentation of caesareans on request was often an emotional one, particularly when authors revealed that they were "victims" of an unwanted caesarean themselves. In such cases, the authors' own experiences – moreover, of different kinds of caesarean – were applied to caesareans by choice.

As regards looking into the reasons for caesareans on request, advice books explored the relationship between technology and shifts in doctors' attitudes, as well as the rise in caesarean deliveries. However, they lacked further explanations of whether these aspects had any impact on maternal requests. That is, they did not question how exactly planned caesareans became caesareans on request.

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[392] *Telegraph* 20.12.2007, no author mentioned, no page numbers given.
[393] *Telegraph* 02.12.2007, no author mentioned, no page numbers given.
[394] *Telegraph* 02.12.2007, no author mentioned, no page numbers given.

Nevertheless, advice books suggested ways in which caesareans on request could have become popular, among mothers as well as in debates. Once more, obstetricians were blamed for having acted out of financial greed or fear of litigation. The increasing focus on technology also became a popular topic of discussion in advice books. Technology was increasingly applied to childbirth issues, which caused obstetrics to turn away from "nature" (represented by vaginal delivery). Consequently, vaginal birth became "stigmatised" and was thought to be uncontrollable and therefore dangerous.

Many advice books had no understanding of risk assessment in the context of decision-making, particularly those which held a negative attitude. According to these publications, caesareans were still a dangerous issue, containing a high level of physical and psychological risk. Therefore, they did not even try to develop an understanding of women's motives for surgery; they were convinced that decision-making reflected medical recommendations only. In such cases, patient autonomy was viewed as women merely carrying out what had been suggested by their consultants, meaning that it only seemed to be their own decision. Whether or not this presumption may be true will be further explored in the next chapter, which provides insight into the debates among expectant mothers on the Internet.

5.8 Summary

In order to understand why women want to learn more about pregnancy and childbirth – in this case, from popular scientific advice books – it is helpful to learn about the social role of becoming a mother. Women at the time knew that motherhood would change their life and that they would find themselves in a role as yet unknown to them – like giving birth. They wanted to learn as much as possible about their new circumstances in order to get things right as soon as they began.

Reflections on motherhood showed that although women perceived motherhood as being a generally happy state, they also feared that they would not fulfil their new role at the same time. However, perceptions of motherhood always derived from a particular cultural and social environment. Society reacted to motherhood by viewing and treating new mothers differently in comparison to their former role as a woman.

In the modern age, becoming a mother can be planned, starting with being able to choose when family planning begins. Women had high expectations of themselves and feared making mistakes (including making poor decisions).

There was a broad range of popular scientific advice books on pregnancy and childbirth. These publications dealt with the issue of caesareans on request in different ways. First, advice books addressed pregnant women or other medical laypersons. They discussed topics in a simplified, general way and aimed to prepare their readers for anything that might occur during pregnancy and childbirth. The method they used was to provide as much information as possible, in order to discuss all possible events, and approached the reader as a "good friend" rather than as a

patient. That is why they often contained reports by other mothers in order to create a peer group. The aim of advice books was not to provide new evidence or perform research; instead, they reproduced what had already been said and experienced. Their approach was an interdisciplinary one, combining medical facts with personal opinions and experiences.

Most advice books dealt with caesareans on request in a brief and concise way, and often as part of their overall introduction to abdominal birth, compared to detailed sections about vaginal birth. Moreover, when discussing caesareans, these books restricted themselves to a list of indications and an overview of the possible risks and advantages, as well as presenting emergency surgeries as a "last resort" after a failed trial of labour. At the same time, few popular scientific advice books could manage without mentioning caesareans on request, either because the authors wanted to disseminate their own personal opinions about this mode of delivery or in order to refer to celebrities who had chosen this mode of delivery and hit the headlines. This was, however, reason enough to mention advice books in this thesis.

Cultural differences were only found in popular scientific advice books inasmuch as they referred automatically to the respective healthcare system of the country in which they were published. Usually, they also saw no need to introduce or explain these healthcare services in detail, probably presupposing that readers who lived in these countries would be familiar with any relevant policies.

Due to their various approaches, advice books revealed different opinions on caesareans on request, from rejection (and the restriction of caesareans to emergency cases only) to approval of caesareans as an

alternative birth mode. Moreover, authors usually included their own opinion; as regards subjectivity, advice books were sometimes very biased.

As various advice books focused on the disadvantages of caesareans on request, this mode of delivery was not presented as an alternative to vaginal delivery. Publications did not necessarily make an effort to enquire into the circumstances which had led to changes in obstetrics and the development of caesareans on request. They simply mentioned that the notion of maternal request existed. This marginalisation of caesareans on request was obvious; often they were sidelined for detailed information on vaginal delivery in the table of contents alone.

In general, advice books limited their discussions on any topic to a couple of pages (or even paragraphs); thus, topics could only be introduced superficially and concisely. Any additional information was omitted (e.g., the historical development of caesareans), as the main aim of advice books was to provide help. Although authors noted that changes had taken place in the field of obstetrics, they did not bother to find out more about them. They often assigned recent developments to doctors' behaviour. As advice books aimed to focus on mothers-to-be and thus on how they were affected by changes in obstetrics, authors suggested that in spite of increased technology and medicalisation, advances were not necessarily beneficial to childbirth and hence to mothers-to-be.

6 So what do *you* think? – Virtual assessments on Internet discussion boards

In contemporary society, the interest in medical information has grown, and patients are increasingly seizing the opportunity to learn about aspects of medicine on the Internet.[395] Thus, in addition to medical consultations, pregnant women access online platforms in order to learn more about childbirth issues.[396] Internet discussion boards can provide insight into communication among expectant mothers. The fact that discussions take place within a peer group and in an atmosphere that creates a familiar environment, suggests that women, because they feel comfortable, communicate more frankly and straightforwardly in terms of making their views public.

This chapter aims to bridge the gap between medical and expectant women's perceptions of caesarean sections on request. It investigates the discussions about this mode of delivery via four English and German online parenting-themed communities and analyses the discursive behaviour and attitudes of online participants. Debates among laypersons, particularly on online discussion platforms, play an important role with regard to the exchange and formation of opinions. On these so-called boards, women meet their peers; they gather information and disseminate their own personal opinions. Online forums not only reflect that caesarean sections on request are a controversial issue (as in the medical world); they also make it clear that women's own understanding of the term "caesarean on request" differs from medical definitions, including a difference in the perception of medical

[395] Hardey 1999, p. 821.
[396] Emmett/Shaw *et al.* 2006, p. 1440.

evidence. Medical practice can learn about women's thoughts and concerns from such online platforms and use this knowledge to provide individualised guidance in consultations regarding modes of delivery.

This chapter differs from its predecessors because it concentrates on Internet sources and particularly discussion boards, on which pregnant women have their say. To begin with, this chapter explores the functions and structures of discussion platforms and then introduces the boards that have been studied. It is also necessary to expand on the selection of threads and forums which have been analysed in general. The main section of this chapter examines particular debates on caesareans on request, in terms of their content and themes. Statements made by women seemed to be honest and there were lively debates.

In addition to how caesareans on request are represented, this chapter also considers women's thoughts and concerns, as well as what they expect from online communication.

6.1 Caesareans on request and the Internet – room for debate

We know from the previous chapters that caesarean sections on request were defined as caesareans without medical justification, at least among medical professionals. However, expectant mothers often had a different conception in mind, which could lead to misapprehensions. In this chapter, women's understanding of the term "caesarean section on request" and their associations with this mode of delivery will be discussed. If they were aware that women could interpret medical information in a different way, obstetricians could benefit from this knowledge and address concerns on a more individual basis. Moreover, such an awareness on the physician’s

side could help to improve communication between women and consultants and ultimately reshape the doctor-patient relationship.

However, how can we find out what pregnant women think? Much has been said about caesarean sections on request, and researchers have become aware that caesareans by choice represent a complex issue. Although medical studies have identified that the fear of childbirth and general uncertainty represented the main reasons for requesting a caesarean delivery, verbatim accounts of expectant mothers' opinions are rare in obstetric publications. Most articles about caesarean sections on request approach the issue exclusively from a clinical angle, although it was mentioned that doctors tended to refer to patient choice when faced with requests for caesareans.[397] Respecting women's autonomy implied that obstetricians were aware of their patients' thoughts, but at the same time, the actual level of interest in the views of pregnant women remained low. However, the importance of women's opinions, not only for reconstructing debates but also for understanding their motives and the overall phenomenon of caesareans on request, is obvious.

Health psychologist Clare Emmett *et al.* (2006) remarked that publicly available sources, such as advice books and Internet platforms, were popular among expectant mothers wishing to fill the gaps in their knowledge without the help of medical consultancies.[398] Thus, Internet discussion boards can provide an insight into the modes of communication used among expectant mothers. At that time, discussion platforms on the Internet were a relatively new means of communication exchange. Several of these so-called boards were dedicated to themes relating to pregnancy and childbirth.

[397] Habiba/Kaminski/Da Fre *et al.* 2006, p. 649.
[398] Emmett/Shaw/Montgomery *et al.* 2006, p. 1440.

For a long time, childbirth has been viewed as a personal and private matter, only to be discussed with consultants or people close to the expectant mother. However, on Internet discussion boards, women, whose identity is well protected by a self-chosen username, chat frankly about all aspects of pregnancy and birth. Various online communities specialising in parenting issues, such as the English-speaking *Babyworld*, offer discussions about a variety of themes and, moreover, can be accessed from all over the world. Obviously, the Internet has become a substantial and international source of information. It allows quick and anonymous access to an infinite amount of information. The information which women were looking for seemed only one click of the mouse away and, often, discussions on forums could replace (or at least help women to prepare for) professional consultations.[399] The fact that discussions took place within a peer group, thus creating a family environment, suggested that women were more open and straightforward in terms of making their opinions public.

6.2 Approaches to online boards

In this chapter, I explore women's opinions about caesareans on request by studying "threads" (i.e., forum discussions) from four English and German forums.[400] While obstetricians approached the issue of making decisions from a professional angle and with a certain emotional distance, women participating in forum debates were usually affected directly, due to being in the midst of birth preparations or because of their own caesarean experiences. Therefore, this chapter adds an "applied" component to the professional perspective which was introduced previously. In addition,

[399] Hardey 2001, p. 394.
[400] The chosen mixture of English and German culture and language results from the comparative approach of my PhD thesis, upon which this article's topic is based.

although the Internet is a popular means of communication, online forum conversations have not yet been studied extensively – at least not with regard to caesareans on request.[401] As the Internet plays a significant role in modern communication,[402] it should not be neglected when researching mothers' opinions.

Internet boards that focus on parenting issues contain a substantial number of threads about caesarean sections on request, usually alongside general discussions on childbirth. In order to provide a comprehensive profile of how Internet forums approach the subject of caesareans on request, a cross-section of four major English and German boards (two in each language) was chosen to represent the online board landscape. In order to facilitate comparison, only boards that had similar overall themes and sub-forums were selected. Furthermore, all of them shared a classic forum structure, with threads and answers listed chronologically for the purpose of better readability.[403]

In addition to general parenting topics – ranging from family planning to schooling – all of the boards contained sections on everyday issues ("off-topic"), technical request forums (how to use the board) as well as introductory or new member sections, because the boards are intended to be viewed as a "second home."[404] Obviously, the boards addressed all stages of life. As long as topics matched the overall theme of a sub-forum, there were no restrictions.[405]

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[401] Thus far, research has concentrated on forum structures, e.g., Stommel (2008), who analysed usernames and related them to forum themes, such as eating disorders. Her research focuses predominantly on how usernames contribute to/shape a user's identity.
[402] E.g., Münz, http://aktuell.de.selfhtml.org/artikel/gedanken/foren-boards (retrieved 07.01.2009).
[403] Münz, http://aktuell.de.selfhtml.org/artikel/gedanken/foren-boards (retrieved 07.01.2009).
[404] Steinmann, http://aktuell.de.selfhtml.org/artikel/projekt/forum/ (retrieved 07.01.2009).
[405] Cf. Duttweiler 2008, 6.

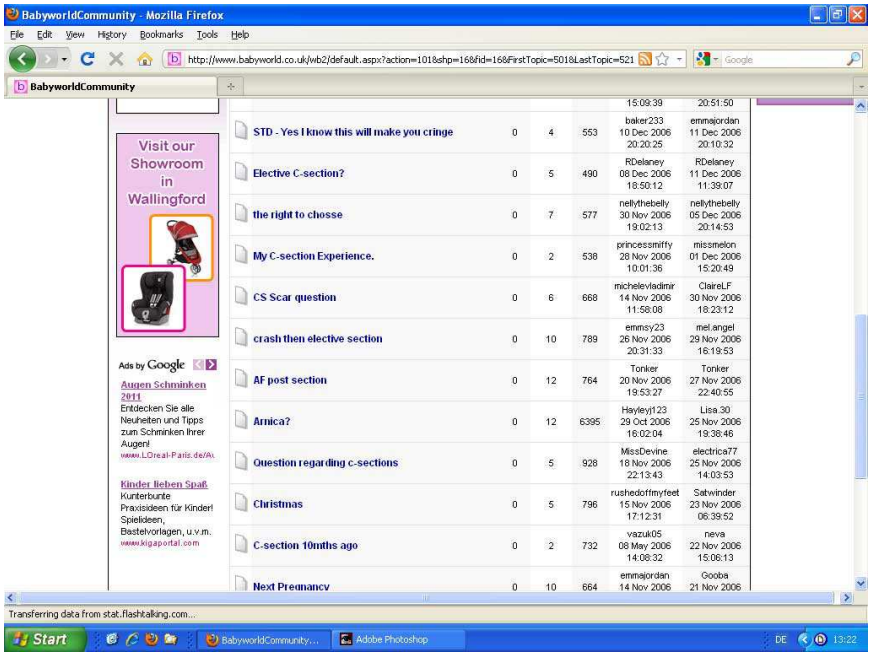
Boards were selected according to the activity level of their users. The number of members alone would have been an insufficient determinant, since there were boards which had a large number of users, but no active discussions, i.e. no new contributions. I preferred active boards with lively discussions because they showed what was of interest to their users at a particular point of time. Boards represented another, contemporary and up-to-date means of publication. Topics were taken from real life, discussed by everyday persons that were directly affected by childbirth themes because users were mostly mothers or expecting women.

6.3 Case studies: Four specific boards

6.3.1 *Babyworld*

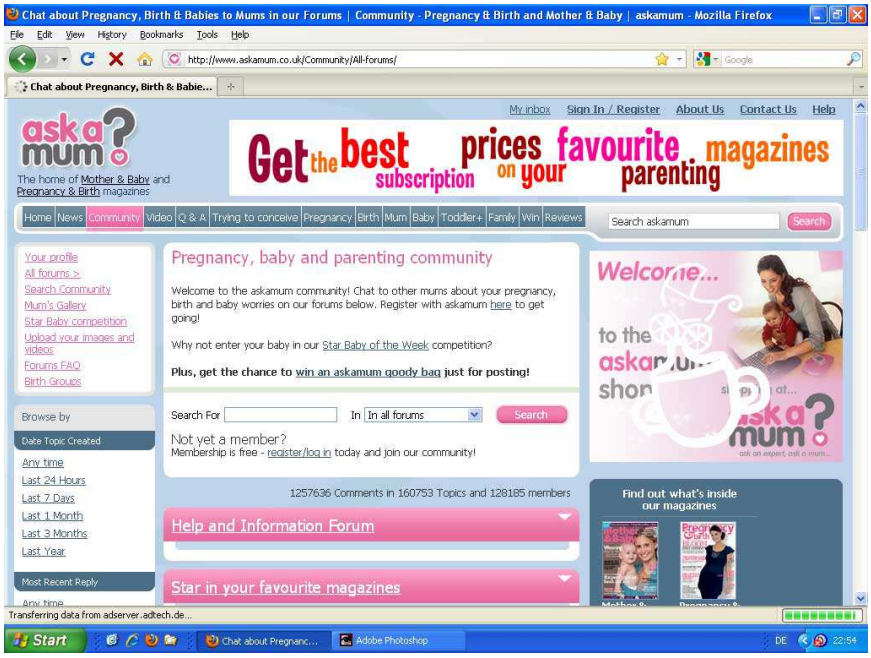
(Image 3: Screenshot of Babyworld main page, retrieved August 2010)

Babyworld (http://www.babyworld.co.uk/) is one of the oldest British online parenting communities and was launched in 1996. Its goal is to provide a platform for all users seeking information about parenthood, and to encourage communication between its members. One of its sub-forums is exclusively for members of the British Armed Forces. Judging from the high posting frequency and the number of forums and usernames, *Babyworld* is a very large board indeed. However, it is not possible to find the actual number of members from the website.



(Image 4: Babyworld, overview of the sub-forum on caesarean sections, retrieved March 2011)

6.3.2 *Ask a Mum*



(Image 5: Screenshot of Ask a Mum main page, retrieved August 2010)

Ask a Mum (http://www.askamum.co.uk/) describes itself as a link between first-hand user knowledge and the two magazines *Pregnancy & Birth* and *Mother & Baby*. It comprises the standard parenting themes relating to pregnancy, birth and the stages of child development. These are further divided into sub-forums for each month of the year and therefore constitute a substantial number of forums, compared to other subgroups. As *Ask a Mum* is the online feature of *Pregnancy & Birth* and *Mother & Baby*, a special forum is dedicated to discussions about the content of the magazine.[406]

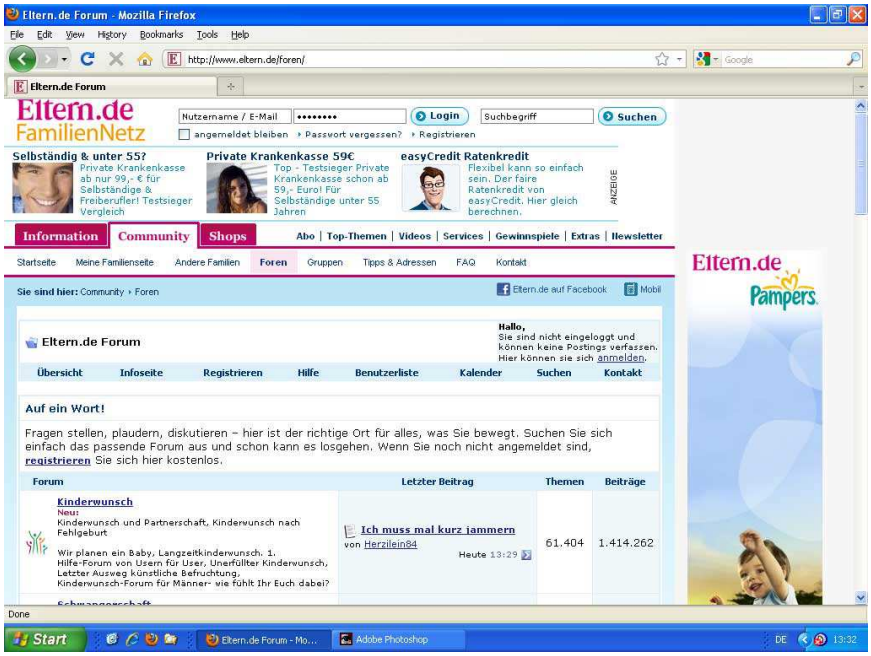
6.3.3 *Elternforen*

(Image 6: Screenshot of Elternforen main page, retrieved August 2010)

406 "Star in your favourite magazines," http://www.askamum.co.uk/Community/ (retrieved 17.08.2010).

Elternforen (http://www.elternforen.com/) also focuses on parenting themes and fosters a general exchange between its members by additionally providing gender-themed forums on subjects such as relationship issues (including a dating platform) and employment matters. The parenting groups are the most active forums, with a high posting frequency.

6.3.4 *Eltern*



(Image 7: Screenshot of Eltern main page, retrieved August 2010)

The *Eltern* (http://www.eltern.de/) discussion board is an online feature of a print magazine of the same name which is the most popular and oldest parenting periodical in Germany. The purpose of the online platform is similar to that of *Ask a Mum*: it supplements the magazine and encourages debates on printed articles. Another focus is on networking: Eltern offers a large

parent community network on which users can set up a personal homepage or a weblog.

6.4 Collecting data from boards

All of the boards were explored in terms of size (the number and activity level of members, which indicated a board's popularity), the variety of sub-forums, and whether the topic of caesareans on request would fit into the forum's context. Appropriate threads were analysed regarding their core statements about caesarean requests, their purpose and the degree of user interaction.

The fact that a forum's authors could delete or edit contributions at any time presented a challenge. At first, it may seem that the possibility that users may edit the content disqualifies boards as a research source; on the other hand, this feature actually reflects the modern use of the Internet, including adaptation to developments within conversations. Users certainly have their reasons for editing posts; for instance, they may have changed their mind or no longer want to participate in the forum. As a relatively new means of communication, most discussions started in the mid-2000s, and boards are generally up-to-date on many issues.

The time span for analyses was set from the first available thread until the end of 2008. There are substantial discrepancies regarding the start date, ranging from 2003 (*Elternforen*) to 2007 (*Ask A Mum, Eltern*). Older threads were not always available, due to the forum's maintenance policy, which

means that inactive or archived[407] conversations were deleted regularly by administrators.[408]

For each of the four boards, the data collection process concentrated only on forums with an overall theme relating to childbirth, as subgroups about caesarean sections are usually found in such forums. Particular keywords, either in the title or the main body of the discussion, qualified threads for research and data collection purposes.

6.4.1 A note on the use of usernames

Usernames (Internet aliases) are referred to only in order to distinguish between forum participants and to assign statements to particular speakers. Usernames, if mentioned, should not be confused with a person's real identity. Personal details are only referred to if they were mentioned openly in discussions and if they are relevant to the study of the threads. In general, my research focused on opinions and argumentation, rather than on individuals. Therefore, any further investigation of attributes relating to users is not dealt with in this analysis, and this article does not attempt to reveal any personal data. Last but not least, all forums that were consulted for this paper represent an anonymous space within the Internet. Accordingly, users never disclosed their contact data (even email addresses were not accessible) or real identity.

[407] Read-only threads that allow no further responses.
[408] In order to avoid the disappearance of threads during the composition of this article, all posts were preserved on a USB flash drive.

6.4.2 Gathering relevant discussion threads

The following search items were applied in order to identify debates on caesarean sections on request:

English term	German equivalent
Elective/planned caesarean section (CS, c-section)	geplanter Kaiserschnitt, geplante Sectio (caesarea)
Caesarean section (CS, c-section) by choice Caesarean section (CS, c-section) on request Request caesarean section (CS, c-section)	Wunschkaiserschnitt/Wunschsectio WKS (abbreviation of Wunschkaiserschnitt) Kaiserschnitt/Sectio auf Wunsch

Sub-forums on birth reports[409] did not qualify for this research, as they did not contain relevant conversations. Moreover, most of these reports concerned vaginal delivery, while very few discussed emergency or elective caesareans.[410]

6.5 General observations

The aforementioned Internet boards fulfilled the purpose of providing a space for communication.[411] Expectant mothers were attracted by the appealing main theme of parenting and to sub-forums that were even more closely related to their individual concerns. It was likely that users would become involved with such forums prior to registration, as most of the forums allowed open access, i.e., interested readers could browse discussions without registering. In this way, users could become acquainted with the

[409] In these forums, mothers described their birth experience in their own words.
[410] Although this is not the aim of this paper, the low number of birth stories about elective caesareans (compared to vaginal delivery and emergency caesareans after a failed trial of labour) might suggest that "request caesarean mothers" did not feel the urge to present their choice publicly. This, however, is just an assumption, as no forums contained any hints to support this hypothesis.
[411] Steinmann, http://aktuell.de.selfhtml.org/artikel/projekt/forum/ (retrieved 07.01.2009).

forum's structure, which may then influence their decision to become a member.

As regards the content that was analysed in this research, online conversations took place using usernames (or username, i.e., an Internet alias) that had been chosen by the users themselves. These usernames could display personal characteristics, such as the user's first name. On all of the boards in question, the majority of usernames were feminine, presumably for identification reasons. As linguist Wyke Stommel noted (2008), this applied particularly to "sensitive online groups [in which] usernames play an especially important role in identity construction."[412]

6.6 Discussion themes

Launching a thread involves communicating a personal concern and, consequently, the user expects an answer. Software engineer Stefan Münz stressed the authors' purpose of making themselves heard.[413] Similarities between the content of threads allowed them to be grouped into three major discussion themes: "advice," "pros and cons" and "reports."

[412] Stommel 2008, p. 141. The term "sensitive online groups" refers to boards that are limited to a certain topic; Stommel herself conducted research on an eating disorder forum.
[413] Münz, http://aktuell.de.selfhtml.org/artikel/gedanken/foren-boards/ (retrieved 07.01.2009).

6.6.1 Advice

This formed the largest group of topics. All of the threads in the "advice" category had a similar structure. The user introduced a particular issue which related to her current pregnancy or a previous birth experience. The title of an exemplary thread was "Nervous about requesting an elective section," and the user began by introducing her previous experiences, in order to refer to her current birth plans:

> I had a very traumatic birth last time. Was induced at 37 weeks due to pre-eclampsia. The induction was horrendous and after four (yes, four!) days ended up in an emergency section. To cut a long story short, after the birth, I suffered from Post-Traumatic Stress Disorder for two years and I am still anxious about issues of labour and delivery. (…) The only way I can imagine having this baby is by an elective section.

Based on these facts, the thread opener then posed one or more precise questions to the community.

> So basically, my questions are:
> 1: How does the process of requesting an elective section work?
> 2: What is the best way of asking for this to ensure I get it?[414]

Sometimes, the women wanted to better inform themselves about general aspects of caesareans. For example, this first-time expectant mother who wanted a caesarean by choice feared the possible side effects of epidural anaesthesia. The title was "I'm doing an elective c-section, questions about epidural," although her text read more like a report:

> I am really scared of epidurals (I'm scared of hospitals and needles...), they say you can have bad headaches or even get

[414] Lucy25 (Internet alias) 2008, *Babyworld*.

> paralysed if they don't do it right... just the thought of it scares me, my doc told me everything will be fine but I'm still scared.[415]

In other cases, women wanted to be prepared for appointments with consultants; this could be the first time they announced their wish for a caesarean or a follow-up meeting, for instance, after having already been rejected for a caesarean on request, when they planned to bring up further arguments.

This *Ask a Mum* member talked about a meeting with her midwife to whom she suggested that she would like to deliver by caesarean:

> Had my booking in appointment today, and obviously we discussed my previous delivery and what I wanted this time.

The midwife, however, proposed a trial labour, but agreed to refer the woman to a consultant. The user was worried about what might happen.

> (…) but I'm really worried about what it is going to take for me to get an elective section, What if the consultant says no and forces me to start labour naturally and go through hours of what happened last time?[416]

In this thread, one user enquired on behalf of a desperate friend who had been refused a caesarean delivery by choice. She was interested to hear how others had succeeded in putting through a request for a caesarean.

> She [the friend] was told that it's not hospital policy to give elective sections without a good medical reason.
> I was wondering if others had managed to get through this type of 'policy' and if so how?[417]

[415] Butterfly.Ki$$eZ (Internet alias) 2006, *Babyworld*.
[416] Jedimum (Internet alias) 2008, *Ask A Mum*.
[417] Lupitt (Internet alias) 2007, *Babyworld*.

Thus, like popular scientific advice books, forums helped women to come to a decision when they seemed insecure. Their indecision was expressed in threads such as the ones quoted above and, for example, when expectant mothers asked for the opinion of their peers on caesareans on request, enquired into what they would do or sought help regarding decision-making. However, obtaining advice from others was comparable to the suggestion of bodies including NICE: that it was advisable to get a second opinion.[418] Thus, it was confirmed that women could feel uneasy and worried about decision-making, but also that the process of risk assessment was fully considered and that the decision to request a caesarean section was not thoughtless or spontaneous.

6.6.2 Pros and cons

These threads presented the actual pros and cons of a discussion, but they were relatively rare. Real debates on the benefits and disadvantages of request caesareans usually contained no personal information in their opening posts; often, the user simply raised a statement and waited for reactions, until two contrasting views and the respective user groups had formed. The following was taken from a survey on *Eltern* that was launched by a member:

> Mich würde mal interessieren, was ihr von den sogenannten Wunschkaiserschnitten haltet? (…) Erzählt ihr doch mal, wie ihr das Thema seht.[419]
> [I would like to know your opinion on so-called request caesareans. Just let me know what you think about that.]

[418] NICE 2004, p. 39.
[419] LasseFinn (Internet alias) 2008, *Eltern*.

6.6.3 Reports

In this type of thread, the user talked about an experience or simply made a statement in order to present an issue to the community. Although no explicit questions were posed, some users would comment anyway. In the following extract, a *Babyworld* member announced her (elective) caesarean, along with an explanation for why she had chosen a particular date:

> C-section confirmed for...
> Friday 10th November.
> I had the choice of the 9th, 10th or Monday 13th, but Monday is my birthday and I want, if possible, the baby to have a separate birthday so opted for the Friday.[420]

A similar thread was found in *Eltern*:

> Ich hab' meinen gewünschten KS-Termin
> und zwar wie gewünscht sehr terminnah - am 6.3., was auch der errechnete ET ist! [421]
> [Got the caesarean section date I had been asking for, close to the date I opted for – on 06.03, which equals the due date!]

As report threads may refer to various topics, they are difficult to categorise. The issues discussed were fairly individual, as it was impossible to predict how a thread might progress. Thread openers often simply posted a message, e.g., informing other users about a recent publication about caesareans on request, sharing their joy when they had been granted a caesarean by choice or simply communicating other feelings. Threads like these also work well without replies; hence, answers were not necessarily expected.

[420] Cinderelli (Internet alias) 2006, *Babyworld*.
[421] Anonymous guest user 2007c., *Eltern*.

6.7 The representation of caesareans on request on parenting boards

The visual appearance of the boards was the most striking feature that distinguished Internet forums from other means of communication. Münz[422] claimed that threads actually represent visualised group discussions. In the analysis above, debates on caesarean sections on request were embedded in sub-forums about caesareans in general, i.e., groups discussing all aspects of caesarean birth. Only *Elternforen* did not provide a group which was specifically dedicated to this mode of delivery; instead, its members posted their concerns and questions in the "pregnancy complications" forum. In the absence of an alternative, the choice of the "pregnancy complications" group suggests that caesarean birth was still represented as an "abnormal" (i.e., unusual) way to give birth, especially considering that *Elternforen* provided a separate forum on vaginal delivery.

6.7.1 The progression of posts and styles of communication

User interaction on boards happened in written form and in real time, with opening posts launching topics for discussion. In the next step, a variety of users provided their statements (reply posts).[423]

Users seeking advice described their concerns in an opening post which related to the title they had chosen. Opening posts could provide more or less detailed birth stories. The presentation of an individual case allowed other members to gain an impression of the thread opener's birth history, which helped to asses her situation.

[422] Münz, http://aktuell.de.selfhtml.org/artikel/gedanken/foren-boards/ (retrieved 07.01.2009).
[423] Münz, http://aktuell.de.selfhtml.org/artikel/gedanken/foren-boards/ (retrieved 07.01.2009).

Within the collected data, the title sometimes contained a question:

> Can I refuse to try VBAC?[424]
> Can you request a CS if the baby is big?[425]
> Wie bekommt Frau den WKS? [How can one put through a caesarean on request?][426]

Alternatively, questions sometimes arose within the opening post:

> What is it going to take for me to get an elective section? What if the consultant says no and forces me to start labour naturally and go through hours of what happened last time?[427]

The desire to gather information was identified as one reason for making a request public. Women often seemed to feel the need to make use of everything that discussions on pregnancy care offered.[428] This could comprise extending their pre-existing knowledge, as well as showing interest in other members' opinions. As threads could attract the attention of a large group of people, it was likely that the opening post would receive replies. It was typical in forums for answers to a thread to be provided by various members, which would lead to diverse opinions and pieces of advice.[429]

However, regardless of the category of the thread – advice, pros vs. cons or report – discussions about caesarean requests usually shared particular characteristics. The boundaries between the thread categories were unclear and conversations contained many personal remarks. Opening posts, however, often indicated an interest in learning about other women's thoughts and experiences. Requests for advice on how to communicate with

[424] Ny20005 (Internet alias) 2007, *Ask A Mum*.
[425] Babs12 (Internet alias) 2005, *Babyworld.*
[426] Birgitt (Internet alias) 2008, *Eltern*.
[427] Jedimum (Internet alias) 2008, *Ask A Mum*.
[428] Katz Rothman 2007, p. 30.
[429] Duttweiler 2008, <11> (meaning section 11, online reference).

medical professionals and to ensure that a request for a caesarean would be granted comprised the most popular posts. In these cases, the user's request had either already been rejected by a consultant, meaning that she was eager to hear positive advice from insiders, or else the thread opener planned to opt for a caesarean and thus wanted to be sure that her wish would be granted.

Replies were usually sympathetic and supportive, often expressing compassion for any user who had mentioned a previous distressing birth experience. In the English forums in particular, members took the thread opener's concerns very seriously. A woman's wish for a caesarean was respected and accepted, and conversations remained friendly even when critics asked the woman to rethink her choice of a surgical delivery. Fellow users shared their own personal tricks, such as "cry a bit"[430] (in front of the consultant) or "[take] your birth story in your own words on paper"[431] as advice for ensuring that a caesarean would be granted. Such practical tips would rarely be found in parenting magazines or medical sources.

What brought the aforementioned members to answer and to get in touch with people they did not know? Discovering similarities in someone's birth story or finding oneself in the same situation (e.g., asking for a caesarean, so that another user might be prompted to open a similar thread) certainly encouraged participation. In the examples above, the users clearly empathised with each other and therefore wanted to share their experiences by adding their own story to a thread. In the example below, women reacted to a fellow user who remembered her previous traumatic delivery and was considering a caesarean:

[430] Discodiva81 (Internet alias) 2007, *Babyworld*.
[431] RDelaney (Internet alias) 2008b, *Babyworld*.

Hun [Honey] we are in the same position.

I can understand how much it must have been worrying you.[432]

However, in addition to sharing similar experiences, the fact that someone gave the impression of being informed – e.g., by the media or a third party – about the situation described was sufficient to prompt further replies. Knowing about something could make users think they are "experts," which could evoke their wish to communicate their knowledge or experience.[433]

6.7.2 Boards' approach to the topic

The evaluation of the titles and content of threads provides an impression of how forums represented the issue of caesarean sections on request. Strikingly, "elective caesareans" acted as a synonym for "caesareans on request";[434] the latter was often used in debates among medical professionals.[435] Therefore, in forums – and in this sense, there was no difference between English and German forums – "elective caesareans" even replaced the medical term, while "planned caesareans" was used to describe caesareans that were scheduled in advance and for medical reasons. As regards perceptions of caesarean deliveries, some users used their own experiences of emergency caesareans to indicate how other women might feel about request caesareans. This represented another instance of various types of caesarean being confused, as users also referred to impaired healing after severe blood loss and to coping with the delivery situation in general (i.e., being overwhelmed by the surgery), as well

[432] Musicfreak (Internet alias) 2007, *Babyworld*.
[433] Duttweiler 2008, <8>.
[434] Sashamystaffie (Internet alias) 2007, *Ask A Mum*.
[435] Paterson-Brown 1998, p. 462

as the emotional recovery.[436] This was particularly noticeable on German boards.

Nevertheless, the discussions distinguished clearly between various types of caesarean. Emergency sections were generally accepted as an adequate reason for surgery. Elective caesareans were not criticised when they were performed due to breech presentation or multiple births – although in connection with breech babies, the use of ECV[437] or natural remedies to make the babies turn by themselves was often recommended. In most discussions, the fear of labour was denied as an acceptable reason; women often stressed that in the first few minutes after having delivered vaginally, they had already forgotten their pain and fear.

Evaluations of caesarean sections on request differed on the German boards. Women in the decision-making stage were often exposed to critical remarks, and threads that even mentioned caesareans by choice often led to disputes over request caesareans in general. If a specific problem was presented, it may not have been referred to again (due to users on the thread drifting away from the topic), as users prioritised discussions about principles.

It can be assumed that participants in German forums were aware of this possible thread development and were therefore more cautious, re-thinking their concerns before starting a thread. Making their questions public involved a risk: that discussions might get out of control. Therefore, it seemed likely that, in forums, the attitudes shown towards caesarean sections on request corresponded with the attitude that users adopted towards women who wanted to opt for this route of delivery. These attitudes also reveal that abdominal childbirth was sometimes viewed as an "inferior" way to give birth

[436] Tobi75 (Internet alias) 2008, *Eltern*.
[437] I.e., trying to turn the baby in the womb to cephalic (head first) presentation.

compared to vaginal delivery, which was often associated with normality. The fact that vaginal birth is considered more natural was almost seen to dictate the way in which a woman should deliver her child. Therefore, caesareans on request were not always considered to constitute a "proper" delivery; instead, they were judged to be an "easy way out" while, on the other hand, as emphasised on the boards, other women described how they had battled for hours with labour pains and birth injuries.[438] Celebrities, by the way, were only mentioned when caesarean sections on request were debated, but they were never referred to in discussion threads about vaginal delivery.

Users who admitted that they planned to give birth by request caesarean or who had already done so had to justify themselves repeatedly, or at least face further enquiries from other users. Sometimes, they were no longer taken seriously or were even laughed at or pitied because their decision was seen to be wrong in the eyes of some other users (this was also depicted visually by emoticons).[439] In extreme situations, replies also alluded to the notion that such women were incapable of being mothers because they would not allow their baby to be born the "normal" (i.e., vaginal) way.[440] As stated by sociologist Isabelle Azoulay, in laypersons' conversations, the qualities of a good mother were often related to how she gave birth, and any support, such as painkillers, would disqualify her.[441]

Thus, on the one hand, participants who were against request caesareans nonetheless stated that they had no problems with emergency sections or the surgical delivery of twins. Emergency caesareans were fully accepted by the online communities because they represented a life-saving

[438] LasseFinn (Internet alias) 2008, *Eltern*.
[439] Sumsemilia (Internet alias) 2003, *Elternforen*.
[440] Anonymous guest user 2007a, *Eltern*.
[441] Azoulay 1998, p. 205.

necessity when vaginal delivery was no longer possible. This was something decided upon by doctors, and as such, the expectant mother had no influence on the mode of giving birth. Consequently, "emergency section mums" were pitied because they had missed the "real" birth event; once again, a reference to vaginal childbirth.

On the other hand, if users admitted that they feared labour and had no idea of what to expect, other participants claimed that this would not justify requesting a caesarean. They sometimes extended their thoughts by stating that caesareans by choice should be prohibited and should only be performed for good reason.[442] According to this opinion, doctors support this mode of delivery simply because it increases a hospital's income (these users emphasised that, compared to vaginal delivery, the costs of caesarean sections are much higher).[443] In addition, these users assumed that caesareans were preferred by obstetricians, not only because they involved routine surgery, but also because they could be planned in advance and thus prevent the need for obstetricians to work additional shifts, an opinion that is shared by the authors of advice books and selected medical publications.[444]

Another major difference was apparent in the discussions: in Britain, it seems to be harder to get one's request for a caesarean granted. (This actually contradicts German obstetrician Volker Lehmann's statement that – at least in the past – British doctors were more generous regarding caesarean indications.[445]) Thus, expectant mothers put a great deal of effort into preparing for consultations and would not give up even if their first attempt was rejected. This may explain why, in forum discussions, their

[442] Anonymous guest user 2007a, *Eltern*.
[443] Sumsemilia (Internet alias) 2003, *Elternforen*.
[444] Churchill 1997, p. 63.
[445] Lehmann 2006, p. 239.

choice was respected by their fellow users and only rarely questioned. The German health system, however, offered a free choice of hospitals, midwives and obstetricians. Boards such as *Eltern* and *Elternforen* often claimed that obtaining a caesarean by choice was relatively easy in Germany and that this route of delivery was perhaps taken for granted in forum debates.

6.8 Frequently asked questions about caesareans

A traumatic previous birth, such as an emergency caesarean or a vaginal delivery with severe perineal trauma and healing complications, was the most common motive for women who were considering requesting a caesarean delivery. Stillbirth represented a particular, taboo topic. It was rare in the English forums for first-time mothers to want to opt for a caesarean. One could argue about whether or not the specific cases discussed in the threads would actually qualify as true caesareans by choice, i.e., those with no medical justification.

In any case, reasons were always linked to individual experiences and expectations. Most of the time, users pointed out complications that had occurred during a previous pregnancy, such as gestational diabetes or a baby in the breech position. Both were accepted as medical reasons for a planned caesarean delivery, and these mothers were unlikely to be turned down when they approached their consultant.[446] A complete absence of medical conditions was rare. One first-time expectant mother, for example, explained her fears about labour and "the unknown" aspect of vaginal delivery,[447] a topic that NICE had written about in its guidelines for caesarean

[446] Shaunsbird (Internet alias) 2005, *Babyworld*; Dudenhausen 2001, p. 80.
[447] Anonymous guest user 2007b, *Eltern*.

sections (2004).[448] According to this institute, the main reason for considering a caesarean on request was that first-time pregnant women in particular could feel uneasy about labour and delivery. The forum threads reflected these assumptions. In NICE's view, mental implications – such as fear or even tokophobia[449] – were acceptable reasons for requesting an abdominal delivery; however, counselling and obtaining a second opinion were recommended.[450] Nonetheless, the latter suggestions were harder to find on the English boards, while in the German online communities, women were often encouraged to rethink their plans. Moreover, replies often reproduced personal views, such as:

> [Ich kann] nicht nachvollziehen, wieso jemand einen WKS möchte.[451]
> [I cannot understand why someone would opt for a caesarean on request.]

Another popular category of advice occurred when women asked other users to assess their case, as they wanted to know whether they would qualify for a request caesarean.[452] Those who replied almost always compared the thread opener's situation with their own experience in order to answer the question.

In other threads, users asked about the best time to have the surgery done, what to take to hospital or how long they would have to stay in hospital.[453] Once again, the answers to these questions varied. It proved hard to deduce from the forum discussions whether, in the end, the answers were considered helpful and put into practice. Thread openers neither led nor

[448] NICE 2004, p. 38.
[449] I.e., fear of childbirth.
[450] NICE 2004, p. 38.
[451] Anonymous guest user 2007b, *Eltern*.
[452] Xhazelx (Internet alias) 2007, *Babyworld*.
[453] Sunshine23 (Internet alias) 2008, *Eltern*.

dominated the follow-up conversations, and they did not necessarily react to the course of the discussion. It is likely that they followed the threads, as initiating a debate is usually a sign of an overall interest in the topic, particularly if the thread was based on personal experience. In some cases, the women expressed relief at finding an opportunity to talk about their distress.

Most threads about caesarean sections on request on the German boards became pros vs. cons debates. Users presented harsh counterarguments based on personal opinions (including negative experiences of emergency caesareans). This also applied, however, to the "pro-request caesarean" users. The statements were mostly only assumptions containing examples from the user's personal life. In both English and German online communities, the impact of the obstetrician's perspective or medical perceptions in general was often overruled by subjective remarks. Instead, individual experiences were considered to be the standard by which to form opinions.

Real pros vs. cons disputes (i.e., threads that were launched as such) were rare in English forums; by contrast, in German forums, they were occasionally initiated as debates on principles. Threads that questioned the social acceptance of caesareans on request could be allocated to this category. These were specific to German boards and aimed to explore the reasons why women's decisions were often questioned, and why mothers had to justify their birth plans. The attitudes shown towards caesareans by choice could be supportive, but also sceptical and hostile. Disputes were much more emotional compared to the English online communities; they could include hot-tempered arguments filled with subjective statements.

Arguments against request caesareans tended to focus on the wellbeing of the baby, which was considered to suffer from being "cut out of the womb" or "delivered unnaturally."[454] Occasionally, these statements were provided by "caesarean-inexperienced" women as well those who could never imagine giving birth surgically. Mental effects were popular topics for discussion, e.g., the negative impact of caesareans on bonding or breastfeeding.[455] Women planning a caesarean on request were often named "controlling" or simply "cowardly."[456]

Groups supporting request caesareans consisted of users who had or would have a caesarean by choice. Often, mothers who had experienced a previous traumatic birth were found amongst these groups. These mothers valued the safety and predictability of planned caesareans, which also included fewer risks for the baby, and took into account that, whether elective (including unwanted caesareans for medical reasons) or on maternal request, the way in which the surgery was performed remained the same.

Similarly, report threads which were intended to narrate an experience without expecting a discussion could transform into lively debates. This shift applied in particular to the German forums; for example, if a woman happily announced her caesarean appointment (not necessarily on request, but elective), the community would enquire about her motives.[457]

6.9 Relation to the medical perspective

Medical discourses played a minor (if any) role on these boards. There was not much contact between the opinions expressed on forums and

[454] LasseFinn (Internet alias) 2008, *Eltern*.
[455] As the mother will have to recover from surgery, sometimes she is unable to breastfeed directly after birth (Mander 2007, p. 128).
[456] LasseFinn (Internet alias) 2008, *Eltern*.
[457] Anonymous guest user 2007c, *Eltern*.

medical viewpoints, made visible by the fact that forums neither referred to medico-professional publications nor seemed to be interested in discussing medical perceptions. References to medical content, such as the NICE guidelines, were rare and did not seem to be of much interest (in *Babyworld*, for example, only one thread enquired as to whether there were any human rights issues regarding request caesareans[458]). Instead, a user's personal experience served as the standard for assessing a problem.

Hence, prior knowledge of medical perceptions was not expected on boards. If threads referred to medical aspects, they were usually embedded in narratives of encounters with obstetricians or in birth-report posts and were therefore, once again, restricted to personal experiences. More general medical findings, however, were often introduced in connection to the disadvantages of abdominal delivery, i.e., as a warning to women. In these cases, users emphasised the surgical aspects of caesareans, such as the necessity of anaesthesia, the longer recover period and other potential impairments for the mother and her baby. Stressing that caesareans on request constituted major surgery (although this applies to every type of caesarean section) was popular in both German and English online communities.

> Und man darf nicht vergessen, es ist eine Bauch-OP![459] [One should not forget that it is abdominal surgery!]

> A section is major surgery after all and I can never understand why anyone would choose to have one unnecessarily.[460]

[458] Heartsease (Internet alias) 2006, *Babyworld*.
[459] Anonymous guest user 2007b, *Eltern*.
[460] Butterfly.Ki$$eZ (Internet alias) 2006, *Babyworld*.

Central themes of medical discourses, such as the patient-doctor relationship or surgical progress regarding improved tissue healing, had less of an impact on forum discussions between laypersons. If mentioned, users commented subjectively on medical statements and focused on moral and ethical views instead, such as a woman's right to make her own choice or the view that caesareans on request should generally not be allowed.

> Ich denke, es sollte jedem frei überlassen sein, zu entscheiden, warum er einen WKS möchte!?[461] [I think that everyone should decide for herself whether she wants a caesarean by choice!?]

> Dass so was in Deutschland nicht verboten ist... *kopfschüttel*[462] [That [caesareans on request] should be banned in Germany… *shakes head*]

6.10 Summary

The topic of caesarean sections on request is still an issue in obstetric discourses and is therefore often associated with debates among medical professionals. However, another important group that is affected by aspects of childbirth is formed of mothers and pregnant women. In order to explore their points of view, threads about caesarean sections on request were analysed on four English- and German-speaking Internet discussion boards. These focused on parenting themes and provided sub-forums in which users discussed the issue of caesarean delivery.

The research on these Internet boards has confirmed that the preparation for childbirth had become an everyday matter for the women involved.[463] The boards indicated which topics were the most popular among women, and statements as well as attitudes could be deduced from online

[461] Anonymous guest user 2007b, *Eltern*.
[462] Sumsemilia (Internet alias) 2003, *Elternforen*.
[463] Paterson-Brown 1998, p. 463.

threads. Furthermore, the platforms demonstrated that caesareans on request are still a popular topic in connection with childbirth issues.

On the online boards, expectant mothers discussed their worries and opinions openly and frankly. They communicated their anxiety in their own words. These online communities, due to their themes relating to parenthood which foster the involvement of peers and related groups, encouraged the women to reveal their concerns but also to disseminate their own experience. However, it should be noted that only a small percentage of women participate in forum discussions, and thus one could say that they represent a minority. Conversations were often emotional and biased because the women referred to their personal experiences. This occurred regardless of the language and nation in which the debate took place.

Caesarean sections were no longer viewed as emergency interventions only; more often, abdominal birth was performed either as planned surgery or was chosen by the woman (maternal request). However, how women perceived caesarean sections on request could differ substantially from what was communicated by obstetricians. Although the term "request caesarean" was generally understood to indicate surgery chosen by the women themselves, forum debates did not always distinguish between the emotional impact of unexpected surgery and surgery that had been chosen voluntarily. In addition, in this context, the discussions only occasionally referred to risks and restricted themselves instead to the benefits or disadvantages, depending on the user’s attitude. As forum participants are normally medical laypersons, misunderstandings of medical issues were not uncommon. However, on the boards, providing an opinion proved to be enough to call oneself an expert.

Moreover, users were likely to report unhappy events and insecurities. A good patient-doctor relationship might be taken for granted and therefore not worth mentioning, but if consultants were introduced in the forums, they were usually criticised. How the women felt about caesarean sections on request was in general closely connected to their perception of the medical profession.

This, and the mothers' perception of request caesareans, can show doctors the areas where further patient education is needed in order to avoid misconceptions, and to develop a better understanding of women's motives and concerns from which both sides would benefit.

7 Putting it all together: A recap of the views of medical professionals and women

This chapter combines what has previously been said about caesarean sections on request: medical and popular scientific statements as well as women's opinions. Thus, it summarises the previous chapters and also leads on to the concluding remarks in Chapter 8. Overall, it aims to construct a comprehensive image out of all of these views, and to explore the interactions of the participating groups. Can any general statements be deduced when medical arguments are joined with those of women?

The previous chapters all concerned different groups participating in the debates, but they all reflected on the same topic: caesareans on request.

Three main statements can be deduced from the material covered by this thesis:

1. Caesareans on request are a current, controversial issue and still in the headlines. Approaches and discussion themes, however, have changed slightly, compared to the time around the turn of the century;
2. Interest in caesarean sections on request was disseminated from the medical professions via media attention to celebrity women and "everyday mothers";
3. This is a multidimensional topic. In addition to the medical field, it affects the emotions as well as social issues.

7.1 What was it all about?

In obstetrics, caesarean sections on request still represent a central topic which has not lost its relevance since it arose during the 1990s. Current debates, however, have obviously shifted. Compared to previous years, they have become more tolerant and open towards this mode of delivery; however, at the same time, they still view caesarean delivery on request as a matter of risk assessment.

Early discussions resembled an orientation stage, during which medicine and research pursued the goal of attaining an overview of caesareans on request as an upcoming mode of delivery. At first, general issues were concerned, such as attempts to define the new phenomenon and its characteristics. However, there was also the question of whether obstetricians should support caesarean delivery by maternal choice. It was not long before superordinate institutions (e.g., professional organisations such as FIGO) recognised the disputes and contributed to debates by publishing guidelines or statements. However, no common sense verdict was achieved on how to deal with request caesareans and the variety of opinions. The question of whether an expectant mother should be allowed to opt for a caesarean birth remained controversial. Moreover, national and international institutions added moral as well as ethical arguments to the debates.

In further stages, expectant mothers also gained attention. Due to the need to involve emotional and ethical considerations, studies began to explore women's motives and reasons for wanting caesareans on request. Thus, other disciplines started to contribute to the discussions. Moreover, patient choice and risk assessment issues were never out of date in the context of childbirth and particularly caesareans on request. This mode of delivery was always viewed as a matter of risk analysis and decision-making.

These two aspects represented a key theme, and moreover they showed that caesareans on request and caesarean delivery in general were considered equal to vaginal birth.

7.1.1 A topic with many dimensions

The overall analysis of the discussions showed that caesareans on request constituted a multidimensional issue involving medical, emotional and socio-cultural aspects. Depending on the discursive environment, emphases were placed differently. The existence and "usage" of caesarean sections on request spread from the medical professions (mainly obstetrics) to celebrities and "everyday" women. It was the survey by Al-Mufti, McCarthy and Fisk which provided evidence in 1996 that a novel mode of delivery existed among obstetricians and moreover that abdominal delivery on request was no longer a brand-new discovery. Various publications had already elaborated on caesarean birth as surgery by choice (e.g., Chamberlain 1993);[464] these publications, however, did not study its practical use but the general option of considering caesarean delivery either as a preventative treatment – upon the recommendation of a doctor – or even on request by the expectant mother. The study by Al-Mufti *et al.* provided another approach to these thoughts by introducing results from clinical practice, albeit more or less accidentally (initially, they had researched obstetricians' personal preferences in terms of prenatal diagnostics). Moreover, the publication made clear that caesareans on request had already been put into practice, at least within the group of obstetricians, as

[464] Chamberlain 1993, p. 403.

well as that a substantial proportion of doctors would consider caesareans on request as a mode of delivery for themselves or their partners.

Due to the publication of the article by Al-Mufti and his colleagues in 1996, it is possible to mark the point in time at which caesareans on request became a topic of debate. It remains, however, unclear when exactly obstetricians had started to actively perform this type of surgery. These areas have not yet been extensively researched or questioned. Of course, there may be opportunities in the future to evaluate clinical patient records, in order to learn more about the actual beginnings of caesarean sections on request and their implementation in obstetric practice. Hospital data, however, are limited: on the one hand, a maternal request has not been an accepted reason to perform a caesarean for long, and on the other hand, it is still difficult to differentiate between elective and request caesareans, because approved medical indications are necessary.

The existence of caesarean sections on request or, more specifically, their clinical application, led to critical statements about whether this sort of choice was justified. In particular, debates expressed concerns about the necessity of an "artificial" alternative to vaginal birth, as giving birth vaginally is natural for every woman. According to publications on these issues, vaginal delivery should be advocated, which meant adhering to existing childbirth paradigms that viewed vaginal birth as the standard mode of delivery. Consequently, caesareans should be avoided and remain as emergency interventions. As the discussions progressed, publications focused increasingly on the risks of vaginal delivery, which were also researched further. Highlighting the possible implications of vaginal birth led researchers to emphasise the benefits of caesarean sections. At this stage in

the debates, the big question of whether caesareans on request were justified was predominantly restricted to medical arguments.

This approach initiated a "battle" between vaginal delivery and caesareans on request, and a number of publications assumed that advocates of the latter wanted it to become equal to vaginal birth and to replace "natural delivery" at some point in time. The grounds for discussions were provided by comparisons of nature and technology, which furthermore resumed the pre-existing critique of the medicalisation of childbirth and the dominance of birth technologies. In addition, the debates emphasised that caesarean delivery had undergone changes; it was no longer only an emergency intervention, but had shifted to become a predictable, safe option that could be planned in advance.

7.2 Caesareans on request and traditional childbirth paradigms

Caesarean sections on request were always linked to the fact that they represented a major surgical procedure. In addition, their main characteristics were congruent with elective caesarean delivery: both types of caesarean were arranged in advance and the expectant mother was able to familiarise herself with the idea of having her baby born surgically. Moreover, they provided enough time for other preparations, such as educating the woman about anaesthesia, surgical procedures and postpartum hospital stay.

7.2.1 Main features

Exploring the main features of caesarean sections on request was closely linked to distinguishing this phenomenon from the other variants of caesarean delivery. The most important characteristic of caesareans by choice was the lack of any medical necessity. Compared to emergency caesareans, those on request did not aim to heal, but represented the doctor doing the mother a favour – meaning at the same time that these interventions were carried out without any clinical justification. This supported critics' view that caesareans on request were superfluous. Nevertheless, another type of indication emerged in relation to surgical delivery: psychological and psychosomatic reasons. These comprised previous negative birth experiences and trauma as well as the fear of childbirth. This type of indication, however, could be interpreted broadly and thus was allocated to the category of relative indications. It was impossible to provide clear diagnoses, as fear, for instance, is a subjective emotion which cannot be measured empirically. For this reason, getting a second opinion was recommended. Psychological indications were often assigned at the doctor's discretion. In addition, there was no clinical evidence, which further complicated the approach to psychosomatic issues of childbirth. Long-term studies were either planned or in progress, and hence the benefits and disadvantages of caesarean sections on request could not yet be proven. However, this did not prevent the participants in debates from spreading their opinions and strengthening their argumentative positions.

What distinguishes caesareans on request from other types of caesarean is that they lack any medical indications. These were generally present in elective and, even more clearly, in emergency caesarean sections,

when even the weakest relative indication was a reason to perform surgery. One particular determinant was, moreover, that the mother approached the doctor with her request; she was therefore the one to initiate the surgery (although the doctor's agreement was required). As regards clinical assessment, there were no differences in the planning and performance of elective and request caesareans. Categorising them as "social" aspects, however, could be problematic, as it can be hard to reconstruct who first brought up the idea of caesarean delivery (the obstetrician or the expectant mother). Researchers also struggled with these facts, and retrospective surveys had many grey zones; mothers did not always remember everything or concealed facts.

Nevertheless, women who opted for a caesarean delivery on request were often healthy and had an uncomplicated pregnancy. There were also cases in which doctors suggested a caesarean, even if the women had not yet brought up the issue but was probably considering abdominal delivery – it became hard to say where elective caesareans ended and where caesareans on request began. In addition, even when mothers-to-be seemed to be healthy and self-confident, they could have experienced trauma during a previous childbirth (or miscarriage, although this has not been researched as fully). There were many reasons behind indications and identifying indications was not easy; however, caesarean sections on request were usually based on relative (psychological) indications.

7.2.2 Definitions

The first attempts to define caesareans on request focused on the lack of medical necessity. Caesarean sections on request, thus, were performed for no medical reason, as well as chosen by the expectant mother. This fundamentally clinical explanation classified request caesareans as representing the doctor doing the mother a favour by fulfilling her demand. While there is a clear term for this mode of delivery in the German language ("Wunschkaiserschnitt" meaning "caesarean section on request"), English-speaking publications caused confusion by using various terms, such as "caesarean on request," "caesarean on demand," "caesarean by choice" or "caesarean for no medical reason." Ultimately, all of these phrases meant the same thing, but in different words. To this day, no generally accepted term has been agreed upon. The impact of the mother's request in particular has proven to be a controversial subject, in connection with psychological indications, as a maternal request was not sufficient on its own. NICE, for example, suggested getting a second opinion or seeking counselling. In Germany, caesareans on request were accepted as a separate mode of delivery and the mother's wish was respected as long as it was adequately communicated, i.e., under the condition of informed consent.

Obstetric practice, however, may have differed from standard indications and may instead have assessed cases on an individual basis. No studies questioned obstetricians about how they understood caesarean sections on request and how they would define them.

7.2.3 High-level institutions, moral and ethics

The opinions of high-level institutes, i.e., international organisations such as the WHO and professional associations including FIGO and the DGGG, should play a major role in debates about caesareans on request. For a long time, the *Fortaleza Declaration*, published by the WHO in 1985, was the only statement of its kind with regard to the topic of birth technology. Hence, the paper achieved a kind of hegemony. Critics of caesareans on request often quoted the publication in order to demonstrate that caesareans by choice were not justified and not at all necessary, as the Declaration recommended a maximum overall caesarean rate of 15%. This, however, was already being exceeded by many Western countries when debates on request caesareans began. In the view of critics, capacities for caesarean delivery were thus exhausted, and the rise in caesareans was far from being beneficial (according to the argumentation of the WHO). It was, however, generally ignored that the Declaration had been published in 1985 – approximately 11 years before caesareans on request had started to gain any attention. Moreover, the paper was never updated, which was why supporters of request caesareans, such as German lawyer and medical ethicist Markus, declared the WHO paper void (2006), as it had been published too long before caesareans on request became an issue.

A more contemporary statement was published in 1998 by the international obstetricians' federation FIGO, finally linking medicine and ethics in the context of "caesarean delivery for nonmedical reasons." Thus, FIGO openly addressed the ethical aspects of caesareans on request. According to the federation, caesareans by choice were inconsistent with the ethos of healing, which each doctor was committed to, and this was why this mode of delivery lacked any medical justification. FIGO distanced itself from

the new attitude of some obstetricians who performed caesareans on maternal request and without medical justification. The federation, however, expressed that it was prepared to revise its statements, should new evidence arise confirming the benefits of caesareans on request. However, until then, vaginal delivery should be assumed to be the safest way to give birth. FIGO asked obstetricians to reconsider their attitudes.

It was striking that, for FIGO, medical evidence determined their position and influenced their statements, even those on ethical issues. This showed clearly that caesarean sections on request were no longer an exclusively medical topic.

Ethical considerations had an impact on the NICE guidelines as well, which came out in 2004. This guidance recommended questioning the mother's reasons for requesting a caesarean, and having them confirmed by a second opinion. NICE did not respect a maternal request as the sole determining reason for a caesarean. As an institute which also had to take NHS budgets into consideration, NICE quickly recognised that the rise in caesarean section rates would lead to increasing costs. Similarly to other clinical fields, obstetricians also had to budget their expenses and avoid interventions which at first glance seemed to be unnecessary. Counselling was not intended to make women change their mind, but the notion that they would rethink their motives made the NICE guidance seem slightly disrespectful of women's decisions. NICE's own goal of cutting expenses was probably more important to them than helping mothers-to-be to experience their self-determined birth event.

Similarly to NICE, the scope of which was restricted to the "NHS zone," the statement by the DGGG (2008) was also bound to its national

sphere of action. The DGGG handled the issue of caesareans on request in a fairly liberal manner. It fully respected the mother's wish, as well as psychological indications. The DGGG publication was characterised by its detailed statements; it explained the term "caesarean section on request" and also assessed the legal situation in Germany. Based on this extensive presentation, the DGGG concluded that caesareans on request were morally and medically justified, as long as the woman was healthy and aware of all the risks involved. Moreover, the DGGG refuted the argument that caesareans on request were performed for defensive reasons by, for instance, pointing out that (in Germany) obstetricians were not allowed to be the first to mention the option of request caesareans, before the mother herself considered this mode of delivery. Doctors, therefore, had to refrain from recommending caesareans.

7.3 Women's reasons and the search for causes

Caesareans on request involved two groups: pregnant women and obstetricians. However, for a long time, research on the role of the mother-to-be was neglected. Only in the context of researching causes did recent studies begin to enquire into women's motives as well. Previously, publications had focused primarily on the medical environment and thus reproduced obstetricians' attitudes and opinions.

The study by Al-Mufti, McCarthy and Fisk (1996) presented a good example; indeed, the authors mentioned women's personal reasons for requesting caesareans, but they chose only medical professionals for their survey. Other publications following this study also only took the opinions of doctors into consideration and discussed caesareans on request in the

context of obstetric practice. Not much was revealed about the patient's shift to being a mature partner who participated in the decision-making process. Women were not mentioned concerning anything that went beyond communicating their request for a caesarean delivery. Their thoughts and emotions were not topics of interest. However, by including emotional and social aspects in debates, research began increasingly to notice mothers-to-be, as well as their leading role as active participants in issues concerning request caesareans.

The motives of both groups (obstetricians and women), were fairly similar. Once again, safety and predictability played important roles, which indicated again that caesarean sections on request were strongly associated with risk assessment and control. As the performance of the surgery was always the same, women and doctors knew what to expect, with no exceptions. Information was easily to gather, while, in contrast, statements on the course of vaginal birth could differ substantially. Advice books, for instance, used to reproduce an ideal, complication-free version of the stages of vaginal delivery, while referring only marginally to its possible risks. Knowing about the surgical procedure, which was always identical, allowed both parties to experience less stress in terms of the upcoming birth event.

Other reasons for caesareans on request mainly resumed what Al-Mufti, McCarthy and Fisk had found in 1996. Years later, the main statements of their study were confirmed once again. Doctors emphasised that the safety of caesarean delivery had increased and that the surgery had become more reliable, thanks to technological and medical advances. The risks were low and comparable to those of vaginal delivery. The fact that caesareans bypassed birth injuries was also viewed as a substantial benefit;

once again, doctors seriously considered women's concerns and their worries regarding sexual and overall wellbeing after delivery. In addition, according to some articles, caesareans on request could furthermore avoid severe emotional birth trauma, e.g., long labour and emergency caesareans, as well as assisting experienced mothers to overcome negative memories. "Risk groups," i.e., women who presented a higher risk of possible complications during childbirth, according to their consultants' opinion, were recommended to give birth by caesarean. However, as this type of caesarean section was not always voluntary or desired by the mother-to-be, but initiated for medical reasons, it could not be compared to actual caesareans on request.

7.3.1 A matter of risks

The concept of "risk" also experienced a shift in how it was perceived. Sociologist Deborah Lupton (1999) noticed that risk had become something that was applied to everyday situations and even used as a colloquial term.[465] Consequently, the term "risk" is now frequently used as a synonym for "danger" and is also applied to personal (i.e., subjective) perceptions. For a long time, however, risk referred to natural powers, such as tornadoes or flooding – forces that could not be controlled by humans.[466] However, in today's modern age, risk is also associated with technology and controlling certain events.[467] Childbirth has certainly become one of these events, as it was often stressed by critics of caesareans on request that childbirth used to rely on a woman's natural powers.[468] According to Lupton, the general

[465] Lupton 1999, p. 5.
[466] Lupton 1999, p. 5.
[467] Lupton 1999, p. 7.
[468] E.g., Schücking 2001, p. 194.

meaning of risk implies that the result of a situation may not match expectations ("negative or undesirable outcomes, not positive outcomes"[469]). This is the case for caesareans on request: mothers aim for a healthy baby, which symbolises the best possible outcome. Relying on the unpredictability of vaginal delivery seems impossible. Taking a risk (i.e., requesting a caesarean) means that the expected benefits of this decision would outweigh the disadvantages, but it is not guaranteed that the situation would become dangerous, nor that the benefits will actually occur – however, they exist, if only in theory.

7.3.2 The impact of risk assessment and research into the benefits and disadvantages for obstetric practice

From a clinical viewpoint, there were certainly benefits of request caesareans, particularly for a healthy woman who did not plan to become pregnant again.[470] From a psychological viewpoint, it was noted that caesareans by choice could prevent negative birth experiences. Feelings of unease due to unknown and unpredictable situations, such as vaginal delivery, were, however, not uncommon, and many expectant mothers felt uncertain about childbirth. Thus, mixed feelings were considered to be fairly normal. There were, however, women who did not respond to counselling and who were not prepared to overcome their fears. This so-called tokophobia – the medical term for the fear of childbirth – was an accepted psychological indication and often sufficient justification to initiate a caesarean on request. However, for obstetricians, the mental state of women was hard to assess and even harder to diagnose. Moreover, women had to

[469] Lupton 1999, p. 8.
[470] The risk of scarring with regard to the womb, which was said to impair further pregnancies by increasing the possibility of spontaneous abortion, had not been extensively researched when this thesis was written up.

deal with many other issues which influenced their decision-making and which could cause further uncertainty. In addition to their immediate environment (family and friends, but also doctors and midwives), the media and popular science (advice books) expressed their interest in childbirth issues and often addressed women's feelings. Women learned about celebrity mothers who had delivered by caesarean on request, while popular scientific publications addressed the issue in a personal and sometimes subjective way, aiming to deliver a particular image of request caesareans as a lifestyle event.

Doctors, it seemed, ignored these kinds of publications and the mass media. They had to defend themselves against presumptions of defensive medicine, an attitude which aimed to minimise risks and avoid them in advance. As these attributes matched caesareans on request, critics claimed that this mode of delivery represented a purely preventative – and thus unnecessary – procedure, resulting from a defensive attitude. Obstetricians would only agree to caesareans on request in order to escape litigation (which could affect them financially as well as their or the hospital's reputation). Therefore, the reasons for exploring the attitude of obstetricians were complex. Training and experience were other important aspects, as they could also determine an obstetrician's reaction towards caesarean sections on request. Some studies stated that young obstetricians were probably better acquainted with surgical performances than complicated vaginal births, such as breech deliveries.[471]

Obviously, various factors were involved. In addition to the underlying medical circumstances (including the chosen hospital), personal conditions

[471] The consultant's gender (although not a topic of this thesis) may also have had an impact; diverse publications assumed that male doctors generally had a stronger interest in technology and were thus more open-minded in terms of caesareans on request.

and individual reasons were taken into account in the decision-making process. Based on these factors, risk assessment could take place. In a more comprehensive, broader view, different health systems played a role as well, because only within these borders – set by various health policies – could decisions be made. Hence, how doctors and women dealt with caesareans on request was ultimately a matter of a country's health system.

While this thesis was still in progress (i.e., after 2008), no new evidence regarding the benefits and disadvantages of caesareans on request or the comparison of vaginal birth and request caesareans was delivered; that is, the statements mentioned in the publications in question were bound to what was said in those texts. Arguments against caesareans on request also stayed the same. Clinically speaking, critics often stressed that in spite of medical advances and decreased mortality rates, caesarean sections still entailed all of the risks of abdominal surgery, because they constituted surgery. In particular, they referred to the woman’s state of health afterwards, which could mean long-term sequelae (e.g., troubles with scarring or healing, difficult further pregnancies) but also psychological implications, such as bonding with the newborn.

Discourses among mothers showed furthermore that many women transferred their negative feelings in connection with emergency caesareans to caesareans on maternal request. In this way, they compared an unplanned and possibly unwanted situation with a requested and planned event. While women referred to their own experiences, obstetricians aimed to apply a theoretical approach, e.g., by evaluating the scope of patient autonomy and doctors’ responsibility in order to apply their findings in practice at a later point in time.

In spite of this, obstetricians as well as women also voiced their doubts about whether requests for caesareans should be taken seriously, a topic which was also addressed by studies about the reasons behind caesareans by choice: in these studies, women had their say, and talked about their concerns and expectations. Suggestions such as those expressed by NICE regarding second opinions and counselling added to the fact that requests for a caesarean delivery may not be fully accepted nor justified. These initial, hardened positions still exist. In recent years, however, caesareans on request have been increasingly tolerated. A neutral group has formed, including women who would never opt for a caesarean themselves but who, on the other hand, do not judge other mothers. The more motives were found, the more sympathy developed. It became clear, particularly in debates among women, that mothers-to-be did not choose a caesarean delivery because they wanted a particular birthday for their baby, or out of vanity or convenience. Women dared to talk about their individual reasons, which evoked positive feedback.

Nowadays, everyone has at least heard that there is such a mode of delivery as a caesarean section on request. Acceptance has increased, and so has tolerance. Caesareans by choice are no longer a taboo, let alone a myth. As more and more "everyday" (non-celebrity) mothers started talking about their experiences, the topic became an issue addressed by "normal people" too; it became closer to the hearts of everyday women. On the one hand, this demonstrates that caesareans on request are an option for everyday mothers as well, while on the other hand, the issue has become a common part of modern, contemporary obstetrics.

7.3.3 Causes and reasons

Caesarean sections on request were often linked to the overall increase in caesareans. Critics claimed that caesareans by choice had contributed to the rise in caesarean rates, but studies could not confirm this assumption. However, the increase in elective caesareans in connection with the decrease in emergency surgeries was a fact, which signified that caesareans were being scheduled in advance, instead of reserved for emergency cases. Doctors had adapted to obstetric developments. At this point in time, they favoured the reliability of predictable surgery over the uncertainties of a (probably complicated) vaginal birth. Planned caesareans entailed less risk than emergency surgeries. Due to medico-technological advances, surgical procedures had become safer. As a result of this, mortality rates associated with caesarean delivery decreased. Under certain conditions (complication-free surgery performed on a healthy woman), the risks were similar to those of a vaginal birth in terms of their impact. Instead of general anaesthesia, epidurals became standard and new surgical techniques accelerated tissue healing and thus reduced the overall healing period. Moreover, hospitals supported bonding, so that the mother could hold her baby immediately after delivery.

Statistics regarding caesareans only reflected changes in obstetrics. Doctors had adopted a more liberal attitude towards caesarean sections, which had led to an extension of indications, and particularly relative ones. Also called "weak indications," these had previously been restricted to medical aspects (twin delivery, breech position, fetal or maternal distress), and later considered psychological issues as well. They generally allowed a more flexible and broader interpretation. Outside of the clinical viewpoint, the impact of patient choice had increased. Mothers could inform themselves

about medical issues via the Internet or popular scientific advice books; the general public had access to expert medical knowledge for the first time. Expectant mothers were better educated and had learned about their rights as a patient; however, being medical laypersons, they sometimes felt overwhelmed by this amount of information and the decision-making process.

7.3.3.1 Patient autonomy

The entire debate on caesarean sections on request contained references to patient autonomy, and patient choice was therefore one of the key issues. Patient autonomy – which replaced the previous paternalistic patient-doctor relationship[472] – created a link between obstetricians and expectant mothers, and it also connected clinical approaches with medical laypersons' views, as well as with the generally emotional topic of childbirth. Patient choice (involving the mother-to-be in decisions) had not always been an option. In former times, women trusted their doctors' recommendations. They may also have felt safe, considering the experience of medical professionals, and that may be why they did not see any reason for questioning a doctor's opinion and challenging medical expertise.

In 1993, *Changing Childbirth* aimed to support expectant mothers' rights. The report emphasised the concept of choice in general. Later publications which focused exclusively on caesareans on request clearly linked choice to patient autonomy, and in caesareans on request, they found one way of demonstrating patient choice. However, it was the issue of safety – which had resulted from the decreased risk of surgery – which allowed this choice to be put into practice. As long as the mortality and morbidity rates of

[472] Nessa/Malterud 1998, p. 394.

caesareans were still unreasonably high, patient autonomy with regard to opting for a certain mode of delivery did not represent an option.

In their argumentation and to emphasise their wish, women thus referred to their right to self-determination and patient autonomy. Most obstetricians agreed to this. Informed consent and an awareness of any benefits and disadvantages of the requested surgery, however, was an absolute precondition to making a proper decision. Moreover, patient autonomy comprised more than just patient rights; first, it required "mental competence,"[473] to quote medical ethicists John Nessa and Kirsti Malterud. Women needed to be aware of what their decision meant and its possible consequences. Above all, they still depended on the obstetrician's agreement. The expectations of mothers and doctors could differ substantially. This procedure expressed that patient autonomy had its limits, and in addition, the condition of being "fully informed" was often not fulfilled (although surgery was performed anyway).

Women themselves remarked that they did not receive extensive information or that they did not understand everything they had been told, especially when doctors used medical terms. In most cases, there was not enough time for detailed and individual consultations. Additional information, often gathered by the women themselves, could cause further confusion, because of the amount of information and its origins in popular scientific sources, which did not always reproduce medical facts correctly. Thus, it could become difficult to realise "informed consent" in practice, even when it is the goal.

[473] Nessa/Malterud 1998, p. 397.

7.3.3.2 Defensive medicine

The practice of defensive medicine, as well as the preventative attitudes of obstetricians, also attracted attention. The field of obstetrics was confronted with an increasing number of lawsuits. Patients no longer hesitated to bring an action against malpractice, and doctors could not protect themselves fully against litigation. They could, however, try to mitigate specific risks in advance by performing a caesarean. This preventive attitude was termed "defensive medicine." At first, it was limited to preferring elective caesareans instead of risking emergency ones.

It was often claimed in various publications that caesareans on request were a defensive procedure. Taking into account their predictability and the reduction in lawsuits, this may be true. However, the defensive attitude of doctors in terms of caesareans on request was realistically a passive one, because they had only to agree to a request proposed by the expectant mother. However, this changed nothing in relation to the preventative aims mentioned above.

It is not clear whether caesareans on request contributed to a reduction in the number of malpractice suits. On the one hand, this is because of the lack of adequate studies, while on the other hand, in retrospect, it is difficult to assess whether the dreaded emergency case would actually have happened – an alternative attempt to deliver vaginally would not always result in complications.

Patient autonomy and defensive medicine were reflected in risk assessment. In their change of attitude, doctors began to respect patient autonomy, even though this meant that they could be accused of maintaining a defensive position. Women made their decision by considering the option

associated with the lower risk. Decision-making processes in the context of caesarean sections on request therefore always contained the study of risks.

7.4 Dissemination via obstetrics, the media and expectant mothers

It can be deduced from the "biography" of caesarean sections on request that discussions were at first limited to obstetrics, before they extended to other medical fields. Of course, the medical professionals who dealt with childbirth issues first-hand and who performed caesarean deliveries (obstetricians) were the first to learn about caesarean sections on request. This clinical discipline was (according to the study by Al-Mufti, McCarthy and Fisk) best acquainted with the benefits and disadvantages of any mode of delivery. In addition, obstetricians were also better informed with regard to advances in their field. This is why Al-Mufti *et al.* trusted in their competent decision-making.

Since Al-Mufti and his colleagues announced their survey in *The Lancet* in a letter to the editor, other medical disciplines have also paid attention to this new mode of birth (caesarean sections on request). The first step towards the generation of interdisciplinary debates and the dissemination of information about the subject had been taken. It was not long before caesareans on request were no longer an issue which was exclusive to obstetrics. In particular, in the context of ethical approaches and psychosocial considerations, other disciplines such as the social sciences joined in. Journals published articles about caesareans on request, either as the main or a side issue, and the phenomenon was discussed from various angles.

From journals, the topic spread to medical newspapers (such as *Deutsches Ärzteblatt*). These were also accessible to medical laypersons, for example, via the Internet. The daily press had also heard of caesareans on request and often republished statements from medical newspapers. Magazines and other media, such as television programmes, also reported on caesareans by choice, and the general public heard about this mode of delivery. Headlines about celebrity mothers who had given birth by caesarean on request stirred emotions. The popularity of these women attracted readers (and viewers), as they were interested in news about their favourite celebrity and not necessarily in medical statements. Nevertheless, the mode of delivery gained attention, as caesareans on request were something exotic and extraordinary. Moreover, family planning, pregnancy and birth appealed to almost everyone – a new topic for a broader public was found. In a more specialised and smaller environment, parenting magazines reported on abdominal delivery on maternal request. Popular scientific advice books also addressed the topic.

Some women exchanged their thoughts via the Internet, having gathered information from advice books. These popular scientific advice publications generally aimed to provide a basic overview of the issue and general information. Many women felt that they did not learn everything they needed to know about choice and delivery modes from their consultants. Thus, they sought further information by themselves, and the Internet served as an alternative information source. Moreover, from the mid-1990s onwards, it started to become a powerful communication tool. In addition to general and specialised platforms on health issues, expectant mothers consulted online discussion boards. In the context of these boards, they had a double

role: they were looking for information and providing it at the same time, by talking about their own experience and spreading their opinions.

While the general press, including parenting magazines, were eager to communicate their statements in a comprehensive and simplified style, online debates were different. The participants in forum discussions let their minds wander and unleashed their thoughts. Discussion threads often lacked structure and topics drifted away from the initial subject. Nobody minded about whether statements were correct, particularly when medical information was concerned; nothing that was written down in forums was verified. "Expert" was also a relative term on boards. Anyone who provided information or pretended to know something counted as an expert. In these laypersons' debates, medical expert knowledge did not play a role.

Moreover, by consulting the Internet, women had access to international sources. They were no longer bound to national debates and found themselves able to access a variety of information which they would not have found in their immediate environment. However, as women were often restricted by language issues, they tended to stay loyal to national boards conducted in their mother tongue. Cultural differences became obvious in international (i.e., English-speaking) forums, particularly when respective health services were concerned.

At the beginning of the 21st century, the Internet and celebrity magazines made a substantial contribution to the dissemination of information on caesareans on request. However, in the next step, this led to the development that, at one point, caesareans by choice were no longer unusual, even though women still had to justify their decision. However, the volume of critical remarks decreased and they became gentler; people

reflected on their opinion as more information became available about caesarean sections on request. However, at the same time, the number of debates – many of them hot-tempered – gave the impression that request caesareans in high demand. This was not true, as statistics revealed; in fact, only the popularity of the topic had risen considerably, while the percentage of surgeries was still relatively low.

7.5 The dimensions of caesarean sections on request

As an interdisciplinary topic, caesareans on request have affected various fields of debate. In the medical context, primarily clinical evidence has been applied, such as the preparation for and performance of surgery, techniques, advantages and disadvantages and indications – all clinical aspects. This area is definitely related to the medical profession and entails obstetric issues.

Mothers too were interested in medical topics; however, most of the time, the information they could access was limited. Women's approach to caesareans on request was characterised by an emotional attitude, probably because they did not know much about the clinical context. The social sciences (anthropology, psychology) in particular used to describe childbirth as a very emotional event, challenging not only to the mother-to-be but also to her future plans. These disciplines said that after giving birth, relationships were redefined. Thus, many factors affect young and expectant mothers. Advice books in particular, as well as the Internet (discussion boards and parenting platforms) referred to the postpartum emotional state.

On the other hand, very little was known about how obstetricians felt with regard to caesarean sections on request. Journals reported internal

conflicts between the medical ethos that doctors should never harm their patients and obstetricians' personal attitudes towards caesareans on request. On Internet boards, which discussed many topics openly, the participants did not show any interest in the emotional state of doctors, but focused on their own concerns.

The social and cultural dimensions of request caesareans were fairly complex. They covered an enormous range of people, going beyond obstetricians and mothers. The cultural environment and what it offered determined how caesareans on request were viewed. This environment comprised general attitudes towards technology and advances (including ways of thinking and traditions), but also health policies and their range and limitations. As with every medical intervention, caesareans on request had a superordinated power – ultimately, the borders of the health system determined what was possible, permissible and ethically justifiable. Patient autonomy, thus, had its limitations, the moment a request for a caesarean was rejected or referred for a second opinion. Thus, there was a notably different approach to the issue by women in Britain and Germany. Cultural differences became more obvious as a result of the comparison of online discussion boards. Participants, however, did not refer to them deliberately, but they could be deduced from their experiences, which happened within a particular health system. This was normally the country in which they lived and acted. Cultural borders were recognised, as soon as the comparison showed that attitudes in Germany were more critical than in Britain – at the same time, it was harder to have a caesarean request granted in Britain.

How childbirth was planned reflected the state of a society, a topic that was not generally neglected by publications on request caesareans. In one of

her articles, *Telegraph* journalist Julia Llewellyn Smith quoted British historian Tina Cassidy (2008), who confirmed that the way in which childbirth was viewed depended on the era. History showed that it was, moreover, often a matter of power and politics, referring once again to health policies.[474] The state in the mid-1990s was characterised by a high desire for safety and control, but also by convenience and technology. There was a concrete moment for starting a family, and childbirth should fit into this framework. Plannability and protection against risks were significant issues for society; the way in which society dealt with childbirth, and particularly caesareans on request, reflected this attitude.

7.6 Closing remarks

As social structures and behaviour undergo shifts, what can be said about caesareans on request as a fashion? As this mode of delivery appeared fairly frequently in various media and because of hot-tempered controversies, caesareans on request represented a trend topic. However, as with any fashion, the level of attention decreased in time. This applied to celebrity media in particular, while medical research continued to carry out its studies. However, at a certain point in time, caesarean sections on request were no longer viewed as something extraordinary. Even though they were still considered as being far from "normal" (or socially accepted), as the controversies did not come to a halt, they caused less of a stir. More neutral reactions as well as the amount of information available contributed to this development. Caesareans on request received less attention, and society experienced a kind of "saturation" as regards the topic, while reflecting on the

[474] Llewellyn Smith 2008, no page numbers given.

facts that had already been disseminated. New evidence and arguments were not yet available. Vaginal delivery and caesareans on request existed in parallel to one another; the latter had gained acceptance, at least in part.

From the articles and forum debates discussed in this thesis, it became clear that women considered their choice thoroughly and that it was sometimes hard for them to come to a decision. Thus, in the decision-making process, they considered many possible situations, which did not confirm that caesareans on request were only a fashion, or that expectant mothers were naïve followers.

Moreover, and due to social changes, it became clear that caesareans on request represented the final stage (thus far) of obstetric advances. Beyond the mother's decision as to how she wanted to give birth, there were no further choices. After elective caesareans, there were caesareans on request. Their safety and predictability corresponded to the needs of society at the time.

The broader context showed that the way in which the phenomenon of request caesareans was handled was always restricted to the health system of the relevant country, i.e., doctors and their attitude towards technology and medicalisation, and also the patient-doctor relationship, which expressed the scope of patient autonomy. Moreover, the budgeting of clinical services under the state-controlled NHS differed from German health economy policies, which were dominated by a choice of health insurance companies. States' attitudes regarding litigation revealed a similar situation, as well as doctors' training and the resulting experience.

Personal factors which influenced approaches to caesareans on request included views of birth paradigms and whether people were open-

minded towards the unknown and advances. Advocates of caesareans on request used to criticise the current state of the art. Personal attitudes depended on the degree of information which an individual had received, but also on his or her biography, experiences and expectations.

Thus, there was no "universal" mode of delivery which could be achieved and which would involve the same benefits and disadvantages for every woman. However, the start of the 21st century was characterised by the fact that women could choose between modes of delivery, and they put a great deal of effort into reaching a decision. Caesareans on request were a characteristic feature of this time.

8 The hypotheses revisited

Ultimately, changes evoked the adaptation of obstetric behaviour. Doctors revised their practice, and expectant mothers reacted to this as well. To close, let us revisit the hypotheses which were mentioned at the beginning of this thesis and examine them in light of the findings.

8.1 Caesareans experienced a shift from emergency interventions to surgery by choice

This was one major aspect which ensured that caesareans on request were made possible. Without the medical prerequisites – the provision of safety and caesarean delivery as a routine surgical technique – it would not have been possible to transfer decision-making power to women. However, it was a struggle for caesareans to free themselves of the attribute of emergency interventions. Nevertheless, they did so, meaning that they could be scheduled in advance, first on recommendation by doctors and later at the request of expectant mothers.

Looking back at these changes, the shift from elective caesareans to those on maternal request in particular did not take too long. When Al-Mufti, McCarthy and Fisk, three obstetricians from London, devised their survey in the mid-1990s, caesarean sections were no longer reserved for emergency cases only. Only a few decades previously, caesareans had been a matter for critical situations only. However, surgery was not without its risks, taking into account general anaesthesia and possible bleeding; this is why every effort was made to avoid caesarean sections.

Of course, indications that abdominal surgery should be performed immediately when there was a real danger to the mother or her baby still existed when caesareans on request became part of obstetric disputes, but other factors which could be diagnosed long before the onset of labour and which made it necessary to schedule a caesarean in advance were then being considered as well.

As clinical conditions had improved, obstetricians became more confident in scheduling surgeries in advance, by referring to relative indications. This was said to be less stressful for the mother, with a lesser emotional impact (she was mentally prepared for surgery, instead of surprised by a possible emergency intervention). As emergency caesareans always contained more risks than planned ones, there were good reasons to prefer elective caesareans when risks were foreseeable in time.

This resulted in an increase in planned surgeries, while the rate of emergency caesareans decreased. At the same time, there was a general rise in caesarean sections from the 1990s onwards. However, the step from elective to request caesareans had not yet been taken.

Planned caesareans were rated by obstetricians as entailing fewer risks and being safer, meaning that risks were estimated to be under control. Due to the reliability of elective caesareans, it was no longer unrealistic to consider performing them for preventative reasons, i.e., without an obvious medical need, but because complications may still occur in theory. The subsequent developments are discussed in Chapter 2 – in 1996, Al-Mufti *et al.* extended these thoughts by discovering maternal requests. Thus, the shift in caesareans from one variant to another was confirmed and addressed in medical debates. It became obvious that caesareans had become an "on

demand" service which did not require medical conditions, but which were grounded instead on maternal wishes and patient autonomy. Caesareans on request existed – and still exist – in parallel to other types of caesarean, i.e., elective and emergency caesareans.

What were the preconditions for caesareans on request? Technological developments can be assessed by their progress and how they advance. Changes in birth technologies allowed a better performance (quicker and less severe) and, as a result, the recovery period decreased. However, they also led to the revision of indication catalogues and their adaptation to new circumstances. The extension of (mainly relative) indications happened step-by-step; first, certain risk factors were included (such as breech position), in order to ensure a medically complication-free pregnancy later on, as well as psychological implications, such as birth traumas.

When the performance of caesareans became routine (as regards surgical skills), this finally had an effect on obstetric practice as well, which was shown in the rise in caesarean deliveries. The proportion of surgeries on request, however, remained unclear. It was hard to reconstruct from statistics whether a caesarean had been requested by the mother or whether it was recommended by the doctor based on relative indications.

Moreover, patient autonomy had gained greater influence. Expectant mothers knew their rights and seized the opportunity to take part in decisions or, at least, to approach consultants with their expectations. Thus, they too had a share in the shift in obstetric behaviour and the development that caesareans on request became another mode of delivery.

8.2 Caesareans on request are preventive surgery

In general, the purpose of caesarean sections on request was to avoid dangerous situations which had thus far existed only in theory, i.e., they had not yet occurred. Thus, it was not about real, actual events. Therefore, caesareans on request can be classified as preventative surgery. When risks were assessed, caesareans on request referred to potential complications – whether these would actually happen was not known. For this reason, surgeries could not take place under medical indications, as where there was no immediate danger, medical indications could not be employed. Caesareans on request were, in fact, clinically unjustified.

The situation differed with regard to psychological circumstances. As we can deduce from the forum debates shown in Chapter 6, the presumptions of medical studies were confirmed: expectant mothers worried about their unborn child's health and wellbeing, but also about their own state of emotional and physical health. Before they came to a decision, they experienced insecurity and fear, but they also assessed risks. However, as caesareans on request had no medical justification, the decision could only be based on psychological indications. These comprised the pregnant woman's emotional state, as well as the comparison of theoretical threats to the real benefits of a caesarean delivery as grounds for decision-making – therefore, the decision was based on a fictional risk situation.

Thus, criticism of the financing of caesareans on request by public sources was partially justified because of unclear (in this context, nonmedical) indications. Nevertheless, the actual benefits of caesarean delivery played a substantial role because they outweighed the particularly heavy sequelae of vaginal birth. Although caesareans on request may not always have been necessary, they were always given as an option.

Psychological indications, therefore, were no more than a theoretical approach to potential implications.

8.3 The change in attitudes towards risk represents another precondition for caesarean sections on request

The fact that the perception of risks had changed proved to be beneficial for caesareans on request. In this context, the improved safety of the surgery and its preventative use played a role, in connection with the general predictability of its outcome. The desire for safety had risen for both obstetricians and mothers-to-be. Chapter 4 showed that doctors wanted to protect themselves against litigation, as patients' instinct to shy away from malpractice suits had lessened. Lawsuits, therefore, presented a considerable risk. Doctors thought that the potential complications of caesareans were easier to control.

Women worried increasingly about their postpartum emotional state and physical integrity, and how they would probably be affected by giving birth vaginally. Opting for a caesarean could mean a "solution," or at least predictability. In addition, obstetricians stated that there were particularly few risks with healthy young women. The tolerance of risks, therefore, had notably decreased. In contrast, there was a stronger need to feel safe.

Nevertheless, it should not be ignored that choosing a caesarean section involved the risks inherent in deliberately accepting surgery. It implied that – as previously mentioned when reflecting on caesareans on request as preventative surgery – the result of the individual risk assessment was in favour of a caesarean birth, i.e., for the expectant mother, a caesarean would be more beneficial than a vaginal delivery.

8.4 Attitudes towards childbirth and modes of delivery have also changed

There was a paradigm shift regarding childbirth issues. Caesareans involved fewer risks and were better to plan; their implications could partially be compared to those of vaginal birth. At the same time, advances in the performance of caesareans showed that vaginal delivery contained risks. These risks, e.g., birth injuries or prolonged labour, were increasingly discussed in obstetrics, resulting in vaginal birth being associated with risks and unpredictability. Caesareans on request, however, allowed mothers to decide for themselves which risks they were willing to accept. Planning, control and safety no longer applied to pregnancy only, but had been extended to childbirth issues as well.

At the turn of the century, expectant mothers wanted to know what to expect from childbirth and they wanted to be sure. The surgical process of caesareans had always been the same, and the operation itself had become safer, which contributed to the fact that doctors as well as women were less critical with regard to abdominal delivery. Caesareans gained popularity, at the expense of vaginal birth. This had long been the standard birth mode. However, it was no longer to be achieved at any cost.

However, changes in paradigms were not new to the history of childbirth. Obstetrics is characterised by advances, which have recently been expressed by technology and medicalisation, but also by precautions, when caesareans on request became a topic of debate in the mid-1990s.

However, the development of caesareans could also represent the next logical step in the progression of this mode of delivery. At first, caesareans on request were observed sceptically because they represented a change and a challenge to tradition. However, as the debates progressed

and more information became available, maternal requests gained acceptance. Controversies, it seemed, were based on the lack of medical justification, which nourished doubts regarding the necessity of the surgery. However, it should be taken into account that caesareans on request did not aim to be an alternative to vaginal birth or to push aside vaginal delivery. However, maternal request became a possible option.

9 Conclusions

Why has this thesis been carried out, and what can we learn from it? This is certainly a good question to ask at the end of my approach to caesarean sections on request. The reason why I chose caesarean sections on request as a research topic was because I thought that it deserved more attention, as there were not many publications on caesareans on maternal request when I started my PhD (this applied especially to monographs and textbooks). This has changed in the meantime; the evidence is plain in advice books on pregnancy. However, although everyone (or at least, every expectant mother) now seems to have heard of caesareans on request, there are still many different definitions and opinions – and misconceptions.

Moreover, it seemed interesting that there was such a great stir about childbirth and a route of delivery which obviously existed for no medical reason but which was achieved by mothers who had chosen it. This presented another perspective on modern obstetrics and the contemporary doctor-patient relationship.

I aimed to relate as much information as possible about caesarean sections on request, and thus I tried to collect a variety of information from various sources and different fields of research, including popular scientific publications. I never intended to give advice or support a particular position because I believe that one learns more about a topic by analysing and discussing contrasting positions, and I feel that in the case of caesareans on request, there is no "good" or "bad" path to follow when deciding for or against a mode of delivery.

Caesarean sections on request went through a development, from a new phenomenon – which attracted attention and led to controversies, as well as to support – to acceptance; they are still not taken for granted, but over the next few years, reactions have become more tolerant and relaxed. A change in the perception of risks has probably contributed to caesareans on request gaining approval. Risks were no longer ignored but mothers-to-be seized the opportunities they were offered by medical advances, in order to challenge their anxieties. Thus, risks were not always viewed as an impairment, but as a challenge.

Expectant women also made use of contemporary means of communication, such as internet discussion forums, or consulted popular scientific publications. Both types of media were easy to access.

I aimed to show in this thesis that caesareans on request are more than just an alternative route to childbirth. They are more strongly connected with emotions than rational clinical approaches. Mothers sometimes struggle to come to a decision and to ensure that it is granted by consultants, while doctors are sometimes torn between their medical responsibility and the possibilities of modern technology, which has undoubtedly made childbirth safer, in terms of reducing morbidity and mortality rates. The birth itself marked the end of many debates, pro vs. cons discussions (and thus power relations) and emotional insecurities. The phenomenon of caesareans on request was significant in terms of becoming a mother and making decisions during pregnancy, as well as communicating with doctors and (probably) peers and establishing and defending one's own position. Moreover, it concerned personal rights and the protection of oneself and the unborn child. Learning about the possibility of choice could be overwhelming, but gathering

information could be even more so. Last but not least, research has also aimed to convince others of its own position.

In the end, the topic of caesareans on request is an interdisciplinary one. Although caesarean birth, as a mode of delivery, can be allocated to the field of medicine, aspects of decision-making and patient autonomy (also including the transition to motherhood) can have a wider scope, for example the influence of society and a person's role within a group of peers.

The passage from pregnancy to motherhood can be a complex one. Safety and risk are two words which dominate nearly every chapter, and caesareans on request are based on these terms. Nowadays, women know a great deal about childbirth. Information is widely available on the Internet and in advice books, and thus obstetricians are no longer the only source of information.

Considering surgery and coming to a decision can be daunting. In the case of childbirth, this process is even harder, as – regarding caesareans on request – surgery is not always medically justifiable and the vaginal route to giving birth will always be present. Becoming a mother is a life-changing event, and pregnancy itself can be full of surprises and new experiences, as we have learned throughout this thesis.

Sometimes – for instance, in forum debates – it seemed that women would not have known about caesarean sections on request if they had not stumbled upon this mode of delivery in the celebrity press or on the Internet. The media created a certain glamorous image of caesareans on request by linking them to celebrities, which did not match the experience of everyday mothers. Thus, the image reported by the media was one-sided and, moreover, applied to only a small percentage of mothers. In addition, the

motives of celebrity mothers remained unclear. However, readers kept these reports in mind, and thus the idea that caesareans on maternal request existed. It could be difficult for obstetricians to catch up with this "glamorous view" of caesareans and to present a more realistic approach, as celebrity reports do not take into account clinical aspects or medical evidence.

However, women as well as obstetricians shared the goal of maintaining the lowest possible level of risk. Risks were no longer taken for granted but viewed as something that could be avoided, i.e. the approach to risks and their perception changed. Being able to control and being prepared even for the unexpected became a major issue in childbirth preparation. Thus, many expecting mothers associated contemporary medical progress with the avoidance and exclusion of risks, which led to a change in attitude towards risks. Mothers were more active when considering possible adverse effects, which more or less represented a defensive approach. What was meant by risk or viewed as dangerous, however, could be fairly subjective. However, as caesarean delivery was – due to the usage of technology representing human control – often associated with a reduction of risks (or, in other words, safety), requesting a caesarean expressed the woman's wish to be on the safe side. A great deal of anxiety and insecurity always accompanies the anticipation of giving birth. This is mainly because nobody can say for definite what results an attempt to deliver vaginally will produce. Whether and to what extent caesareans on request lessened this fear remain unclear. However, as the outcome and surgical performance of caesareans were standardised, this routine certainly contributed to the relief felt by women and doctors.

Childbirth, of course, has undergone many trends and fashions because it has experienced many developments. Caesarean sections on

request represent one of these, and participants – mainly doctors and mothers-to-be – have demonstrated that they have found a way to deal with changes and that they are willing to accept new circumstances and to act out their autonomy responsibly. The challenge posed by caesareans on request to vaginal delivery is not necessarily a negative development. Caesareans are now routine surgery and their overall rate is around 30%, both in Britain and Germany. Thus, at least according to this proportion, they can no longer be viewed as stigmatised. They are fairly common these days and therefore nothing unusual. If vaginal delivery is no longer advocated as the standard and only acceptable mode of delivery due to the increase in caesarean sections, mothers who have an emergency caesarean will probably start to feel better about their birth experience when they learn that caesareans are no longer a taboo but an approved way to give birth.

From Chapters 5 and 6, we know that mothers who had experienced an emergency (or unwanted) caesarean could feel distressed and like "second-class mothers" because they felt that everyone else was able to give birth vaginally and that they had failed in doing so. Caesareans on request enabled people to talk about this mode of delivery and caesarean sections in general. Overall, acceptance of this mode of delivery has risen, which will hopefully make "unwanted caesarean" mothers feel better. Not the mode of delivery, but motherhood itself, should determine the quality of motherhood.

In addition, one should not underestimate the importance of communication, not only regarding deciding on a mode of delivery by the mother-to-be, but also when taking a closer look at debates on caesarean delivery on request. Patient-doctor relationships, too, were characterised by communication. In my view, a balanced relationship between obstetricians

and women would help both parties to feel more confident and safe (i.e. mutual respect, exchanging thoughts and benefiting from each other's experience, although in different areas of childbirth). Obstetrics will have to face further changes, since medicine and technology will constantly progress, and both women and doctors will be affected by those advances.

This thesis never aimed to judge the choices and reasons of obstetricians and mothers, because there is no right or wrong – there are only varieties from which to choose. To conclude, the most important thing is that the mother is happy and confident with whatever decision she makes, which will make it the right decision for her.

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