"TOO POSH TO PUSH"
OR
TOO QUICK TO CUT?

DECONSTRUCTING MEDIA REPRESENTATIONS OF ELECTIVE CAESAREAN SECTIONS

by

Sarah Christine Berry
Bachelor of Arts (Honours), McMaster University, 2004

THESIS SUBMITTED IN PARTIAL FULFILLMENT OF
THE REQUIREMENTS FOR THE DEGREE OF

MASTER OF ARTS

In the
Faculty of Arts & Social Sciences

Department of Women's Studies

SIMON FRASER UNIVERSITY

Summer 2007

APPROVAL

Name:	**Sarah Christine Berry**
Degree:	**Master of Arts**
Title of Thesis:	**"Too Posh To Push" or Too Quick to Cut? Deconstructing Media Representations of Elective Caesarean Sections**

Examining Committee:

Chair:

Dr. Marilyn MacDonald
Assistant Professor, Department of Women's Studies

Dr. Cindy Patton
Senior Supervisor
Professor, Sociology/Anthropology and Women's Studies

Dr. Brian Burtch
Supervisor
Professor, School of Criminology

Dr. Marina Morrow

Internal Examiner
Assistant Professor, Faculty of Health Sciences, Department of Population and Public Health

Date Defended/Approved: July 5, 2007

ABSTRACT

In March 2004, Canadian obstetrician Mary Hannah published a controversial article about elective caesarean sections in the *Canadian Medical Association Journal.* Hannah argues that "a growing number of women are requesting delivery by elective caesarean section without an accepted 'medical indication'" and suggests that physicians should support women's requests (2004: 813- 814). Despite a paucity of research surrounding elective caesarean sections, many print media journalists and authors throughout Canada accept Hannah's claim, and allege that "too posh to push" women are responsible for high rates of caesarean sections and birthing interventions.

I situate media representations of elective caesarean sections in the context of Canada's evolving maternity system, and explore how media reporters manage birthing "uncertainties" through the construction of "truths" about women's birthing choices. Media authors' insistence on blaming mothers in media representations of elective caesarean sections obscures the broader cultural, social and economic contexts in which women give birth.

ACKNOWLEDGEMENTS

This thesis includes and reflects the work, insights, and support of a range of scholars, colleagues, friends, and family members, to whom I owe a debt of gratitude.

I owe special thanks to Dr. Cindy Patton, who offered to act as my senior supervisor and encouraged me to develop my initial ideas and arguments about this topic into a formal thesis project. Dr. Patton's critical and honest insights sustained and supported my work from its formative stages to this final product. Many thanks also to Dr. Brian Burtch, my second supervisor, for his close readings of my work, meticulous editorial suggestions, and important insights into maternity care services. I am also grateful to Dr. Marina Morrow, my external examiner, for her willingness to read my final transcript, and for her valuable contributions to my thesis defence.

To my parents and family: I could not ask for more attentive ears or supportive words! Finally, thanks to Jeremy Kloet, my best friend and partner, for the endless amounts of encouragement, support, patience and interest that he invests in my life and work.

TABLE OF CONTENTS

CHAPTER ONE

RISKY BIRTHS AND "BAD" MOTHERS: ELECTIVE CAESAREAN SECTIONS IN THE MEDIA

"Fundamentally, the 'bad' mother serves as a scapegoat, a repository for social or physical ills that resist easy explanation or solution"
(Ladd-Taylor & Umansky, 1998).

Birthing involves multiple uncertainties. From due dates to labour durations, birthing processes and experiences defy rigid predictability and strict timetables, and yet systematic sciences of birth are continually developed around these highly changeable processes, complete with mathematical formulas, projected outcomes, and carefully regulated and sterilised maternity wards. In the midst of vast birthing uncertainties, obstetrical experts in North America go to great lengths in their quests for birthing knowledge. One recent form of birthing risk management involves the use of high-technology birthing simulators that cause pregnant robots and mechanical foetuses to exhibit a range of potential complications. Maternal and neonatal birthing simulator NOELLE™ "can be programmed for a variety of complications and for cervix dilation. She can labor for hours and produce a breach [sic] baby or unexpectedly give birth in a matter of minutes" (Associated Press, 2006). Unlike computerized mannequins and simulated births, however, women's bodily processes remain stubbornly unique, and despite high-technology risk surveillance, birth remains a largely variable process.

As maternity services evolve, and surgical and technological interventions in birth become more common, many birthing experts warn that crises are emerging in maternity systems worldwide. Recently, influential American

obstetrician Marsden Wagner published an insider's perspective on maternity services in the United States, in which he contends that such services are deeply flawed and even abusive of women and babies (Wagner, 2006). The American maternity system, a self-professed "Cadillac" of maternity services with highly-trained birthing specialists, expensive equipment, and high levels of interventions ranks particularly poorly according to indicators such as maternal mortality (Wagner, 2006: 9). Researchers in the United Kingdom offer similar concerns about maternity services, and argue that intensive interventions, exaggerated perceptions of risk and a lack of informed, supported birthing choices for women undermine quality birthing care (Kirkham, 2004; Symon, 2006). In Canada, academic and popular authors warn that rates, risks, and costs of obstetrical interventions are rising to unacceptable levels. Canadian newspaper journalists announce that overused birthing interventions such as caesarean sections "drain public health dollars" (Munro, 2006) and cite a recent national birthing costs report to highlight the financial difference between a vaginal birth and a caesarean section: $2,800 compared to $4,600, respectively (Canadian Institute for Health Information, 2006).

While birthing experts generally agree that modern maternity services are evolving in favour of technologically- and surgically-assisted births, they offer vastly different explanations for this trend. How and why did this "crisis of interventions" develop? Who is responsible for rising rates of obstetrical interventions? What can and should be done to improve birthing services, cost-effectiveness, and outcomes? In the realm of birthing, many "experts" offer

countless birthing "truths." From pelvic floor surgeons to midwives to taxpayers, each birthing "expert" has a vested interest in how maternity services are framed and understood. Some individuals blame selfish mothers for demanding unnecessary and expensive interventions, while others assert that obstetricians prefer technologically-supported births.

Embedded within the broader debate about maternity services and increasing birthing interventions are serious concerns over rates of elective, or pre-planned, caesarean sections. Over the past several years, rates of caesarean sections have increased throughout Canada, despite the fact that the procedure carries a number of risks for mothers and babies, and high costs for taxpayers. In some cases where a woman or her foetus's life is at risk, a caesarean section can avoid a fatal outcome. However, caesarean sections also carry a number of potentially life-threatening risks such as haemorrhage and serious infections (Canadian Institute for Health Information, 2006). In view of these and other possible risks, the World Health Organization suggests that rates of caesarean sections should fall between approximately 5 to 15 percent of all births (Canadian Institute for Health Information, 2006). Birthing experts argue that rates that are lower or higher than these limits could be dangerous for mothers and babies (Canadian Institute for Health Information, 2004; Wagner, 2006: 48). In spite of the World Health Organization recommendations, rates of caesarean sections have steadily increased in Canada since the 1980s, and particularly over the past several years (Savage, 2000; Anderson, 2004; Canadian Institute for Health Information, 2004).

In the midst of uncertainty about what forces are driving high rates of caesarean sections, a proliferation in media coverage is especially apparent in media reporters' use of the catchphrase "too posh to push." Journalists and authors of newspapers, magazine articles and other forms of media increasingly attribute rising rates of caesarean sections and other birthing interventions to a cohort of women who are supposedly too self-absorbed or "posh" to give birth vaginally, and they berate women who demand elective ("pre-planned") caesarean sections (Bueckert, 2006; Fralic, 2005; Munro, 2004). Interestingly, very few of these authors attempt to situate caesarean section increases within the broader social, cultural and political contexts in which women give birth. The majority of media representations of elective caesarean sections centre on the medical risks versus benefits of caesarean sections, thus privileging a biomedical agenda.

While media authors direct some attention towards the wide range of factors and interests that contribute to rising rates of caesarean sections, they pay greater attention to women's individual roles, choices, and responsibilities with respect to birth. This individualization of responsibility and framing of mother's "choices" incites condemnation of mothers by journalists, fellow mothers, and health care professionals. Physicians argue that they are confronted by mothers who demand caesarean sections in the absence of medical necessity, and they lament the ethical dilemmas in which they find themselves. Journalists, many of whom are also mothers, spend lines of text chastising mothers for selfishly choosing caesarean sections over "natural" birth,

or for attempting to gain control over a "natural" process (Fralic, 2005). Still others contend that if women cannot withstand the pain of "natural" birth, perhaps they will not make good mothers at all (Lovric, 2005), as perceived irresponsibility over birthing choices is extrapolated to women's decision-making capacities in general, and especially to their prospects as mothers.

Ironically, many of the same assertions of irresponsibility, selfishness, and 'bad mothering' directed towards women who undergo elective caesarean sections are also employed in the context of debates about forced caesarean sections and home birth. Media authors simultaneously deride women for choosing caesarean sections, for failing to choose caesarean sections, and for neglecting to engage in physician-assisted births. Along the continuum of possible birthing "choices," therefore, it seems as though women are the safest from criticism if they subordinate their decision making to the expertise of biomedical professionals. Even so, journalists and authors of pregnancy and parenting books urge women to prepare themselves for every aspect of their pregnancy and birth, and an increasing tendency to pit foetal rights against mothers' rights contributes another dimension to debates about elective caesarean sections and birthing "choices."

In standard media representations, authors overlook a wide range of factors and interests surrounding caesarean sections and birth. Legal factors, individual physicians' preferences, the appropriation and dominance of birth by biomedical "experts," and constructions of knowledge around birth, including perceptions of risk and pain, are largely unexamined in media representations.

Rather, many authors simply attribute the complex "problem" of elective caesarean sections to mothers, who allegedly make uniformed birthing choices within the Canadian maternity system, and "press" their doctors to allow them to have medically unnecessary caesarean sections (Fayerman, 2004).

"Bad" mothers and birthing "choices"

A broader debate around women's behaviours and choices in pregnancy, childbirth, and mothering surrounds the popular media debate about elective caesarean sections. Blaming women for social problems is not a new phenomenon, for "bad" mothers are historically familiar figures, appearing in a number of cultures and eras. "Bad" mother labels and current images of poor mothering derive in part from late eighteenth and early nineteenth century conceptions of motherhood, and Victorian ideals of femininity and motherhood that require women to be completely devoted to their children's needs (Ladd-Taylor & Umansky, 1998). A "bad" mother fails to live up to these selfless mothering standards (Ladd-Taylor & Umansky, 1998:6).

"Bad" mother images and ideals persist into the 21st century in North America, and continue to resurface during times of social and political instabilities. Betty Freidan notes that during the 1940s to 1960s,

> "*It was suddenly discovered that the mother could be blamed for almost everything. In every case history of the troubled child; alcoholic, suicidal, schizophrenic, psychopathic, neurotic adult, impotent, homosexual male; frigid, promiscuous female; ulcerous, asthmatic, and otherwise disturbed American, could be found a mother*" (1963: 191).

The image of a "bad" mother depended on the selfless and sentimentalized icon of the "good" mother, who was expected to fulfil her "natural" duties as a wife and

mother. Ladd-Taylor and Umansky (1998) note that "mother-bashers" in the post-World War II period in the United States saw mothers' problems as stemming from their selfish desires. They cite former American president Theodore Roosevelt, who argued that a good mother was "sacred," but a woman who "shirks her duty as wife and mother, earns the right to our contempt" (Roosevelt, 1908 in Ladd-Taylor and Umansky, 1998: 10). Roosevelt and others considered a woman's "irresponsibility" as a mother as a form of treason worthy of disrespect and condemnation.

Mother-blaming in North America intensified throughout the 1980s. Douglas & Michaels (2004) argue that an explosive interest in mothers took hold in the media, generating and reproducing impossible standards of mothering and ideals about motherhood. To promote these standards, authors began to profile celebrity mothers in women's magazines, and offered mothers an "ever-thickening mudslide of maternal media advice" (Douglas & Michaels, 2004: 6). Douglas & Michaels refer to this intensified, media-centred form of mother-blaming as "the new momism:" an amalgamation of ideas and practices through which authors and other individuals co-opt feminist ideals of autonomy and promote the illusion that women make free and informed choices about motherhood (2004: 5).

Current images and authors' disparagements of so-called "too posh to push" mothers exemplify this form of "new momism" and mirror historical representations of "bad" mothers. Journalists assert that women are making straightforward choices about caesarean sections, and they willingly express

their contempt for women who are "too posh to push" in terms of their prospects as mothers. One author argues that

> *"if modern career women are simply 'too posh to push' perhaps they should consider adoption. Or better yet, they should abstain from parenthood entirely. At the very least, women who ask for a caesarean when there is no medical reason should be required to pay for it. And if there are any complications in the months following the operation, these women should be financially liable"* (Lovric, 2005).

Lovric implies that there are standards of birthing that correspond to good mothering, and she considers herself authorized to reprimand mothers who fail to live up to this imagined standard. She adopts the Victorian ideal of "good" mothering that Ladd-Taylor and Umansky refer to, when she instructs women to "work everything else around your baby because baby should come first" (Lovric, 2005). Authors also implicate feminism as one of the forces driving high rates of caesarean sections. In reference to women's ostensibly selfish birthing choices, Lovric (2005) argues that it's "really quite sad – though not surprising – that the feminist agenda has yet again taken such a selfish route."

What is worrying about these assertions is that popular media authors often fail to consider the circumstances in which women make birthing choices, or whether women are in fact making these choices at all. While not all authors express their contempt in such explicit ways, they frequently adopt mother-blaming frameworks to describe women's birthing choices and alleged demands for elective caesarean sections. According to Ladd-Taylor and Umansky (1998), "bad" mother labels deflect attention from the complex dimensions of a problem or dilemma, in favour of more simplified or enticing explanations. They point out that "the 'bad' mother serves as a scapegoat, a repository for social or physical

ills that resist easy explanation or solution" (Ladd-Taylor and Umansky, 1998: 22).

The contemporary milieu in which women give birth and make birthing "choices" is indeed one that resists easy explanation or solution. Current maternity services are steeped in a history of medical dominance, paternalism and ideologies about women's bodies and behaviours. Within pregnancy and childbirth, specifically, women's behaviours and choices are the subject of intense scrutiny. Women are expected to submit to ongoing surveillance by biomedical professionals throughout their pregnancies, and to self-monitor their behaviours and choices according to biomedical standards. When women fail to follow physicians' orders undergo caesarean sections or other medically-assisted birthing procedures, they face potential derision by the media and the threat of legal repercussions.

In terms of legal repercussions, there are several documented cases of forced caesarean sections in North America, in which physicians seek legal authorization to remove a foetus surgically from its mother (Kolder, et al, 1987). Media representations of forced caesarean sections invoke discourses of mother-blame and "bad" mother ideologies to describe mothers who refuse the advice of their physicians. Within the context of legally-enforced caesarean sections in the United Kingdom, for example, Gies (2000) notes that coercive or punitive treatment of women is portrayed as justifiable and even "natural" where women fail to live up to medical societal standards of "good" mothering. "Good" mothers are expected to be "naturally" self-sacrificing, to submit to the advice of

medical professionals in matters relating to pregnancy and birth, and to actively practice "good" mothering according to standards set by biomedical "experts." The privileged role of biomedicine in birth in popular media critiques of women's birthing choices. Media authors berate women for electing to undergo caesarean sections deemed medically "unnecessary" and for failing to undergo medically "necessary" caesarean sections. In either case, media authors perceive women as selfish due to their non-compliance with standards of pregnancy, childbirth and mothering as required and defined by biomedical "experts."

Thesis Structure

My aim in undertaking this thesis is to situate recent media representations of elective caesarean sections and locate notions of "choice" in this broader network of birthing interests and power relations. Instead of unquestioningly blaming women for the "problem" of elective caesarean sections, I construct a framework within which to theorize these media representations. Using the tools of discourse analysis and rhetorical theory, I consider framings of elective caesarean sections and birthing "choices" within a collection of 32 newspaper articles from March 2004 to October 2006. My analyses of these media representations are feminist, in that I specifically highlight the role of gender in framing and circumscribing women's birthing options and choices. I recognize that women make a number of choices about birth within a complicated and often limited range of 'options,' and in the face of disparaging and paternalistic representations of birth and mothering. I contend that media representations are productive of "truths" about women; that is, they work to not

only represent or reflect reality, but also to shape and produce it. Newspaper journalists have the potential to influence individual perceptions of the appropriateness of particular obstetrical interventions, and to promote misleading or inaccurate representations of elective caesarean sections. Through my analyses, I aim to expose the inadequacies of these frameworks in explaining the "reality" of elective caesarean sections, and to avoid mother-blaming, in favour of more nuanced understandings of the "problem" of elective caesarean sections.

In chapter one, I provide an historical overview of birthing practices and maternity services in Canada. I explore the movement of birth "out of the bedroom and into the clinic" (Kitzinger, 2000: 52) and the implications of this movement on birthing practices generally, and caesarean sections specifically. I also describe the medical and non-medical causes of caesarean sections, and concerns over the financial, physical and emotional costs of caesarean sections for mothers and babies.

In chapter two, I move on from historical and background information to outline my methods for analysing media representations of elective caesarean sections. I introduce and discuss a number of theorists' works in the areas of media, discourse, and rhetorical analysis to construct a comprehensive analytical framework. Drawing largely on the work of Glen Stillar (1998), I map out the literary and argumentative tools that authors use to construct "truths" about elective caesarean sections and mothers' "choices." Following Stillar, I also explore Kenneth Burke's method of analysis known as "dramatism," which identifies five important elements of discourse: act, scene, agent, agency, and

purpose (1962). I describe the usefulness of these elements in relation to media representations of elective caesarean sections.

In chapter three, I organize and present my analyses of media representations of elective caesarean sections according to Kenneth Burke's "dramatistic" approach to discourse. I situate journalists and authors' discussions of elective caesarean sections within the context of evolving maternity services, and explore how they manage public and personal perceptions of birthing "uncertainties" through the construction of "truths" about women's birthing choices. I also explore how authors invite audiences to understand the roles, choices, and responsibilities of various agents involved in elective caesarean sections, in order to construct ways of seeing the "problem" of elective caesarean sections.

In chapter four, I argue that within media representations of elective caesarean sections, authors struggle to define problems, solutions and meanings about elective caesarean sections to negotiate uncertainties about birthing, women, and the world around them. I note that when women do request caesarean sections, their reasons appear to be constrained in a number of complex ways by the features of the birthing system within which they operate, the power relations and hierarchies that exist among agents within maternity services, and the symbolic struggles over birthing meanings and practices that occur. I conclude that these factors work to shape not only the range of choices that women have available to them, but also the ways in which they are portrayed as "agents" of birthing systems in media representations.

CHAPTER TWO

"OUT OF THE BEDROOM AND INTO THE CLINIC:" A REVIEW OF THE LITERATURE

"The modern medical system brought care out of the bedroom and into the clinic. Care was no longer part of the intimate relationship between a woman and her midwife, but a series of repeated investigations administered by the medical system that often took place in public"
(Kitzinger, 2000: 52).

According to recent figures, approximately 99% of all births in Canada take place in hospitals (Canadian Institute for Health Information, 2004; Statistics Canada, 2004). Birthing practices in Canada are remarkably tied to a medical, technocratic model of birth, in which obstetricians and medical professionals implement an arsenal of risk management practices and technologies. Of the over 300,000 births that take place in Canadian hospitals each year, only one quarter of them occur without surgical interventions such as forceps, episiotomy, induction, or anaesthetic (Canadian Institute for Health Information, 2004). Caesarean sections in particular have emerged as an increasingly acceptable form of specialized risk management. In fact, some obstetricians suggest that caesareans sections should be used as a "prophylactic" measure of risk avoidance in all births (see Bewley & Cockburn, 2002).

Modern medicine has not always enjoyed a monopoly on birthing practices, however, and mothers and birthing activists have campaigned against medical control of birth. An ongoing challenge to high-intervention birthing practices is that they confer no added medical benefits to mothers or babies (Sakala, 1993). In fact, interventions such as caesarean sections sometimes have iatrogenic effects; that is, in some cases they actually cause harm to

mothers and babies. Conversely, evidence suggests that low-intervention midwifery care produces more favourable birth outcomes. According to findings released in 1998 by the U.S. National Center for Health Statistics, midwifery practices result in lower infant mortality and higher birth weights, despite the fact midwives' practices often include low-income women who are at higher risk of poor birthing outcomes (De Vries, 2004: 14 -15). Nonetheless, birth experts argue that health professionals often neglect to implement or encourage low-intervention birthing practices (De Vries, 2004; Lomas & Enkin, 1989; Sakala, 1993).

In chapter 2, I sketch out the evolution of birthing practices and maternity services in Canada. This history provides a necessary background for understanding the issues and concepts embedded in current debates about elective caesarean sections. I discuss the importance of the movement of birth "out of the bedroom and into the clinic" (Kitzinger, 2000: 52) and the impact of this shift on birthing practices generally, and caesarean sections specifically. I also explore the causes and consequences of high rates of caesarean sections.

"Out of the bedroom and into the clinic"

Caesarean sections have a long history. As early as 508 B.C. in Sicily, historical records indicate the surgical removal of a child through its mother's abdomen (Morrison & MacKenzie, 2003). While individuals often attribute the emergence of the term "caesarean" to the birth of Julius Caesar, this claim is unfounded, and the term more likely derives "from the Latin word 'caedere,' meaning 'to cut'" (Morrison & MacKenzie, 2003: 20), For centuries, caesarean

sections were extraordinarily risky procedures, performed on mothers post mortem (Morrison & MacKenzie, 2003). According to Shearer (1993), the earliest recorded caesarean section in which the mother survived took place in Switzerland during the sixteenth century. Although many successful caesarean sections are recorded in the eighteenth and nineteenth centuries, they were considered a dangerous last option well into the twentieth century. It was during the twentieth century that advances in hygiene, surgical, and anaesthetic techniques reduced both the risk of the procedure and surgeons' reluctance to carry them out (Morrison & MacKenzie, 2003; Shearer, 1993).

Arguably, the most important shift in birthing practices to occur during the twentieth century was the displacement of care from the home to the hospital (Declerq et al, 2001; Kitzinger, 2000). In fact, Declerq et al (2001) argue that nearly every trend in maternity care is attributable to this shift from home to hospital, including increased use of birthing technologies and interventions, the changing role of midwifery, and even the definition of birth itself. Whereas birth at home was viewed by many as a social event centred on the values of the domesticity and family, it became part of a growing medical institution with its own set of values and goals. Although Declerq et al (2001: 7) note that "safe and rewarding birth experiences are not the exclusive domain of either home or hospital births," since maternity services and women's birthing experiences are incredibly diverse, they also argue that place of birth significantly shapes birthing outcomes and experiences.

Prior to the formalization of hospital maternity services, women often gave birth at home with family and friends, and relied on the support of other women during pregnancy, labour, and delivery (Kitzinger, 2000; Wertz & Wertz, 1989). Community midwives played a central role in birth, providing continuous labour support for women. Birth traditionally involved women assisting each other and providing individualised care and support (Mason, 1988 in Burtch, 1994). While Canadian birthing practices have evolved dramatically toward hospital-based practices, women in many parts of the world still give birth at home, and in these places birth is viewed as a community event rather than an inherently medical matter (Kitzinger, 2000).

The shift from local midwifery and community birthing practices to institutionalized, hospital births involved the confluence of a number of ideas and events. Important developments occurred in the organisation and delivery of modern medical practices during the nineteenth and twentieth centuries, which resulted in growing confidence in hospitals, and increasing numbers of patients. In the nineteenth century, groups of physicians successfully countered perceptions of hospitals as dirty, dangerous places (DeClerq, et al, 2001; Starr, 1982). In addition to hospital reforms, the proliferation of research laboratories served to increase confidence in medicine, and allowed the profession to take advantage of heightened interest in public health (Stacey, 1988).

Following the First World War, public health nurses played a role in promoting medical management of birth, which involved increased experimentation with a number of technological interventions, including

caesarean sections (Mason, 1988 in Burtch, 1994). The continued application of birthing technologies and interventions and the organized campaigns of physicians against midwifery services also contributed to the marginalization of midwifery services throughout North America. In many Canadian provinces, "physicians led successful campaigns to eradicate the occupation, depriving women of the option to seek out a midwife to care for them during pregnancy and childbirth" (Wrede, Benoit & Sandall, 2001). Whereas hospitals were once considered dirty and dangerous places, midwifery care came to be associated with ignorance, incompetence, and lack of sanitation (Ehrenreich & English, 1978). Although the marginalization of midwifery services in Canada was moderated in part by geography (long distances and inadequate transportation made physician-attended births less likely to occur) the shift from home to hospital occurred rapidly in urban Canada (Burtch, 1994). Within a span of 20 years - from 1939 to 1959 - hospital births increased from 40 percent to 93 percent of all Canadian deliveries (Cosbie, 1969 in Burtch, 1994). Wrede, Benoit & Sandall (2001) note that by World War II in Canada, childbirth was largely considered a medical event.

Alongside the dramatic shift from home to hospital births in the 1950s, rates of caesarean sections began to rise steadily. This was in part due to the increased safety of the procedure, since doctors did not fear maternal mortality as they had in previous decades (Francome & Savage, 1993; Shearer, 1993). However, physicians performed numerous surgical interventions and caesarean sections in their efforts to reduce infant and perinatal mortality rates in the 1960s

(Shearer, 1993). When infant mortality rates fell in the 1970s, these efforts appeared to be justified, yet there is little evidence to support the belief that increased medical interventions in birth were responsible for decreases in infant and perinatal mortality (Francome & Savage, 1993; O' Driscoll & Foley, 1983; Shearer, 1983). In fact, Bewley and Cockburn (2002: 599) suggest that factors such as "social conditions, healthier mothers, and neonatal intensive care" may better account for reductions in perinatal mortality rates.

Amid concerns that escalating surgical interventions and caesarean sections were unjustified, and in the context of widespread movements and protests in the 1970s, an alternative birth movement emerged. Daviss (2001: 70) argues that the alternative birth movement in North America had two main goals: the "reform of 'medicalized' birth and the establishment of professional midwifery." In Canada, a number of interest groups aligned themselves with the alternative birth movement and took on the cause of integrating midwifery into provincial health care systems. Although Canada did not legally recognize midwifery prior to the 1970s, midwifery care finally became fully licensed and funded in Ontario in 1993. Other Canadian provinces such British Columbia, Alberta, Saskatchewan, Quebec and Manitoba adopted similar regulatory legislation for midwives, although midwifery services are still not yet regulated, funded, or accessible in many parts of Canada (Wrede, Benoit & Sandall, 2001).

Unfortunately, despite the efforts of the alternative birth movement and the activism of various social movements and interests groups, rates of caesarean sections increased or remained stable through the 1980s. In 1986, numbers of

caesarean sections in Canada reached an all-time high of nearly 20 percent, prompting the formation of a panel to examine the causes of rising rates (Savage, 2000). The panel confirmed that rates of caesarean sections were too high, and made recommendations to prevent further escalation. In response to these and other recommendations, medical professionals developed guidelines in Canada to address concerns about caesarean section rates (Anderson, 2004).

Overall, official policies and guidelines in the 1980s favoured demedicalisation, and professional associations recommended reductions in technological birthing interventions. In 1986, the World Health Organization (WHO) held a conference to address technological interventions in maternity services. Sixty-two conference attendees from over 20 countries reviewed international differences in and outcomes of caesarean section rates, and concluded that a rate of 10 percent was optimal. They adjusted their recommendations to a range of 10 to 15 percent to account for hospitals serving high-risk populations, where rates of caesarean sections would presumably be higher (Wagner, 2006).

Although caesarean section data collected in Canada from the early 1980s to 1990s seems to suggest that a general shift in medical practices occurred during this period, Richman (1999) argues that national averages are misleading. He asserts that when caesarean section rates are combined across different geographical areas, local differences in maternity practices are obscured and that "there was not a uniform change in caesarean delivery among all hospitals [in Canada]" over this time span (Richman, 1999: 395). Contrary to

popular beliefs about demedicalisation in the 1980s, Richman asserts, "this lack of change illustrates the extent to which the general exhortations of the professional associations regarding rate reduction were ignored" (1999: 395). Consistent with Richman's assertions that medical professionals ignored rate reduction recommendations, Canadian caesarean section rates have soared past WHO recommendations of 10 to15 percent. Currently, approximately 1 in 4 Canadian babies are delivered by caesarean section (Canadian Institute for Health Information, 2006).

Consequences of Caesarean Sections

Why is there such concern over high rates of caesarean sections? Caesarean sections are major surgical procedures and, like any other major surgical interventions, involve a range of potential risks and benefits. However, unlike most other surgeries, caesarean sections also involve a both a woman and at least one foetus, and therefore pose a unique set of considerations. Moreover, escalating caesarean sections present taxpayers with an array of financial consequences. Some experts suggest that not only are the risks to mothers and babies unacceptable, since they are in many cases clinically unjustified, but the costs of performing them are also too high where they are deemed medically unnecessary.

Risks to Mothers

One of the most important risks posed to mothers by caesarean sections is maternal death, also referred to as maternal mortality. Most of the research on caesarean sections and birthing interventions over the past several years refers

to some measure of maternal mortality. Maternal mortality is difficult to define and measure, since complications due to pregnancy and childbirth can persist for indefinite periods, and methods of measuring maternal death are variable across geographic areas and health systems. The International Classification of Diseases (ICD-10) describes maternal death as

> *"the death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management but not from accidental or incidental causes"* (World Health Organization, 2004).

Recently, the ICD-10 added another category of maternal mortality - late maternal death - to include "death of a woman from direct or indirect obstetric causes more than 42 days but less than one year after termination of pregnancy" (World Health Organization, 2004). Some causes of maternal death due to complications of caesarean sections include deep vein thrombosis (formation of a fatal blood clot), haemorrhage (blood loss), and major infection, which are associated with most major surgeries (Cox & James, 1995; Liu, et al, 2007).

While definitions and estimates of maternal mortality vary, researchers often use maternal mortality ratios (maternal deaths per 100,000 live births) to estimate maternal mortality figures, and many studies show that caesarean sections generally pose a higher risk of death for mothers than vaginal births (Frigoletto, Ryan & Phillipe, 1980; Hall & Bewley, 1999; Moldin, Hokegard & Nielson, 1984; Pettitti et al, 1992). Although the Canadian national maternal mortality ratio is one of the lowest in the world, experts argue that such ratios "may mask important elevated risks for particular sub-groups of the Canadian

population" (Health Canada, 2004). In a recent study of caesarean section estimates and outcomes, Betrán et al (2007) also caution that when population caesarean section rates in developed countries such as Canada surpass the World Health Organization's recommendation of 15 percent of all births, risks of the procedure start to outweigh the benefits, and "may be an indicator for excess maternal mortality" (104).

Apart from mortality risks, caesarean sections also present a wide range of short- and long-term maternal health consequences, which medical professionals commonly refer to as *maternal morbidities*. While caesarean sections are in some cases life-saving procedures, they are also severely disabling for some mothers. Since caesarean sections are major surgical procedures, they include a number of risks that are common to surgery, such as "anaesthesia accidents, damage to blood vessels, accidental extension of the uterine incision, damage to the urinary bladder and other organs" (Wagner, 2000: 1677). In addition to these risks, some birth experts argue that minor morbidities associated with caesarean sections are underreported and underestimated. They point out that poor documentation of these morbidities occurs due to rapid discharge of women from hospitals after giving birth, and the fact that some women seek post partum care for complications from midwives or primary care physicians who were not involved in their birth experience (Penna & Arulkumaran, 2003: 404).

Beyond the short-term morbidities associated with caesarean sections, a number of serious long-term consequences also exist. These risks involve future

reproductive problems such decreased fertility due to scarring or damage from previous caesarean section procedures (Shearer, 1993; Morrison & MacKenzie, 2003; Wagner, 2000). Women who undergo caesarean sections take longer to conceive (Murphy, Stirrat & Heron, 2002), and face potential ectopic pregnancy, miscarriage, or serious placental problems (the placenta may adhere to the uterine wall, for example, and necessitate hysterectomy) (CIHI, 2004; Shearer, 1993; Wagner, 2000). Additional long-term complications include increased risk of gallbladder disease and appendicitis (Bewley & Cockburn, 2002), amplified menstrual symptoms (Morrison & Mackenzie, 2003) and adverse psychosocial impacts such as anxiety, depression, and psychological trauma (Mutryn, 1993).

Risks to Babies

Caesarean sections also present an array of risk for babies. One of the leading immediate risks of caesarean section for babies is respiratory morbidity, which involves neonatal breathing difficulties that require mechanical ventilation, oxygen therapy, and nursery care (Bewley & Cockburn, 2002; CIHI, 2004; Morrison & MacKenzie, 2003; Penna & Arulkumaran, 2003; Shearer, 1993; Wagner, 2000). These respiratory complications often arise in elective caesarean sections, where babies are born before the spontaneous onset of labour. According to some birth experts, risk of respiratory complications doubles for each week early that caesarean surgery is performed (Morrison, Rennie & Milton, 1995). Associated with respiratory complications and iatrogenic prematurity are the added risks of "maternal separation and anxiety, poor feeding, jaundice,

cannulation and cross-infection, sometimes with multi-resistant hospital acquired organisms" (Bewley & Cockburn, 2002: 600).

While respiratory problems comprise one of the most important risks for babies, a number of less-common complications also result from caesarean sections. Accidental incisions into and scalpel lacerations of the foetus occur in approximately 1% of caesarean sections (Miller, 1988; Morrison & Mackenzie, 2003; Smith, Hernandez & Wax, 1997). Breastfeeding complications (such as difficulties initiating or maintaining feeding) also occur more frequently among women who deliver by caesarean section rather than vaginally (Mazur & Mikiel-Kostyra, 2000). Although respiratory problems, lacerations, and breastfeeding difficulties appear to resolve over time, some authors argue that these small differences can add up to long-term health or developmental concerns for babies when they reach child- and adulthood (Bewley & Cockburn, 2002: 600). Researchers note that the potential consequences of these seemingly small risks necessitate routine disclosure of all of the potential risks and benefits of caesarean sections to pregnant women (Penna & Arulkumaran, 2003: 405).

Financial costs

Over the past several years, the financial burden of increasing obstetrical interventions on health care systems worldwide has generated considerable concern among health planners, researchers, taxpayers, and popular media authors. In the United Kingdom (UK), a1997 audit revealed that caesarean sections in the UK cost about £760 more than a vaginal birth (Audit commission, 1997). More recently, the Canadian Institute for Health Information assessed and

reported the financial costs of various birthing methods and interventions in Canada. In their report, the authors note that in 2002 – 2003, caesarean sections cost approximately $5,200, compared to vaginal births at $4,600 (Canadian Institute for Health Information, 2006). They argue that the higher costs of caesarean sections are due to "a greater use of hospital resources, including local and general anesthesia, longer hospital stays, nursing care and medical and surgical supplies" (Canadian Institute for Health Information, 2006: 23).

Indirect and Intangible Costs

Apart from the direct financial costs of caesarean sections, there are also potential indirect or intangible costs associated with caesarean sections. Beyond the staffing and material costs associated with surgical birth, women often bear prolonged physical pain and emotional traumas that are unaccounted for in medical and media reports of caesarean costs. Most authors present a health services perspective on birthing costs that neglects the indirect or intangible costs to a woman and her family and to society. Petrou, Henderson & Glazener (2001) demonstrate that the majority of UK publications about caesarean sections "[fails] to take account of the economic implications of the long-term health consequences of caesarean section and alternative modes of delivery" (Petrou, Henderson & Glazener, 2001:160).

Balancing the Risks & Costs of Caesarean Sections

Any determination of the relative risks and costs of a caesarean section, or of any birthing or surgical intervention for that matter, requires a consideration of the social, cultural, and economic contexts in which the intervention is to take

place. Questions about the physical condition of the mother, foetus, maternity care system, resources, and maternity care provider(s) must be weighed against one another. Birthing experts suggest that a physicians and researchers should rank birthing risks to determine what risks are acceptable for women to incur in order to avoid other potentially more serious or life-threatening complications (Bewley & Cockburn, 2002). According to influential American obstetrician Marsden Wagner (2000) this balancing of risks does not often occur. Wagner (2000) argues that doctors do not provide women with a full range of information about the relative risks and benefits of caesarean sections, and he asserts that this is at least partially attributable to physicians' defence of their own interests. He notes that "if a CS is done, the woman and her baby take the risks while if the CS is not done, the doctor takes the risk" (Wagner, 2000: 1677).

Rationales for caesarean sections

To understand why physicians perform caesarean sections, and to determine when performing a surgical birth outweighs its potential risks, it is necessary to examine the medical and non-medical indications for the procedure. As Wagner (2000) points out, there are vested professional interests, institutional interests, and other non-medical factors that influence a physician's decision to carry out a caesarean section. In this section, I outline some of the medical criteria and non-medical indications and interests that contribute to rates of caesarean sections.

Medical Indications

Given the inherent risks that caesarean sections pose for mothers and babies, some birthing experts argue that physicians should only perform them in instances where there are serious risks to the mother and baby. Within current obstetrical practices, however, medical indications for caesarean sections are a contentious area, and medical indications fall along a continuum. Francome and Savage (1993) distinguish "absolute indications" versus "relative indications" and explain that "absolute indications for [caesarean sections] are those in which the baby cannot be delivered without danger to the life of the mother or child" (1993: 1208). They include in this category placental complications such as placenta praevia (implantation of the placenta over the cervix opening) and abruptio placentae (separation of the placenta from the uterus), both of which pose serious threats to the mother and foetus due to excessive bleeding (Francome & Savage, 1993). Other "absolute" indications for caesarean section include a transverse or breech positioning of a foetus (where a foetus lies with its feet sideways or down, respectively, making delivery difficult) and a prolapsed umbilical cord (where the umbilical cord descends into the birth canal ahead of the foetus, sometimes cutting off oxygen to the foetus) (Francome & Savage, 1993).Yet even within the category of "absolute" indications, the authors note that some women can successfully deliver vaginally, despite the presence of these "absolute" indications. For example, birthing attendants can sometimes safely turn a baby from a transverse position into a head-down position, without resorting to a caesarean section (Francome & Savage, 1993: 1208).

Francome and Savage describe relative indications as "the more loosely defined conditions of fetal distress and 'failure to progress' or dystocia, which seem to be diagnosed with increasing frequency" (1993: 1209). Indeed, foetal distress and dystocia are frequently documented in obstetrical and birth-related literature as among the most common indications for caesarean sections. The top four most common indications for caesarean sections fall into the more clinically ambiguous categories of "relative" indications, rather than "absolute" indications, and include foetal distress, dystocia, previous caesarean section, and breech presentation of the baby (Cunningham et al, 2001; Francome & Savage, 1993; Sakala, 1993; Shearer, 1993). Upon closer examination, the ambiguity of each of the four common indications becomes evident.

Dystocia, commonly referred to as "failure to progress," refers to slow, abnormal, or obstructed labour in birth. Physicians often use the term as a "catch-all category" to describe a wide and inconsistent range of circumstances in which they consider a woman unable to give birth vaginally (Sakala, 1993). Despite the fact that women do not labour according to rigid patterns or timetables, some hospital staff diagnose dystocia after a woman has laboured for 12 hours (Sakala, 1993: 1179). Even in the face of such ambiguity, however, physicians make dystocia diagnoses with increasing frequency.

Foetal distress, which refers to situations in which oxygen levels to the foetus are compromised, is a similarly sweeping diagnosis that has increased dramatically since the 1980s (Sakala, 1993). This is due in part to the increasing availability and use of technologies to measure foetal distress. Among the most

common of these technologies is the electronic foetal heart monitor, which measures sound waves associated with blood flow in the foetal vessels and heart (Blincoe, 2005). Despite its popularity, the practice of continuous foetal heart monitoring is a contentious issue among birthing experts (Frigoletto & Nadel, 1988; Parer & Livingstone, 1990). Much debate surrounds the relative accuracy of technologies to measure foetal distress and the proper implementation of foetal heart monitors in pregnancy and labour. In fact, some studies demonstrate that electronic foetal monitors are inaccurate in identifying foetal distress, and may contribute to excesses of caesarean sections (Sakala, 1993). Blincoe (2005:109) also underlines the "glaring lack of systematic, scientific study of fetal monitoring practice in normal or low-risk labour."

Other supposed indications for caesarean sections such as breech presentation and previous caesarean section are similarly uncertain areas of obstetrical practice (Martel & MacKinnon, 2004; Hannah et al, 2000). Birth experts, researchers, and professional organizations offer differing opinions on whether or not physicians should carry out a caesarean section in each case. Despite this uncertainty, hospital policies often mandate that physicians deliver breech foetuses by caesarean section, and require a woman who has previously undergone a caesarean section to undergo caesarean sections in all subsequent births.

While dystocia, foetal distress, breech presentation, and previous caesarean section are the documented rationales for most caesarean sections, a number of other clinical factors also contribute to caesarean section decision-

making. These factors include fears related to pelvic floor weakening, urinary and faecal incontinence, perineum damage, reduced sexual functioning, and labour pain (Anderson, 2000; Bewley & Cockburn, 2002; Byrd et al, 1998; Hofberg & Brockington, 2000; Morrison & MacKenzie, 2003; O'Boyle, Davis & Calhoun, 2002; Sultan & Stanton, 1996). According to one birthing expert, undergoing or performing a caesarean section solely in order to avoid these risks is indicative of a "just-in-case attitude" that has encouraged high rates of unnecessary obstetrical interventions (Sakala, 1993: 1180). This controversial attitude is exemplified by some obstetricians' suggestions that perhaps caesarean sections should be offered to all women as a "prophylactic" measure (Feldman & Freiman, 1985).

Non-medical Indications

While one might expect that high-risk sub-populations of pregnant women undergo the highest numbers of obstetrical interventions, research shows that this is not the case. In fact, a number of studies demonstrate a positive association between rates of caesarean sections and socioeconomic status (Stafford, 1990; Stafford, 1991; Gould, Davey & Stafford, 1989). Rates of caesarean sections are also consistently higher in private clinics compared to public clinics, which are more likely to serve low-income women (Gregory et al, 1999; Roberts, Tracy & Peat, 2000). Moreover, caesarean section rates are lower among low-income women who are at higher risk medically and who experience higher rates of range of poor birth outcomes (Hurst & Summey, 1984; Stafford, 1990). One example of such a group is the Zuni-Ramah Native

American population in the United States. Although Zuni-Ramah women belong to a low-income, high-risk population, they generally undergo few obstetrical interventions and generally receive assistance from nurse-midwives instead of obstetricians (Leeman & Leeman, 2003 in Wagner, 2006). Although the national caesarean section rate in the United States reached a high of 29 percent in 2004, researchers found that the Zuni-Ramah Native American population had a substantially lower caesarean rate of approximately 7 percent (Leeman & Leeman, 2003 in Wagner, 2006).

Evidently, high rates of caesarean sections are neither entirely attributable to absolute medical indications, nor do they result in significantly better outcomes for mothers or babies (Sakala, 1993). So why are caesarean sections so prevalent, at least in some wealthy countries, and apparently among those with middle or higher incomes? Raymond DeVries, a long-time birthing activist and researcher, underlines the necessity of considering birthing interventions in relation to their broader cultural context:

> *"more than any other area of medical practice, the organization and provision of maternity care is a highly charged mix of medical science, cultural ideas, and structural forces. Other medical specialties are marked by a technical uniformity that crosses national borders, but the design of care at birth varies widely and clearly bears the marks of the society in which it is found" (De Vries, 2004: 15).*

A wide range of factors and interests inevitably shapes caesarean section decision-making. In fact, a large body of evidence suggests that an array of non-medical indications contributes to rising rates of caesarean sections (Saleh, 2003). While these non-medical indications are not necessarily mutually

exclusive, they can be roughly categorized into professional, organisational, and maternal interests.

Professional interests

Professional interests are one of the most frequently discussed areas of non-medical indications for caesarean sections. From avoidance of malpractice claims to peer pressure to time constraints, a number of authors point out that there are many reasons why a doctor might recommend and/or perform a caesarean section. Authors use the term "defensive obstetrics," for example, to describe obstetrical practices based on avoidance of malpractice litigation. While defensive obstetrics arguably violates the medical and ethical principle of putting patient interests first (Wagner, 2000: 1678), obstetricians themselves admit to practicing defensive medicine (Birchard, 1999). In a 1993 study of British obstetricians, the most frequent non-medical indication given for caesarean sections was avoidance of litigation (Francome & Savage, 1993: 1204).

Aside from litigation concerns, evidence also suggests that obstetricians perform caesarean sections without clear medical indication to avoid criticism from their peers and patients (Murphy, 2002). Obstetrician Marsden Wagner argues that such behaviours are indicative of "tribal obstetrics" in which obstetricians prioritize their personal and professional interests over and above patients' preferences and well being (2006: 22). Time constraints and remuneration are potential factors that affect obstetricians' decisions to perform caesarean sections. In comparison to the unpredictability of vaginal births, which often require that an obstetrician remain on-call for many hours, caesarean

sections most often take place during daylight hours, at pre-determined, convenient times (Penna & Arulkumaran, 2003; Wagner, 1994). In some cases, doctors also receive more money to perform a caesarean section than a vaginal birth (Wagner, 2000).

Organisational Interests

Beyond the ground-level practices of health professionals, the broader organisation and delivery of maternity care services also contributes to high caesarean section rates. For example, while midwifery care is frequently associated with lower interventions and better outcomes for mothers and babies, this evidence is frequently ignored in health policy and provision decision-making (De Vries, 2004; Sakala, 1993). Although midwifery care has made gains over the past few decades in terms of claiming professional status, it nonetheless plays a marginalized role in maternity care services. Current provisions of maternity services reflect an affinity for scientific and high technology interventions in lieu of lower-cost, less-invasive procedures (Anderson, 2000: 697; Mutryn, 1993: 1271).

Maternal Interests

From decade to decade, as caesarean section rates have increased, mothers, birth experts, health professionals, and media authors have offered various theories to explain these increases. Wendy Savage notes that from the 1980s to the year 2000, reasons cited in the medical literature changed from forceps use and breech delivery, to defensive obstetrics, to maternal preferences (2000: 223). The current vogue in the early 21st century to blame mothers for

high rates of caesarean sections is evident in medical journals, newspaper articles, and a range of internet websites. According to some sources, mothers have simply become too "posh" to push their babies out vaginally. This tendency to blame moms is now so common that some authors even suggest that women who "elect" for caesarean sections should have to pay for them (Mackenzie, 1999).

If one considers the history and evidence surrounding the rise of maternity services, birthing interventions, and caesarean sections, however, the assertion that moms are simply "too posh to push" becomes less probable. As Raymond De Vries aptly notes, what is available and cultural acceptable to mothers in birth is often what they "choose" (De Vries, 2004). In Canada, where 99% of births currently take place in hospitals, the options for birth appear considerably more pre-determined than the "too posh to push" concept suggests. Choice, it seems, is a fraught concept, requiring an examination of what options are actually available and supported. In the next chapter, I map out a framework for analyzing women's alleged birthing "choices" and media authors' constructions of "truths" about elective caesarean sections.

CHAPTER THREE

NEGOTIATED DISCOURSES OF ELECTIVE CAESAREAN SECTIONS: AN INTEGRATIVE ANALYTICAL FRAMEWORK

Representing Caesarean Sections

"Every way of seeing is also a way of not seeing"
Burke, 1935/1984: 49

Representations of caesarean sections are not a new phenomenon. As far back as 508 B.C., caesarean sections are depicted in a variety of historical records and texts (Morrison & McKenzie, 2003). With improvements in hygiene and surgical practices, however, attitudes towards caesarean sections and representations of the procedure in various forms of media changed dramatically. In ancient times, caesarean sections were performed on the bodies of dead or dying women to recover or rescue their foetuses (United States National Library of Medicine, 1998), whereas today they are a common surgical procedure. As surgical techniques and hygiene improved during the twentieth century, "ways of seeing" caesarean sections evolved, and mainstream media representations began to reflect these shifts.

My interest in caesarean sections centres on representations of elective caesarean sections and women's birthing choices in current mainstream print media outlets. I view these media representations as elements of a dialectical cultural process in which media authors select, prescribe, and negotiate cultural meanings related to birth, gender, women, motherhood and medicine. Essentially, I recognize that mainstream media producers simultaneously construct and reproduce cultural meanings related to caesarean sections.

To explore these representations, I collected a subset of Canadian newspaper and magazine articles about elective caesarean sections from January 2004 to December 2006. My collection starts at 2004, when controversial policy recommendations put forward in Canada ignited intense media commentary on elective caesarean sections. I selected these popular media representations from a range of high-distribution newspaper and magazine articles across Canada, such as *The Globe & Mail* newspaper and *Macleans* magazine. While media representations of caesarean sections are abundant in North America, and mothers' choices are depicted in a wide variety of ways, I am interested in whether or not identifiable patterns or hegemonic "ways of seeing" are apparent in media discourses. By identifying dominant discourses, I aim to highlight perspectives or voices that media authors exclude in mainstream print media representations, and to present alternate "ways of seeing" caesarean sections.

My interest in highlighting exclusion and in producing new meanings related to elective caesareans sections underscores the feminist nature of my work. In my analysis, I place women's choices at the centre of my work, and problematise representations of "choice." For example, when journalists argue that some privileged women are "too posh to push," I explore how these framings of elective caesarean sections serve particular interests, and whether such labels are justified. In doing so, my approach to media representations of caesarean sections is informed by a long history of feminist work in the areas of birth, gender, women, motherhood and women's health. As I discussed in chapter one,

women's choices and roles in birth and in countless other areas of life are often circumscribed and prescribed by patriarchal traditions and cultural notions about women and mothers. These areas of the literature provide an important historical grounding for understanding the diversity of women's birthing struggles. In the remainder of this chapter, I introduce and discuss a complementary and integrated set of theorists' works related to media, discourse, and social theory that combine to form a comprehensive analytical framework for analysing media representations of elective caesarean sections.

An Integrative Analytical Framework

Media representations of elective caesarean sections reflect an array of perspectives, ideologies, theories, and practices related to birth, women and medicine. Mirroring the complexity of these representations are the many theories and methods developed to explore and analyse media representations. From communication and media theories to social theory and cultural studies, a wide range of research areas offer methods of discourse and media analysis.

In this chapter, I provide a brief overview of some of the most pertinent areas of the literature that relate to media analysis, and I discuss some of the challenges and possibilities of integrating diverse bodies of work in order to analyse media representations of elective caesarean sections. Following Glen Stillar (1998), I draw on the resources of discourse analysis, rhetorical theory and social theory to map out an integrative analytical framework, and situate my analyses within this pragmatic model. Specifically, I adopt Kenneth Burke's method of analysis known as "dramatism" and identify five important elements of

discourse that are useful for examining media representations of elective caesarean sections: act, scene, agent, agency, and purpose.

Destabilizing Theories: From Reality to Relativity

A range of theoretical challenges to language, truth, reality, and even the notion of representation itself inform my analytical approach to media representations of elective caesarean sections. Over the past several decades, destabilizing theories and poststructuralist thought disrupted the idea that language represents or reflects stable meanings or realities in the world. Changing conceptions of reality and a general shift towards relativity of meanings have important implications for the analysis of media representations, and warrant a critical review of relevant conceptual frameworks and literature.

Language, meanings, and 'reality'

Language lies at the heart of poststructuralist challenges to media analysis. Poststructuralist theorists recognize that language does not merely express fixed meanings in the world, but that meanings and realities are discursively produced in and through language (Weedon, 1997: 22). Similarly, in media representations, ways of seeing birthing experiences are both produced by, and productive of, the broader culture of which they are a part. In a world of competing meanings, language systems offer resources for constructing discourses, or "patterned ways of meaning and ways of doing that construct particular values, subjects, and activities" (Stillar, 1998: 12). Media representations of elective caesarean sections exemplify a spectrum of possible ways of seeing a particular experience, and embody differing values and

subjects. From women's choices to the roles of health professionals, authors of newspaper and magazine articles construct particular discourses of caesarean sections through carefully selected arrangements of language.

Traditionally, critiques of media representations were guided by the assumption that distinctions could be made between supposed misrepresentations of reality, and the actual 'truth' of lived experience. Abbott, Wallace & Tyler (2005: 344) argue that early work on media representations of women was driven by a desire to provide more 'realistic' images of women. Specifically, they argue that "they way it represented women, the media was thought to be guilty of distorting the *reality* of women's lives, portraying a fantasy world rather than the one that women *actually* live in" (Abbott, Wallace & Tyler, 2005: 344; emphases added). Such attempts to expose the "truth" of women's lives are undermined by theorists such as Michel Foucault, who avoid drawing lines between reality and representation. For Foucault, reality is only accessible through discourse, and thus any attempt to uncover the "truth" is a futile endeavour (MacDonald, 2003: 17). Moreover, if reality did exist outside of language and discourse, who would it belong to? Since women's experiences of caesarean sections vary considerably across cultures and according to individual factors and circumstances, any claim to reality necessitates that one selects a particular version from many possibilities.

Negotiated meanings & media effects theories

Mass communication theorists have not always embraced the idea that media authors and audiences negotiate meanings. Early media effects theorists

generally asserted that media authors conveyed powerful media messages to audiences through what is referred to as the "hypodermic" model (Bineham, 1988). Advocates of this model held that meanings were transmitted or "injected" into audience members' minds in relatively consistent and direct ways (Bineham, 1988: 236). These theories of uniformity and direct effects gave way to work that sought to understand how particular meanings or "ways of seeing" are selected, evaluated, and prescribed in media stories (Entman, 1993; Gamson, 1992). Subsequent media framing theory adds complexity to the models of communication, recognizing that heterogeneous individual interpretations are mitigated by and negotiated within complex social, cultural, and political contexts (McLoed & Detenber, 1999; Neuman, Just & Crigler, 1992; McQuail, 1994). Contemporary media effects theorists consider the roles of readers and consumers in relation to meanings produced by mass media, and demonstrate that newspapers and magazine discourses embody a range of meanings that are open to interpretation. Media representations do not simply mirror the world, and interpretations of media discourses are not mere reiterations of media messages. The relationship between media and audiences is much more nuanced, and theorists of communications and media increasingly recognize this complexity.

Conceptualisations of meanings as negotiated - rather than injected or reflected - fall within an understanding of language as "a form of social practice" (Fairclough, 1989: 20). Representations are not viewed as external to the world, but as intimately connected to, constituted by and constitutive of language, culture, and discourse. Myra MacDonald argues that perceptions of media

authors as "gatekeepers" of information are not particularly useful in understanding media representations (2003: 10). MacDonald asserts that models of "constant interaction" should replace such perceptions, in order to acknowledge the contributions of media and audiences, without exaggerating the role of media in producing reality for audiences (2003: 10).

While multiple interpretations exist within discourses, they do not simply co-exist. Power relations and interests shape the way in which language and meanings are constructed and interpreted. In terms of media representations of caesarean sections, common-sense notions of what makes a 'good' or 'bad' mother are invoked in response to women's birthing choices. Journalists also present ideas about femininity and birth as if they are 'natural' or 'normal.' In a recent Canadian newspaper, for example, Lovric (2005) argues that if women cannot take the pain of natural childbirth, they will not make good mothers. Other headlines serve to denounce and even demonize women who undergo elective caesarean sections: one journalist argues baldly that "too-posh-to-push moms set a bad example for society" (Fralic, 2005). The language used in these representations is clearly forceful, and requires an analytical framework that acknowledges competing interests and influential notions within media discourses.

Ideologies

Matheson (2005: 5) notes that "ruts in the road" are formed within language due to social interests, when powerful groups are able to exert their interests by playing into common-sense notions of how the world operates. Far

from being value-free, Matheson argues that "language is ideological...to the extent that it causes us to think in ways that support the interests of [these] groups" (2005: 5). The concept of ideology is useful for media analysis, in that it suggests that some discourses are particularly influential and are shaped by power relations. And yet ideology as a concept has sustained considerable theoretical criticism over the past several decades. The notion originated in the theories of Karl Marx, who likened ideology to false consciousness (Weedon, 1997: 28). Similarly, Louis Althusser adopted the term in his 1971 essay "Ideology and Ideological State Apparatuses," and conceptualized ideology as involving some degree of misrecognition or mediation of reality (Weedon, 1997: 30). Over time, theorists considered the term "too rigid and monolithic to do justice to the plurality and diversity of lived experiences" (MacDonald, 2003: 29). In a postmodern era that eschews grand theoretical explanations, ideology is generally perceived to be an unproductive term.

Nevertheless, theorists such as Terry Locke (2004) reclaim ideology in their work. According to Locke, ideology is both a powerful and unstable concept, dependent upon and determined by the relative numbers of individuals who accept or adhere to particular discourses: ideology is

> "an elaborate story told about the ideal conduct of some aspect of human affairs...its power lies in its truth value, which is determined by the number and nature of its subscription base as much as by some notion of 'explanatory force'" (Locke, 2004: 33).

Importantly, Locke's recognizes that power relations and competing discourses contribute to the prevalence and interpretation of dominant meanings within society. In his attempts to reconcile the contested nature of the term "ideology,"

Locke negotiates a variety of theoretical approaches, and then settles on a pragmatic, critical discursive approach to analysing media discourses. In contrast to earlier theorists, Locke acknowledges that ideologies are not necessarily stable entities, but are constantly in flux.

A number of destabilizing theories and themes in poststructuralist thought undermine the idea that language represents or reflects stable meanings or realities in the world. These theories present challenges for analyses of media representations of caesarean sections, but they also contribute to a more robust framework of analysis by highlighting a range of possibilities. Reconceptualizing ideology, for example, offers new ways to examine power relations within media representations, while avoiding assertions of "false consciousness."

Locating Resources of Meaning Making: Stillar's *Analyzing Everyday Texts*

To this point, I have primarily discussed theoretical or methodological abstractions rather than pragmatic approaches to discourses. By turning my attention to Glen Stillar's framework for analysing everyday texts (1998), I outline my approach here in terms that are more explicit. In his book *Analyzing Everyday Texts* (1998), Stillar maps out a variety of ways to critically approach textual materials (including media discourses), whether at discursive, rhetorical or social levels of analysis. The varying degrees to which authors draw upon these meaning-making resources comprise what rhetorician Kenneth Burke refers to as "the dancing of an attitude" (Burke 1941/1973: 9, in Stillar, 1998: 3). In my analyses, I examine media representations of elective caesarean sections as the dancing of various media authors' attitudes about women, motherhood, and

childbirth, among other ideas. I engage with these author's "dances" at discursive, rhetorical, and social levels of analysis, to identify dominant ideologies and particular patterns of meaning-making.

Discursive resources

Starting from the level of linguistic structures and functions, Stillar outlines the importance of attending to discursive resources within text. Texts are, as Stillar points out, the "instantiation" or representation of meaning-making potentials offered through language systems (1998: 14). I adapt Stillar's term "texts" here to mean "discourses" and use the term "discourses" in my subsequent discussions for consistency.

The organization, content, mode, patterning and clustering of words within discourses all reflect specific choices made within the possibilities and constraints of language systems. Particular phrasings within text serve to advance certain arguments, or to present experiences or situations in ways that are favourable to the author of the text. For example, the author of one 2004 newspaper headline asks, "Are B.C. Women Too Posh To Push? Our 'Embarrassing' Caesarean Birth Rate" (Fayerman, 2004). Stillar argues that such patternings show "how things are in the world" (1998: 33). In this case, the author clearly connects caesarean birth rates with women's preferences, not with obstetrical practices or any other factors. Thematic structures, whether declarative or interrogative in mood, and cohesive devices that are used to relate parts of discourses, work together to shape overall attitudes towards the world. With very little text, the author of the headline above combines interrogative and

declarative phrases to construct a particular argument about caesarean sections. The author's choice of the word "embarrassing" and connection of the word to women's choices further contributes to the overall force of the headline; the author implies that caesarean rates are high, women's choices are responsible for these rates, and the situation is embarrassing for British Columbians.

Far from being benign or incidental features of discourses, media authors' choices not only reflect, but actually construct and reconstruct the social context in which elective caesarean sections are lived and understood. Constructions of ideologies begin at the mundane levels of verb choice, phrasing, word choice, and dialogic roles assigned to individuals within text. Drawing on the work of Halliday, Stillar points out that language functions to make meanings; the implications of choices within discourses serve a particular *function* for authors of discourses. These goals and end-points are also influenced by, and in turn influence social contexts.

Locke's (2004) conception of 'ideology' is apposite here, in terms of the importance of considering cumulative choices that authors make within language systems. When similar patterns or themes within texts are repeated, or when large numbers of individuals subscribe to them, they retain a certain degree of power, or ideological force. Over time, the meanings produced cumulatively within these texts appear as "common sense" understandings of how things are in the world. Consequently, the organizational and structural choices that media authors make in representations of elective caesarean sections are significant in terms of their collective or ideological force.

Stillar also sketches out three main functional resources put forward by Halliday to identify the discursive elements of discourses (1998: 20-21). These resources involve the ideational, interpersonal, and textual facets of meaning-making, which authors draw on simultaneously within discourses. According to Stillar, the functional consequences of these resources are to represent ideas and experiences, make social connections, and generate cohesion within text.

Rhetorical resources

To identify the rhetorical resources of discourses, Stillar draws together the work of Halliday and others to acknowledge how authors construct social relations through language systems. In particular, he points to the work of Burke and rhetorical theory, and discusses Burke's notions of socially-motivated, orienting, and consequential rhetorical acts (1998). For Burke, as for Halliday, the role of choice within language systems is an important rhetorical resource, in that particular choices function to "induce cooperation" within a social context (Burke, 1950/1969b: 43, in Stillar, 1998: 59).

According to Stillar, Burke's attention to the orienting and attitudinal elements of discourses represents an important rhetorical resource for understanding and analysing everyday texts. In fact, Stillar goes so far as to argue that orientation is an inextricable feature of textual representations (1998: 61). Authors' unique combinations of experiences, individuals, and emotions within discourse indicate authors' different interpretations of reality. Rather than representing every possible feature of human relations and experiences, the constraints of language systems require that authors use combinations of

elements to construct meanings. Consequently, Burke argues that every representation is alternately a reflection, selection, and deflection of 'reality' (1966: 45, in Stillar, 1998: 64).

Burke's ideas about representations suggest a number of ways to approach discourse analysis. For Burke, humans enact relationships and experiences through discourses "in terms of," or through "terministic screens" of language systems (1966: 50 in Stillar, 1998: 60). While these screens are both constraining and enabling, they are nonetheless necessary for negotiating meaning within discourses. When authors combine various elements of Burke's pentad (five-point) model in discourses, social contexts and relations influence their selections; authors' choices are filtered through "terministic screens. As features of "social" discourses, terministic screens are not neutral, but are instead inevitably orienting and attitudinal. Between terministic screens and dramatistic pentad ratios within discourses, representations serve to reflect, perpetuate, and construct social inequities and divisions.

In media representations of elective caesarean sections, Burke would direct us to consider the dramatistic elements of act, agent, scene, agency, and purpose (1945/1969a: xv, in Stillar, 1998: 63). The relative contributions and combinations of each of these elements, according to Burke, work to produce the dramatic features of representations of "reality." Media authors set a particular scene and use various combinations and selections of agents and acts to represent experiences or relations. These unique combinations are important to consider in relation to the overall rhetorical structure of discourses.

One way in which Stillar argues that language systems produce and reproduce social inequities and divisions is through unequal access to language systems. Stillar points out that "not every person has access to and 'control' of the particular registers that help construct the social fields in which they participate" (1998: 84). The relative accessibility of resources within language systems are important to consider in terms of how media authors represent elective caesarean sections. The framing of knowledge, experiences, and relations within these representations may alienate some addressers and addressees. By appealing to particular authoritative sources or statistics, for example, media representations have the potential to reflect, perpetuate, or construct social inequalities.

Social resources

Stillar's attention to the unequal accessibility of language systems anticipates his turn towards the social resources of language, and particularly the works of Anthony Giddens and Pierre Bourdieu. Rather than existing separately from the discursive and rhetorical theories of language, the social resources that Stillar draws attention to both complement and extend analytical possibilities. Specifically, Stillar sketches out the dialectical relationship between symbolic and social practices, and the implication of this dialectic for understanding discourses, through the works of both Giddens and Bourdieu.

Giddens' work on the "duality of structure" is useful in terms of how it conceives of connections between social structures and social practices. He argues that

> "[s]tructure [is] the medium and outcome of the conduct it recursively organizes; the structural properties of social systems do not exist outside of action but are chronically implicated in its production and reproduction" (Giddens, 1984: 374, in Stillar, 1998: 94).

Giddens establishes that social systems and language systems are not separate entities, but are produced by and are productive of social realities, experiences, and practices. To conduct comprehensive analyses of media representations, it is necessary to explore the broader social contexts in which they take place, and to search for connections between elements of the discourses and their larger contexts.

Bourdieu also offers a range of ways to understand "context." In particular, Bourdieu's notion of "habitus" is elaborated by Stillar as "a set of embodied cultural dispositions that social agents bring to bear in social practice" (Stillar, 1998: 95). Arrangements of "dispositions" within a habitus are cultivated through an array of experiences, socialization processes, and elements of culture. Traces of habitus are embedded within authors' negotiations of language systems, and they dispose individuals towards certain presentations of issues or ideas. These dispositions and traces of habitus are important to consider within analyses of media representations of elective caesarean sections, in terms of how they shape authors' understandings and attitudes about women, motherhood, childbirth and a range of related issues. Socialization of gender roles, and assumptions about how women or mothers are supposed to engage with health

professionals, for example, are reflected in a variety of ways within media representations.

Stillar also draws upon Bourdieu's concept of "linguistic habitus" as a resource for discourse analysis. He argues that linguistic habitus determines not only what meanings are produced, but also what "evaluative dispositions" are assumed in relation to those meanings (Stillar, 1998: 101). The differing values, significance, and forms of capital that authors imbue discourses with are connected to the linguistic habitus of the author. Linguistic capital is often distributed unequally within linguistic and social systems, reflecting social divisions and hierarchies. Media authors' consistent framings of the issue of elective caesarean sections highlight these social divisions and hierarchies, and exemplify how power relations are exercised through language systems. Rather than being inherent features of language systems, power relations are features of the social systems and practices of which language is a part.

Conclusions

Despite the challenges that destabilizing theories and poststructuralist thought pose for analyses of media representations of elective caesarean sections, the integration of works outlined within this chapter provide ample justification for a comprehensive analytical approach. By drawing on a wide range of theoretical traditions and concepts, I aim to approach media representations of elective caesarean sections in a more comprehensive manner than reliance on any one framework would afford. Using the discursive, rhetorical, and social resources outlined by Stillar, and paying particular attention

to Burke's dramatistic approach, I conduct discourse analyses with a wide-ranging conceptual tool set. As I navigate authors' representations of birthing and women's bodies, I recognize that absolute truths do not exist. Rather, my primary analytical goals are to identify overarching themes and patterns within these meanings, to highlight excluded meanings, and to open up spaces in which new birthing "truths" can be produced and negotiated.

CHAPTER FOUR

MANAGING UNCERTAINTY, CONSTRUCTING CHOICES: MEDIA REPRESENTATIONS OF ELECTIVE CAESAREAN SECTIONS

"The truth is rarely pure and never simple"
Oscar Wilde

In this chapter, I analyse recent Canadian print media representations of elective caesarean sections from March 2004 to October 2006. Rather than accept the premise that women are merely "too-posh-to-push," I situate these media representations within the context of the evolving maternity services, in which rates of birthing interventions are rapidly increasing without clear health benefits for women and babies. I explore how media authors manage birthing uncertainties through the construction of "truths" about elective caesarean sections. Blaming women for elective caesarean sections and other high rates of interventions provides an easy answer to a highly complex problem, but obscures the historical and cultural legacies and professional responsibilities that shape women's birthing options in Canada. Throughout my analyses, I acknowledge that "truths" about elective caesarean sections are complex, but I also identify patterns within the range of truths that media authors construct, particularly in relation to how they characterize women's roles, responsibilities and choices in birth. The patterns and themes I identify in this chapter are important in terms of their potential influence on the synergistic relationship between media production and consumers' ideas and perspectives on elective caesarean sections. For example, the frequencies with which authors convey certain information patterns or themes across media outlets are noteworthy,

given that newspapers and magazines are trusted sources of information for many individuals. When authors communicate or promote these sets of knowledge claims to the exclusion of alternative perspectives, individuals may eventually accept them as truths. This point is particularly salient in the context of my research, since a central Canadian media conglomerate, CanWest Global, owned many of the newspapers that I included for analysis. CanWest Global often publishes stories repeatedly over time and across several newspapers, creating a wave of similar knowledge claims across Canada about elective caesarean sections.

I ground my systematic analyses of print media representations within a pragmatic, hybrid model adapted from Glen Stillar (1998). Stillar draws on the resources of discourse analysis, rhetorical theory, and social theory to examine various forms of textual representations. Following Stillar, I integrate the theories and methods of Kenneth Burke to explore meanings in texts, and use elements of Burke's dramatistic approach as the primary organizing principles for my analyses. Burke's analytical structure for analysing human relations and language provides a "*calculus* – a vocabulary, or set of coordinates" to explore and locate the motivational and purposive elements of language and acts (Burke, 1957). This set of coordinates includes 5 main elements - act, scene, agent, agency, and purpose - which I identify in newspaper and magazine articles about elective caesarean sections. Burke notes that

> *"in a rounded statement about motives, you must have some word that names the act (names what took place, in thought or deed), and another that names the scene (the background of the act, the situation in which it occurred); also, you must indicate what person or kind of person (agent)*

performed the act, what means or instruments he [sic] used (agency), and the purpose" (Burke, 1962: xvii).

According to Burke, it is necessary to consider the elements of a dramatistic approach collectively, in terms of associational clusters or interrelationships. Authors use a number of "implicit equations" or ratios through which they combine elements such as act, scene, and purpose in strategic ways (1957: 18). When each of these structural elements is considered as part of a larger drama, discourses emerge that embody motives and intent.

Throughout this chapter, I identify common "implicit equations" and patterns of birthing "truths" within media representations of elective caesarean sections. Using Burke's dramatistic approach, I explore how authors of newspaper and magazine articles invite audiences to understand the roles, choices, and responsibilities of various agents involved in elective caesarean sections. Rather than merely cataloguing elements of Burke's dramatistic approach, I highlight the intrinsically attitudinal and orienting nature of media representations, in terms of how journalists and authors construct multiple ways of seeing the "problem" of elective caesarean sections. Within such representations, authors combine elements of language together to form powerful statements about risk, choice, birth, and women's bodies.

Situating Caesarean Sections: The "Scene"

"*...the scene (the background of the act, the situation in which it occurred)...*"
(Burke, 1962: xvii)

Canadian women give birth in the midst of a tangled and shifting network of ideologies, values, uncertainties, technologies, and power relations. Within this

birthing "scene," individuals and organizations compete for professional authority over women's bodies, and struggle to promote their own interests and ideas about birth, motherhood and femininity. This backdrop defies simple encapsulation, and yet in the 32 newspaper and magazine articles that I reviewed, media authors generally present simplistic scenes of elective caesarean sections. Professional hierarchies and power struggles that exist between obstetricians, nurses, midwives, anaesthesiologists, doulas and mothers are absent from most authors' discussions of elective caesarean sections. Journalists fail to discuss the differing interests and ideologies of these birthing "experts," and in some cases, sum up the entire Canadian birthing scene in a few simple sentences. In general, authors disregard the historical and cultural complexity of birthing issues in favour of more narrowed, medically-dominated perceptions of birth.

According to Burke, authors' constructions of literary works are strategic, stylized acts; they weave together relationships, events, and ideas in meaningful ways, for particular ends (Burke, 1957; 3). The methods by which authors craft the overall Canadian scene of birthing services in relation to elective caesarean sections are similarly motivated acts, comprising his or her hypotheses or theories of the "problem" of elective caesarean sections. In crafting a scene, an author situates an act, locates agents in relationship to that act, and proposes solutions based on her or his constructions. Within the media representations that I discuss here, authors select and connect specific events and ideas from within the larger, more complex scene of birthing in Canada. While each author

constructs the Canadian birthing scene in a unique way, a number of important patterns emerge in my analyses.

Framing the debate: rising rates and women's choices

I began collecting newspaper and magazine articles related to elective caesarean sections in March, 2004, when a controversial article on elective caesarean sections was published in the *Canadian Medical Association Journal* (CMAJ). In the article, Dr. Mary Hannah, a Canadian obstetrician, argues that "a growing number of women are requesting delivery by elective caesarean section without an accepted 'medical indication'" and suggests that physicians should support these requests (2004: 813- 814). Hannah's focus on women's choices serves to frame the debate in a very specific way. While not all journalists and authors accept her conclusions, Hannah's framing of the elective caesarean debate is adopted by nearly all authors of newspaper and magazine articles about elective caesarean sections from March 2004 to present.

It is disconcerting to recognize that so many media authors readily accept Hannah's premises, and that these premises serve as the foundation of the debate about elective caesarean sections. Hannah constructs her entire argument about elective caesarean sections around women's demands for the procedure, without ever substantiating her claims. She provides no statistics or research to support an alleged trend in women's requests, but immediately explains why it exists, discusses the risks and benefits of undergoing an elective caesarean section, and instructs physicians on how to respond to women's requests. Hannah's allegations are baffling, since at the time of publication of her

article, there was a paucity of data on elective caesarean sections, and considerable uncertainty over whether women actually request them or physicians recommend them. Recent research suggests that most women prefer to plan for a vaginal birth (which Hannah acknowledges in her 2004 CMAJ article) and the majority of caesarean sections are ordered by physicians, not requested by women (Childbirth Connection, 2006).

Nonetheless, many authors unquestioningly accept Hannah's premises, and adopt her framing of elective caesarean sections as a woman's choice issue. The consequences of these authors' shortsighted reasoning are evident in several media representations of elective caesarean sections. One author, for example, cites Hannah's 2004 CMAJ article, accepts her premise that many women are requesting caesarean sections, and then extends the argument even further:

> *"[c]ertainly, it seems unwise for expectant mothers to schedule C-sections for no other reason than to avoid the timing vagaries associated with normal childbirth (a growing practice among busy career women)"* ("The posh must push," 2004).

Similarly to Hannah, the author offers an explanation ("timing vagaries") for an unsubstantiated trend, and then names the type of woman ("busy career woman") that would allegedly request an elective caesarean section. In spite of such flawed reasoning, the author makes brazen conclusions about this hypothetical group of "busy career" women:

> *"[f]or women able to find a compliant doctor, elective C-sections are currently funded by medicare in all Canadian jurisdictions. That practice should end....whether or not a given woman needs a Caesarean for legitimate medical reasons is a question best left to a treating physician. In those cases where vaginal delivery would be dangerous, C-sections*

> *should continue to receive public funding. But when it comes to elective cases, our mantra should be 'push or pay'"* ("The posh must push," 2004).

Embedded within the author's statements is a range of assertions about birth and women's bodies. Media authors commonly portray birth as a medical event. Not only does the author immediately chastise women for attempting to exercise choice in the medical domain of birth, but s/he also proposes policy changes based on Hannah's unsubstantiated claims. The moralizing phrase "push or pay" implies that women should be punished for trying to avoid labour and vaginal birth in favour of a caesarean section. Overall, the birthing scene that media authors construct is one in which women are expected to surrender decision-making and control over their bodies and birthing experiences to their physicians.

High-technology and timetables: birth as a medical event

In nearly all of the articles that I reviewed, authors present an overwhelmingly technological, medicalized birthing scene. They discuss rising rates of caesarean sections and birthing interventions, busy physicians, high numbers of complications and high-risk women, and numerous risks and benefits of vaginal versus caesarean sections. The manner in which authors present women's birthing experiences is also markedly medicalized. Journalist Tanya Talaga recounts one woman's experience according to medical terminology and risk assessments:

> *"[Ju-Young] Bae first had a C-section four years ago during the birth of her son. She said she failed to dilate properly after 20 hours of labour, so doctors surgically removed the baby. Second time around, her C-section was planned. But less than a day before that planned C-section, her water broke and she had to hustle to the hospital. 'I got here at 3 a.m. and at 3:50 I was having the operation'"* (2004).

In Bae's first birthing experience, she "fails" according to medical standards of birthing: she does not dilate "properly" according to a medical timetable, and so doctors decide to surgically remove her baby. Talaga portrays Bae's birthing experiences largely in terms of physicians' determinations and medical assessments or requirements, not in terms of Bae's demands for a specific birthing method. But while Talaga states that "Bae's birthing experience clearly illustrates some of the [Canadian birthing] trends," Talaga goes on to frame elective caesarean sections as a woman's choice issue in her article (2004). She argues that "women are choosing to have a C-section so they don't have to go through the pain of vaginal birth" (Talaga, 2004). Talaga's inclusion of a largely physician-determined birthing experience runs contrary to her assertions that women are increasingly requesting caesarean section. Following several other journalists, she also fails to provide any research or evidence to support her assertions regarding increasing maternal requests for caesarean sections.

High costs and taxpayers' tabs: birth and Canadian health care

Nearly all authors either cite Hannah's article directly in their discussions of elective caesarean sections, or implicitly adopt her framing of the debate as one of maternal choice. However, a birthing report published in 2006 by the Canadian Institutes for Health Information (CIHI) added a new dimension to authors' perceptions and written representations of the Canadian birthing scene. CIHI researchers produced a report entitled "Giving Birth in Canada: The Costs" to outline maternity services expenditures in Canada, and on April 26, 2006, they published a media release for the birthing report. Authors of the release

specifically emphasized that caesarean sections in Canada cost approximately 60 percent more than vaginal births ($4600 and $2800, respectively) and highlighted the rising rates and costs of birthing interventions. The CIHI media release renewed a media furor over elective caesarean sections and journalists across Canada hastily published "too-posh-to-push" headlines:

> "'*Too posh to push' Canadian moms opting more for C-sections*" (Munro, 2006).
>
> "*Canadians are 'too posh to push.' 1 in 4 births is a C-section: Taxpayers foot bills for women too scared of normal birth: report*" (Munro, 2006).
>
> "*Canadian health system paying high cost for women who are 'too posh to push'?*" (Bueckert, 2006).

Remarkably, while the CIHI report does not include any connections between costs of birth, women's birthing choices, and elective caesarean sections, journalists and media authors immediately attributed birthing costs directly to women's demands for elective caesarean sections. One journalist writes that "more women opting for [a caesarean] have helped drive the cost of childbirth to more than $1-billion a year, according to a national report" (Munro, 2006). Authors' inaccurate interpretations of the CIHI findings regarding cost differences are clearly reflected in their constructions of the Canadian birthing scene.

Following publication of the CIHI report in 2006, most authors frame elective caesarean sections as risky and expensive procedures within the context of an already overburdened Canadian health care system. One author in particular links women's choices to this overburdened system, and argues that women who undergo 'unnecessary' caesarean sections take up space in operating rooms where other patients are likely waiting for surgery:

> "The operating room has to be readied [for a caesarean section], supplies and equipment deployed, and a bed taken up in a four-day stay, compared to anywhere from a few hours to two days for a vaginal birth. When operating room time is at a premium for hip and knee replacements, heart bypasses and other surgeries with unconscionably long waiting lists, it is the epitome of bad practice to fill those operating rooms with women having unnecessary elective surgery, on the taxpayers' tab" ("Let moms fund vanity," 2006).

The author's strident connection between unfounded claims of women having 'unnecessary' surgery to potentially missed heart bypasses pits an apparently benign surgery with a lifesaving one. Connecting mothers specifically and exclusively to such fatalities, without presenting solid evidence to support such a notion, is not only offensive to women and mothers, but also misleading and potentially costly. According to the author, moms selfishly book expensive caesarean sections to salve their "silly" concerns about pain, or to escape any possible marring of their figure:

> *...elective C-sections performed for the mother's or doctor's convenience, or because the mom is afraid of labour pain, stretch marks and other unpleasantness associated with vaginal delivery, are an unnecessary strain on a resource- and cash-strapped health system.* ("Let moms fund vanity," 2006).

The author focuses on women's choices, and fails to consider the broader scene of birthing in Canada, or the possibility that a range of factors (including obstetrical practices) contribute to escalating birthing costs in Canada. Such a narrow focus on mothers' vanity and birthing fears obscures the systemic problems in Canada's health care system, and is not likely to support the alleviation of compounded financial pressures.

"A culture of poodles:" situating women's choices

Beyond the boundaries of the health care system, authors also discuss notions of "culture" in which they situate elective caesarean sections and other birthing interventions. One journalist includes a reference to birthing women as "a culture of poodles" and refers to "cultural phenomena" such as women's astrological beliefs and their perceptions of what constitutes quality care (Munro, 2004). Another author similarly refers to "cultural factors" and notes that

> *"some women from places like Hong Kong and Taiwan prefer caesarean sections and press their doctors to schedule them as elective surgery...women of Chinese descent who were having their babies at B.C. Women's [Hospital] were mostly from Taiwan and Hong Kong, where C-sections on demand are typical" (Fayerman, 2004).*

Still another author describes women's "too posh to push" preferences as a "cultural trend" and "disturbing medical phenomenon" in which surgery is performed for a mother's convenience ("Let moms fund vanity," 2006). In almost every newspaper and magazine article, authors blame women for selfishly choosing caesarean sections. Where authors cite "culture" specifically, they often use the term as a catch-all category to explain women's supposed vanity or desire for convenience, in lieu of more complicated explanations for Canada's changing birthing practices.

In general, Kenneth Burke notes that the "scene" of a literary work serves as a "fit 'container' for the act" and contains "'agents' in the sense of actors" (1962: 3). In the case of media representations of elective caesarean sections, there is a clear correlation between the scenes that authors generate and the act-agent ratios that they present (i.e. women choosing caesarean sections).

Most authors construct "containers" of elective caesarean sections that are relatively shallow: they contain a narrow range of birthing possibilities, involve a select number of birthing experts, and include only specific types of mothers. The confines of these literary spaces are purposive, in that they anticipate a limited set of conclusions about elective caesarean sections and the assertion that women are "too posh to push."

Seeking Caesarean Sections: The "Act" and "Agents"

"...the act (names what took place, in thought or deed)...also, you must indicate what person or kind of person (agent) performed the act..." (Burke, 1962: xvii)

Many authors appear to engage in a flight of imagination regarding elective caesarean sections. Starting from the largely unfounded premise that women are "too posh to push," accusations of cavalier, selfish attitudes abound, and escalating health care costs related to women's selfish "choices" take on legendary proportions. Authors are quick to link the "act" of choosing a caesarean section to women as autonomous "agents." Along the spectrum of journalistic styles and reporting methods, this connection is elaborated using a blend of sarcastic or comedic elements with more formal research findings to construct a specific context or "container" for elective caesarean sections. According to Kenneth Burke, "the work of every writer contains a set of implicit equations" among elements such as acts, scenes, and agents (1957: 18). Likewise, media messages and meanings about elective caesarean sections are the products of "equations" or interrelationships between these elements. Authors introduce agents and articulate acts in ways that offer a compelling

statement about elective caesarean sections; they argue that mothers *choose* caesarean sections.

Riskier mothers: physical characteristics and birthing "choices"

Authors frequently introduce mothers as "agents" of elective caesarean sections by making general statements about Canadian women. They allege that Canadian women are they are getting older, heavier and are choosing to take fertility drugs to conceive later in life, putting them at high risk for caesarean sections:

> "*Canadian mothers are older than they used to be when they give birth....many women are taking fertility drugs that result in multiple births. Canadian women are fatter than they used to be, and it may be harder for overweight mothers to deliver bigger babies"* (McIlroy, 2004).

Overwhelmingly, authors centre their discussions of elective caesarean sections on women's choices: women *choose* to wait longer to have children, they *choose* to take fertility drugs, and they fail to maintain their weight. These choices are seen as determinative of high rates of caesarean sections, to the exclusion of any other factors. In cases where other factors or roles are discussed, they are minimized in comparison to women's choices. The author of a *Toronto Star* article, for example, lists a number of woman-specific indications for elective caesarean sections, and then briefly mentions and downplays the role of obstetrical preferences in contributing to high rates of elective caesarean sections:

> "*...the increase in Caesareans is due to a number of factors...to a lesser extent, doctors' fears of malpractice litigation*" (Carey, 2004).

Carey primes her readers to accept that women's choices are the most important determining factors to consider in relation to elective caesarean sections. Her premises are also underscored in the first sentence of her article, where she immediately connects high rates of caesarean sections to women who delay pregnancy and childbirth until later in life.

"Too posh to push" mothers: birthing "fad" or fiction?

Apart from general at-risk categories of birthing women, authors also specifically name certain types of women as agents of elective caesarean sections. In the articles that I reviewed, the most commonly cited woman is a "too posh to push" mother. Authors present the disparaging "too posh to push" expression as self-evident, and do not provide evidence or statistics to support the existence of such women:

> "*The too-posh-to-push crowd should give some thought to what they ask for when they opt to have their baby via caesarean section. They think they have chosen the easier way, but, too late, they will discover that they have not*" (Gaffney, 2004).

Rather than exploring the role of elective caesarean sections in relation to high overall rates of caesarean sections, and carefully examining the statistics, research and broader factors related to these overall rates, authors do the opposite. They cite the popular "too posh to push" phrase, take for granted that mothers' supposed choices and demands are to blame for high rates of birthing interventions, and then offer moralizing critiques and personal assessments of these choices. Absent from most authors' methods of reasoning are alternate explanations and evidence that are relevant to the overall context of the

caesarean debate and to women's unique experiences of pregnancy and childbirth.

Media authors also offer other negative representations of women either in addition to or in lieu of the "too posh to push" expression. They depict superficial, spoiled mothers, modern and educated professional women, and busy, "time-stressed, multi-tasking MTBs [mothers-to-be]" (Wells, 2004). In their descriptions, authors are at times sarcastic and disdainful of women's alleged choices. They adopt a women's choice framework in the absence of supporting evidence, and engage in derisive commentaries about "tummy tucks" and "female fads:"

> "*Why, this is easy, [too-posh-to-push] moms must say to themselves. We'll just program the hour into our Palm Pilot, book a little pedicure before heading off to the delivery room and, oh, while you're in there doc, how about a little tummy tuck. Why, golly, having a baby is like ordering pizza, but for that pesky scar, and the weeks of discomfort afterward*" (Fralic, 2005).

> "*Female fads have always been a bit baffling. Take the thong for instance. Do women really revel in the though of having to endure a perpetual wedgie? And what about shoulder pads? What women in her right mind wants to look like a burly football player? The latest trend, however, has created quite a controversy. Elective C-sections. That's right. It seems certain women are actually choosing to have a caesarean...*" (Lovric, 2005).

In their commentaries, these authors fail to consider whether women are in fact requesting caesarean sections at all. They dismiss some women's fears about birth, and portray women as frivolously choosing caesarean sections in the same manner that they would order a pizza or wear shoulder pads. In effect, such comments undermine the emotional and psychological aspects of women's varied birthing experiences, and ignore the power of cultural expectations and beauty norms that impel women to engage in a range of behaviours.

The biomedical birthing imperative and birthing "experts"

While authors frequently blame and berate women for undergoing elective caesarean sections, they rarely solicit women's perceptions or consider their experiences of maternity services. Women's experiences of birthing are recounted only 8 times in the 27 different articles about elective caesarean sections that I reviewed. Conversely, authors cite obstetricians' or physicians' perspectives 36 times in these articles. What is particularly worrying about this positioning of women versus physicians is that media authors position physicians in privileged positions as gatekeepers of birthing "truths." In the spaces that journalists designate for medical opinions, obstetricians often shift the burden of responsibility for high rates of elective caesarean sections and birthing interventions to mothers:

> "*We have women coming in with the impression that caesarean section is an easier alternative to vaginal birth....There is no reason to think there is an esthetic advantage in having a C-section...And if women are frightened of vaginal birth, it is because they don't appreciate that we can take care of pain in labour. If things go wrong, we can do a C-section if we have to*" (Munro, 2006).

Very few authors provide similar spaces within which mothers can offer their perspectives on elective caesarean sections, or respond to obstetrical framings of the caesarean section debate. This exclusion of mothers skews perceptions in favour of obstetrical perspectives, and fails to offer readers alternate ways of viewing "too posh to push" claims.

An overwhelming reliance on biomedical conceptions of birth and on biomedical "expert" opinions about birthing is evident in most articles about elective caesarean sections. While caesarean sections births are distinctly

biomedical procedures in terms of their delivery and regulation by trained medical professionals, the birth process itself does not necessarily require medical intervention. Nevertheless, birth in general is portrayed in media representations of elective caesarean sections as no less "naturally" biomedical or requiring of medical supervision than a caesarean section.

Several authors imply that the best birthing experience for women is a medically-monitored one, where women comply with the recommendations of "expert" medical birthing professionals. Attempts to arrange one's birthing experience outside of this narrow range of medical acceptability are often harshly criticized. In one particular article, published in both *Macleans* magazine (26 April 2006) and the *Globe & Mail* newspaper (27 April 2006), journalist Dennis Bueckert cites influential Canadian obstetrician Jan Christilaw. A former president of the Society of Obstetricians and Gynaecologists of Canada, Christilaw refers to women's supposed preferences for caesarean sections as "almost silly," and then discusses at length the medical reasons why, in her professional opinion, such a decision is misguided. Christilaw's dismissal of women's choices as imprudent undermines women's decision-making capacities and follows the popular trend in focussing on women's supposedly superficial choices. Christilaw addresses women directly in her comments about elective caesarean sections:

> *"If you think you're going to have a better figure if you have a C-section rather than a vaginal birth, you're realistically wrong. It'll take longer for your abdominal muscles to get back into shape and of course you'll have a scar on your abdomen..."* (Bueckert, 2006).

Further, in reference to sexual performance and/or pleasure, she states:

> *There's really no suggestion of when you look at the statistics for the whole population that having a C-section is actually going to make sex better for you in the long run* (Bueckert, 2006).

And, finally, in terms of convenience for mothers, she argues:

> *You have a busy life, you check into the hospital on Friday at five o'clock, have your C-section and you're done as opposed to having to wait for the natural process to get started some time over a two-week period. It may take 12 to 24 hours before you have your baby. You never know what's going to happen. If you're flying your mother-in-law in from Australia, well it's not too convenient* (Bueckert, 2006).

Notably, none of Christilaw's comments are directed at the larger culture in which women give birth, or other potentially significant factors that determine high rates of caesarean sections. As an obstetrician, Christilaw's narrow focus on women's choices and demands is important, since she fails to consider the potential influence of obstetrical practices in determining rates of elective caesarean sections.

To be fair to Christilaw, it is possible that she did discuss obstetrical practices or other factors in her discussions with the author, and that her comments were excluded to bolster the author's argument and conclusions about "too posh to push" moms. However, other obstetricians also alternately position themselves as leading authorities on birth and disinvested parties in relation to elective caesarean section rates. Although obstetricians personally order and perform caesarean sections, they insist that women and not physicians are driving the trend:

> *"'There is very little difference in the fee paid to a physician for a C-section versus a vaginal birth...this [trend] is not being pushed by the medical profession, at least in Canada'"* (Carey, 2004).

Abby Lippman, health researcher and author of a *Globe & Mail* article about elective caesarean sections, argues that physicians' framing of the debate as one of women's choices is irresponsible. She asserts that

> "[f]or a physician to say merely that a C-section is a woman's choice would seem to reflect not so much paternalism, which we all reject, but some refusal of professional responsibility" (Lippman, 2004).

Rather than acknowledging their central role in caesarean sections, obstetricians refer to women's birthing preferences and "rights to choose" their preferred birthing method. In doing so, they deflect attention from their professional responsibilities and place women at the centre of critiques.

Excluding the "esoteric:" midwives, doulas and alternative birthing agents

Authors' inclusions of obstetricians' specifically *biomedical* opinions, to the exclusion of all other "expert" opinions, determine particular framings of the issue of elective caesarean sections. Bueckert and others choose to interview and quote only obstetricians and medical professionals such as Christilaw, rather than midwives, doulas, or women who have first-hand, experiential knowledge of birth. Authors refer to the opinions of professional medical organizations at least 46 times in 27 different articles, compared to only 5 women's health groups, and 5 alternative birthing groups. In terms of other birthing experts, authors cite or refer to midwives 9 times, doulas 5 times, and only one nurse's comments are included. Where authors do mention or cite other birthing experts, their depictions are not necessarily positive. One author, when discussing "esoteric," non-medical birthing options, includes a doctor's perspective:

> *"A little while back, I asked a doctor friend for his take on natural childbirth. He rolled his eyes, as if he'd heard the question once too often.'Parents*

> *forget how many things can go wrong,' he told me. 'Delivering a baby is a major medical procedure. It's potentially dangerous, and it hurts like hell. Who do you want to be on the receiving end – a trained doctor backed up by modern life-saving machines and painkillers, or some woman with a Guatemalan hat?'"* (Kay, 2006).

The author includes bigoted comments from his "doctor friend," who links incompetent care to an ethnicity or type of individual, and fails to explore any other birthing providers' perspectives on the issue. The doctor's comments reflect and reproduce the hierarchies and power relations that exist within Canadian maternity services, where approximately 99% of births take place in hospitals, and funding for midwifery and alternative birthing supports is unevenly distributed or even non-existent across provinces (Canadian Institute for Health Information, 2004; 2006). Within this context, authors depict obstetricians with their "lifesaving machines and painkillers" as "true" birthing experts, and exclude other non-medical perspectives.

Constructing Women's Desires: "Purpose" and "Agency"

"...what means or instruments he [sic] used (agency), and the purpose..."
(Burke, 1962: xvii)

Authors' descriptions of elective caesarean sections are not meaningless exercises, but strategic ways of constructing and explaining a problem. As Burke notes, authors combine a number of literary elements together to construct a "rounded statement about motives" (Burke, 1962: xvii). They set a scene, identify an act, and name agents in ways that suggest particular purposes or intentions. In media representations of elective caesarean sections, authors most often present the "problem" of elective caesarean sections as one of women's unnecessary, risky, and costly requests for surgical births. Within this framing of

the issue, authors explain the purposes behind the problem by constructing women's desires for elective caesarean sections. They also describe the means through which women attempt to achieve fulfil their birthing desires.

Celebrity-mommy "wannabees:" in pursuit of the designer birth

Authors commonly describe women in media representations of elective caesarean sections as "too posh to push." This worn-out expression suggests a purpose for women's choices: that they are too posh to give birth vaginally, and base their decisions on selfish or superficial motives. To understand why authors choose to construct women's birthing desires in this manner, it is necessary to trace the emergence of the popular "too posh to push" expression.

The phrase "too posh to push" originates from the celebrity birth experience of Victoria Beckham. Beckham, also known as "Posh Spice," was a member of the popular British music group "The Spice Girls." Beckham received an onslaught of media attention when a journalist reported that she had chosen a caesarean section for the birth of her first child, to avoid going through the pain and consequences of labour and vaginal birth. Despite Beckham's insistence that the caesarean section was indicated due to the breech position of her baby, media outlets in the United Kingdom and elsewhere promoted the idea that Beckham was clearly too "posh" to push her baby out vaginally. Authors and journalists quickly adopted the catchy phrase to describe celebrity mothers' caesarean births.

Since the emergence of the "too posh to push" phrase, celebrity mothers who undergo caesarean sections are often placed under intense media scrutiny,

and media reporters pressure women to disclose whether or not their surgical births were medically indicated. Recently, high-profile celebrities Gwen Stefani and Angelina Jolie responded to these pressures by disclosing their respective reasons for undergoing caesarean sections. They both clearly noted that their procedures were medically necessary. Given media outlets' tendencies to label celebrity mothers as "too posh to posh," it is understandable that mothers make such admissions to avoid the disparaging label. These admissions are also significant because they underline the role of obstetrical practices in determining the procedures, rather than the "bevies" of supposedly "too posh to push" mothers that journalists such as Shelley Fralic refer to (Edmonton Journal, 29 September 2005).

Fralic's analysis, in line with other celebrity-focussed reports of elective caesarean sections, draws on the recent birth experience of celebrity mother Britney Spears in order to support her critique of "too posh to push" mothers. Fralic notes that

> "*Britney joins a bevy of too-posh-to-push moms, many of them trend-setting celebrities like Victoria Beckham, whose three sons by soccer star husband David were all delivered by elective, planned caesarean sections*" (2005).

While Spears, unlike Victoria Beckham, never officially released a statement regarding the reasons that she underwent a caesarean section, Fralic nonetheless spuriously references an excerpt from one of Spears' pre-birth interviews to sustain her own conclusion that Spears opted for a caesarean section:

> "*Spears recently told Elle magazine that she was spooked by her mother's description of vaginal childbirth as being the most excruciating pain she had ever endured, and she wasn't having any of that. So she opted for a C-section*" (2005).

Spears notes in the *Elle* magazine article that she is indeed fearful of giving birth, but she does not explicitly state that she is planning to undergo a medically unnecessary caesarean section, nor did she report, post-partum, that she had undergone such a procedure. Without presenting evidence to support the notion that Spears actually requested a "medically unnecessary" caesarean section, Fralic assumes that this is the case.

Many other journalists and authors help to promote the idea that "too posh to push" celebrity moms have caesarean sections to avoid the pain, inconvenience and potential physical disfigurement and consequences of vaginal birth, despite a glaring lack of evidence to support such claims. The most common celebrity reference is, unsurprisingly, to Victoria "Posh Spice" Beckham. Beyond merely singling out Beckham, however, media authors now indiscriminately apply the term "too posh to push" to mothers in general.

Selfishness, scheduling, scars and sex

Extending far beyond the superficiality claims directed at either Victoria Beckham or celebrity mothers are the countless intimations of small-mindedness directed at mothers in general who supposedly choose elective caesarean sections. These charges come from health professionals, women, men, and fellow mothers, who imply or even demand that mothers be entirely self-sacrificing. They consider methods of birthing noteworthy, debatable, or even contemptible where it appears that such methods are related to mothers'

attempts to care for or maintain their physical appearance or functioning. Authors discuss women's alleged desires for caesarean births in terms of their refusals to neglect or compromise particular aspects their personal health and well-being, whether physically, sexually, or otherwise:

> *"...the pre-booked C-section is being touted as the answer to this particular time – labour management issue...7 a.m. Pilates. 8 a.m. Call Jay re: highlights. Go blonde! Noon. Have baby.... From there we begin to imagine legions of young, toned MTBS (mothers-to-be) adopting the baby-booking birthing practices of Victoria (Posh Spice) Beckham....Why, this is easy, they must say to themselves. We'll just program the hour into our Palm Pilot, book a little pedicure before heading off to the delivery room and, oh, while you're in there doc, how about a little tummy tuck?* (Fralic, 2005).

In most cases, media authors dismiss women's choices as uninformed and superficial. Authors equate supposedly vain, aesthetic choices with improving one's appearance through hair highlights, fitness classes, pedicures and tummy tucks. One author sums up the effects of childbirth as "stretch marks and other unpleasantness" ("Let moms fund vanity," 2006). In doing so, the author obscures potentially serious consequences of birth, which can include major infections, urinary and bowel incontinence, and other severe physical impairments. Where authors do mention these potentially devastating side effects, they state them briefly or minimize them in comparison to other factors.

Journalists and authors also argue that women's birthing choices reflect their desires for convenience, and prioritizing of career over parental obligations. They depict impatient, career-oriented women, who seek to fit birthing into their busy social schedules:

> *"Certainly, it seems unwise for expectant mothers to schedule C-sections for no other reason than to avoid the timing vagaries associated with*

> *normal childbirth (a growing practice among busy career women)"* ("The posh must push," 2004).

Authors centre their discussions on women's choices, and describe the selfish desires that apparently motivate these choices. For example, Kay assumes that women make entirely autonomous birthing choices, and assumes that these choices are motivated by "parental narcissism" (2006). Likewise, Bueckert references a doctor's opinion, who frames the relationship between a doctor and a mother: he depicts women as demanding and self-serving, and doctors as accommodating and selfless (2006). Authors generally avoid considering how women's choices are circumscribed by the broader contexts in which they take place, and fail to acknowledge the power relations and hierarchies that exist within maternity services. Even worse, they construct "truths" about women's birthing desires in the absence of evidence to support these claims.

A mother's perspective: managing birthing fears and uncertainties

Contrary to the claims of many authors and obstetricians, research on elective caesarean sections suggests that very few women request or desire to have an elective caesarean section, and demonstrates that some women's preferences for a caesarean section may be related to serious concerns or fears related to the birthing process (Childbirth Connection, 2006). Where authors dismiss women's fears of labour pain and birthing consequences, they discount the costly emotional and psychological investments that women make in birth, and the extreme physical pain that some women endure. In contexts where supports for women in women during pregnancy, childbirth and the post-partum

period are discontinuous and inadequate, some women may opt for a caesarean section to avoid poorly-supported birthing experiences.

In a *Chatelaine* magazine article that I reviewed, author Rebecca Eckler discusses her choice to request an "unnecessary" caesarean section (2006). While Eckler states "my daughter made it from my belly to my arms in 20 minutes – less time than it takes to straighten my hair" she does not indicate convenience as the reason for her decision. Instead, she states,

> "*I was utterly terrified to give birth. Thoughts of, How is this butterball going to come out of me? kept me up at night, my heart pounding so fast I had to catch my breath. That was the main reason for my decision*" (2006).

Eckler's reasoning challenges the superficiality claims that media authors regularly attach to women's birthing choices. She asserts that her decision to have a planned caesarean section "was not one I entered into lightly" (2006). In her article, Eckler alludes to the silence and shame that surround women's birthing experiences:

> "*...no one talks about their actual labour. Even my best friend, whom I've seen naked and who could blackmail me for millions with all the secrets she knows, told me, 'I can't talk about it,' after she had her first baby. Another good friend of mine told me her labour 'wasn't that bad,' as she gently sat on the couch, as if she were sitting on a bed of thorns, a week after having her baby*" (2006).

She also outlines how her decision served to mitigate the lack of continuity of care and support that women face in modern obstetrics:

> "*Many women these days don't have the luxury of their own obstetrician, whom they've gotten to know over the months, delivering their baby if the doctor isn't on call when they go into labour. With a scheduled C-section, not only did I know my obstetrician would be there, I could also make sure my mother, who lives in another city, was there that day*" (Eckler, 2006).

Eckler's comments highlight the impersonality that exists within Canadian maternity services, where trust and familiarity are lacking in relationships between women and their care providers. In the absence of guaranteed supports, Eckler views a planned surgical procedure as a way of ensuring that trusted individuals will be present throughout a much-feared process. Furthermore, she challenges authors' assertions that women's preferences for caesarean sections are necessarily uninformed or reflect a "cavalier attitude" towards their baby's health ("Let moms fund vanity," 2006). She counters,

> "*Sure, there are constant studies done about the risks of having a C-section. They warn about hemorrhaging, blood clots and breathing difficulties for the baby. But for every study that points to the risks of C-sections, I can find one to show these risks are true of any method of birthing*" (Eckler, 2006).

Eckler's chose to request a caesarean section based on a number of deeply-held fears, uncertainties and ideas about birth. Her decision represents an attempt to account for the inadequacies and uncertainties of a flawed and discontinuous maternity system, rather than a set of superficial desires.

Even where women do request caesarean sections in the absence of indicated medical necessity, it is important to consider whether responsibility for such a decision should lay exclusively with mothers. Many authors fail to acknowledge or consider the ethical and professional responsibilities of physicians who perform caesarean sections on women. If a procedure is determined to be unethical or unsafe by a treating health professional, then he or she is obligated to inform the mother, and is ultimately the one responsible for conducting such a procedure. In the majority of media reports that I reviewed,

authors largely neglect to discuss professional responsibilities and contributions, in favour of women's allegedly selfish motives.

Manipulative mothers and compliant doctors: imagining agency

Although many media journalists argue that women are responsible for choosing caesarean sections, they nearly always fail to mention how women achieve their desired birthing ends. Conceivably, this is due to the fact that a very small percentage of women demand caesarean sections. Where authors do offer explanations of women's means to obtain their desired birth, they depict women as persistent and persuasive, and physicians as compliant:

> *"Some women...press their doctors to schedule them as elective surgery"* (Fayerman, 2004).

> *"For women able to find a compliant doctor, elective C-sections are currently funded by medicare..."* ("The posh must push," 2004).

Authors position doctors as cornered by the forceful requests of demanding women, using terms such as "compliant" and "cede." Only one author references a mother's perspective, and this explanation comes from fellow journalist Rebecca Eckler, whose choice to undergo a caesarean section I discussed in the preceding section. The author includes a quote from Eckler, and then explains her rationale:

> *" 'I was prepared to lie and cry and do whatever'...[Eckler] was desperate two years ago to deliver her baby by scheduled caesarean section rather than deliver the old-fashioned way"* (O'Brian, 2005).

The impression that emerges from these authors' descriptions is one of a lopsided communication process, in which uninformed women manipulate their doctors to help them achieve their desired birthing experience. Authors portray

women as "bad" mothers when they do not comply with physicians' directions, and sympathize with physicians who feel "obligated" to perform caesarean sections for assertive mothers.

The Tyranny of "Normal" Birth: Moralizing Mothers' Choices

Another common thread throughout many articles about elective caesarean sections is the moralizing discourse that many authors feel authorized to apply to women who undergo elective caesarean sections. In fact, having a 'normal' vaginal birth is sometimes raised the level of a moral virtue that moms are expected to achieve. On the other hand, some authors also imply that having a vaginal birth that is too "natural" or "esoteric" is also considered to be an error in birthing judgement. In a National Post article (2006), author Jonathan Kay criticizes the range of birthing preferences available to women, from too "esoteric" to "too posh to push." Kay describes the 'esoteric' preference in the following way:

> *...many modern mothers opt instead to "go natural." Some do it for health reasons...But a more common motivator is the newfound conceit that birthing should be a spiritual event – one that can't be experienced in it's full glory when half your body is numb...More esoteric options, such as "water births" and "hypnobirthing," are also going mainstream. So too are doulas - - non-medical birthing coaches who range in disposition from no-nonsense hand-holders to incense-burning wiccans* (2006).

Rather than affirming the rights of individual women to determine their most preferable or appropriate birthing experience, Kay argues that such behaviour represents a "newfound conceit." Following his discussion of potential 'esoteric' options, Kay cites a male physician's opinions about 'natural' birthing:

> *Who do you want to be on the receiving end - - a trained doctor backed up by modern life-saving machines and painkillers, or some woman with a Guatemalan hat?* (2006).

While Kay admits that the physicians' comments are harsh, he nonetheless states later on in the article that he agrees with the physician. Kay also moves on further in his critique, however, to berate women who he considers "too posh to push":

> *...many [mothers] are "too posh to push" - - planning C-sections to coincide with the end of the fiscal year, or a lull in litigation schedules. This is but a different form of parental narcissism - - albeit one that emphasizes the material comforts rather than the spiritual* (2006).

Interestingly, Kay uses the phrase "parental narcissism" in order to scold mothers who are "too posh to push", rather than using the more gender-specific phrase "female narcissism" or the seemingly contradictory "maternal narcissism:" contradictory, since the word "maternal" often invokes images of a self-sacrificial, nurturing, and caring disposition. A reliance on euphemisms is evident among other authors as well, including Fralic, who, as I pointed out previously, used the less specific term "society" in place of the word "women" in her discussion of the self-absorption exhibited by "too posh to push" women (2005).

Implied in many representations of elective caesarean sections is the idea that having a caesarean section is not a "normal" or "natural" method of giving birth (although what exactly is considered "normal" or "natural" is not often explained), and thus should be avoided by women. For women to actually choose to undergo a caesarean section "unnecessarily" is therefore unthinkable to many authors, and is considered worthy of admonishment. However, there are several ironies inherent in such admonishments. First of all, birth experiences are

incredibly variable, both according to subjective, experiential accounts, and in terms of purportedly objective measures such as length of labour, cervical dilation, types of complications, and timing of contractions. Any attempt to define a particular birth as "normal" is therefore illogical, since no perfect standard of birthing exists. While mathematical averages are calculated for and may even be useful in managing certain aspects of labour and birth, the term "normal" in relation to birthing experiences is culturally variable and subjective, as are notions of what of risks are acceptable in relation to birth. Interestingly, when media authors use the term "natural" to describe birth they are often referring to an uncomplicated, biomedically-monitored hospital birth. It is ironic that conceptions of "natural" birth involve a process that occurs within a sterile environment, surrounded by foetal heart monitors, machines, groups of trained medical professionals, and surgical space nearby in the event that the "natural" process becomes an emergency procedure.

Despite such ironies, many media representations of elective caesarean sections use the terms "normal" and "natural" birth frequently, implying that there are some common-sense understandings of the how the terms are to be defined. In one particular CanWest Global report published in both the Vancouver Sun ("Doctors, patients," 4 May 2006) and Montreal Gazette ("Increase in Caesareans," 2006), the costs of various types of births are included:

> *A report from the Canadian Institute for Health Information estimated the average cost in 2002-03 for a Caesarean section at $4,600. A natural delivery, by contrast, ran to $2,800.*

What is particularly interesting about this reference is that the term 'natural' replaces the word 'vaginal' from the Canadian Institute for Health Information (CIHI) findings. CIHI calculated the costs of in-hospital, vaginal births, as well as caesarean sections. However, the author implies that this type of medically-monitored vaginal birth, despite involving high rates of medical intervention or medications, is a "natural" and perhaps even "normal" procedure. Other media representations also set the terms "normal" or "natural" birth in stark contrast to "caesarean" birth, implying that any vaginal birth, regardless of whether or not it involves an episiotomy, medication, or even forceps, is still somehow more acceptable than a caesarean section:

> *...the topic [of elective caesarean sections on maternal request] is polarizing certain groups in the medical community and eliciting venomous reactions from women and doctors who feel passionately one way or the other: natural or caesarean....there are hundreds of studies comparing the risks and outcomes of* natural *versus caesarean deliveries.... "there is a certain immeasurable difference between the two types of delivery"* (O'Brian, 2005; emphasis added).

Considering the enormous differences that exist between types of deliveries, it is difficult to understand why the author fails to distinguish between types of vaginal deliveries, and chooses to lump all of these types of births together under the heading "natural."

Exploring the Complex Space of Birthing: Alternate Media Representations

One of the most atypical representations of elective caesarean sections that I encountered was an article from the Globe and Mail (Picard, 2004). Apart from the fact that the phrase "too posh to push" is entirely absent from the article, the author, Andre Picard, demonstrates a complex understanding of his subject

as he explores surgical interventions in birth. Rather than assume that women are demanding caesarean sections in record numbers, Picard describes the experience of Gillian Brouse, a woman who physicians repeatedly advised to undergo an elective caesarean section. After continually declining a surgical birth, Brouse eventually gave birth vaginally after a "short, uneventful labour" (Brouse, in Picard, 2004). Picard's inclusion of Brouse's experience highlights the role of obstetrical practices in birthing decisions, and provides an alternative to common "too posh to push" labelling of women. In his article, Picard also interviews obstetrician Jan Christilaw (a well-referenced obstetrician in Canadian media representations of elective caesarean sections) and cites some seemingly uncharacteristic comments from Christilaw in reference to obstetrical practices:

> *"There are a lot of red flags that should go up about how obstetrics are practiced in this country today," Dr. Christilaw said. Dr. Christilaw said, for example, that women are still undergoing far too many episiotomies, a surgery that research has shown is rarely justified. Similarly, she called the rise in caesareans, particularly elective caesareans, "troubling."* (Picard, 2004).

Picard's referencing of Christilaw here is unique, in that he includes Christilaw's attention towards obstetrical practices rather than just women's preferences. Christilaw's alignment of increasing rates of caesarean sections with injudicious use of episiotomy (a highly-debated, non-elective procedure in which physicians surgically enlarge the perineal area to ease delivery), suggests that physicians are perhaps too quick to use technological interventions. Furthermore, Picard's overall representation of birthing "experts" is unique, in that he incorporates the comments of a midwife. Picard cites Kim Campbell, president of the Canadian Association of Midwives, in the following way:

> *"Labour works well most of the time if you let nature follow its course, but this is a sad reflection of our desire for convenience above all else"...the truly skilled practitioner, whether a midwife, family physician or obstetrician, knows how to monitor a birth patiently and "pull out the tool box only when you need it." But what the data show, [Campbell says], is an approach that is characterized by the saying: 'Give a man a hammer and everything becomes a nail.'* (Picard, 2004).

Campbell's comments provide an alternative perspective on medical interventions, and expand the intellectual boundaries of argumentation around elective caesarean sections. Rather than hastily blaming moms, Campbell underlines the responsibilities of range of birthing practitioners to ensure optimal birthing experiences and outcomes. Picard's demonstrates a complex grasp of the issue of elective caesarean sections, and re-frames the issue to include a wider range of "agents."

Journalist Amy O'Brian (2005) also attempts to explore the complex intersection of factors influencing rates of caesarean sections. Despite maintaining an initially narrow focus on mothers' choices in relation to rates of elective caesarean sections, O'Brian eventually questions the validity of such a focus. She highlights the comments of Colin Birch, a pelvic-floor surgeon from Calgary who argues that increasing rates of caesarean sections are not necessarily reflective of "too posh to push" moms. Birch suggests increased rates of interventions are due to physicians' attempts to avoid potential complications and litigation. He argues

> *"I think the caesarean-section rate is going up and I think it has a lot to do with the discomfort of perhaps new graduates to do forceps delivery, vacuum delivery – which is tagged with medical legal concerns..."* (Birch in O'Brian, 2005).

In addition to noting Birch's take on the caesarean section dilemma, O'Brian also provides alternate explanations for increased rates of caesarean sections. She explains:

> *According to the maternity centre's booklet, other possible reasons for the climbing C-section rate include side effects associated with certain medical interventions such as induction and electronic fetal monitoring; an unwillingness to offer vaginal birth to women expecting twins or a breech birth; and a lack of basic care such as continuous labour support* (O'Brian, 2005).

Considering that O'Brian follows the convention of referencing only medical "experts" opinions in her article, rather than doulas' or midwives' opinions, her attention to systemic factors such as lack of continuous labour support is an unusual insertion in a media representation of elective caesarean sections. However, while her rationale and inclusion of voices may be somewhat lacking in nuance, it nonetheless represents an important step away from focussing on and/or blaming mothers' choices alone for high rates of caesarean sections.

CHAPTER FIVE

DECONSTRUCTING CHOICES: ACKNOWLEDGING THE COMPLEXITY OF BIRTHING DILEMMAS

"When we examine more fully the immediate social context in which women give birth, the options and resources that define the context become clearer" (Fox & Worts, 1999: 330).

Contesting "too posh to push" claims

For media audiences and journalists, "too posh to push" is presumably an easily digestible media headline. It offers journalists a simple yet provocative encapsulation of a highly complex network of ideas and birthing practices, and suggests a narrow range of approaches to the "problem" of elective caesarean sections. Authors argue that increasing numbers of women request caesarean sections for selfish reasons, and they attribute high rates of expensive, risky caesarean sections to women's alleged requests. For some authors, the solutions are glaringly obvious: doctors should deny women's requests, or make them pay out-of-pocket for medically unnecessary procedures. Unfortunately, answers to the elective caesarean section dilemma are not that simple, and the premises upon which authors make "too posh to push" claims are questionable.

Amid the din of "too posh to push" voices, resistance is starting to build. Birthing activists, mothers, midwives, and even obstetricians increasingly contest connections between high rates of caesarean sections and women's supposed birthing choices. They argue that authors' representations of women's birthing choices obscure the fact that research related to "patient choice" caesarean sections is sparse, and in some cases flawed. Furthermore, they point out that women's birthing choices are constrained by the limited number of options and

supports available to them, and by features of their social environments. Labelling of women's choices as "too posh to push" does not clarify birthing dilemmas; it draws attention from possible solutions.

Recent evidence concerning elective caesarean sections suggests that very few women prefer or elect to have their baby by caesarean section, and that women's desires extend far beyond selfishness and superficialities. A Swedish study conducted in by Hildingsson et al (2002) demonstrates that only a small minority of women wish to have a caesarean section. When researchers queried women early in pregnancy about their birthing preferences, most women stated that they preferred a vaginal delivery. Among women who did prefer a caesarean section, the authors note that these women constituted a "vulnerable group" (Hildingsson et al, 2002: 618), and in contrast to popular "too posh to push" allegations, they point out that

> "*...a wish for a caesarean section was not associated with well educated urban women, keen on making their own decisions, scheduling childbirth into their well controlled agendas and career planning. Contrary this stereotype, women who wished a caesarean section had more often considered abortion, were more depressed and worried about their pregnancy, not only about the birth but about many other things as well, and they were not more interested in making their own decisions than women who preferred a normal delivery*" (Hildingsson et al, 2002: 622).

The authors directly contest media authors' assumptions about women's birthing demands. The authors of a large survey conducted recently by a Childbirth Connection, a not-for-profit agency in the United States, also counter perceptions that numerous women opt for surgical births. Only one out of 1574 women who participated in the *Listening to Mothers®* survey chose an elective caesarean

section in the absence of medical necessity (Childbirth Connection, 2006). In response to the survey data, one researcher argues that

> *"Mothers have spoken; they are not electing to have caesareans without medical reason. Virtually all who had primary caesareans believed there was a valid medical reason for the surgery"* (Childbirth Connection, 2006).

Findings from both of these studies lend support to the notion that women are not merely "too posh to push" and suggest that other factors contribute to high rates of caesarean sections.

In 1999, a group of researchers from the Centre for Family Research at the University of Cambridge in the United Kingdom began a three-year study to investigate "too posh to push" claims, and explore the role of women's choices in their negotiations with healthcare professionals (UK Parliament, House of Commons, 2002). Their findings highlight some of the uncertainties surrounding notions of "choice" and raise serious questions about the validity of "too posh to push" claims. One their key findings is that while 77% of 785 obstetricians cite maternal choice as the primary reason for a caesarean section, very few obstetricians actually report experiencing these requests personally. The researchers also found that obstetricians offer variable definitions for "maternal choice." Some obstetricians report "maternal choice" as the reason for a procedure even if it is medically indicated or recommended. Based on these and other findings, the researchers recommend that journalists and others avoid blaming mothers for rising rates of caesarean sections, but *"recognise the place of maternal fear, driven in part by the clinical environment in which much maternity care takes place"* (UK Parliament, House of Commons, 2002).

In response to the few studies in which authors suggest that maternal requests are important contributors to high rates of elective caesarean sections, some researchers counter that such findings are often flawed (Gamble & Creedy, 2000; Walker, 2004). In a review of 10 international studies, Gamble & Creedy (2000) explored predictors of purported maternal requests for caesarean sections, and found that a range of factors can affect reporting of maternal requests, such as methods of data collection and entry, and the role of care providers in producing data. Walker et al (2004) also point out that many studies demonstrate a bias towards studying women's roles in relation to rates of caesarean sections, and report characteristics such as age, previous deliveries, and personality variables, without exploring the larger sociocultural context in which caesarean sections take place. Together, these studies strongly oppose popular "too posh to push" claims.

Moving beyond statistics: the broader field of decision-making

While it is important to explore the evidence surrounding the magnitude and existence of women's caesarean section requests, a primary reliance on statistics alone cannot clarify the issues that are at stake in the elective caesarean section debate. Neither do statistics nor research findings related to maternal requests fully account for the power relations in which birthing practices are embedded. Even if a large body of evidence and statistics existed to support the notion that maternal requests for caesarean sections are primary contributors to high caesarean section rates, a closer look at the broader picture of birth would still be necessary to understand *why* these "choices" occur.

Dixon-Woods et al (2006) offer a framework for exploring the "bigger" picture of birthing dilemmas and decision-making. Using social theorist Pierre Bourdieu's concepts of habitus, field, capital and symbolic power (1990; 1992; 1989), the authors present some ways of conceptualizing power relations within these practices and decision-making processes. Bourdieu's concepts provide a lens through which one can explore struggles for birthing "truths" and meanings, both inside and outside of maternity services. Following Dixon-Woods, I adopt these concepts generally to reflect upon and evaluate some of my research findings related to media representations of elective caesarean sections.

Bourdieu's concept of *field* offers a way to understand representations of maternal "choices" in media representations of elective caesarean sections. According to Dixon-Woods, fields are the social spaces within which individuals and groups in society are distributed and distinguished (2006: 2744). Fields operate according to various rules and realities, and serve as the location for *symbolic struggles* - struggles over meanings and ways of seeing the world (Dixon-Woods, 2006: 2744). To navigate these fields and struggles, individuals draw on various forms of *capital*, which include social and cultural resources such as "prestige, authority, and charisma, and importantly, the legitimate ability to define situations" (Dixon-Woods, 2006: 2744). Finally, *habitus* refers to an "implict understanding" by individuals of their social locations, and a sense of one's " 'place' relative to others, which may include forms of hierarchical positioning," which in turn influence practices (Dixon-Woods, 2006: 2744).

Within the field of hospital birthing services, where 99% of births in Canada take place (CIHI, 2004), a woman's "sense of place" relative to others is well-defined. In hospital hierarchies, physicians are perceived as birthing "experts" and are often deferred to in decision-making. Dixon-Woods notes that women experience "deficits in capital" such as authority when they enter into hospitals, whereas physicians are fluent in medical knowledge and language of the field (2006: 2749). Habiba et al (2004: 422) also point out that while consent is upheld as an important aspect of doctor-patient relationships, it is often achieved through a patient's acquiescence, rather than a shared decision-making process.

The fact that obstetricians are positioned as the "experts" in their field may explain why they feel authorized to frame the elective caesarean debate as one of women's choices, and why their opinions and framings are adopted so readily by journalists and authors of media representations. In my analyses, I found that nearly all authors accept obstetrical framings of the issue of elective caesarean sections as related to maternal preferences. These framings appear misinformed when one considers that research in this area fails to support the existence of high numbers of women's requests for caesarean sections. But in light of physicians' influence over the field of birthing, the adoption of these framings is understandable; authors implicitly recognize the prominent positioning of physicians within maternity system hierarchies, and affirm physicians' symbolic power to define and ascribe meanings to a situation. In effect, authors reproduce

the hierarchies of the maternity system within media representations of elective caesarean sections.

Wagner (2006) acknowledges the prominent positioning of obstetricians within the medical field in his discussion of obstetric "omertà". An obstetrician himself, Wagner notes that obstetricians follow a set of unwritten rules about how to practice obstetrics. He argues that

> *"[o]ne of the most convincing demonstrations of the power of tribal loyalty in obstetrics is Mafia-like "omertà:" tribal members are taught never to speak about the tribe or any of its members in public in a negative way. Never. We may talk to one another about the terrible way a certain tribal member practices obstetrics, but only in private" (2006: 22-23).*

Within the field of maternity services, individuals engage in a number of activities according to their positions in birthing hierarchies. For physicians, this involves the maintenance of their dominant positions, which as Wagner points out, can have a number of negative effects on women's health and well-being. Wagner argues that "an organization built on special privileges is too invested in maintaining its privileged position to engage in soul-searching or self-examination" (2006: 36). He alleges that while obstetrical interventions such as caesarean sections are overused, they persist, to the detriment of some women and babies, due to this tribal reasoning or "obstetric omertà" (2006: 39).

Other obstetricians echo Wagner's concerns, and maintain that abuses of authority exist among obstetricians in the field of maternity services. DeMott (2000) concedes that "in medical care a great deal of perceived power and influence is present, and the advice of physicians is seriously heeded by many under our care" (264). He suggests that when physicians offer women elective

caesarean sections as a birthing choice, they may be "trying to get away with something" (2000: 264) and muses,

> *"What would the motivations be for caregivers to recommend elective delivery before labour? What would their life be like? It would not be all bad. We would all get more sleep! We could lay off all the labor nurses and fire all the midwives....[h]owever, we would have more dead mothers" (DeMott, 2000: 265).*

In yet another obstetrician's commentary on elective caesarean sections, Klein argues that increases in caesarean sections are "a physician issue, not a maternal issue" (2007: 214). He notes that the only available evidence about maternal requests suggests that obstetricians are responsible for increases in caesarean sections, due to their increasing comfort with the procedure.

While obstetricians clearly play a significant and often neglected role in contributing to high rates of caesarean sections, Béhague (2002) and Fox (2002) warn against overstating the influence or agency of either party in doctor-patient relationships, and particularly in relation to childbirth. It would be shortsighted, therefore, to re-frame the debate about elective sections entirely in terms of obstetrical practices. Authors of media representations of elective caesarean sections often overstate the role of maternal "choice" in relation to rates of birthing interventions, but a thorough analysis of the debate requires an appreciation of how such "choices" are both circumscribed and productive. Fox (2002) examines research related to women's birthing experience, and suggests that while some women experience alienation within maternity services, other women accept and appreciate these services, despite their limitations (328). Fox

also warns against ignoring the agency of some women who seek out or willingly subscribe to medical management of their birthing experiences (Fox, 2000: 329). Béhague (2002) agrees, noting that in some contexts "[f]or some women, access to the technological control over their own births holds important implications for social status which, in turn, affords them access to better quality care" (477). Béhague explains that in Brazil, for example, caesarean sections are associated with the private system, where women expect to receive better care, more attentive doctors, and specialized medical attention (2002: 483).

In situations where women do request caesarean sections, their reasons appear to be constrained in a number of complex ways by features of the birthing system within which they operate, the power relations and hierarchies that exist among agents within maternity services, and symbolic struggles over birthing meanings and practices. These factors work to shape not only the range of choices that women have available to them, but also the ways in which they are portrayed as "agents" of birthing systems in media representations.

Imagining Change: creating new spaces for birthing decisions

Media authors' insistence on blaming mothers in media representations of elective caesarean sections cannot be simply dismissed. While resistance to reports of women's "posh" birthing choices is growing, spaces of dissent are comparatively few. Walker (2004) contends that "[i]gnoring the cultural framework in which women give birth had led largely to the use of strategies to reduce caesarean section being aimed at the level of individual women" (123). He points out that campaigns are developed to target women's "requests," with the

intention of reducing high rates of caesarean sections. These large-scale campaigns adopt a "choice" framework that is not likely to result in measurable changes to intervention rates, and neglects the roles and responsibilities of physicians and obstetrical practices in contributing to high rates of caesarean sections. Walker argues that in order to develop appropriate strategies, researchers must shift their focus "from women's role to the investigation of broader cultural norms" (2004: 123).

Paradigm shifts are not enough, though. In Canada, substantive changes need to occur in maternity services in order to create new birthing options for women, and new spaces of decision-making. Currently, birth is almost entirely medically managed in Canada. But in order to promote optimal birthing experiences and options for women and to halt increasing birthing interventions, significant professional and organisational changes are required. According to Wagner (2006: 22) the "power of tribal loyalty" works fiercely to prevent such shifts. However, women are not merely passive victims of obstetrical intervention or "mother-blaming" and many mothers work to carve out their own spaces within or outside of less-than-perfect a maternity system.

Well-known birthing activist and midwife Sheila Kitzinger, in response to a researcher's assertion that caesarean section rates are due to "'increasing maternal input into childbirth'" argues that "'birth has always entailed a great deal of "maternal input" '" (Harris, 2001: 102; Kitzinger, 1998 in Harris, 2001: 102). Given the historical subordination of women's voices in birth, the most obvious place to start "imagining" change in childbirth is through listening to mother's

voices: in birthing situations, through medical research, and in media representations. Rather than investing energy in trying to imagine or construct women's birthing desires might be, birthing "experts" simply need to listen. As Kitzinger points out, "maternal input" into childbirth already exists. In order to address high rates of caesarean sections, and to promote truly optimal birthing experiences and outcomes, researchers, physicians, birthing "experts" and media authors must acknowledge, support, and integrate mothers' knowledge and experiences of birth into maternity services.

REFERENCE LIST

Abbott, P., Wallace, C. & Tyler, M. (2005). *An Introduction to Sociology: Feminist Perspectives*. London: Routledge. pp. 318-363.

Althusser, Louis. (1971). Ideology and Ideological State Apparatuses. In *Lenin and Philosophy and Other Essays.* New York: Monthly Review Press. p. 127.

Anderson, G.M. (2004). Making sense of rising caesarean section rates. *British Medical Journal* 329 (25 September): 696-697.

Associated Press. (2006, April 16). Pregnant robot gives birth all over the world. *MSNBC.com.* Retrieved May 17, 2007 from http://www.msnbc.com/id/12304362/

Audit Commission. (1997). First class delivery: improving maternity services in England and Wales: Abingdon, Audit Commission Publications.

Béhague, D.P. (2002). Beyond the Simple Economics of C-Section Birthing: Women's Resistance to Social Inequality. *Culture, Medicine and Psychiatry* 26: 473-507.

Betrán et al (2007). Rates of caesarean section: analysis of global, regional and national estimates. *Pediatric and Perinatal Epidemiology* 21: 98-113.

Bewley, S. & Cockburn, J. (2002). II. The unfacts of 'request' caesarean section. *BJOG: An International Journal of Obstetrics and Gynaecology*, 109 (June): 597 – 605.

Bineham, J.L. (1988). An historical account of the Hypodermic Model in mass communication. *Communication Monographs* 55: 230-233.

Birchard, K. (1999). Defence union suggest new approach to handling litigation costs in Ireland. *Lancet*, 354: 1710.

Blincoe, A.J. (2005). Fetal monitoring challenges and choices for midwives. *British Journal of Midwifery* 13 (2): 108-111.

Bueckert, Dennis. (2006, April 26). Canadian health system paying high cost for women who are 'too posh to push'? *Macleans*. Retrieved April 30, 2006 from www.macleans.ca

Bueckert, Dennis, (2006, April 27). High costs linked to C-section rate. *The Globe and Mail.* Retrieved April 30, 2006 from www.theglobeandmail.com

Burke, Kenneth. (1984). *Permanence and change: an anatomy of purpose* (4th ed.).Berkeley and Los Angeles: University of California Press. (Original work published 1935).

Burke, Kenneth. (1962). *A Grammar of Motives & A Rhetoric of Motives*. Cleveland: The World Publishing Company.

Burtch, Brian. (1994). *Trials of Labour: The Re-emergence of Midwifery.* Montreal & Kingston: McGill-Queen's University Press.

Byrd, J., et al. (1998). Sexuality during pregnancy and the year postpartum. *The Journal of Family Practice*, 47: 305 – 308.

Canadian Institute for Health Information. (2004). *Giving Birth in Canada: A Regional Profile.* Ottawa: Canadian Institute for Health Information.

Canadian Institute for Health Information. (2006). *Giving Birth in Canada: The Costs.* Ottawa: Canadian Institute for Health Information.

Carey, Elaine. (2004, March 2). C-section? You'll soon get to choose. (Ontario edition). *Toronto Star*, p. A01.

Carey, Elaine. (2004, April 22). Caesarean births reach all-time high in Canada; Report points to older, high-risk mothers, fewer doctors opting for obstetrics. (Ontario edition). *Toronto Star*, p. A02.

Childbirth Connection. (2006). New national survey results from mothers refute belief that women are requesting cesarean sections without medical reason. Retrieved March 20, 2006 from www.childbirthconnection.org

Cox, J. & James, D. (1995). Deep vein thrombosis prophylaxis at caesarean section in the United Kingdom. *Journal of Obstetrics and Gynaecology* 15 (3): 179.

Cunningham, F., Gant, N., Leveno, K., Gilstrap, L., Hauth, J., Wenstrom, K. (2001). *Williams Obstetrics.* Toronto: McGraw-Hill Medical Publishing Division.

Daviss, Betty-Anne. (2001). Reforming Birth and (Re)Making Midwifery in North America. In *Birth By Design: Pregnancy, Maternity Care, and Midwifery in North America and Europe.* (Edited by De Vries, R., Benoit, C., van Teijlingen, E. R., & Wrede, S.). New York: Routledge.

Declerq, Eugene, et al. (2001). Where to Give Birth? Politics and Place of Birth. In *Birth By Design: Pregnancy, Maternity Care, and Midwifery in North America and Europe.* (Edited by De Vries, R., Benoit, C., van Teijlingen, E. R., & Wrede, S.). New York: Routledge.

DeMott, R. (2000). Commentary: A Blatant Misuse of Power? *Birth* 27 (4): 264-265.

De Vries, Raymond. (2004). *A Pleasing Birth: Midwives and Maternity Care in the Netherlands.* Philadelphia: Temple University Press.

Dixon-Woods, M. et al (2006). Why do women consent to surgery, even when they do not want to? An interactionist and Bourdieusian analysis. *Social Science and Medicine* 62: 2742-2753.

Doctors, patients need to know pros and cons of C-sections. (2006, May 4). The Vancouver Sun. Retrieved June 13, 2006 from http://www.canada.com

Douglas, Susan J. & Michaels, Meredith W. (2004). The Mommy Myth: The Idealization of Motherhood and How It Has Undermined Women. New York: Free Press.

Eckler, Rebecca. (2006, June). To push, or not to push. Rebecca Eckler argues for the other side of choice. *Chatelaine*. Retrieved June 13, 2006 from http://www.chatelaine.com

Ehrenreich, B. & English, D. (1978). *For Her Own Good: 150 years of the experts' advice to women.* New York: Dell Publishing

Entman, R. (1993). Framing: Toward a Clarification of a Fractured Paradigm. *Journal of Communication* 43 (4): 51-58.

Fairclough, Norman. (1989). Language and Power. London: Longman.

Fayerman, Pamela. (2004, September 14). St. Paul's C-section rate of 42 percent 'is too high.' *The Vancouver Sun*, pp. B1, B7.

Feldman, G. & Freiman, J. (1985). Prophylactic caesarean section at term? *New England Journal of Medicine*, 312: 1264 – 1267.

Fox, B. & Worts, D. (1999). Revisiting the critique of medicalized childbirth: A Contribution to the Sociology of Birth. *Gender & Society* 13 (3): 326-346.

Fralic, Shelley. (2005, September 29). Too-posh-to-push moms set bad example for society. *Edmonton Journal*, p. A13.

Francome, C. & Savage, W. (1993). Caesarean section in Britain and the United States – 12% or 24%: is either the right rate? *Social Science and Medicine* 37: 1199 – 1218.

Friedan, Betty (1963). *The Feminine Mystique.* New York: Norton.

Frigoletto, F.& Nadel, A. (1988). Electronic fetal heart rate monitoring: Why the dilemma? *Clinical Obstetrics and Gynecology* 31: 179

Frigoletto, F., Ryan, F. & Phillipe, M. (1980). Maternal mortality associated with cesarean section: an appraisal. *American Journal of Obstetrics and Gynecology* 136: 969 – 970.

Gaffney, Jane. (2004, 14 September). Too-posh-to-push moms should try a soothing lullaby. [Letter to the editor]. *The Vancouver Sun*, p. A14.

Gamble, J.A., Creedy, D.K. Women's requests for cesarean section: A critique of the literature. *Birth* 27: 256 – 263.

Gamson, W.A. (1992). *Talking politics.* Cambridge: Cambridge University Press.

Gies, Lieve. (2000). Contesting the Rule of Emotions? The Press and Enforced Caesareans. *Social and Legal Studies* 9 (4): 515-538.

Gould, J., Davey, B. & Stafford, R. (1989). Socioeconomic differences in rates of

cesarean section. *New England Journal of Medicine* 321, 233 – 239.

Gregory, K.D., Ramicone, E., Chan., L., Kahn, K.L. Cesarean deliveries for Medicaid patients: comparison in public and private hospitals in Los Angeles county. *American Journal of Obstetrics and Gynecology* 180: 1177 – 1184.

Habiba, M. et al (2004). Women's accounts of consenting to surgery: is consent a quality problem? *Quality and Safety in Health Care* 13: 422-427.

Hall, M. & Bewley, S. (1999). Maternal mortality and mode of delivery. *Lancet*, 354: 776.

Hannah, Mary, et al. (2000). Planned caesarean section versus planned vaginal birth for breech presentation at term: A randomized multicentre trial. *The Lancet* 356 (9239): 1375 – 1383.

Hannah, Mary. (2004). Planned elective cesarean section: A reasonable choice for some women? *Canadian Medical Association Journal* 170 (5): 813.

Harris, L.H. (2001). Counselling women about choice. *Best Practice & Research Clinical Obstetrics & Gynaecology* 15 (1): 93-107.

Hildingsson, I., et al (2002). Few women wish to be delivered by caesarean section. *BJOG: An International Journal of Obstetrics & Gynaecology* 109 (6): 618-623.

Hofberg, K. & Brockington, I. (2000). Tokophobia: an unreasoning dread of Childbirth: A series of 26 cases. *British Journal of Psychiatry* 176: 83 – 85.

Hurst, M. & Summey, P.S. (1984). Childbirth and Social class: The case of Cesarean delivery. *Social. Science and Medicine* 18: 621.

Increase in Caesareans has multiple causes. (2006, May 2). The Gazette (Montreal). Retrieved June 13, 2006 from http://www.canada.com

Kay, Jonathan. (2006, February 20). Natural childbirth? No thanks. *National Post*. Retrieved February 27 from http://www.canada.com

Kirkham, Mavis. (Ed.) (2004). *Informed Choice in Maternity Care*. Houndmills: Palgrave Macmillan.

Kitzinger, Sheila. (2000). *Rediscovering Birth.* New York: Pocket Books.

Klein, M. (2007). Women's Views of Elective Primary Caesarean Section. *Journal of Obstetrics and Gynaecology Canada* 29 (3): 214-218.

Kolder, V., Gallagher, J. & Parsons, M. (1987). Court-Ordered Obstetrical Interventions. *New England Journal of Medicine* 316 (19): 1192-1196.

Ladd-Taylor, Molly. & Umansky, Lauri. (Eds.) (1998). *"Bad" mothers: the politics of blame in twentieth-century America*. New York: New York University Press.

Let moms fund vanity C-sections: Non-essential surgical deliveries are driving up health-care costs (2006, April 28). Calgary Herald. Retrieved June 13, 2006 from http://www.canada.com

Lippman, Abby. (2004, March 3). C-section fight does a U-turn: Optional caesarean sections are under serious consideration by doctors, a move that would reverse the long battle to limit surgical intervention in maternity care, says Abby Lippman. [Commentary]. *The Globe & Mail*, p. A21.

Liu, S. et al. (2007). Maternal mortality and severe morbidity associated with low-risk planned cesarean delivery versus planned vaginal delivery at term. *Canadian Medical Association Journal* 176 (4): 455-460.

Locke, Terry. (2004). *Critical Discourse Analysis.* London: Continuum.

Lomas, J. & Enkin, M. (1989). Variations in operative delivery rates. In *Effective Care in Pregnancy and Childbirth*, Vol. 2. (Edited by Chalmers, I., Enkin, M. & Keirse, M.J.N.C.) Oxford: Oxford University Press.

Lovric, Lydia. (2005, September 26). Some moms are too posh to push. *Winnipeg Sun*. Retrieved October 4, 2005 from htpp://www.winnipegsun.com/News/Columnists/Lovric_Lydia/2005/09/26

MacDonald, M. (2003). *Exploring Media Discourse*. London: Arnold.

Mackenzie, I.Z. (1999). Should women who elect to have caesarean sections pay for them? *British Medical Journal,* 318: 1070.

Martel, M., MacKinnon, C. (2004). SOGC Clinical Practice Guidelines: Guidelines for vaginal birth after previous caesarean birth. *Journal of Obstetrics and Gynaecology Canada*, 26 (7): 660 – 670.

Matheson, (2005). *Media Discourses: Analysing Media Texts*. New York: Open University Press.

Mazur, J., Mikiel-Kostyra, K. (2000). Determinants of newborn feeding in maternity hospital care. Part II: factors associated with exclusive breast feeding. *Ginekol Pol* 71: 604 – 611.

McIlroy, Anne. (2004, April 22). Special Delivery: C-sections hit all-time high in Canada. *Globe & Mail*, p. A1.

McLoed, D. & Detenber, B. (1999). Framing effects of television news coverage of social protest. *Journal of Communication* 49 (3): 3-21.

McQuail, D. (1994). *Mass Communication theory: An introduction* (3rd Edition). Thousand Oaks, CA: Sage.

Miller, J. (1988). Maternal and neonatal morbidity and mortality in cesarean section. *Obstetrics and Gynecology. Clinics of North America* 15: 629.

Moldin, P., Hokegard, K. & Nielson, T. (1984). Cesarean section and maternal mortality in Sweden 1973 – 1979. *Acta Obstetricia et Gynaecologica Scandinavica* 63: 7 – 11.

Morrison, J. & MacKenzie, I.Z. (2003). Cesarean Section on Demand. *Seminars in Perinatology* 27 (1): 20-33.

Morrison, J., Rennie, J., Milton, P. (1995). Neonatal respiratory morbidity and mode of delivery at term : influence of timing of elective caesarean section. *British Journal of Obstetrics and Gynaecology*, 102: 101 – 106.

Munro, Margaret. (2004, September 10). Canadian women seek easier, speedier route to childbirth. *The Vancouver Sun*, p. A3.

Munro, Margaret. (2006, April 27). Popular C-sections drain public health dollars. *National Post*. Retrieved June 13, 2006 from http://www.canada.com

Munro, Margaret. (2006, April 27). 'Too posh to push' Canadian moms opting for more C-sections. *The Vancouver Sun*, p. A10.

Munro, Margaret. (2006, April 27). Canadians are 'too posh to push:' 1 in 4 births is a C-section: Taxpayers foot bills for women too scared of normal birth: report. *The Ottawa Citizen*. Retrieved June 13, 2006 from http://www.canada.com

Murphy, D. (2002). Uses of error – an obstetric perspective. *Lancet*, 360: 941.

Mutryn, C.S. (1993). Psychosocial Impact of Cesarean Section on the Family: A Literature Review. *Social Science and Medicine* 37 (10): 1271-1281.

Neuman, R.W., Just, M.R. & Crigler, A.N. (1992). *Common Knowledge: News and the construction of political meaning*. Chicago: University of Chicago Press.

O'Brian, Amy. (2005, November 21). For and against birth by C-section: More women are requesting caesarean delivery. Is it ethical? Is it healthy? The answers depend on who you ask. *The Vancouver Sun*. Retrieved November 21, 2006 from http://www.canada.com

O'Brian, Amy. (2006, January 2). C-section debate rages on: Rising numbers not just vanity and scheduling. *Edmonton Journal*, pg. C1. Retrieved March 25, 2006 from ProQuest Canadian Newsstand.

O'Boyle, A., Davis, G., Calhoun, B. (2002). Informed Consent and birth: protecting the pelvic floor and ourselves. *American Journal Obstetrics and Gynecol*ogy187: 981 – 983.

O'Driscoll, K. & Foley, M. (1983). Correlation of the decrease in perinatal

mortality and increase in caesarean section rates. *American Journal of Obstetrics and Gynecology* 61: 1 - 5.

Parer, J. & Livingstone, E. (1990). What is fetal distress. *American Journal of Obstetrics and Gynecology* 162: 1421 – 1427.

Penna, L. & Arulkumaran, S. (2003). Cesarean section for non-medical reasons. *International Journal of Gynecology and Obstetrics* 82: 399-409.

Petrou, S., Henderson, J. & Glazener, C. (2001). Economic aspects of caesarean section and alternative modes of delivery. *Best Practice & Research Clinical Obstetrics and Gynaecology* 15 (1): 145-163.

Pettitti, D., Cefalo, R., Shapiro, S. & Whally, P. (1992). In hospital maternal mortality in the United States: Time trends and relation to method of delivery. *American Journal of Obstetrics and Gynecology* 59: 6 – 12.

Picard, André. (2004, 10 September). Natural birth no longer the norm in Canada. *The Globe & Mail.* Retrieved June 14, 2006 from http://www.theglobeandmail.com

Richman, Vincent. (1999). Lack of local reflection of national changes in cesarean delivery rates: The Canadian experience. *American Journal of Obstetrics and Gynecology* : 393-395.

Roberts, C.L., Tracy, S., Peat, B. (2000). Rates for obstetric interventions among private and public patients in Australia: population based descriptive study. *British Medical Journal* 321: 137 – 141.

Health Canada. (2004). Special Report on Maternal Mortality and Severe Morbidity in Canada – Enhanced Surveillance: The Path to Prevention. Ottawa: Minister of Public Works and Government Services Canada.

Saleh, S. S. (2003). The changing trend in the rate of caesarean section at a teaching hospital. *Journal of Obstetrics and Gynaecology* 23 (2): 146-149.

Sakala, Carol. (1993). Medically Unnecessary Cesarean Section Births: Introduction to a Symposium. *Social Science and Medicine* 37 (10): 1177-1198.

Savage, Wendy. (2000). The caesarean section epidemic. *Journal of Obstetrics and Gynaecology* 20 (3): 223-225.

Shearer, Elizabeth. (1993). Cesarean Section: Medical Benefits and Costs. *Social Science and Medicine* 37 (10): 1223-1231.

Shearer, M. (1983). Not identifying the sources of the recent decline in perinatal mortality rates. *Birth* 10: 33 – 37.

Smith, J., Hernandez, C. & Wax, J. (1997). Fetal laceration injury at cesarean delivery. *American Journal of Obstetrics and Gynecology* 90: 344 – 346.

Stacey, M. (1988). *The Sociology of Health and Healing*. London: Unwin Hyman.

Stafford, R. (1990). Cesarean section use and source of payment: an analysis of California hospital discharge abstracts. *American Journal of Public Health* 80, 313 – 315.

Stafford, R. (1991). The impact of nonclinical factors on repeat caesarean section. *Journal of the American Medical Association* 265: 59 -63.

Starr, Paul. (1982). *The Social Transformation of American Medicine*. New York: Basic Books.

Statistics Canada. (2004). *Live Births and Fetal Deaths, by Place of Birth, Canada, Provinces and Territories, Annual.* Retrieved June 13, 2006 from http://cansim2.statcan.ca/cgi-win/CNSMCGI.EXE

Stillar, Glen F. (1998). *Analyzing Everyday Texts: Discourse, Rhetoric, and Social Perspectives.* Thousand Oaks: Sage Publications.

Sultan, A. & Stanton, S. (1996). Preserving the pelvic floor and perineum during childbirth – elective caesarean section? *Br J Obstet Gynaecol* 103: 731 – 741.

Symon, Andrew. (Ed.) *Risk and Choice in Maternity Care: An international perspective.* Edinburgh: Churchill Livingstone Elsevier.

Talaga, Tanya. (2004, September 10). Childbirth 'changing in Canada,' study finds; medical intervention is more common. C-sections reach an all-time high. (Ontario edition). *Toronto Star*. p. A20.

The posh must push or pay. (2004, March 11). National Post, p. A19.

United Kingdom Parliament, House of Commons. (2002). Memorandum by Centre for Family Research, University of Cambridge (MS 50). UK Parliament Publications. Retrieved March 26, 2006 from http://www.publications.parliament.uk/pa/cmselect/cmhealth/464/464w42.htm

United States National Library of Medicine. (1998). *Caesarian Section- A Brief History.* National Institutes of Health. Retrieved March 13, 2007 from http://www.nlm.nih.gov/exhibition/cesarean/cesarean_1.html

Wagner, M. (1994). Pursuing the birth machine: the search for appropriate birth technology. Sydney: ACE Graphics.

Wagner, M. (2000). Choosing caesarean section. *Lancet*, 356: 1677 – 1680.

Wagner, Marsden. (2006). *Born in the USA: How A Broken Maternity System Must Be Fixed To Put Women and Children First.* Berkeley: University of California Press.

Walker, Ruth, Turnbull, Deborah & Wilkinson, Chris. (2004). Exploring the role of Culture in an Australian Community. *Birth* 31 (2): 117-124.

Weedon, C. (1997) *Feminist Practice and Poststructuralist Theory.* Oxford: Blackwell.

Wells, Jennifer. (2004, March 6). C is for confusion over whether to cut or push. (Ontario edition). *Toronto Star*, pg. K01.

Wertz, R.W. & Wertz, D.C. (1989). *Lying-In: A History of Childbirth in America.* Expanded edition. New Haven: Yale University Press.

World Health Organization. (2004). *Maternal Mortality in 2000: Estimates developed by WHO, UNICEF, UNFPA*. Geneva: World Health Organization. Retrieved March 13, 2007 from http://www.who.int/reproductive-health/publications/maternal_mortality_2000/mme.pdf

Wrede, S., Benoit, C. & Sandall, J. (2001). The State and Birth/ The State of Birth. In *Birth By Design: Pregnancy, Maternity Care, and Midwifery in North America and Europe.* (Edited by De Vries, R., Benoit, C., van Teijlingen, E. R., & Wrede, S.). New York: Routledge.