

Choice, Control and Childbirth: Cesarean Deliveries on Maternal Request in Shanghai, China

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Rates of cesarean deliveries—a surgical procedure used to deliver a baby through the mother’s abdomen—have risen dramatically in China within the past 25 years, from 3.4% in 1988 to estimates of 58% in 2010 (Hellerstein, Feldman, and Duan 2014). There are a host of structural and provider factors contributing to this phenomenon in China including: rapid development and urbanization; increasing hospitalization of births; low provider to patient ratio; a highly strained medical system; and provider financial incentives to perform cesarean sections (Hellerstein, Feldman, and Duan 2014). Nevertheless, there are also an increasing number of women in China who directly request cesarean deliveries. In particular, the proportion of cesarean deliveries on maternal request (CDMR), has increased dramatically from 2% of all cesareans in 1994 to 28% in 2011 (Zhang et al. 2008; Liu et al. 2014) which covers 21 cities and counties in two provinces in southeast China. We examined the rate of cesarean delivery and cesarean delivery on maternal request in 1.1 million singleton births from 1994 to early 2006. Cesarean delivery on maternal request was defined as a prelabor cesarean delivery for a singleton gestation without contraindications for vaginal delivery at 38 weeks of gestation or later. During the 13-year study period, the percentage of women who had high school or higher education increased from 13% to 46%. The overall cesarean rate increased from 22% in 1994 to 60% in 2003 and moderated to 56% in 2006. The corresponding rates of cesarean delivery on maternal request (per 100 all deliveries. However, while C-sections are life-saving operations, unnecessary surgeries for low-risk mothers may lead to increased maternal and neonatal morbidity compared to spontaneous vaginal delivery (Lumbiganon et al. 2010). It also contributes to reproductive risks for women who wish to have more children in the future.

Who are these women who request cesar-

eans? According to the literature, they are often of higher socioeconomic status, are older, live in cities, have health insurance (Tang, Li, and Wu 2006). Researchers have also found that factors for their decision include anxiety about the inability to complete a vaginal delivery, worry about fetal safety, concern about the effect of vaginal delivery on their figure or sex life, and the ability to choose an auspicious delivery date. Other major factors include fear of pain – less than 1% of women in labor are given epidural analgesia—as well as the demand for a “perfect” child or birth outcome, as a consequence of state policy restricting parents to one child (Tang, Li, and Wu 2006).¹ This family planning policy also shaped risk-benefit calculations, leading women to believe that there would be no future reproductive consequences to having a cesarean (Li and Zhao 2007; Hellerstein, Feldman, and Duan 2014).

Given this landscape of childbirth, I was particularly interested in understanding the interplay of all of the actors involved in the birth decision-making process and, in particular, at the moment of the request. To what extent are women’s requests acknowledged or rejected by doctors, and how do larger structural factors, like state policy, play into these doctor-patient interactions? In other words: who decides how a mother delivers?

Ethnographic orientation

To explore this issue, I conducted ethnographic fieldwork in Shanghai, China for two months at Jiangbei District Hospital, a medium-sized, state-owned hospital. Provider salaries come from the government, although bonuses are paid by hospitals from user fees. Around 2,400 deliveries occur there every year, a little more than a third of which are by cesarean. During my two months, I was able to conduct participant-observation in the outpatient and inpatient departments, attend prenatal classes, and interview women, providers and family members about birth and, in particular, delivery decision-making.

1 The state relaxed this family planning policy, also known as the “One-Child Policy,” in 2016. Now all couples are allowed two children.

Going into the field, I was expecting to investigate CDMR, which is more common among higher socioeconomic women, as noted in the literature. However, the majority of the women giving birth at Jiangbei only had a junior high or high school education and were typically migrants working temporarily in Shanghai. At first, I thought this demographic would not be conducive to my research question pertaining to CDMR. But as I delved deeper into my fieldwork, I realized that socioeconomic status did not matter in terms of who *requested* cesareans; instead, it mattered in terms of who *received* them, and whether the requests were considered “legitimate.” This led me to further ask: who possesses the power to make delivery decisions within the Chinese medical system?

The state-provider-patient relationship

In China, the doctor-patient relationship is generally paternalistic. The doctor is seen as an authoritative figure in medical decisions. Often times doctors would perform an exam without informing the woman of what they were doing. In cases in which the physician recommended a cesarean delivery for a medical reason, the woman almost always conceded. In turn, physicians are subordinate to the state in many ways. Doctors working in public hospitals are salaried state employees paid by government and have little say over working conditions or levels of pay (Yang 2008). According to one OB/GYN, physicians are paid only 1600 *renminbi* per month (250 dollars), which must be complemented by bonuses based on the number of procedures they perform.

In regards to cesarean decision-making, the Shanghai government has begun to control public hospitals’ C-section rates; if it goes above certain percentage, they will cut a portion of the hospital’s income. In response to this pressure, physicians and nurses have started to reduce unnecessary C-sections, particularly those requested by mothers. As Min Wang, a nurse-midwife at Jiangbei, told me,

“Before the rules were looser. In other words - if you know that person, if the mother requests it, or if the mother adamantly says, ‘I want a cesarean’ - then [doctors] will allow it. So then in the cesarean indication

box we would write “requested surgery.” But right now, everything is stricter. Now it’s not like if you want a cesarean you can have a cesarean. You have to have a medical indication like macrosomia [excessive fetal birth weight], uterine scar, placenta previa [in which the baby’s placenta covers the opening in the mother’s cervix] or other medical issues. Before if you requested it they would give it to you. But now if you request it there is no way to give them a cesarean.”

With stricter controls on cesarean section rates, supposedly “scientific” and “medical” reasons are now the only justifications for cesarean deliveries. However, these restrictions on CDMRs are not foolproof policies. I found that women continue to request and receive cesareans in spite of medical and state authority and scientific guidelines—challenging the paradigm of power structures in the state-provider-patient relationship and demonstrating their agency in birth decision-making.

Women who received requested cesareans

Who are these women who are able to navigate medical and state authority, and how are they able to do so? I found that, as indicated in the literature, those who requested and received a cesarean were more likely to be of high socioeconomic status. According to the logbook of cesarean deliveries at Jiangbei, of women who requested and received cesareans, 90 to 95% were of “VIP” status, or patients who had purchased private, more expensive rooms. The reasons for these requests were consistent with those found in previous research, which I have mentioned earlier. The ways in which these women defended their requests, however, provide insight into how they overcame medical and state authority. Some would refuse to change their personal decision, despite doctors’ recommendations. These women would often indirectly use money or their VIP status to stake their demand, reflecting the commercialization and commodification of health care. Others who requested and received cesarean sections had conceived by in vitro fertilization (IVF). According to one of the doctors I interviewed, requested cesarean deliveries were jus-

tifiable for IVF babies because of the enormous amount of economic investment already funneled into creating the “precious” baby. To them, cesarean sections presented a safer, more controlled method to protect this investment during delivery – again reflecting a certain consumerist and medicalized view of reproduction and childbirth. These examples also show how the predominant power structures and scientific basis for cesarean decision-making may be complicated by women’s social and economic capital.

This is further exemplified by the fact that the majority of the nurse-midwives at Jiangbei requested cesareans when they gave birth, even as they discouraged other women from doing so. Like other women, they feared pain or the risk of vaginal birth to their baby. As nurse-midwife Fang Liu told me,

“If you were to ask me which is better, cesarean or vaginal, I would definitely tell you, vaginal delivery is better. This is definite. Using what we have learned in our specialty training, we have learned vaginal delivery is better because there’s less harm to the body, the recovery is faster, all that. But, if you told me to choose, I would still choose cesarean. It’s because I felt like I was just too afraid of childbirth pain. I felt like I was afraid of pain. I didn’t feel like I was the courageous type of person.”

Her story demonstrates how the calculus of decision-making depends on the role that one takes—whether as a provider who takes into account state and professional guidelines in medical-decision making, or as a woman who is giving birth herself. It also, again, raises questions about the supposedly “scientific” basis to delivery decision-making.

Women who did not receive requested cesareans

As I mentioned previously, women of lower socioeconomic status request C-sections as well. However, they do not necessarily receive them because providers may not consider their requests legitimate. Granted, the majority of these women I interviewed did not prefer cesarean deliveries and did not request them before labor. Still, even as they asked for one during labor due

to the experience of labor pain, the providers would simply ignore, dismiss, or roll their eyes at them.

But a request is a request. I argue that the reasons women request cesareans before labor *are the same* as those who request it during labor, except the former is in response to the *fear of* pain and labor whereas the latter is in response to the *experience of* it. In either case, their reasoning for cesarean delivery was not any more “scientific.” But when it comes to these lower socioeconomic status women who request cesareans during labor, physicians paternalistically assume that they can handle the pain or that they do not really know what they “really want” because they are not making a rational risk-benefit analysis. However, that physicians do not see requests as valid thus effectively renders these women’s appeals invisible. It dismisses the legitimacy of their claim to agency and control over childbirth. This view, perpetuated by scholars examining only the cesarean deliveries requested by mothers *and fulfilled by doctors*, brushes over the lived experiences of all Chinese women, as well as the underlying doctor-patient power dynamics that construct the “legitimate request.”

In summary, I have noted that the state and medical profession hold significant authority in controlling the childbirth process in China, although women may have the ability to navigate that authority in the form of CDMR. However, this is highly stratified along socioeconomic lines, and such medical decisions are not necessarily based off of “scientific” but social and economic reasons. That many women continue to demand cesarean sections point to larger issues beyond the power dynamics in the medical system including: the medicalization of childbirth, lack of pain relief or social support during labor, and the One-Child Policy – topics beyond the scope of this paper. While top-down Chinese policies have been more or less effective in reducing cesarean section rates, they have done little to affect the underlying environment generating fear of vaginal childbirth. This can only be addressed by adjusting norms, changing population reproductive policies, providing universal pain relief, and offering social support for all women.

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