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‘A bit of a compromise’: Coming to terms with an emergency caesarean section

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During the midwife-hosted antenatal class Cath attended in a private hospital in Cape Town, South Africa, where she would eventually give birth, pregnant women were encouraged to name the kind of birth they wanted. They were presented with three options: “natural all the way with no medication”, “natural but open to medication”, or “elective caesarean”. The ‘choice’ women were expected to make featured as an important point of concern in their antenatal care and in their preparations for birth.

Hannah, a participant in the class, recalls a particularly striking moment when the midwife went around the room and pointed at each of the participants and asked, “Who is your gynae”. She went on to predict diverse birth outcomes, irrespective of participants’ stated intentions to birth vaginally. For Hannah this was an “eye opening” experience. A first time mother, she was now invited into a highly politicised birthing environment. Hannah had been uncertain about what kind of birth she wanted, but at 8 months pregnant she had decided on a ‘natural’ birth as opposed to a ‘caesarean’, with the caveat that in the event that an *emergency* caesarean section was a likely outcome, she would proactively opt for an *elective* caesarean.

At 39 weeks and near the end of her pregnancy, she found herself sitting opposite her obstetrician who told her there was “a real threat of the umbilical cord wrapping around [the baby’s] neck as she … drop[s] down,” adding that because the baby was “so big” there was “a high likelihood of [Hannah] tearing”. For the first time, the obstetrician instructed her to make a birthing decision: to continue trying for a vaginal birth or to opt for an elective caesarean section. Hannah asked about the likelihood of an emergency caesarean section. Her doctor explained that although it was difficult to tell, “because she is so big, because she hasn’t dropped yet, it’s likely”. Hannah felt overwhelmed. “I probably sat there for 10 min going, um ah um ah um ah”, she said, but eventually she had weighed up all the risks she had been presented with and decided to have the caesarean section. “I suppose it was a decision made in fear,” she concluded.

Like all of the other mothers in the research I conducted in 2016, Hannah had significant knowledge about the benefits of vaginal birth and had heard all the “negative things” about having a caesarean section. But now she was expected for the first time to gauge: “Is this right for my child?” and “am I giving my child a disadvantage by electing to have a caesar?”

Her doctor offered her an appointment at 6am the following day. Hannah was caught off guard. Despite the classification as an elective caesarean section, the circumstances made it feel like an emergency.

Hannah gave birth by ‘elective’ caesarean at 8am the next day. She described the birth as “lovely” and “sweet”, but also said she was sad that she had not birthed ‘naturally’.

I Bifurcated models of birth

As Jennifer Rogerson (2016a, 2016b) describes, birth in the South African private health sector is framed as a choice between a vaginal (‘natural’) or caesarean section (‘surgical’ or technocratic) birth. Caesarean birth is presented as a binary: either ‘elective’ or ‘emergency’. C-sections are highly likely in private healthcare facilities, with rates in excess of five times the WHO recommended rate of 10-15% (WHO, 2015; Chadwick and Foster, 2013; Gray & Vawda, 2016; Leone, Padamas and Matthews cited in Rogerson 2016b: 6). Despite their awareness of high c-section rates in the private sector in South Africa, all the women with whom I worked wanted to have their ‘natural’ birth in hospital, thus complicating the simplistic divide between natural and technocratic birth that appears in much international literature. Predicated on their understandings of the ‘universal feminine’ right to birth and what Cath described as a “womanly need”, the women anticipated that well-prepared birth plans and extensive “bodywork”, as a participant called it (see also Nash, 2011 on “body projects”), would ensure that, despite medical birth environments, their births would be ‘natural’. By this they meant much more than that the baby would be born vaginally and without intervention. ‘Natural’ birth also included dispositions and settings conducive to calmness in birth. However, as concerns about c-section rates in private hospitals demonstrates, vaginal births in such settings are statistically unlikely. And, as Hannah’s experience demonstrates, the distinctions between natural and technological and between emergency and elective caesarean are blurred as birth nears or labour progresses.

II Degrees of emergency

As Cath and Hannah's experiences indicate, middle-class women desire a 'natural' birth but are likely to have a caesarean section that may be classified as either 'elective' or 'emergency'. Despite the immediacy implied by the term, arriving at an (unscheduled) 'emergency caesarean' is the result of a process that participants in this study understood to be shaped by "degrees of emergency". In what follows, we describe how women perceived this process. We are not examining medical indicators of danger, but tracing how 'emergency' materializes and is understood by women about to deliver. A variety of factors shaped their perceptions. Four are significant. One is the birth environment itself, another, interpretations of 'medical time,' a third, the provision of medical information and fourth, the relinquishing of control to experts (Davis-Floyd & Sargent, 1997; Beckett, 2005; Lazarus, 1994).

The birth environment

Many participants prepared birth plans to shape their experiences of birth in hospital. Such plans included soft music, dimmed lighting, being able to move about and so on. These were efforts to reduce the sterility of the hospital space. Nevertheless, women spoke about the ways that staff dispositions and the hospital environment shaped the decision to have a caesarean section. For example, Anna felt that staff became "very medical" in their attitudes to her birthing process, while Ingrid spoke about the shift from the labour ward to the cold and sterile operating theatre as producing a feeling of emergency. The calmness of medical procedure had the ironic effect of producing a sense of emergency. Other women reported that the techniques of surveillance used to ensure fetal and maternal well-being had the effect of making a caesarean seem "natural" under the circumstances. In other words, they experienced the information they accessed from medical technologies as indicators of well-being and jeopardy. Technologies, particularly those related to fetal heartbeat monitoring, cervical dilation and maternal blood pressure, produced a distinct set of relations to temporality, something that we frame as 'medical time', and these in turn shaped women's responses to both medical information and the experts who offered it.

Medical Time

Bertha had been laboring for nine hours when her doctor told her that the fetus was in distress. Having requested an epidural, she and the fetus were constantly monitored. She could not feel her labour but was acutely aware of the fetal heartbeat, magnified by the beeping monitor next to the

bed, that pulsed loud and soft in response to the contractions. The fetus heartbeat dropped significantly during contractions and Bertha interpreted this as dangerous evidence that the baby was struggling. As a result, when her caregiver expressed concern about the fetus's well-being, and suggested a caesarean section, she agreed understanding it to be an emergency. The audibility of the technologies accompanying her birth undergirded her decision. Hannah, whose birth was classified as an elective caesarean, experienced it as an emergency because the medical information she had been given and the speed with which a surgery slot was made available made it feel like time was of the essence. As Simonds (2002) notes, biomedical management of procreative time produces the effect of *working against time* rather than with it, and with that, an ascending sense of emergency.

In the ways that women experienced biomedical models of time in birthing, the neat lines between 'emergency' and 'elective' caesareans became increasingly unstable. And, as women moved through the process of 'natural' birth becoming surgical, they decentred the locus of control from their own decision-making to that of experts, in the best interests of the child.

Medical information and the relinquishing of control

The provision of medical information was pivotal in the framing and shifting of birthing processes. While not all women received the same quantity of medical information, there appeared to be a positive relation between the provision of medical information and the likelihood of a late 'elective' caesarean. Women's birth narratives suggest that the information they received (for example, about the size and well-being of their fetuses, the size of their pelvis, the presence of placental calcification, their own blood pressure etc.) had the effect of "grooming" them into preparedness for a c-section birth. The contrast with what women know to be "best for baby" in terms of birthing (e.g. the transfer of microbiota through the vaginal canal, the relative ease of breastfeeding after a vaginal birth, lower rates of maternal depression, and so forth) are here overruled by the immediate interests of the fetus as understood by expert medical knowledge. The framing of fetal well-being was instrumental in decisions to shift from "natural" to "caesarean birth", despite women's knowledge of what medical science currently says is best for babies. Thus, women's understandings of expert knowledge shaped their acquiescence to changed birth procedure (see Jordan 1993; Davis-Floyd 1992; Kitzinger 1984; Wolf 2003). As one woman put it, "I had an elective caesarean, but it wasn't my choice", adding that she had done so because "you feel like you are putting your baby at risk".

The shift to a caesarean section is the result of an articulation of value in which the women become containers for life, responsible for it, their own ideals secondary to what they experienced as the inevitable exigencies of medical knowledge and expertise. This shift is critical in coming to terms with what Koster (2016) calls ‘an in between birth’; a birth that is not quite what one planned.

III Coming to terms with an in-between birth

There is a large literature on the question of control in birth (Lazarus, 1994; Lupton & Schmied, 2013; Beckett, 2005; Macdonald, 2006). A feminist literature asserts the right of women to control their bodies and the birthing process in a context where birthing is highly medicalized (Davis-Floyd, 1994; Macdonald, 2006). Women in the research were ambivalent about their birthing experiences. Despite preparing for “natural births”, women ‘chose’ caesareans because they understood the fetus’s well-being as priority, even where their births were described as ‘elective’ and especially where the birth was described as an emergency. Animating values of time and a commitment to the baby’s well-being foregrounded the technical understandings of danger to life over birthing process.

How did this happen? Doctors appealed to women’s ‘maternal instincts’ in their description of shifts in medical situations. For example, Myra’s doctor told her that if she refused the caesarean she would be putting her baby in danger and would be responsible for whatever negative outcomes arose. She reported that her doctor said, “If you want to try a natural birth, so be it, but that will be on your head. And if anything happens to the baby its your fault”; a refrain repeated by other women. As we have seen, women saw medical technologies as offering objective and clear evidence about the well-being of their fetus and deferred to expert knowledge about medical time and its relation to ‘emergency’.

Although ambivalent about the shift from natural to caesarean birth, women accommodated surgical birth in two ways. Firstly, they framed the intervention as necessary for the well-being of the baby, as described above. This had the effect of making them “good mothers”, willing to bear the consequences of a medical intervention for their children. Secondly, they drew on their preparation for ‘natural’ birth and their birth plans to shape their experiences and perceptions of the birth and mediating their distress at unexpected and undesired caesarean sections. While the “degrees of emergency” shaped how much of their plan was materialised, their preparation reinstated elements of ‘the natural’ into the surgical experience. With hindsight, women spoke about the importance of having had a fetally-initiated labour; having been able to labour, even if only

briefly; ‘the crawl’ and holding their unwashed baby immediately post-birth; waiting for the umbilical cord to stop pulsating before being cut; initiating breastfeeding immediately – all features of natural birth planning models in which they had immersed themselves. Indeed, as Catherine, a doula, exuberantly exclaimed at one of the birth preparations Koster attended, “I just assisted the most natural emergency caesarean section ever!” Her comment demonstrates the complex juxtapositions and interconnections of “emergency caesarean” and “natural birth.” Dimmed lights, soft music, quiet voices accompanied the emergency caesarean. The umbilical cord was left to finish pulsating, skin-to-skin contact was immediate and the infant crawled to the breast. These are key criteria in many women’s birthing plans and became important dimensions of how women came to terms with unanticipated caesarean sections.

Conclusion

As Daphne de Marneffe (2004) notes, ambivalence is a central part of human experience in relation to others, institutions and social structures. Yet that ambivalence is frequently overwritten by discourses of “the good birth”, “the good mother” and so forth. Preparation for natural birth can facilitate acceptance of caesarean sections that have been produced and experienced as medical emergencies, even if framed as ‘elective’. This does not necessarily offset the potential negative consequences of caesarean sections (e.g. higher rates of maternal depression, difficulties in breastfeeding, etc.), but it does suggest that too simple a bifurcation between natural and technocratic birth ignores the ways in which birthing – even technocratic birthing – is experienced as a process. We have argued that in settings where unduly high rates of caesarean section are produced through medical understandings of emergency, women make sense of their experience by drawing on both prevailing cultural models (the good mother) and by reframing their preparations for birth.

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