

Childbirth and Choice

In 1997, less than 10% of babies in New South Wales were delivered by caesarean section. Since then, the rates have sky-rocketed, with over a quarter of mothers delivering by caesarean in 2005. This is far above the World Health Organisation recommendations, which suggest that caesareans should account for around 10% of all births. The caesarean section has become mainstream, yet women seem divided between those who have a natural childbirth, and those who have surgery. Healthcare appears just as divided, between obstetricians who generally have high rates of caesareans, and midwives who advocate women's right to natural and non-interventionary birth. It seems that every other week there is media commentary on childbirth and how women are choosing caesarean section as a "lifestyle" choice. Inspired by celebrities, this is the generation who are seen as "too posh to push".

How do we make sense of all of this? How has the caesarean moved from a life-saving surgery to a fashion decision?

At a basic level, there are probably very real reasons for the turn to caesarean. These include the obstetrician's fear of litigation and higher numbers of older mothers, whose labours may be more dangerous or difficult. But this movement has also in part been consumer driven. Women are demanding elective caesareans, fearing pain and damage to their baby or themselves. Many women now seem to believe that they cannot give birth themselves, and that surgery is a safer, surer way.

It is worth, then, thinking about how and why the caesarean was developed. In the late nineteenth century, childbirth was still a risky business. The majority of Australian women had frequent and relatively unproblematic experiences of childbirth: it may not have been particularly pleasant, but they survived with no long-term damage. But most women knew others who had died in childbirth – sisters, cousins, neighbours. In 1898, it was estimated that women had a one in thirty-two chance over her lifetime of a full term labour resulting in immediate maternal death. This excluded the women who died from post-labour complications. A woman's risk was often greater if she was poor, as poor diet and malnutrition increased her risks of a complicated labour and stillbirth.

For a woman with a complicated delivery, the options were few. Most simply had to endure, hopefully with the aid of pain relieving drugs. The forceps could be used, but their effectiveness was dependent on the skill of the doctor. For women whose labours lasted five days or a week, it is not surprising that they were open to new technologies, no matter how scary they might be.

The first caesareans were often done quickly, when the mother had died during childbirth, in an effort to save the baby. This was common in Catholic nations, where it was necessary to baptise the infant. Slowly, the cutting surgery began to be used on women who were still alive, in a desperate

attempt to save them and their babies. These early operations, first performed in Australia in the 1880s were ugly experiments, and death rates were high. Over 50% of mothers died during the surgery. In some cases, there were very real practical difficulties. These were often home births: candle-light was not good for surgery, and often doctors ran out of basic items such as catgut for stitching. Doctors persevered, perhaps because they wanted to save the child, when it was clear the mother would die either way.

The caesarean was then, a complicated turning point in the history of women in Australia. It did saved lives, some mothers and more babies. But it was also gruesome, experimental surgery, with enormous risks.

Over time, the surgery became safer, particularly with the development of antibiotics in the 1940s. With new drugs, infection could now be treated more effectively. For women giving birth now, the caesarean is generally a low risk surgery, though maternal mortality is still statistically higher than in natural childbirth, even once complications are accounted for.

That might be the problem – many women do not realise that there are risks in surgery. Caesarean section is understood now as safe and sure – and it mostly is. But the risks are still greater than a vaginal delivery. We need to ensure women have this information, and the more specific information pertaining to their own cases, so that they can make informed decisions about childbirth. The risks of choosing an elective caesarean for non-medical purposes must be highlighted.

Medicalised childbirth, including the caesarean section, is neither good nor bad, but can be both a necessity and a choice. We need to make technologies transparent, and give women the information to make informed choices about birth. Some intervention will always be necessary – but this does not mean we want to pathologise all birth, or suggest that all women need surgery. It is a tricky, even slippery distinction.

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