

ARE BRAZILIAN WOMEN REALLY BEGGING FOR CESAREANS?

**[AS MULHERES BRASILEIRAS
SÃO REALMENTE “DOIDAS”
POR UMA CESÁRIA?]**

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Much of the discussion in the literature about the high rates of cesarean section in Brazil focuses on women's desire for the procedure. Focus on women's demand seems to be even truer of the popular perception of why cesareans are so common in Brazil. Doctors and the media often portray women as clamoring or begging to deliver their babies surgically. Reasons given for women's desires for cesareans include: the avoidance of pain during a vaginal delivery, reasons related to aesthetics and sexual pleasure, and the woman's belief that the procedure is safer for her and her baby. What is often obscured in the discussion is the central role that doctors play in maintaining the high rates of cesarean section in Brazil. A cesarean section is a major surgery that only a doctor can order. A woman may express her desire for one type of delivery over another, but under the highly medicalized model of birth operating in Brazil, doctors ultimately make the decisions to operate. In the current framing of this debate, doctors' power to make decisions is obscured. Furthermore, women rarely question doctors' motives for performing cesareans, nor do women typically hold doctors responsible for the high cesarean rates.

Not all of the debate focuses exclusively on the role of women in pushing up or maintaining the high cesarean rates in Brazil. Faúndes, Cecatti (1993) note cesareans are more convenient and

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remunerative for doctors, and that these motives clearly have played a role in its increase. However, they suggest the doctors' role in the high rates is on equal par with the women's desire for the procedures. What is missing from such an analysis is a discussion about the differences in power among the women and the doctors (Lorber, 1997). Doctors clearly have more decision-making power in the hospital birthing situation, and their medical expertise and authority is often marshaled in their favor to convince a woman to "choose" a cesarean.

Mello e Souza (1994), on the other hand, suggests women's role in the rise of cesarean rates is overemphasized. Doctors use women's supposed fears to their advantage.

By medicalizing social and psychological concerns regarding vaginal childbirth and reinforcing the idea that C-sections are unquestionably safe, efficient, and desirable, physicians have gradually transformed an emergency procedure into routine practice. ...In seeming to respond to ethical concerns in the doctor-patient relationship, physicians have masked other more insidious motives for so many operative deliveries: their own interests, popularity and convenience (Mello e Souza, 1994, p. 364-365).

She argues the language of choice, that is, the right for a woman to choose the way in which she will deliver obscures whose "interests are being served" (Mello e Souza, 1994, p. 364). Doctors co-opt the notion of a women's choice to justify their own questionable ethics regarding cesarean deliveries.

In addition Carranza (1994) found in her interview study of middle income and high income women in Brasilia that a majority of women, at least at the beginning of pregnancy, wanted to deliver vaginally. The vast majority in her study delivered by cesarean. Not one of the women questioned her doctor's decision to operate much less resisted that decision.

This paper responds to some of the claims made in the literature that privilege women's supposed desire for cesarean section. A postpartum survey contains questions about women's attitudes regarding cesarean and vaginal birth and questions about their de-

sired delivery preferences. The results raise doubts about the “accepted knowledge” that women are begging for cesareans. Participant-observation and in-depth interviews illustrate the role of the doctors. I focus on the interactions between women and their doctors leading up to cesarean decisions to show how doctors often encourage women to “choose” a cesarean. Obstetricians portray the situation in such a way that women feel relieved when a cesarean is considered necessary. Analysis of women’s narratives of their deliveries reveals the “invisibility” of doctors’ roles. I conclude with dissenters’ voices to this argument. While it is true that the majority of women in my sample, particularly first-time mothers, want to deliver vaginally, a minority of women do want to deliver by cesarean. We explore their reasons for preferring cesareans.

In the first part of this paper we compare attitudes and preferences of women in the public and private hospitals. Women who deliver in the different sectors have vastly different birth experiences and different delivery outcomes. We will see if these women also view vaginal birth and cesarean differently from one another. In the second part of the chapter, we focus on women’s experiences in the private hospitals. The excessive use of cesarean deliveries in private hospitals, coupled with the ability of private patients to “contract” for medical services in the private sector, means that the issue of choice is more salient among women who deliver in private hospitals. While women in public hospitals may express a desire for cesarean delivery, if they do not have a strong medical indication for one, it is unlikely that anyone will heed their requests. Also, since women who deliver in public hospitals typically do not have the same doctor for prenatal care and for delivery, it is extremely difficult to schedule a cesarean ahead of time, if that is the delivery method they desire. Women in the private sector, on the other hand, are better able to choose doctors who will deliver their babies in the way that the women want. If a woman in the private medical system wants to deliver vaginally, she may find a doctor who is known as a good *parteiro*, someone who actively promotes vaginal birth. In contrast, if a woman is set on having a cesarean, she may seek out a doctor known for readily accepting the wishes of the patient. But the question remains, are women, particularly in the private sector, really asking for cesareans?

Data and Methods

Data for this paper come from nine months of fieldwork Hopkins' did in a public and private hospital in Porto Alegre and Natal from August 1995 through May 1996. Three complementary research techniques were used: (1) participant-observation in each of the hospitals' maternity/obstetric wards; (2) a postpartum survey of 321 women who had given birth in the hospitals; and (3) in-depth interviews with a subsample of 40 women from the postpartum survey. The researcher did participant-observation for approximately four weeks in each of the hospitals when she watched the labor and delivery of numerous women in both settings, noted the interactions between women and the medical staff, spoke with doctors and women about their attitudes and practices regarding type of delivery, and gathered data on the institutional organization and standard procedures of care in each establishment.

Eighty women were interviewed postpartum in each hospital (81 in the public hospital in Natal) for a total of 321 interviews. A multistage random sample based on parity, type of delivery and type of hospital was used (see Table 1). First, approximately 30 percent of the sample (N= 100) were women who had given birth for the first time while the remaining 70 percent (N= 221) had given birth to the second or higher-order child. We divided the sample based on parity for two reasons. First, regarding cesarean section, the first birth is crucial in Brazil. Many doctors (and woman) hold the belief that "once a cesarean, always a cesarean" so if a woman delivers by cesarean during her first delivery, she is often "locked in" to this type of delivery for the rest of her reproductive life. So it is crucial to capture the experiences and attitudes of a woman delivering for the first time in order to assess her beliefs, without the contaminating influence of prior delivery experiences. The second reason we divided the sample based on parity and weighted it toward second and higher-order births, was to capture the experiences of women who are sterilized or who want to be sterilized but failed in their attempts to do so.³

3 Female sterilization was another important component of Hopkins' dissertation research.

Table 1

DISTRIBUTION OF POSTPARTUM SURVEY SAMPLE BY PARITY,
TYPE OF DELIVERY AND TYPE OF HOSPITAL IN PORTO ALEGRE AND NATA

| Birth order | (N) | % Cesarean | % Vaginal | % Total |
|--------------------------|------------|-----------------------|----------------------|--------------------|
| Public hospitals | | | | |
| First birth | (48) | 42 | 58 | 100 |
| Second or higher birth | (113) | 39 | 61 | 100 |
| Total | (161) | 40 | 60 | 100 |
| Private hospitals | | | | |
| First birth | (52) | 60 | 40 | 100 |
| Second or higher birth | (108) | 77 | 23 | 100 |
| Total | (160) | 71 | 29 | 100 |
| Total sample | | | | |
| First birth | (100) | 51 | 49 | 100 |
| Second or higher birth | (221) | 58 | 43 | 100 |
| Total | (321) | 56 | 45 | 100 |

Source: Postpartum Survey, 1995-96.

Different sampling frames for the public and private hospitals were employed because of the very large differences in cesarean section rates between them. According to 1995 vital statistics data, the two public hospitals in the sample had a combined cesarean section rate of 25% while the private hospitals in the sample had a c-section rate of 76%. Our goal was to oversample on cesarean section deliveries in the public hospitals and oversample on vaginal deliveries in the private hospitals in order to ensure that we captured the “minority” experience (that is, women who delivered by cesarean in the public hospitals and women who delivered vaginally in the private hospitals). The final sampling frame, presented in detail in Table 1, reflects these differences. Forty percent of the public hospital sample delivered by cesarean and 71 percent of the private sample delivered by cesarean.

ASSESSING WOMEN’S ATTITUDES

An influential paper on the factors behind the rise of cesarean section in Brazil posits that one of the reasons women seek out cesareans is motivated by fear of vaginal childbirth. Women are

said to believe that vaginal birth causes stretching and will thus compromise their sex lives, and they believe vaginal birth is less safe for the newborn than cesarean (Faúndes, Cecatti, 1991, 1993). Though these reasons, which the authors refer to as “sociocultural factors,” have subsequently been cited as “facts,” the authors preface their remarks with the following:

We do not know of any published Brazilian study about the influence of sociocultural factors on the C-section rate. The discussion that follows is based on the collective opinion of a selected group of Brazilian obstetricians and other specialists, who met to review the problem of the increasing cesarean rate in the country and the possible determining factors (Faúndes, Cecatti, 1993, p. 34-35).

We used the hypotheses proposed in the paper about pain, sexuality and safety to develop a series of statements to assess women’s attitudes about cesarean section, vaginal delivery, and female sterilization.

We expected to find large differences between public and private patients because of the cultural, educational, and experiential differences between the majority of women who deliver in public hospitals and the majority of women who deliver in private hospitals. Therefore, we were surprised with the results. Where we had expected large differences, they did not exist, or if they existed, they were in the opposite direction than expected. For instance, because the incidence of cesarean is so high in the private sector, we hypothesized that more women who delivered in private hospitals would be concerned about the negative effects on sexuality of vaginal deliveries. In fact the opposite is true, as we show below. We also expected to find proportionally more women in the private hospitals to believe a vaginal delivery is more painful than a cesarean and to believe a cesarean has positive aesthetic consequences. Again, women’s responses did not bear this out.

Table 2 shows women’s responses to attitude statements in the Postpartum Survey. Differences are presented by type of hospital in which the woman delivered. The table also presents Chi-square differences.

Table 2
**DISTRIBUTION OF ATTITUDES CONCERNING CESAREANS,
 VAGINAL DELIVERY, AND FEMALE STERILIZATION, BY TYPE OF HOSPITAL**

| Statements assessing attitudes | Type of Hospital | % | | | | Chi-Square difference (p-value) |
|--|------------------|-------|----------------------------|----------|------------------------|---------------------------------|
| | | Agree | Neither Agree nor Disagree | Disagree | Don't Know/ No Opinion | |
| A. Recuperation, Body and Sexuality | | | | | | |
| 1. A woman recuperates her figure faster after a vaginal delivery than after a cesarean. | Public | 85 | 4 | 4 | 8 | 0,19 |
| | Private | 84 | 5 | 1 | 11 | |
| 2. The recuperation after a cesarean is longer than after a vaginal delivery. | Public | 91 | 1 | 2 | 6 | 0,42 |
| | Private | 91 | 3 | 4 | 3 | |
| 3. A cesarean delivery leaves a large scar. | Public | 69 | 17 | 11 | 3 | 0,00 |
| | Private | 30 | 20 | 46 | 5 | |
| 4. A cesarean delivery preserves a woman's beauty more than a vaginal delivery. | Public | 20 | 6 | 57 | 17 | 0,00 |
| | Private | 6 | 6 | 76 | 13 | |
| 5. The vagina remains "stretched" after a vaginal delivery. | Public | 58 | 3 | 26 | 14 | 0,02 |
| | Private | 41 | 4 | 38 | 18 | |
| 6. A vaginal delivery impinges on a woman's ability to give sexual pleasure to her husband. | Public | 16 | 1 | 70 | 14 | 0,00 |
| | Private | 3 | 2 | 80 | 15 | |
| 7. A vaginal delivery impinges on a woman's ability for herself to experience sexual pleasure. | Public | 21 | 1 | 63 | 16 | 0,00 |
| | Private | 4 | 3 | 77 | 17 | |
| B. Pain | | | | | | |
| 8. A woman does not feel pain during a cesarean operation. | Public | 61 | 2 | 27 | 10 | 0,26 |
| | Private | 69 | 4 | 22 | 6 | |
| 9. A woman feels considerable pain after a cesarean operation. | Public | 81 | 4 | 7 | 9 | 0,01 |
| | Private | 72 | 7 | 17 | 4 | |
| 10. A vaginal delivery is more painful than a cesarean. | Public | 67 | 6 | 22 | 5 | 0,02 |
| | Private | 66 | 4 | 16 | 14 | |
| C. Cesareans vs. Vaginal Deliveries | | | | | | |
| 13. From the point of view of the baby, a cesarean is safer than a vaginal delivery. | Public | 22 | 11 | 54 | 13 | 0,45 |
| | Private | 30 | 11 | 48 | 12 | |
| 14. From the point of view of the woman, a cesarean is safer than a vaginal delivery. | Public | 18 | 7 | 67 | 8 | 0,60 |
| | Private | 14 | 9 | 70 | 6 | |

Source: Postpartum Survey, 1995-96.

The first panel of Table 2 includes seven statements about recuperation after birth, the body and sexuality. Eighty-four to ninety-one percent of women in the public and private hospitals agreed with the statements that a woman recuperates her figure more quickly after a vaginal delivery and that the recuperation after a cesarean takes longer. No significant statistical differences exist between the two hospital groups. The next two statements concern aesthetic reasons why women may be drawn to cesarean section: a cesarean leaves a large scar, and a cesarean preserves a woman's beauty more so than a vaginal birth. Differences do exist between the two hospital sectors. Sixty-nine percent of women in the public hospitals said that a cesarean left a large scar while thirty percent of women who delivered in the private sector did. This result is not surprising, given that women in the private hospitals have more experience with cesarean section (either they or someone they know have had a cesarean), and so are probably more likely to be aware that the "bikini cut" of a typical cesarean does not leave a large scar. The fourth statement in this group assesses whether women think a cesarean delivery maintains a woman's beauty more so than a vaginal birth. The majority of women in both sectors disagreed with this statement. Surprisingly, proportionally more women (twenty percent) in the public hospitals than women in the private hospitals (six percent) agreed with this statement.

The next three statements address the notion that women seek a cesarean delivery because they do not want to lose sexual functioning after a vaginal delivery. While over half (fifty-eight percent) of the women who delivered in the public hospitals agreed with the statement that the vagina remains "stretched" after a vaginal delivery, a considerably smaller proportion (sixteen percent to twenty-one percent) believe sexual pleasure for herself or her husband is harmed as a result of a vaginal delivery. Loss of sexual functioning, though often cited in the literature, does not seem to be a salient motivation for cesarean delivery.

Panel B of Table 2 shows women's attitudes about the pain associated with the different delivery types. The majority of women in public and private hospitals agree that during a cesarean operation a woman does not feel pain, sixty-one percent and sixty-nine percent respectively. A majority that a woman feels considerable pain after a cesarean operation. Comparing the two delivery experiences overall,

two-thirds of women in public and private hospitals as well as by delivery type agree with the statement that a vaginal delivery is more painful than a cesarean. The results on pain therefore are mixed. The majority of women agrees a cesarean is not painful during the operation but is very painful after the operation. Overall, a majority also believes a vaginal birth is more painful than a cesarean.

The third group of statements assesses women's attitudes about the safety of the two types of delivery for the woman and her baby. Thirty percent of women in the private hospitals, and twenty percent of women in the public hospitals agreed with the statement that, for the baby, a cesarean is safer than a vaginal delivery. There were no significant statistical differences between the responses from the two sectors. In terms of the woman's safety, the majority disagrees that a cesarean is safer for her than a vaginal birth, and no significant differences exist between hospital types. In other words sixty-seven to seventy percent of women do not believe a cesarean is safer for the woman.

The statements assessing women's attitudes call into question authors' claims that the reason for the high rates of cesarean is due to women's fear of negative aesthetic or sexual consequences of a vaginal birth. Safety concerns for themselves and their babies also are not salient issues for the majority of these women. Fear of pain is a potential motivation for women's desires for a cesarean. However, a higher proportion of women who delivered vaginally believes a vaginal delivery is more painful than a cesarean. In other words, the pain of the delivery per se does not necessarily motivate a woman to choose one type of delivery over another.

DELIVERY DESIRES *VERSUS* DELIVERY OUTCOMES

To assess women's delivery desires against the actual outcomes of the birth, women were asked how they had wanted to deliver their babies. The question was: "You had a vaginal birth/cesarean. Did you want to have this type of birth *before* you entered the hospital?" Table 3 shows the results by parity and hospital type. It is somewhat problematic to ask this after the birth has taken place since the outcome of the delivery can affect the answer. Therefore, these results should be interpreted with some caution.

Table 3

PERCENTAGE OF WOMEN WHO WANTED A VAGINAL DELIVERY
BY ACTUAL TYPE OF DELIVERY, BY HOSPITAL AND PARITY

| Delivery Desire vs. Delivery Outcome | Parity | | | |
|--|--------|---------|--------|---------|
| | 1 (%) | (Ratio) | 2+ (%) | (Ratio) |
| Private Hospitals | | | | |
| % of women who delivered by cesarean who wanted to deliver vaginally | 72 | (21/29) | 37 | (28/76) |
| % of women who delivered vaginally who wanted to deliver vaginally | 95 | (20/21) | 96 | (24/25) |
| No preference | - | (1) | - | (1) |
| Public Hospitals | | | | |
| % of women who delivered by cesarean who wanted to deliver vaginally | 80 | (16/20) | 67 | (29/43) |
| % of women who delivered vaginally who wanted to deliver vaginally | 88 | (21/24) | 81 | (55/68) |
| No preference | - | (4) | - | (2) |

Source: Postpartum Survey, 1995-96.

Did a majority of women who delivered by cesarean, particularly those in the private hospitals where rates are high, want to deliver by cesarean before entering the hospital? Table 3 presents the proportions of women who wanted a vaginal delivery before entering the hospital by actual type of delivery and by type of hospital. We further divide the samples into first-time mothers and those who delivered second or higher-order births. It is important to divide the samples by parity because a woman's previous experience with a delivery type may condition her to want or expect that kind of birth in subsequent deliveries.

The top panel of Table 3 presents women's delivery desires versus the actual delivery outcome for the combined private hospital samples. Twenty-one of twenty-nine, or seventy-two percent, of first-time mothers who delivered by cesarean entered the hospital wanting to deliver vaginally. In contrast all but one of the twenty-one women who delivered a first child vaginally wanted normal childbirth before entering a private hospital. A considerably smaller proportion of

women giving birth to a second-plus child by cesarean preferred a vaginal birth. This is not surprising given Brazil's low rates of vaginal birth after cesarean and the commonly held belief among women and doctors that "once a cesarean, always a cesarean". In other words women who delivered a first birth by cesarean may be more likely to have prepared themselves psychologically for a second cesarean. Many of them may have entered the hospital wanting, or at least expecting, another cesarean. Still, over a third of the women who delivered a second child by cesarean wanted to deliver vaginally. As with first-time mothers, all but one of the women who delivered vaginally wanted that type of delivery when they entered the hospital. The crucial event then seems to be the first birth. A considerably higher proportion of women entered the hospital wanting a vaginal delivery for the first birth compared to a second or higher-order birth. This result calls into question the assumption that women who deliver in private hospitals clamor for cesareans.

The bottom panel of Table 3 presents women's delivery desires versus delivery outcomes for those who delivered in the public hospitals. Sixteen of the twenty women, or eighty percent, who delivered a first child by cesarean entered the hospital wanting to delivery vaginally. All but three of the twenty-four women, or ninety-one percent, who delivered vaginally wanted that type of delivery before entering the hospital. For second and higher-order births, there is not as large a difference compared to first births as among the women who delivered in the private hospitals. Compared to the private hospital samples, a larger proportion of women who delivered by cesarean in the public hospitals to a second-plus child wanted a vaginal birth. Sixty-seven percent of women who delivered by cesarean entered the hospital wanting a vaginal birth. Among women who delivered a higher-order birth vaginally, thirteen of sixty-eight, or nineteen percent, wanted to deliver by cesarean. Many of these women wanted a cesarean in order to have a chance at a tubal ligation.

"BEGGING" *VERSUS* THE POWER TO DECIDE: DOCTORS' ENCOURAGEMENT OF CESAREAN SECTION

In this section we present three cases of women who delivered in private hospitals to further dispute the claim that women

are begging for cesareans. They show how doctors use their authority to order or induce women to ask for cesareans. The first two cases come from the participant-observation portion of the study, and the last two cases come from the in-depth interviews.

Case #1: Branca⁴

Branca is in labor with her first child at Hospital Araucária, a private hospital in Porto Alegre. She eventually delivers by cesarean. Branca's case shows how doctors often frame their decisions to perform cesareans in terms of women's demands, not in terms of how cesareans may benefit the doctors. It also shows that women who deliver in the private sector are afraid of the pain of childbirth and that many do not seem to receive adequate psychological preparation for the rigors of labor and delivery. Branca's obstetrician, Dr. Sálvio, shows interest in the research and insists that one recognize the pressure doctors face from women to perform cesareans. Dr. Sálvio repeats over and over how women pressure him to do cesareans because of fear of childbirth. However, he does not discuss ways to deal with those fears.

Branca's cesarean makes her the seventh person in her division at work to have a baby recently. Only one of them delivered vaginally. When the researcher asks her what her coworkers said about cesareans she replies, "They say that a cesarean is faster, painless. That it's a small cut and that you can wear a bikini afterward. And that you don't suffer too much after the surgery". So, Branca is disposed toward having a cesarean, and if she were to have one, her experience would not be extraordinary compared to her friends' experiences.

Soon after Hopkins arrives and explain the research, Dr. Sálvio launches into a long explanation of why he thinks cesarean rates are higher in private hospitals. Quoted loosely, Dr. Sálvio said:

Dr. Sálvio: In the public hospitals, the cesarean rate is a lot lower than in private hospitals. In private hospitals, we doctors have a lot more pressure to do cesareans. In public hospitals, doctors

⁴ All names used in this paper, including those of the hospitals, are pseudonyms.

don't even know the women's names. But we know the private patient all throughout her pregnancy. In public hospitals, the doctors send the nurses to examine the patients. But we stay with the private patient for as long as it takes, stay with her all during labor. We get a lot of pressure from the women to do cesareans during prenatal visits and during labor, because they don't want to go through the pain. *To Branca*: You came to my office already wanting to do a cesarean, didn't you?

Branca: Well, I talked about it, didn't I? I don't want to have to go through the pain.

First, Dr. Sálvio finds it necessary to justify his actions regarding his use of cesarean section. Second, he places the bulk of the responsibility for the high rates on women's shoulders. They pressure their doctors, he argues, and doctors do the surgery. Third, he notes the time pressure doctors feel when they attend private patients. Since obstetricians stay with their private patients during labor "for as long as it takes," they may feel pressure of another sort. They may feel pressure to end the labor in the most expedient way. Finally, he remarks that the main reason for the pressure doctors feel from women is their fear of the pain of childbirth. However, he says nothing, not at this time or at any time throughout the labor and cesarean delivery, that may undermine this "accepted knowledge". In other words he accepts that fear of pain among his private patients is justified and immutable. Branca said she had "talked about" wanting a cesarean, but she never said that she had asked for one.

Some time later, in the midst of a contraction, Branca cries out, "Oh, I can't take it anymore". Dr. Sálvio turns immediately to the researcher:

Dr. Sálvio: You see? That kind of thing is subliminal. We suffer pressure. Psychological pressure. Also we doctors receive a lot of pressure from the hospital, from the statistics. They don't want us to do so many cesareans. For instance, the people from downstairs (administration)

come with their statistics. (The medical director) comes to me and says, 'you did ten deliveries last month, and eight were cesareans'. But he's not here in the labor room, suffering the kind of pressure we do.

Again, Dr. Sálvio insists that the researcher understand the incredible pressure he receives from the women to perform cesareans. He bristles that the hospital's medical director criticizes the number of cesareans he performs. He feels the administrators does not understand the pressures that working obstetricians face. Again, Dr. Sálvio frames the debate in terms of the women, absolving himself of responsibility for the high rates.

The cry of pain, "Oh, I can't stand it anymore" is the most common statement the researcher heard from women in labor. Women in the public hospitals said this over and over for hours, asking the doctors to do anything to they could to deliver the baby. The doctors, who also work in the private sector, calmly ignore the requests to "do something" or simply pat the women on the shoulder and tell her it will all be over soon. So, doctors *can* resist women's pressure to perform a cesarean. Finally, "I can't stand it anymore" is not a request for a cesarean but an expression of the pain and discomfort of the labor.

A few minutes later, Branca again says she cannot stand it anymore, and her doctor says to us in the room, "See, that was the fourth attempt to pressure me". He does not calm her fears or suggest ways to cope with the pain. Instead, he seems to be preparing her to "ask" for the cesarean. Indeed, during the next big contraction, Branca moans and says:

Branca: Oh Sálvio, now I'm putting on the pressure.

...

Dr. Sálvio: We have an alternative called analgesia (an epidural). Do you want it?

Branca: Oh, I don't know.

Dr. Sálvio: You want to do a cesarean right now, don't you?

This is the first mention of an epidural. It is unclear if the obstetrician has discussed this with his patient before this point. However, since an anesthesiologist is not on hand to do the epidural, it is probably not a “real” option. Furthermore, the doctor also seems to be preparing Branca for a request for a cesarean.

Dr. Sálvio breaks the amniotic sac and turns to the researcher, “It’s green. Meconium⁵. Even though the baby is okay, it’s an indication for a cesarean. *Turning to Branca*: You won! You won!” Dr. Sálvio’s triumphant claim that Branca “won” is not consistent with what has transpired to this point. True, Branca was in pain and afraid of pain. She also used her doctor’s words to say that she was “putting on the pressure”. But she never asked for a cesarean, so it is unclear who won.

Looking for confirmation, Dr. Sálvio asked the researcher:

Dr. Sálvio: To the folks in administration, this is just another cesarean for comfort. Do you think it is?

Kristine, *nervously, searching for the appropriate thing to say*: Well, it’s a medical indication, the meconium.

Dr. Sálvio: If this were a woman having her sixth child and eight centimeters dilated, she’d have the baby within fifteen minutes. But this is her first child, and only five centimeters dilated and there’s no way to be sure (*He had done an exam earlier and said she was six centimeters dilated*).

The point is not whether the researcher agrees with his medical diagnosis. She has no expertise to make that kind of decision. What is crucial is how the obstetrician frames the situation so that he is justified in his decision and also how important it was for him to see that I believed the cesarean was medically necessary.

5 A meconium stain in the amniotic fluid is an indication that the fetus has passed a bowel movement. This can lead to difficulties such as respiratory infections if the fetus aspirates some of fecal matter in the amniotic fluid.

After the surgery is over, Dr. Sálvio comments again on the pressures that patients put on him to do a cesarean.

Dr. Sálvio: How many times (did Branca put on the pressure)? Five at least.

Kristine: At least.

Dr. Sálvio: And I resisted.

Kristine: Yes.

Dr. Sálvio, in a lower mirthful voice directed toward the assistant obstetrician: But not much. (Mas não muito.)
Then he laughs.

This last comment and the laughter shows he is aware that the “pressure” is not unbearable. He clearly has the power to frame the situation in terms of pressure from others. That he is so amused with himself reveals that he recognizes his power and takes full advantage of it so that he can finish his work early and, as he tells me on his way out the door, he can go out for a good lunch and drink some beer.

Case #2: Sofia

Thirty-six year old Sofia is pregnant for the second time. Her first pregnancy ended in a miscarriage, so she is about to give birth for the first time at Hospital Araucária. Sofia originally requested a cesarean from her obstetrician because of her “advanced age,” but her doctor assured her a cesarean was not necessary. Ever since that first conversation with Dr. Paulina, Sofia has wanted a vaginal delivery. However, after about four and a half hours of labor in the hospital, Dr. Paulina orders a cesarean section because Sofia’s dilation has stalled. Sofia’s case shows some private obstetricians during prenatal care encourage their private patients to consider vaginal delivery. It also shows these same obstetricians do not exercise a lot of patience for the natural progression of labor and may order cesareans for their own convenience.

After Sofia has been in the hospital about three hours, the researcher confirms with her doctor that there was no reason to schedule a cesarean. She responds:

Dr. Paulina: Just because she's thirty-six? No. Everything is going well. *Pause*. But that doesn't mean that we'll wait until tomorrow morning. *To Sofia*: If I examine you and your dilation hasn't evolved after all this walking, then there's no reason for you to suffer.

Dr. Paulina's answer opens the door for a decision to do a cesarean. She also frames the potential need for the cesarean in terms of the woman's pain, emphasizing that there is no need for Sofia to "suffer". About an hour later, Dr. Paulina asks Sofia if she feels the need to empty her bowels (*evacuar*). Sofia says she does not. Then a few minutes later she tells Sofia, "If you change your mind about having a vaginal birth, it's really common". Again, Dr. Paulina is opening the door for a cesarean, almost encouraging Sofia to change her mind.

The researcher overhears Dr. Paulina talking to the pediatrician on the telephone. She tells him that she will examine her patient in twenty minutes to see if the dilation has progressed beyond five centimeters. "If she's still five centimeters, then she can't have a normal birth. But everything is going well". She repeats this information to Sofia, telling her, "But if nothing has changed, we'll still have to wait awhile. I'd have to call the anesthesiologist, the pediatrician, and the assistant obstetrician. Thank God it's nothing urgent. Everything's set". These statements suggest the decision to do the cesarean has already been made.

Dr. Paulina does the vaginal exam at the appointed time and discovers that Sofia is still five centimeters dilated.

Dr. Paulina, *shaking her head*: Five centimeters. From four until seven p.m. all those contractions didn't progress things. It's the same dilation.

Though Dr. Paulina did not actually tell Sofia she had to have a cesarean, I see Sofia understands the outcome. She looks very disappointed.

Dr. Paulina, *to the nurse*: She felt the need to void her bowels. Feeling that unrelated to contractions is an indication of cephalopelvic disproportion.⁶

6 Cephalopelvic disproportion means the baby is too large to pass through the birth canal.

Sofia: But I didn't feel the need to empty my bowels.

Dr. Paulina, *ignoring Sofia's comment*: Now I'm going to call the anesthesiologist, the pediatrician, and the assistant obstetrician. And I'm going to talk to (your husband) Marden.

Sofia: Ask Marden what he thinks.

Sofia, *to me, with a low moan*: So much suffering to end in a cesarean. I should have just scheduled one.

This exchange shows Dr. Paulina was unwilling to wait any more time for the labor to progress. The obstetrician has made her decision. Though Sofia did not feel the need to empty her bowels, her doctor nonetheless uses that as the reason for ordering the cesarean. Furthermore, she ignores Sofia's repeated comments. Sofia is concerned that the reason she has to have a cesarean is that the doctor misunderstood her need to go to the bathroom at the wrong time. The doctor returns from her conversation with Marden:

Sofia: What did Marden say? That I have to do the cesarean?

Dr. Paulina: Yes, and your mother-in-law (said so) too.

Sofia: But I didn't have to empty my bowels.

Again, Dr. Paulina ignores this comment. Sofia clearly does not want the surgery and has been hoping that her husband does not want it either. However, Sofia never asks her doctor to wait. Instead, she accepts the obstetrician's authority with only a few ineffectual (and ignored) attempts to convince the doctor that her need to empty her bowels was misunderstood.

This case shows that though some doctors in the private hospital may talk of the superiority of a vaginal delivery, they do not always wait for labor to evolve. Sofia was in labor a very short time when her doctor decided to do a cesarean. The decision is dubious at best, particularly since the doctor's supposed reason was not borne out by Sofia's experience. Perhaps the outcome of this delivery may have been different if it were seven in the morning rather than seven in the evening when the doctor did the "final" examination and determined that the dilation was not progressing. Perhaps Dr. Paulina

wanted to perform the cesarean so that she could return home at a reasonable hour. Dr. Paulina did not explain why the cesarean was necessary. She simply stated that dilation had not progressed. Though Sofia was very unhappy with the decision to operate, she did not question her obstetrician. This is not surprising given that Sofia's family members supported the doctor's decision and that Dr. Paulina left no room for dispute.

Case #3: Dália

Dália was interviewed after the delivery of her second child by cesarean at Hospital Dom Bosco, the private hospital in Natal. She delivered her first child vaginally in a public hospital in Natal. Dália planned to deliver her second child by normal childbirth, but she was afraid the baby was too big to be born vaginally. Her obstetrician, Dr. Catarina, recommended a cesarean during prenatal care and then again on the due date when Dália was only one centimeter dilated. She also motivated Dália to have a cesarean by offering to sterilize her for free after the procedure.

Dália's case shows private doctors often introduce the "need" for a cesarean during prenatal care. Obstetricians also waver on cesarean decisions, as did Dr. Catarina who at one point says they can try for a vaginal delivery. However, the doctor quickly decided to perform a cesarean. Interestingly, she portrayed the decision as Dália's choice. This case also shows the ambivalence women feel toward both kinds of delivery. Dália feared both vaginal and cesarean birth, and the majority of these fears related to her baby's health.

At four months of pregnancy Dália had an ultrasound. The physician who performed the procedure told her the baby was very large. In the eighth month of pregnancy, Dália requested fetal monitoring to see if everything was fine. She felt nervous because her first child was born with the umbilical cord wrapped around its neck, and the placenta was "old". (The placenta had lost some of its function.) Although her first child was healthy, Dália was concerned that a similar problem would arise during her second pregnancy, and the baby might enter fetal suffering if the birth occurred much later than forty weeks of pregnancy. However, after the monitoring, her doctor assured her that all was well with the baby and that the placenta was healthy.

During the interview Dália said that her obstetrician suggested a cesarean during prenatal care. The researcher asked her when the doctor first suggested it.

Dália: She suggested it before the fetal monitoring. She said, 'Dália, I think I'm going to have to perform a cesarean on you. This baby is really big. You'd go through a lot of suffering to have this child through normal childbirth'. So I said, 'All right'. I was a little worried because I'm also a little afraid of a cesarean.

Kristine: What was your reaction?

Dália: At the beginning I was a little scared, you know, because I was scared of the anesthesia, scared of the recuperation because I don't have anyone to help me, you know. ... I was afraid because of the stories I've heard about cesareans. ... I have an aunt who ... had a series of problems with her cesarean. Problems caused by the anesthesia. Because anesthesia is a big risk. ... I was also afraid that the baby would be born bigger than he actually was when he was born, because I really thought that he was going to be bigger (*Dália's baby was 3695 grams at birth.*) So I was pretty afraid. I was afraid of both ways of giving birth. After she suggested the cesarean I was afraid of the both of them. Afraid that he'd be really big and would suffer (during the birth), and afraid of the cesarean too. But ... if a cesarean is better for the baby, then it has to be done. So after the monitoring, the doctor said, 'Dália your baby is fine. He's big but he's fine. Should we try for normal childbirth?' I said, 'Okay then, let's try for the normal way'.

Dália's obstetrician suggested a cesarean during prenatal care when she suspected that the baby was too big. Dr. Catarina did not see the need for Dália to go through all the "suffering" of normal childbirth when a cesarean could solve that problem. This comment shows doctors contribute to or even encourage women's fears of

natural childbirth during prenatal care, to the point of recommending a cesarean. The doctor then changed her mind to “try” for a vaginal delivery. The phrase “try for normal childbirth” comes up over and over in women’s narratives of their births. Doctors often frame natural childbirth as something one can “try” but that a cesarean is always a very real possibility if the trial for labor is unsuccessful. As in the previous case, doctors in the private sector may lack the patience to wait for labor and determine if vaginal birth is possible. Dália was afraid of both kinds of childbirth. She feared that a vaginal delivery might harm the baby. She feared that a cesarean might harm her. But Dália considered a cesarean a necessary risk if it was “better for the baby”.

Once the decision to try again for a vaginal delivery was made, Dr. Catarina recommended an epidural during the labor:

Dr. Catarina: Look, if you want you can have anesthesia. There’s an anesthesia and you won’t feel a thing during normal birth. You could do that.

So the obstetrician in this case did recommend something for the pain of childbirth, though this was not Dália’s greatest fear. She feared that the baby would be born after its due date and that it would go into fetal distress. Since Dália was also concerned about the size of the baby, she agreed to have the epidural.

On Dália’s due date she experienced some light contractions and went to the doctor to be examined.

Dália: So I went to Dr. Catarina’s, and I was one centimeter dilated. The doctor said, ‘Dália, you’re one centimeter now. I’m going to suggest to you that we do a cesarean. Do you want me to operate on you? Because it’s just one centimeter. You’re going to feel (pain) for I don’t know how long’. I was also a little afraid that I’d pass the due date, and the same thing would happen as had happened with my first child. So she said, ‘Do you want me to do a cesarean?’ I said, ‘I want you to because I’m also afraid of spending a lot of time feeling these little contractions’. And another thing I was afraid about

was ... what happened to my neighbor. She had a normal birth, but her baby was pulled out by forceps. I said, 'No way is that normal. No way'. Normal is when the baby comes out spontaneously. Being pulled out isn't normal at all. So I was also afraid of the possibility that the baby would be really big, and they'd have to pull him out. Because (forceps) leave marks on the baby. They say it doesn't cause problems but I don't know, it could.

Though Dr. Catarina said they would try for a vaginal birth, when Dália's due date came and she was only one centimeter dilated, the obstetrician immediately "suggested" a cesarean. She placed her suggestion in terms of Dália's pain, to prevent her from feeling contractions. The obstetrician did not mention anything about whether a cesarean was necessary for the baby's health. Dr. Catarina focused on the pain of childbirth but did not discuss the post-cesarean pain that Dália would surely feel. Again, doctors tap into fears women have about the pain associated with childbirth. They capitalize on these fears by "suggesting" cesareans. This way, the doctor can schedule the surgery and not have to sit with their patients for "I don't know how long".

Dália was afraid of the need for forceps in a vaginal delivery. Many other women echoed this theme in the interviews. They think of forceps as an aggressive way to aid the baby's birth. Like Dália, many think forceps will cause the baby problems. These fears reflect women's ideas about the safety of the two delivery types for themselves and for their babies. Recall that fourteen percent of women who delivered in the two private hospitals felt a cesarean is safer for the woman compared to thirty percent who feel a cesarean is safer for the baby. While those who agree that a cesarean is safer for the baby are still in the minority, women's narratives show women nearly always agree with their doctors to have a cesarean when the health of the baby is thought to be (or portrayed to be) at stake. Women submit to major surgery to avoid potential problems that may arise in the rare case that doctors use forceps to deliver the baby.

DISSENTERS' VOICES

Others in the study actively wanted to deliver by cesarean. Typically, women's motives included fear of the pain of childbirth or desire for sterilization, or both. So not all women interviewed had been hoodwinked or pressured into having a cesarean against their will. A few sought a cesarean and refused to consider normal childbirth. For instance, Abigail, age forty, suffered considerably during her first vaginal delivery. Due to that suffering, Abigail considered a cesarean and ideal birth. Likewise, Graça is a strong proponent of cesarean as a way to avoid the pain of childbirth. She also considers cesarean safer for the baby. Inez wanted a cesarean because her husband was afraid a vaginal delivery would stretch her vagina. (Inez was the only interview subject to voice this fear.) Also, because of Inez's high blood pressure, she wanted a cesarean to insure her and her baby's health.

CONCLUDING REMARKS

Many women fear the pain associated with childbirth and the consequences of a vaginal birth for the baby. Obstetricians overplay these fears to their advantage. The safety of a cesarean is severely overestimated. It has become a routine practice and is considered as safe or safer than a vaginal delivery. Brazilian women are not begging for cesareans. The majority of first-time mothers in public and private hospitals wanted to deliver vaginally. Nearly three-quarters of the women who delivered a first birth by cesarean in the private hospitals, and eight of ten women in the public hospitals preferred a vaginal delivery. Women's preferences with higher-order births are different. The proportion of women who delivered by cesarean in the private hospitals who wanted to deliver vaginally is nearly half that of first-time mothers. Previous experiences with a cesarean or a desire for a tubal ligation done at the time of a cesarean accounts for much of this drop.

Women do not clamor for cesareans. The majority of women, irrespective of where they delivered, consider vaginal birth superior in terms of recuperation. A majority does not believe vaginal delivery negatively affects their or their partner's sexual enjoyment. A majority considers normal childbirth more painful than a cesarean, but most also believe a cesarean causes a lot of pain after the delivery. Less than one-third agrees that a cesarean is safer for the baby. Less than one-fifth of women agree that a cesarean is safer for the woman.

While women in the two sectors are similar in how they view a series of issues related to cesarean and vaginal delivery, large differences exist between women in the private hospitals and women in the public hospitals in views toward female sterilization. Nearly one in four women in the public hospitals think the only way to get a tubal ligation is to deliver by cesarean, compared to only one in fourteen women who delivered in the private hospitals. Though the majority of women in the private hospitals were aware a sterilization was possible outside of a cesarean delivery, many nonetheless actively sought a cesarean with a subsequent tubal ligation, either because they wanted to “take advantage” of an already-ordered cesarean or because they had the cesarean in order to be sterilized.

A small minority of women in both sectors think doctors favor cesarean deliveries. Fewer than one in six women who delivered in the private sector believed doctors favor cesareans. After some of the interviews, women were asked to estimate the cesarean section rate in the hospital where they had given birth. Their guesses were always much lower than the real rates. When told the true rate, seventy-one percent in Porto Alegre and eighty-six percent in Natal, the women expressed shock and amazement.

We noted the voices of women who actively sought out cesareans for many of the reasons that doctors claim. Though a majority of first-time mothers wanted a vaginal delivery before entering the hospital, the majority of women who delivered a second-plus child wanted a cesarean. Previous negative experiences with vaginal birth and fear of the pain of childbirth contributed to women’s desires for cesareans. A chance to become sterilized was also a strong motivating factor.

We presented cases stories that show doctors stimulate demand for cesarean. Obstetricians subtly and blatantly encourage women to choose cesareans. Sometimes, they simply order the surgery without discussion. Doctors cite supposedly unbearable pressures from women and their families to perform cesareans. Some also use a pro-vaginal birth rhetoric but do not wait for labor to progress naturally. Sometimes, they ignore women’s desires. Obstetricians routinely use women’s fears of the pain of childbirth and concerns for the baby’s safety to their advantage. They also encourage women to choose cesareans as the most effective way of getting sterilized.

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