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Caesarean-section, my body, my choice: The construction of 'informed choice' in relation to intervention in childbirth

Judith McAra-Couper, Marion Jones and
Liz Smythe

Auckland University of Technology, New Zealand

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Abstract

The notion of choice, especially of *informed* choice, is a central tenet of maternity services in most western countries; it also underpins debate about rising rates of intervention that are now a feature of childbirth in many of these countries. Our study investigated the shaping of understanding and practice in relation to these rising rates of intervention in childbirth in the New Zealand context. Critical hermeneutics was used to analyse the data from interviews with nine midwives and obstetricians, and six focus groups with 33 women. This article reports on the notion of choice, which featured prominently in all the interviews. It became clear that women's choices were strongly influenced and determined by social change, by the gendering of women, and by values such as control, predictability, convenience, the 'quick fix' and the normalization of surgery. We argue that the prevailing notion of 'informed' choice obscures the structural and social influences on 'choice'.

Keywords

autonomy, childbirth, constructed choice, critical hermeneutics, intervention, normalization, socialization

Intervention in childbirth has been rising in New Zealand, as in many other countries. Our research investigated the reasons for this increasing intervention, identifying the social construction of 'informed choice' as the primary social value shaping not only the understanding of the public, but also the practice of health

Corresponding author:

Judith McAra-Couper, 1/87 Te Kawa Road, Greenlane, Auckland 1061, New Zealand

Email: jmcaraco@aut.ac.nz

professionals (McAra-Couper et al., 2010). The issue of 'informed choice' came to national consciousness in June of 1987 when the country was shocked by a magazine article entitled 'The Unfortunate Experiment' (Coney and Bunkle, 1987), exposing the scandal of a research project that had taken place at a prestigious women's hospital. That research into the prevalence of cervical cancer was at best unethical, and at worst life threatening for the women who had been the subjects of the research; they had absolutely no knowledge about it, and had, therefore, given no consent (Coney, 1988; Papps and Olssen, 1997). The ensuing inquiry, known as the Cartwright Inquiry, sought to make visible the power exerted by health professionals over women, and to ensure that all consumers accessing the health services had the opportunity to make an 'informed choice' (Coney, 1988). The results of the Cartwright Inquiry profoundly challenged and changed the nature of choice and consent in New Zealand. These changes reflected the prevailing milieu created by feminism and consumerism, so that by the 1990s, choice had become a 'right' for people accessing the health services in New Zealand. This right is enshrined in legislation and reflected in the Code of Rights for consumers of health services (Godbold, 2010; Health and Disability Commissioner, 2009).

This concept of 'informed choice' is at the heart of maternity services in New Zealand. New Zealand has a unique maternity service. A pregnant woman in New Zealand chooses a Lead Maternity Carer (LMC) who becomes responsible for ensuring the provision of these maternity services. This process is the 'cornerstone' of maternity care in New Zealand (Ministry of Health, 2008). Over recent years, maternity service providers have become increasingly concerned by the rise in intervention in childbirth (Ministry of Health, 2010). It was this concern that provided the professional catalyst for our research and led to these insights related to informed choice.

The construction of 'informed choice'

For mankind is not free to choose. . . things economic and social move by their own momentum and the ensuing situations compel individuals and groups to behave in certain ways whatever they may wish to do – not indeed by destroying their freedom of choice but by shaping the choosing mentalities and by narrowing the list of possibilities from which to choose (Schumpeter, 1950: 129–30).

Choice, in particular women's choice, has always been socially constructed and politically constrained. It remains, as ever, a highly contested issue (Crossley, 2007; McCallum, 2005). Choice is severely limited at any given time, and is shaped by hegemonic discursive orders and social practices that often privilege the interests of one particular group over those of the individual (McQuire, 2006; Thachuk, 2007). A prime example of this is the way that our everyday world offers choices related to technology. Technology supports certain social options over others, and consequently serves and promulgates the values of particular groups (Fisher, 2010; Williams, 2001). Technology itself is both a product of social values and behaviour,

and a catalyst for creating new social and cultural practices (Flanagin et al., 2009; Wajcman, 2008). The power of the technological network means that processes and skills outside the umbrella of technology are increasingly seen as quaint and old-fashioned. It is this technification of the everyday world that results not only in the normalization and acceptance of technology in pregnancy and childbirth, but also marginalizes the knowing of the woman and the skills of the health professional (McAra-Couper et al., 2010; Wolf, 2001). Choice in the 21st century remains – as Schumpeter (1950) claimed over 60 years ago – limited, constrained and shaped by political, social, economic and cultural interests.

Choice and childbirth

Crossley (2007: 559) argues that choice in childbirth is determined by what she calls ‘two anchors of choice’: the ‘biological embeddedness’ of women’s birthing, and the ‘medicalised context of the birthing encounter within contemporary childbirth’. However, we would argue that the determination of choice arises not only from the medicalised context, but also – and primarily – from the societal context, for it is society itself that produces the values that constrain and limit the choices women make. The common rhetoric related to increasing rates of epidurals and caesarean-sections in childbirth is that ‘it is the woman’s choice’ or ‘it is what women want’. Such rhetoric obscures the social construction and constraints of these choices (McAra-Couper et al., 2010). The evolution of the meaning of choice in relation to childbirth has led to women not only freely choosing elective caesarean-sections, but also to their feeling that they need not explain or apologize for their choice (Kleinhenz, 2008). Discussions on websites about pregnancy and childbirth with titles such as ‘C-section, My Body, My Choice’ capture the prevailing perceptions of the relationship between choice and intervention (Bianca012, 2007). In reality, however, choice does not exist as a neutral entity but as a shaped, constrained and limited entity within which choices are made.

The reality is that choice, informed choice, autonomy and agency are central to any discussions around women’s issues: female genital cosmetic surgery, reproductive rights and women’s bodies in advertising (Braun, 2009; Gill, 2008; Shaw, 2008) to name just a few. Pregnancy and childbirth are no exception. The discourse of choice being the right of every pregnant woman is a central tenet of maternity services in the whole western world (Jomeen, 2007). The New Zealand College of Midwives’ (NZCOM’s) consensus statement on informed choice says that each midwife will support and uphold a woman’s right to informed choice (NZCOM, 1996). The relational model of midwifery in Canada maximizes autonomy and choice (Thachuk, 2007), while informed choice is seen in the UK to be at the heart of maternity care (Stockhill, 2007).

However, the principles of autonomy, agency, the right to choice – and even that which is chosen – are all socially regulated (Gill, 2008). Choice in childbirth, as in all other choices, does not exist in isolation or in a vacuum, but is situated within a social and cultural context (McAra-Couper et al., 2010). Lothian (2008) goes so far

as to claim that choice in childbirth, promulgated by a discourse of autonomy and agency, is an illusion and a myth, because choice is primarily shaped by medical institutions and health professionals. She points out that health professionals are often perceived by consumers of health services to be actually holding the key to safe passage. Crossley (2007) asserts that women's ability to exercise choice during childbirth is, in effect, only nominal. Martin (2007) similarly states that choice for childbearing women is only ever partial, as it is restricted by protocols, hierarchy and fear. The literature shows that the belief that birth is risky – along with a dependence on hospitalization, intervention and technology to ensure safety – actually constrains and regulates choice (Jomeen, 2007; McAra-Couper et al., 2010; Walsh, 2009). Possamai-Inesedy (2006) claims that the 'discourse of risk' prevalent in western society constructs childbirth and pregnancy as risky, even though statistics in developed countries show low mortality and morbidity during childbearing. The concept of 'autonomy' that is touted in relation to 'respecting' maternal requests for caesarean-section is, in effect, also constructed. Unless women are aware of the sexist underpinnings of medicine and the increasing normalization of 'surgical childbirth', it is impossible for them to make an informed choice (Bergeron, 2007: 479).

These regulations and sexist underpinnings that determine choice in childbirth are, as we have already pointed out, intrinsic elements in so many other aspects of a woman's world. Contemporary advertising regulates women not only by objectification through a sexist advertising industry, but also by subjectification, whereby women can 'choose' to be sex objects (Gill, 2008). This regulation that leads to 'subjecthood' takes up 'residency in the psyche' (Gill, 2008: 46). Braun (2009) explores the agency that women have in the choices they make in relation to female genital cosmetic surgery (FGCS). Dislike of one's own vulva is a product of the cultural context: easy accessibility of the procedure, current advertising, and the public debate and discussion that promotes the choice of FGCS (Braun, 2009). The rhetoric of choice that surrounds FGCS mirrors that of elective caesarean-section, which for many women is increasingly normalized as being just another surgical operation that they can choose (McAra-Couper and Hunter, 2010).

The promotion of autonomy in the popular sense (that I am free to choose and do whatever I like) appears to be informed by the belief that the freedom to choose exists in a vacuum, with little or no influence from social context or determinants. Bergeron (2007) argues that unless women really understand the social context and underpinning obstacles to informed choice they cannot exercise informed consent. In addition, the provision of real choice requires that equal resources be given to different options: for example, similar amounts of money that are made available for surgical birth must also be available to facilitate natural birth. Health professionals must be trained in normal as well as abnormal childbirth procedures, otherwise the very allocation of resources also becomes a determinant of choice (Bergeron, 2007). Social and economic determinants construct and legitimate both the processes and the objects of choice.

However, it is important to also acknowledge the literature that identifies the *complexity* of choice in any given context. Widlund et al. (2009) found that even

when women did not receive adequate information about perinatal screening, many were satisfied with the information and the choices they made. Their choices in relation to ultrasound scanning were affected more by their own previously held beliefs than by the information given to them by health professionals. The women strongly believed that the scan would show them whether the baby was alive and healthy, and 90 percent had already made the choice to have an ultrasound before they had received any information at all from a health professional. Scans have become, for some women, a rite of passage in early pregnancy. It is now commonplace for women to regard a scan as an opportunity to get a video and photos of the baby to share with family and friends, rather than as a procedure about which they need to make a considered choice. The scan is no longer regarded by parents/mothers as a clinical tool, but rather as the medium through which you first see your child – a source of reassurance and excitement (McAra-Couper, 2007). This issue of scanning in pregnancy is just one example that illustrates the complexity of choice, and the construction and shaping of choice by multiple influences.

Methodology

This research required a philosophical stance that would explore the ‘shaped’ nature of understanding and practice, and also facilitate an analysis of this shaping. The particular approach used was critical hermeneutics as formulated by Hans Kogler. Kogler (1999) weaves together the analytical tools offered by discourse analysis with the insights of hermeneutics. He claims that it is only through using a ‘methodologically undogmatic amalgam of interpretively gleaned insights and conclusions, phenomenological observations and analytically conceived results and arguments’ that the ‘underlying premises of interpretive praxis’ can be revealed and brought to consciousness (Kogler, 1999: 11). The revealing and bringing to consciousness of underlying premises (the shaping of understanding and practice) is primarily realized in this study through the stories of the participants. These stories present a vivid, rich and in-depth picture of the participants’ worldviews, and so provide ‘interpretively gleaned insights and phenomenological observations’ about the subject matter (Kogler, 1999: 11). This interpretive insight is further informed by critical analysis that brings to awareness the taken-for-granted and invisible influences that shape practice and understanding. This approach enabled a hermeneutical thematic analysis of the worldviews of the participants and a critical structural analysis (discursive orders, social practices, relationships of power and structures of domination) of the shaping and shapers of the understanding of women and the practice of health professionals. This framework underpinned and informed the process of research and provided the ‘method’ of research. Ethics approval was gained from Auckland University of Technology’s Ethics Committee (2001) and the Auckland Health Research Council Ethics Committee (2003).

Nine health professionals (five midwives and four obstetricians) were interviewed individually, and 33 ‘lay’ women took part in six focus groups. The participants were recruited using purposive sampling through the first author’s network

and her knowledge of the population of doctors, midwives and consumers in Auckland city. Purposive sampling was necessary because some practitioners and members of the public were more 'expert' on the topic than others. It was clear that some sectors of society – namely, women who were white and middle class – were increasingly choosing intervention (Ministry of Health, 2006) and so it was important that these women were interviewed; they ranged in age between mid-20s to mid-40s, and all had given birth within the last five years. All obstetricians and one of the midwives were employed within a hospital; the other midwives were Lead Maternity Carers.

The individual interviews and focus groups lasted from 60 to 90 minutes. All were audio-taped: the majority were transcribed by the researcher and the rest by a transcriber who signed a confidentiality agreement. A research assistant attended each focus group, and using pseudonyms, recorded the introductory words of each new speaker, thus ensuring clarity when transcribing the data. The interviews were semi-structured: many of the key areas to be explored were identified before the interviews took place, ensuring consistency across the interviews. Some of the key areas explored were: beliefs around childbirth and understanding of the birth process; background, training, experience, influences, and formative encounters of participants; reasons for the changing patterns of intervention in childbirth; and changes in the last five years that have impacted on intervention.

Questions were open-ended, and there was the opportunity for issues that were not part of the original list of key areas to be added into the interviews, if they showed themselves as having particular significance. For example, a question emerged in the focus groups about the importance of the *way* in which a woman gives birth. It became obvious that this was a key question, and therefore became a specific focus in subsequent groups.

Analysis of the data

The data was analysed using the methodological process and framework informed by critical interpretation (Kogler, 1999). This process provides a method of analysis that uncovers not only the worldviews of the participants but also that which supports and makes possible these worldviews, so that the operation of power on understanding and practice may be revealed. There were three stages. First, a comprehensive interpretive reading of the transcripts was carried out, and was followed by a sorting and categorizing of the data. This stage focused on identifying the worldviews of the participants. The second stage required the formulation of frameworks that facilitated levels of data analysis that revealed the 'shaped' (worldview), the 'shaping' (social practices and symbolic discursive orders) and the 'shapers of meaning' (relationships of power and structures of domination). The final stage was a structuring and exploration of the data and associated literature, which made overt the links between the shapers, the shaping and the shaped. These three stages provided a reflective space in which the shaping of understanding and practice in relation to increasing intervention in childbirth was revealed.

Constructions of choice

The analysis clearly demonstrated that the concept of 'choice' and the 'right to choose' shapes the understanding of women and the practice of health professionals in relation to increasing intervention in childbirth. It highlighted the influence of social change, the gendering of women, the power of control and organization, the normalization of surgery, convenience and the role of technology on the construction of choice.

Social change and choice

The experiences of Fiona, a woman in her 30s, capture the changes in New Zealand society with regard to choice.

The biggest difference between my first and second birth was that I did not have a say with my first. I was young, he was early; they took over. They tried to stop the labour and that did not work. They just wheeled me in and put me up in stirrups which now is like a really unnatural way to have a child and like I did not have any say. The second time around, antenatal classes made a world of difference as they were saying you do have choices. At the antenatal classes the one message I got was, 'It is your choice.' They told you what was on offer and said that you take whatever it is you want to take. I remember thinking, 'Wow it is my choice!' and it was all about our choice and our choosing. This time in the 1990s, this was the time when choice was the thing. What I most clearly remember is the midwife who took the class told us about choice and that it was our choice not theirs.

Fiona's experience clearly illustrates the changing status of choice, and the power of the '*they*' to shape understanding and practice. It is a graphic example of changing consciousness about a woman's power to choose: she travels from the passive place of being 'done to' to the heady position of – seemingly – possessing all the decision-making power. She captures the change in attitude that took place in New Zealand, specifically driven by the Cartwright Inquiry, and against the general background of feminism and consumerism, so that by the 1990s, 'choice' was, as this woman suggests, '*the thing*'.

The identifying of women as consumers means that a woman giving birth has, in effect, the 'rights' of a consumer, and so can choose whatever she wants: 'choice is king' (Anderson, 2006: 51). Traditionally, the decision making in childbirth was vested in those with the most expert knowledge. Today decision making is seemingly vested in the pregnant woman, with the expert simply presenting one opinion among many. The authority of the expert is seen to be secondary, in fact, to the authority of individual opinion or wishes.

These social changes have resulted in the popular and even professional belief that a woman's 'informed' choice is always the right choice. Bob, an obstetrician, comments on these changes:

A pregnant woman who comes in to see you, she is a grown woman, not a child, and she is not to be patronized. If she comes to you and say she wants a caesarean-section because of a, b, c, and d and she understands the risks and has read widely... how can you deny them that choice? What right have we got to say, 'No I am not going to do it'? We used to be able to say 'No' like that, but we cannot do it now – and who wants to do it? It is wrong not to support their choice.

Bob presents a stance taken by most of the health professionals in the study: if a woman is fully informed and aware of all the risks, and chooses a certain procedure or a particular way to birth, then it would be wrong not to support that choice. In fact, his belief is ratified in New Zealand by legislation such as the Code of Rights (1996) and the Health Practitioners' Competency Act (2003), both of which incorporate the rights to be fully informed, and to make an informed choice. This has resulted in a radical shift in the relationship between health professionals and the public. Health professionals can no longer refuse to comply with women's reasonable requests: rather, they are required to listen and to support the choices women are making (Health and Disability Commissioner, 2009).

Bob's belief that it would be wrong not to support a woman's choice raises an ethical challenge with regard to informed choice, autonomy and maleficence. This challenge has been explored in several aspects of the birthing process, but in particular in relation to caesarean-section on maternal request. The primary ethical injunction of 'do no harm' often comes into conflict with the concept of respecting autonomy, which presents unique challenges in relation to maternal requests for caesarean-section. The issue of risks and benefits is often seen as being equally weighted against personal and cultural preferences in the process of decision making (Bewley and Cockburn, 2002). While it is believed that an objective and informed discussion should dissuade most women from an elective caesarean-section, the reality is that, following such a discussion, a doctor will still provide one if a woman so chooses (Latham and Norwitz, 2009). Bergeron (2007) argues that autonomy, 'the child of political liberalism', has been promoted as the ethical principle over and above all others in relation to choice and surgical procedures. However, the medicalization of childbirth, and what she calls the 'medical establishment's infatuation with caesarean-section on maternal request' (Bergeron, 2007: 481) means that so-called autonomy may be little more than the formation of women's choice by the medical model. Bergeron (2007) claims that autonomy to choose an elective caesarean-section is in fact regulated by the birthing culture, by socialization, and by the dictates of fashion.

These ethical concerns are, of course, not limited to the choice of caesarean-sections. Practitioners of elective aesthetic surgery admit that it is difficult to reconcile the ethics of beneficence, non-maleficence and patient autonomy (De Roubaix, 2011). Many women are compelled to comply with constructs of beauty, and society and media fuel the choice to undergo such surgery (De Roubaix, 2010). However, for many health professionals, the ethical tensions between autonomy, beneficence, and doing no harm are reconciled when they are considered alongside the 'reasonable wishes of rational agents' and the

principles of informed consent. This, then, informs their understanding of duty (De Roubaix, 2010). The difficulty is that the rhetoric of choice is used to persuade in such a way that it remains very difficult to judge the relative ethical weighting of autonomy, beneficence and maleficence (Latham and Norwitz, 2009).

Gendering of women

Because birth is primarily a social event, women's choices are influenced by their traditional gendering as expressed in the particular society in which they live (Page, 2003), a reality captured in Crossley's (2007) concept of 'situated freedom'. This notion of 'situated freedom' is captured by Tyler, a woman in her 20s, with two children.

I was worried about my appearance. With my first baby it wasn't important what I wore and 'what I wore to the hospital' became the family joke for years afterwards. So with my second baby I was obsessed that I had to look like the catalogue women and of course it didn't happen. I put a ribbon in my hair for God's sake. I don't know what fantasy I was occupying. It was really strange, like I'm not going to be the grunting, pooing, foul woman giving birth. I was going to be nice, and bought matching pyjamas for the occasion, with slippers that matched. It was like the total fantasy.

A 'nice' woman is certainly not a 'grunting, pooing' woman! Women's beliefs about themselves have been so strongly influenced by their gendered social context that they 'know' there is a certain way to behave, even when giving birth. There is a significant body of literature that explores the processes of socialization that determine the ways women 'should' behave when birthing. Women are gendered in any given society, and in the West, patriarchy and the Judeo-Christian tradition have shaped the understanding of women about how they should behave and dress. Martin (2003) claims that a woman's birthing experience is regulated by these same social mechanisms, namely, internalized beliefs about gender that compel women to act in certain ways. She argues that women bring to the birthing process a clear sense of how they should behave, and they 'often worry about being nice, polite, kind and selfless in their interactions during labour and childbirth' (Martin, 2003: 54). Martin (2003) explores Gilligan's assertion that white, heterosexual, middle-class women are relational, caring and polite, and are in fact subjected to the 'tyranny' of being 'nice' and kind. This internalized sense of how a woman should behave during birth disciplines her and her body, even in the midst of such a visceral event as birth. It is impossible to deny the more obvious institutional control over women's birth experiences and, in particular, the control exerted by hospitals, the medical model and medical technology; however, the social controls over women's birth experiences – often less visible – are no less powerful in the construction of women's choices.

Women's appearance, as well as their behaviour, is socially regulated even in pregnancy and birth. In 1991, when Demi Moore, eight months pregnant, posed nude on the cover of *Vanity Fair* she was credited with making pregnancy sexy.

This image of pregnancy touted by the media increasingly turned pregnancy into a glamorous, sexy and even 'body-beautiful' experience (Daniel, 2006; Upton and Han, 2003). Claudia Schiffer continued this tradition of glamourizing pregnancy by appearing naked while pregnant on the cover of *Vogue* magazine in 2010. Feminine beauty plays a powerful hegemonic role in the perception women have of themselves, even when they are pregnant (Johnson et al., 2004). Celebrity mothers have made overt the idealized body and the idealized pregnant body. Individual women carry these ideals within themselves, with the result that such ideals shape their understanding about the way they should look when pregnant, and behave when birthing (Martin, 2003; McAra-Couper et al., 2010).

The gendering of women continues to ensure that freedom to choose is situated within a context that dictates and applauds certain behaviours and dress, even in the throes of childbirth. The result is that women are likely to choose procedures that are perceived to facilitate 'niceness' and approved behaviour.

Control, predictability and organization

The participants in the research, particularly the women in the public focus groups, spoke at length of social and cultural values such as control. The ability to predict when things would happen greatly influenced the choices they made about childbirth. Vivienne, a 30-year-old mother of two, speaks about control and choice:

Yes, I think if I had said 15 years ago, 'I am not having a normal delivery because I do not want my bottom ripped up', people would have looked at you as if to say, 'Why are you thinking about you for? It is all about the baby; you are really selfish.' Whereas now, I think it is probably a culture change for women in that they are not prepared to have so much left to chance. It is a control thing too. They do not want things happening to them that they cannot control and cannot predict. So therefore they choose a caesarean-section.

Tina, an obstetrician, echoes these sentiments regarding epidurals:

I think there are certain women, professional women, who are in control of a lot of things, for whom control is important and so they will choose an epidural. They are well read, have been on the internet and know they do not have to go through the pain and all it involves, such as losing control.

Warren and Brewis (2004) claim that childbirth challenges the dominant world-view of the body as something to be controlled and remodelled. The embodied event of childbirth is viewed as a process that is out of control and not to be trusted – and therefore in need of regulation. The noise and 'messiness' that are naturally part of childbirth are increasingly regarded as a loss of control and dignity. This means that there is an attraction to procedures such as epidurals. Fleur, a mother of two, speaks about the elective caesarean-section for her second child, which she pictures as a controlled and dignified dinner date.

With my second child, when I had the elective caesarean-section it was like turning up to a dinner date. You go in there and you go up to the room that you are going to come back to after the baby. They put the needle in and then you go on down and you meet everyone and you get into theatre and have the epidural. Then you have the baby and you get sewn up and back to your room.

Women's knowledge of the date, time and place of their caesarean appears to offer some sense of control, and reflects their everyday world, which values and expects control and predictability (Page, 2007). While such values do not in and of themselves lead to women choosing a particular procedure, they do create a milieu where one option may be preferred because of what it appears to offer. Control and predictability stand in stark contrast to the chaotic, unpredictable, irrational and inconvenient nature of birth. Context and the processes of socialization determine choice, and when the everyday world of women values the calm, the controlled, then this worldview demands the choice of an epidural, which is seen to facilitate calmness and control (McAra-Couper et al., 2010). These choices reflect not only the medicalized context in which women give birth, but also the social values of control and predictability that interventions are perceived to offer.

Normalization of surgery

The normalization of surgery was a significant theme in the research. Both the women and the health professionals recognized an acceptance of surgical procedures as providing safe and straightforward solutions. Shanti, a young woman in her early 20s, shares her perception of surgery in general:

Over the next few generations surgery will become more acceptable, more commonplace. Like 'extreme makeover' is becoming really popular and so it is not the big deal that it once was to Jo Public, even though there are still massive risks associated with surgery. Jo Public still sees it as a quick fix and something they are relaxed about; something that is more acceptable. I am sure that surgery will become more acceptable in our generation.

Similar sentiments are echoed by others:

Philomene=I was giggling before because I was thinking about extreme makeovers and you do hear of the stories overseas where when they do a caesarean-section they routinely do a tummy tuck as well!

Jane=Yes that is true, they routinely overseas do a tummy tuck along with the caesarean-section and they get rid of all the excess skin.

Melissa=Do you think it will be long before it happens here? It could be rather good I suppose [laughing].

Surgery has become just another market commodity. Procedures such as liposuction, botox, and cosmetic surgery have become much more normalized (Casanova 2007; Pitts-Taylor, 2007). In the USA, nearly 10 million cosmetic procedures – including surgical procedures – were carried out in 2009. Since 1997, cosmetic surgical procedures have increased by 155 percent (American Society for Aesthetic Plastic Surgery, 2010). New Zealand does not collect data on cosmetic surgical procedures but the New Zealand Foundation for Cosmetic Plastic surgery claims that there has been a 50 percent increase in demand over the last few years (Docherty, 2010). In this milieu, some women equate cosmetic surgery with the choice to have an elective caesarean-section (Lavender and Kingdom, 2006). Choice is, in effect, influenced and determined by this context in which surgical procedures are becoming the norm.

Surgery was also regarded by a number of the participants in the research as being less messy than ‘normal’ childbirth. As we have already shown, the embarrassing ‘messiness’ of birth was, for many women in the focus groups, incompatible with their everyday world. Surgery – especially caesarean-section – was perceived to be a procedure in which this ‘messiness’ of the bodily fluids of childbirth was contained within tubes, catheters, redivacs and other containers. In an operation, body fluids are removed in a way that is sterile, controlled, clean and tidy. This means that there is minimal, or no, contact with the messiness of birth, making it very attractive for many women. While it could be argued that some women have always been challenged in relation to the bodily functions and fluids of childbirth, we would argue that never before have there been so many options, choices and possibilities that allow them to seek out those things that remove and protect them from this ‘messiness of birth’.

The normalization of childbirth as a surgical procedure will inevitably lead to the loss of the body of knowledge that women have about giving birth (Bergeron, 2007). Women’s knowledge will increasingly be only about surgical childbirth. Choices made about birth, informed and constructed by such discourses, can only facilitate increasing intervention in childbirth.

Convenience, ease, the ‘quick fix’ and technology

We can bank and shop online 24 hours a day, seven days a week. Such services shape understanding and fuel the expectation that transactions should be speedy, problem-free, and always suit the customer’s needs (Marchione, 2008). Services are constantly marketed on their ability to deliver at maximum speed, involving a minimum of discomfort or inconvenience for the client (Health Improvement and Innovation Resource Centre, 2010–11; Cash Doctors, 2010). Klein (2004) links the ‘quick-fix culture’ with caesarean-sections on demand, because they are regarded as an easy and convenient way of giving birth. McCourt (2009) claims that consumerism leads to individualism and the ‘quick fix’: people want things immediately, and with minimum risk. Research participants believed that the everyday world in which the ‘quick fix’ is facilitated by technology will become the norm.

Terri, a midwife, links convenience and intervention:

Choosing intervention – well it is convenience. That is the thing you do now: here is your little checklist of what is going to happen next – and see it all fits like this.

Faye, a young woman who shared at length about technology, thinks that:

Young people rely more and more on 21st century technology, so it is not natural or normal to be without technology. Technology is increasingly all around us and there is always something new... You can see why people expect it to be used during birth.

The influence of technology on choice in relation to childbirth is discussed by Lavender and Kingdon (2006) who claim that in Britain, birth without intervention is seen as ‘old-fashioned’; in contrast, some women see caesarean-sections as the modern way to have a baby, because it involves technology that women are at ease with, and that they find reassuring (Lowdon and Chippington, 2002). There is less and less value placed on the ability of the woman to birth naturally and more and more on utilizing the tools of technology to birth, which is seen as ‘progressive’ (Lavender and Kingdon, 2006).

Many of the women in the focus groups felt that technology made birth safer. Sarah, a new mother, shares her belief:

I guess technology means that you feel like you know at the earliest, so maybe you have the chance of doing something maybe. Yeah it feels safer. Humans can be wrong and make mistakes and on the whole technology is more trustworthy

Many participants associated technology with safety. They valued and trusted it because it provided accurate factual information. In one sense the association of safety with technology leaves little room to question its role, its appropriateness or the frequency with which it is used, as such a stance would suggest that the safety of the baby was something that could be compromised. Many women feel that they are obliged to embrace all the available technology to ensure the safety of their baby. This ascendancy of technology over the skill of the health professional and the woman’s ‘knowing’ of her own body, in and of itself, is a precondition for the choices women make.

Some writers argue that the range of choice in relation to technology – whether it be in the everyday world or in childbirth – is not only severely limited at any given time, but is itself actually determined by preconditions (Williams, 2001). Nature and biology – at the heart of childbirth – is no longer regarded in this technological age as an independent, efficient process. (Williams, 2001). In fact, humankind is already well on the journey of embracing technology to enhance and augment nature in so many ways:

Given a choice, people will prefer to keep bones from crumbling, their skin supple, their life systems strong and vital. Improving our lives through neural implants on the

mental level, and nanotechnology... on the physical level will be popular and compelling. It is another of those slippery slopes – there is no obvious place to stop this progression until the human race has largely replaced the brains and bodies that evolution first provided. (Greenfield, 2003: 4)

This ‘inevitability’ that the future of humankind will involve ‘merging intimately with technology’ implies that technology will undoubtedly involve a reworking of all aspects of human reproduction (Greenfield, 2003: 5). Technology is fast becoming the principal determinant of choice in every facet of our lives.

Discussion

Women’s reproductive life from ‘menarche to menopause’ is permeated by the notion of choice: when to have or not have a baby; how to have a baby; which baby to have... all are presented as an array of personal choices. We have argued here that the very *concept* of informed choice and consent can seduce us into believing that choice exists as an independent, value-neutral entity that is not influenced or constructed by the surrounding context and culture. The significant body of feminist critique regarding the medicalization and technification of birth should alert us to the multiple inherent power structures that are, in reality, determining these choices (Davis-Floyd, 1994; Katz-Rothman, 1989; Wolf, 2001). Women themselves need to become aware that they can be co-opted as advocates for many of the procedures of intervention and further medicalization of childbirth. They may unwittingly become agents for changes that do not necessarily serve women well, as they reinforce the beliefs about the ‘emotional and psychological insufficiency’ of women when it comes to childbirth (Bergeron, 2007). Bergeron suggests that the gender injustices leading to choices around the medicalization of childbirth will also be part of the inevitable swing to the de-medicalization that will follow. Once again it will be women who are judged as deficient in the process. This positioning of women in relation to such choices must be made overt, so that the social context that constructs these choices is made visible.

The mantra of ‘informed choice’ and ‘consent’ is all-pervasive. However, the findings of this research make it clear that choice is always ‘situated’: it is powerfully influenced – and even pre-determined – by the context and the milieu in which women give birth. This is not a reason to abandon choice, nor does it lessen the importance of choice that is informed. There is, though, a need for rigorous analysis and detailed examination of the preconditions of choice in relation to childbirth. This research makes a valuable contribution to such analysis by making visible the *construction* of choice that is leading to intervention in childbirth through processes of social change, the gendering of women, the contemporary world’s obsession with control and predictability, the increasing normalization of surgery, and the assumption of ease and convenience. These all need to be exposed as radical ‘shapers’ of choice. Only then will it be clear what is actually forming and informing the choices that are leading to increased intervention in childbirth. This is of the utmost importance, as these choices result in a culture of birth

that calls into question what has traditionally been at the heart of childbirth: the ability of the woman to birth naturally, and the clinical skills of the health professional.

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Judith McAra-Couper is a midwife and midwifery lecturer at Auckland University of Technology (AUT), New Zealand. She has been involved in academic study for many years, and completed her PhD in 2007. She received a postdoctoral scholarship in 2009. This has enabled her, along with her colleagues, to develop a research programme for the Woman’s Health and Midwifery Research Centre at AUT. The areas of interest in research at the present time are maternal mental health, sustainability of midwifery practice and place of birth.