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Choosing Cesarean

Feminism and the politics of childbirth in the United States



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Abstract This article uses the US debate over elective Cesarean section to re-consider some of the more contentious issues raised in feminist debates about childbirth. Three waves of feminist commentary and critique in the United States are analysed in light of the ongoing debate over whether women should be able to choose Cesarean for non-medical reasons. I argue that the alternative birth movement's essentialist and occasionally moralistic rhetoric is problematic, and the idea that some women's preference for high-tech obstetrics is the result of a passive 'socialization' into 'dominant values' is theoretically inadequate. On the other hand, the invocation of women's choice and appreciation of high-tech childbirth serves as a weak foundation for a feminist perspective on childbirth. By limiting their analysis to the rhetorical and discursive nature and functions of 'the medical' and 'the natural', post-structuralist critics of the alternative birth movement obscure the connection of these discourses to practices that have very different consequences for maternal and infant health and, most importantly, for the consumption of health care resources.

keywords *childbirth, feminism, medicine, politics, reproduction*

Introduction

Although popularly conceived as a biological and personal experience, childbirth is also a cultural and political phenomenon, one that is both embedded in and consequential for gender relations (Jordan, 1983; Davis-Floyd, 1992; Davis-Floyd and Sargent, 1997; Rothman, 1982, 1989; Kitzinger, 1981; Leavitt, 1983, 1984; Oakley, 1980, 1993). As a result, feminist scholars and activists have taken an active interest in childbirth over the years. In the early 20th century, feminists in the United States and elsewhere struggled to overcome medical opposition to the use of pain relief during labour (Canton, 1999; Leavitt, 1984). In the 1960s and 1970s, the 'alternative birth movement' catapulted childbirth to the front pages of women's, parenting, and even some news magazines once again. Drawing their inspiration from the women's health and counter-cultural movements, second wave birth activists offered a powerful critique of

conventional birthing practices and advocated alternative approaches to childbirth, especially home birth and midwifery services.

In the United States, this alternative/natural birth movement has come under attack from quite disparate parties. On the one hand, the alternative birth movement has been vigorously opposed by organized medicine, most recently by a segment of the medical community arguing that women should have the right to choose Cesarean section for personal (rather than medical) reasons. At the same time, some feminists are also challenging aspects of the alternative birth movement's rhetoric and goals. These critics have been especially concerned about the alternative birth movement's tendency to valorize 'natural' birth and its associated failure to deconstruct the dualisms (such as nature/culture and nature/technology) that underpin patriarchal ideology.

In what follows, I use the US debate over elective Cesarean section to explore these and other theoretical issues. I argue that the alternative birth movement's essentialist and occasionally moralistic rhetoric is problematic, and the idea that some women's preference for high-tech obstetrics is the result of a passive 'socialization' into 'dominant values' is theoretically inadequate. On the other hand, the invocation of women's choice and appreciation of high-tech childbirth ignores the social and political processes through which those choices are made and serves as a weak foundation for a feminist perspective of childbirth. By limiting their analysis to the rhetorical and discursive nature and functions of 'the medical' and 'the natural', post-structuralist critics of the alternative birth movement obscure the connection of these discourses to different sets of practices that have different consequences for maternal and infant health and, most importantly, for the consumption of health care resources.

This article unfolds in five parts. The first section briefly synthesizes secondary accounts of the 20th century transformation of childbirth in the United States and describes the first and second waves of feminist activism around it. The second section provides an account of recent feminist criticism of the alternative birth movement's rhetoric, vision, and goals. The third section describes medical advocacy of elective Cesarean and the debate it has engendered. The fourth section reflects on the theoretical dilemmas raised by the debate over elective Cesarean for feminist analysts of childbirth, and evaluates recent feminist criticism of the alternative birth activism in this context. A conclusion summarizes the main arguments and highlights their theoretical and political implications.

Childbirth in the United States: transformation and critique

Throughout the 19th century, most women living in the United States delivered their babies at home, typically with a midwife in attendance (Donegan, 1984; Scholten, 1984). After the turn of the 20th century, the location of birth changed rapidly, and by 1939, over half of all birthing women delivered their child in the hospital. Since the 1970s, hospital birth has become normative across racial and demographic groups, with roughly 90 per cent of all US births taking place in hospitals under the supervision

of physicians (Rooks, 1997). Many feminist accounts of the relocation of childbirth from the home to the hospital emphasize the political machinations of the emerging medical profession and the impact of the profession's propaganda on women's beliefs and preferences. According to these analysts, doctors used their growing political and cultural authority to redefine childbirth as a dangerous, pathological event, to denigrate and eliminate midwives, and to fuel the perception that middle and upper class women were less able to withstand the challenges of childbirth (e.g. Daly, 1978; Ehrenreich and English, 1973; Oakley, 1980; Sullivan and Weitz, 1988).

While medical propaganda may indeed have shaped popular perceptions of childbirth and helped to associate doctors and hospitals with safety, historical scholarship indicates that women had long expressed a great deal of fear and trepidation about the potential pain (and danger) of childbirth. Indeed, many first wave feminist activists saw the right to pain relief as an important political issue (Leavitt and Walton, 1984; Leavitt, 1984, 1986; Reissman, 1983; Wertz and Wertz, 1977) and argued strenuously for women's right to relieve their suffering – and hence gain control of the birthing process – through the use of drugs, and specifically, scopolamine. These activists were outraged by obstetricians' reluctance to provide pharmacological pain relief, and saw this reluctance as indicative of physicians' tendency to place their own interests ahead of those of their female patients (Leavitt, 1984: 177). In this sense, first wave feminists' efforts to transform childbirth were less a campaign for drugs than for responsive and respectful medicine, expanded choices in childbirth, and control over one's body and reproductive life.

Scopolamine was eventually shown to be quite harmful to infant health, and its use subsequently declined. However, the use of other forms of anaesthesia became widespread after the 1940s. The legacy of first wave activism around childbirth is thus a mixed one: on the one hand, women won the right to pain relief and compelled obstetricians to at least consider women's preference for it; on the other hand, women arguably lost control over the process of childbirth, as well as the comforts of home and support of female relatives, friends, and midwives (Leavitt 1984, 179).¹

Second wave birth activism: origins

As hospital birth and pain-relieving medication became ubiquitous, modern childbirth came under critical scrutiny once again. Beginning in the 1960s, increasing numbers of women began to wonder aloud if childbirth had to be 'a time of alienation from the body, from family and friends, from the community, and even from life itself' (Wertz and Wertz, 1977: 173). Advocates of 'natural birth' – in which a woman was 'awake and aware' throughout the birth process – emerged in this context. As early as 1940, these critics decried the impersonality, isolation, and passivity that now characterized childbirth. In 1944, the English obstetrician Grantly Dick-Read published *Birth Without Fear* in the United States, which argued that much of the pain associated with childbirth was a product of fear. These ideas spawned what became known as the 'natural childbirth' movement (Rothman, 1982). And

in 1956, seven Chicago-area women founded La Leche League to advocate for more natural forms of childrearing, including 'natural' birth and breast-feeding (Rooks, 1997). Although hardly couched in feminist rhetoric, these early criticisms – replete with the idiom of 'the natural' – had a significant impact on second wave activism around childbirth (Umansky, 1996).

The alternative birth movement emerged as an increasingly coherent and united movement in the United States and other industrialized countries in the late 1960s and early 1970s. Although many activists drew their inspiration from the women's health and counter-cultural movements, a few in the US were also influenced by more conservative childbirth and childrearing philosophies (Umansky, 1996). The alternative birth movement has nevertheless offered a fairly coherent critique of the conventional approach to childbirth, one that emphasized the importance of treating childbirth as an important life experience and family event rather than a medical emergency; the right of women and families to choose their birth setting and attendants; the inhumane and impersonal nature of many routine hospital procedures; and the counter-productive nature of the 'high-tech, low-touch' approach to childbirth. In what follows, I explicate these themes and consider recent criticism of the alternative birth movement's discourse and goals.

Birth as a natural phenomenon

As was discussed previously, second wave feminist birth activists and scholars place a great deal of emphasis on the role of the (male) medical profession in the relocation and transformation of childbirth (see Daly, 1978; Ehrenreich and English, 1973; DeVries, 1996; Leavitt, 1983, 1984; Oakley, 1993; Sullivan and Weitz, 1988). According to these accounts, obstetricians argued 'again and again that normal pregnancy and parturition are exceptions and that to consider them to be normal physiologic conditions was a fallacy' (Kobrin, 1984); this re-definition of childbirth as pathological served to justify and legitimate the expansion of medicine's jurisdiction to include childbirth. As a result, resistance to medical control of childbirth has been framed in the language of 'normality' or the idiom of 'natural' (Kobrin, 1984; Michie and Cahn, 1996). Still today, birth activists' emphasis on the 'normality' and 'naturalness' of birth is best understood as part of an effort to contest medical control of birth and to challenge the increasingly narrow definitions of normality that prevail in hospital settings.

Similarly, the rhetoric of the 'normal' and 'natural' reflects concern about diagnostic technologies that overstate the risks of childbirth. The widespread use of the Electronic Foetal Monitor (EFM), for example, leads to a dramatic overestimation of foetal distress (estimates of the rate of false positives run as high as 98 per cent) and has therefore contributed significantly to rising levels of Cesarean section (Lent, 1999). In short, the development and deployment of the idioms of 'the natural' and 'the normal' can be understood in historical and political terms as a response to the medical profession's pathologization of birth, as well as to the use of technology and application of norms that render birth a 'high risk' event.

Many second wave scholars and activists argue that the conceptualization of childbirth as a pathological process and treatment of it as a (high risk) medical event eroded not only midwives' claim to expertise, but birthing women's as well (see especially Arms, 1994; Davis-Floyd, 1992; Rothman, 1982; Leavitt, 1984). For example, when women give birth in hospital settings, their capacity to act upon their preferences (such as eating or drinking, moving about, and so forth) is limited. In addition, procedures that made labour and delivery more comfortable for physicians – and more difficult for women – were adopted.

Some birth activists argue that the widespread use of such procedures reflects not only the prioritization of doctors' comfort over that of birthing women, but also the 'ideology of technology' which connotes order, rationality, predictability, and control, and treats women's bodies as a (malfunctioning) machine that must be oriented toward these goals (see especially Davis-Floyd, 1992; Martin, 1992; Rothman, 1989). (Here, the implicit contrast is not between nature/pathology, but between nature/technology.) These procedures are also thought to stem from a patriarchal devaluing of women's bodies, and the tendency to conceive of the foetus/newborn as a 'second patient', separate from – and in need of protection from – their mother (Rothman, 1989; Hubbard, 1990).

Birth activists also cite evidence of the safety of home birth to justify their emphasis on the normality and 'naturalness' of birth. Indeed, many epidemiological studies indicate that planned home births attended by trained midwives are as safe or safer than physician-attended hospital births for 'low risk' women (for summaries of these literatures, see Goer, 1995; Rooks, 1997; Wagner, 2000). Birth activists conclude that since midwives, operating from a conception of birth as 'natural', are able to match or exceed doctors' safety record at lower cost, the pathologization of birth is not just unnecessary, but epistemologically and empirically incorrect.

The iatrogenic and dehumanizing nature of medical intervention

Second wave birth scholars and activists emphasize that the vast majority of births involve high – and increasing – levels of technological intervention. Indeed, nearly all US hospital births are now monitored electronically; approximately one in five births is artificially induced; more than one in four is surgical in nature; and four of the eight most common US surgical procedures are obstetric in nature (Keefe, 2002; Moon, 2002). These rates far exceed World Health Organization standards for maternity care, and are, therefore, the subject of much controversy (Wagner, 1997, 2000). As was discussed previously, high levels of intervention are considered problematic because obstetric intervention often results from misleading indicators of risk or narrowed definitions of normality, and because they may diminish women's capacity to make meaningful choices regarding their birth deliveries. Critics also point out that these interventions do not appear to have improved the safety of childbirth: despite its highly interventionist approach, the US boasts higher maternal and infant mortality rates than all other developed, and some developing, nations (Keefe, 2002).²

Second wave birth activists make sense of this apparent contradiction by arguing that although sometimes necessary and life-saving, medical intervention is frequently unnecessary, and often causes harm to women and babies. These critics also stress that each intervention makes another more likely.³ Further, there is evidence that few women are aware of these possible effects when they choose or consent to the procedures that increase the likelihood of subsequent interventions (Goer, 1995).

Some birth activists also register concern about the loss of intimacy that resulted from the modernization and bureaucratization of birth: hospital births, replete with 'the cool penetration of needles, the distant interpretation of lines on a graph' deprive women of 'the warm exchange of breath and sweat, of touch and gaze, of body oils and emotions that characterize births in which there is an intimate connection between the mother and her caretaker' (Davis-Floyd and Davis, 1997: 315). As this quote suggests, the loss of familiar, female supporters during birth and the intimacy of home is a pervasive theme in the literature of the alternative birth movement (see also Leavitt, 1984).

A few more radical critics see the high-tech nature of childbirth and poor women's lack of access to prenatal care as two sides of the for-profit health care coin. As political activist and scholar Angela Davis put it at a hearing on the issue in California in 1981:

As growing numbers of medically indigent women are forced to go without prenatal care and proper nutrition, thus producing very low birth weight babies, every effort is made to keep those infants alive . . . through the use of expensive, profit-making technology . . . The medical establishment's solution to an embarrassingly high rate of infant mortality in this country's poor and Third World communities is increased reliance on the technological miracles that keep low birth weight babies alive, many of whom are born prematurely because their mothers could not obtain early, meaningful and respectful prenatal care. (quoted in Edwards and Waldorf, 1984: 175)

Davis thus situated high-tech obstetrics (and paediatrics) in the context of a health care system that uses its resources in a highly inequitable and injudicious fashion. Such a system ignores the under- and uninsured, and creates incentives to over-treat those with private insurance. This argument has found support in empirical studies: women of higher socio-economic status, who give birth in private hospitals and have private insurance, are more likely to give birth surgically, despite having 'lower risk' pregnancies and deliveries (Gould et al., 1989; Sakala, 1993: notes 91–8; Wagner, 2000).

Midwifery and women's right to choose

Women's right to choose the place and circumstances of their birth deliveries is also stressed by birth activists. Given that physician-attended birth has become the norm, this has largely meant the right to choose a midwife-attended, out-of-hospital birth. As Ina May Gaskin, author of *Spiritual Midwifery* and current President of the Midwives Alliance of North America (MANA) put it, 'We feel that returning the major

responsibility for normal childbirth to well-trained midwives rather than have it rest with a predominantly male and profit-oriented medical establishment is a major advance in self-determination for women' (1975: 11).⁴ To deny this choice is to allow the state to limit reproductive freedom and treat women as mere vessels of the foetus (Rothman, 1989).

Though simple, the rhetoric of choice is one of the most powerful weapons deployed by birth activists in their campaign to increase access to alternative childbirth choices (see Beckett and Hoffman, 2005) and, ironically, links first wave advocates of pain medication to second wave critics of the widespread use of that medication and other medical interventions. However, as critics of the alternative birth movement note, this emphasis on choice does sit somewhat uneasily with the movement's pervasive and quite damning critique of the medical management of childbirth. (What if women actively choose medical intervention?)

In addition, many birth activists argue that midwives offer quality – even superior – care throughout pregnancy and childbirth. Some, invoking the essentialist logic that is so irksome to their critics, stress the overwhelmingly female nature of the profession and the (apparently related) fact that midwifery is rooted in a 'holistic' rather than 'mechanistic' philosophy. According to this line of reasoning, midwives develop more empathic relations with their clients, rely usefully and wisely on their intuition, and trust women's 'embodied' knowledge as well as objective diagnostic data (see Davis-Floyd, 1992; Davis-Floyd and Davis, 1997). This argument implicitly – and sometimes explicitly – relies on an essentialist conception of femaleness by assuming women's greater capacity for intuition and empathy.

Others avoid this essentialism by emphasizing the institutional organization of midwifery practice rather than its gender composition. In particular, midwives' intensive and comprehensive approach to prenatal care is contrasted with obstetricians' perfunctory care (Beckett and Hoffman, 2005). These advocates also point out that midwives use far less technology during labour and delivery, and therefore offer a cost-effective form of obstetrical care (National Organization of Women, 1999).

Natural birth, empowerment, and pain

More controversially, some birth activists argue that the high-tech approach to birth – and especially the use of pharmacological pain relief – denies women the experience of childbirth and the sense of empowerment that results from knowing that one is capable of bringing forth life. Because this argument is typically accompanied by the claim that medical intervention is medically harmful to women and newborns, it is not clear how pervasive the notion that the experience of the pain (and pleasure) of birth endows some spiritual or psychic benefit actually is among birth activists. It appears, though, that withstanding/experiencing the pain of childbirth is seen by at least some in the alternative birth community as a positive occurrence, one that allows women to fully appreciate the power of the birthing body, the drama that is childbirth, the inherent connection between joy and suffering, and the satisfaction that may result from

surrendering oneself to a force more powerful than one's conscious will. Thus, women who choose home birth 'supervalue nature and their natural bodies over science and technology . . . regard the technocratic destruction of birth as harmful and dangerous . . . and desire to experience the whole of birth – its rhythms, its juiciness, its intense sexuality, fluidity, ecstasy, and pain' (Davis-Floyd and Davis, 1997: 316; see also Biesele, 1997: 488). The assumption that women can (or should) find this kind of surrender empowering reveals the influence of a 'strong version' of radical/cultural feminism that celebrates women's life-bearing capacities and the commitment to motherhood they embody (see Annandale and Clark, 1996).

Feminist critics of the alternative birth movement

In recent years, medical opponents of the alternative birth movement have been joined by a small number of feminist critics who have expressed concern about aspects of the alternative birth movement's rhetoric and goals. Some such critics ground their arguments in their own (less than positive) experience of the alternative birth culture. Others, drawing on post-structuralist theory, are especially critical of the alternative birth movement's tendency to celebrate women's reproductive capacities and invert the categories through which women have historically been denigrated. For lack of a better term, I will refer to this body of criticism as the 'third wave' critique, much of which centres on the idiom of 'the natural'.

Deconstructing 'the natural'

Many contemporary feminist critics worry about the influence of cultural feminism on the birth movement and the related tendency to invoke the ideal of 'the natural' (see especially Annandale and Clark, 1996; Michie and Cahn, 1996; Treichler, 1990). The legacy of Derrida is apparent here. For Derrida, 'women have always been defined as a subjugated difference within a binary opposition: man/woman, culture/nature, positive/negative, intuitive/analytical. To assert an essential gender difference as cultural feminists do is to re-invoke this oppositional structure' (cited in Alcoff, 1994: 104). From this perspective, the alternative birth movement's veneration of 'the natural' mistakenly seeks to overturn male domination by super-valuing the denigrated categories with which women have long been associated rather than by deconstructing and destabilizing these hierarchical constructions (Annandale and Clark, 1996; Treichler, 1990). Furthermore, the valorization of 'the natural' leads to the perception of births that do not conform to the 'natural' ideal as 'unnatural', and therefore denies women who experience such births both agency and humanity (Michie and Cahn, 1996).

These critics also point out that the juxtaposition of 'the natural' and 'the medical' obscures the fact that 'the natural' also does cultural work: 'natural childbirth discourse itself serves as cultural initiation' (Michie and Cahn, 1996: 46). Indeed, these analysts argue, childbirth has no meaning or essence outside of its construction through this and other discourses. In short, third wave critics argue that the idealization of 'natural childbirth'

rests on the assumption that both women and childbirth have a true essence or nature that is respected by the natural childbirth movement but violated by the medical establishment: birth activists then 'assert a nature to which birthing women must conform' (Michie and Cahn, 1996: 49). By contrast, third wave critics argue that we cannot know what childbirth 'really is', as 'discourse itself is the site in which birth becomes knowable' (Treichler, 1990, quoted in Annandale and Clark, 1996: 31).

Technology

According to these critics, the second wave critique of high-tech obstetrics also reflects a troubling construction of technology as inherently patriarchal (Annandale and Clark, 1996: 35). In addition, these critics point out that women can and do find the use of obstetric technology to be an empowering experience (1996: 35). To ignore this, they argue, is not only to reproduce restrictive dualisms, but to treat some women's use appreciation of technology as indicative of a kind of false consciousness, a violation of their true (essential) nature. Thus, while second wave feminists tend to see women's seeking/enjoyment of technological intervention as indicative of the ubiquity and power of patriarchal, technocratic, and medical discourses (e.g. Davis-Floyd, 1992; Campbell and Porter, 1997), third wave feminists argue that women's choice/positive experience of high-tech births confirms that technology is not inherently male, and can serve women's needs and purposes.

Domesticity

Some third wave critics are also troubled by what they see as the idealization of domesticity in the rhetoric of the alternative birth movement. As one analyst writes: 'In much of the literature of the home-birth movement, as well as in feminist and proto-feminist accounts of home birth in more general contexts, home functions . . . as a synecdoche for female autonomy; it becomes the place not only of comfort, but of freedom and power' (Michie, 1998: 261). Michie notes that this idealization of the home is an implicit contrast to the alleged sterility, inhumanity, and isolation of the hospital, and that it reverses the medical narrative that equates hospitals with technology and safety and homes with danger and disease. But this veneration of the home, she argues, not only reiterates a long-standing association of women with the private sphere, but also obscures the ways in which power operates in domestic spaces, and particularly the ways in which 'home' may limit young, poor, and abused women's autonomy: 'home might be an especially fraught term for a teenage unwed mother trying to hide her pregnancy from her family by delivering in the bathroom' (p. 264).

The politics of midwifery

Birth activists' tendency to treat midwifery as synonymous with feminism and to overlook possible conflicts between midwives and birthing women is also a source of concern. Some critics argue, for example, that birth activists' emphasis on midwives' provision of continuous care during

labour and delivery obscures the fact that the provision of such care may be very difficult for – even exploitative of – midwives (Annandale and Clark, 1996). Others point out that where they exist, (North American) licensure requirements do not recognize midwives who acquire their training elsewhere or indigenous midwives, and therefore exclude immigrant midwives and reproduce racial and ethnic hierarchy in the profession (Nestle, 2000). Finally, these critics argue that licensure requirements in these developed countries lead aspiring midwives to exploit Third World women. In Ontario, for example, licensure requirements have given rise to ‘midwifery tourism’ in which aspiring First World midwives travel to impoverished countries to gain the experience they need to satisfy those requirements (Nestle, 2000).

Pain and the experience of natural childbirth

Pain is a recurring issue for feminist analysts of childbirth (as well as for countless numbers of women anticipating the experience). First wave feminists saw the right to pain relief during childbirth as an important political issue. Second wave feminists also sought to render women’s voices more powerful, this time by asserting their right to choose a non-medicated and otherwise ‘natural’ birth for both medical and psychological/spiritual reasons. But some third wave scholars, drawing on their experiences with alternative ‘birth culture’, have criticized the alternative birthing community’s knee-jerk rejection of (pharmacological) pain relief and understand this rejection as indicative of a kind of machisma, a belief that birth is ‘an extreme sport’ (Shapiro, 1998; Talbot, 1999). ‘Isn’t it interesting’, one such writer comments, ‘that the movement that’s supposedly feminist is the one that insists on women feeling pain?’ (Shapiro, 1998). Another suggests: ‘Today’s natural childbirth purists don’t see moral punishment in pain but they do see moral superiority in refusing pain relief’ (Talbot, 1999: 19).

According to these critics, the tendency of ‘birth junkies’ to valorize the experience of natural (i.e. painful) childbirth is not only moralistic, but unrealistic. One writer, citing a childbirth educator warning that women with quick deliveries might be disappointed that they were not able to savour the experience, counters that ‘If I could get away with delivering a baby in five minutes, I’d jump at the chance’ (Shapiro, 1998). The idea that women do (or should) savour, enjoy, or feel empowered by the experience of labour and delivery, they argue, romanticizes women’s roles as life-bearers and mothers, and assumes an emotional and physical reality (or posits an emotional and physical norm) that does not exist for many. Echoing their post-structuralist counterparts, these critics argue that the emphasis on birth as a defining moment in women’s lives is deeply problematic: ‘all this emphasis on keen awareness means exalting the moment of childbirth as the moment at which a woman is most authentically, “naturally”, a woman, most in tune with her evolutionary destiny’ (Talbot, 1999: 20).

In short, some feminists perceive the alternative birth movement as rigid and moralistic, insistent that giving birth ‘naturally’ is superior and, indeed, is a measure of a ‘good mother’. The perceived moralism of this

stance is quite troubling to some; according to one feminist critic, the 'natural' philosophy espoused in an alternative birth centre is as tyrannical and prescriptive as the medical model, but pretends not to be by emphasizing women's right to individualized and alternative births (cited in Treichler, 1990: 129–30).

These and other sources of disagreement among feminist analysts of childbirth are not easily resolved, and I do not attempt any final resolution here. Rather, in what follows, I use the debate over whether or not women should be able to choose to deliver their babies surgically for non-medical reasons as a means of exploring the strengths and limitations of both second wave and third wave critiques. I begin with a brief account of the debate over elective Cesarean.

Cesarean section: from problem to choice

The alternative birth movement was perceived at the outset as a serious threat by organized medicine (DeVries, 1996: 53; Edwards and Waldorf, 1984). Organized medicine has also responded aggressively to widespread criticism of the increase in surgical delivery (i.e. Cesarean section (C-section)). Much to the chagrin of consumer, public health, feminist, and governmental organizations, the US C-section rate rose from about 5 per cent in 1970 to nearly 25 per cent by the late 1980s (Grisanti, 1989). This Cesarean 'epidemic' was widely discussed in women's magazines and other media outlets.

Despite disagreement about why C-section rates were increasing, there was, until recently, widespread consensus that this development was problematic. Medical research indicates that unnecessary Cesarean sections are extremely costly and pose significant risk of harm to both fetuses and women (see Goer, 1995; Rooks, 1997; Wagner, 2000). As a result, government and public health agencies such as the Department of Health and Human Services and the World Health Organization included lowering the rate of Cesarean section in their goals, and medical organizations such as the AMA (American Medical Association) and ACOG (American College of Obstetricians and Gynecologists) largely accepted the need to do so. But efforts to reduce the Cesarean section rate were only temporarily successful. After declining to just under 20 per cent in the late 1980s and early 1990s, the incidence of surgical birth began to increase again in the mid 1990s, this time quickly and dramatically. By 2002, an estimated 26 per cent of all US babies were delivered surgically (Moon, 2002).

It was in this context that some obstetricians, including former ACOG President Benjamin Harer, began to argue that high rates of surgical birth are not problematic, but rather are medically and philosophically defensible, even optimal. These outspoken and controversial physicians claimed that such intervention is often chosen by birthing women, and that obstetricians should respect their patients' preferences for surgical birth. The debate over elective Cesarean has received significant media attention, especially after a popular Spice Girl announced her plan to have an elective Cesarean and was dubbed 'Too Posh to Push' by the English press.

Two kinds of argument are marshalled to support the argument that women should be allowed to choose Cesarean. The first is the empirical claim that C-sections have become safer, and that the risks of vaginal birth have been underestimated. Indeed, proponents of elective Cesarean argue that surgical birth is now almost always safer than vaginal birth for the foetus/newborn, and that the short term risks of surgery (including risk of infection, adverse drug reaction, uterine rupture, and death) for women are offset by the long term risks of vaginal delivery, which include the increased likelihood of incontinence and diminished vaginal 'tone' (Walters, 1998; see also Elliott, 2001; Young, 2001). (I will return to this controversial point shortly.) These and related claims have been vigorously disputed by other analysts, and many medical researchers and public health organizations continue to stress the risks of elective Cesareans and point out that many of the alleged 'risks' of vaginal birth (such as incontinence) are easily and inexpensively remedied through behavioural techniques (i.e., Kegels) (see Goer, 2001; Grobman, 2002; Sakala, 1993; Wagner, 2000).

Second, although organized medicine has actively opposed women's right to choose to give birth in birth centres or at home and has supported physicians' authority to compel women to deliver surgically against their will, medical proponents of elective Cesarean make the philosophical argument that women have the right to choose Cesarean section for non-medical reasons.⁵ This argument is couched in terms of patients' right to choose the form of medical care they receive; thus, women's right to choose to give birth surgically is said to be analogous to their right to choose between mastectomy and lumpectomy for treatment of breast cancer (Walters, 1998). Opponents of elective Cesarean argue that this analogy assumes that childbirth is, like breast cancer, a disease, and is, therefore, misleading. By contrast, they aver, to permit women to choose Cesarean birth for non-medical reasons is analogous to allowing a healthy person to 'choose' a kidney transplant or to give antibiotics to a person with a viral infection. In both cases, they argue, the 'treatment' is unnecessary, potentially harmful and costly to the wider community (Wagner, 2000).

Feminism and childbirth reconsidered

The debate over elective Cesarean brings to the fore many of the issues and concerns raised in the feminist literatures on childbirth regarding choice, technology, and medicalization. In what follows, I discuss these three issues and offer some concluding thoughts regarding the (re)construction of a feminist politics and theory of childbirth.

Complicating 'choice' and 'experience'

As was discussed previously, third wave feminist critics stress that the use and experience of technology during pregnancy and birth may be empowering for women, and conclude that medicalization is not necessarily incompatible with feminism and/or women's interests. Furthermore, because technology is not inherently 'male', women's preference

for/enjoyment of it ought not to be seen as a kind of false consciousness or, in Bourdian terms, misrecognition. This argument reflects the post-structuralist emphasis on the need to destabilize rather than invert oppressive dualisms, as well as an appreciation for the diversity of women's experiences and desires.

The fact that many birthing women choose and experience positively pharmacological pain relief provides compelling evidence for this argument. This option was made available as a result of feminist agitation, and many women continue to choose it when possible. Given that many women have feared and sought to minimize the pain of childbirth, that midwives have historically worked to alleviate it, and that many women now choose and appreciate pharmaceutical pain relief, it seems quite reasonable to conclude that medical technology can serve women's interests and feminist purposes.

On the other hand, there is evidence that women make choices regarding medical technology – including pharmaceutical pain relief – on the basis of very partial and biased information about their risks and benefits. For example, US physicians are increasingly inducing labour, sometimes at the behest of pregnant women, but very few of the doctors who use Cytotec® to do so inform their patients that its use for this purpose has been contraindicated by both the manufacturer and the Food and Drug Administration. More generally, studies indicating that considerations of both convenience and profitability shape patterns of medical intervention suggest that doctors often shape and withhold relevant medical information when communicating with their patients (Wagner, 2000). It is also evident that diagnostic technologies frequently overstate the risks posed to the foetus (Lent, 1999). Even when these factors are relevant, patients choose or consent to this intervention in the vast majority of cases. The question thus arises: what if a woman is pleased with her 'choice' to induce labour or deliver surgically but did so because the risks of continuing to labour to herself, or, more likely, her foetus/baby were significantly overstated?

Further complicating matters, the normative and emotional grounds upon which some women choose obstetrical interventions such as labour induction and Cesarean delivery may be reflective of, and perpetuate, patriarchal values. For example, one of the main arguments for elective Cesarean section is that vaginal delivery poses long term risks to the mother, including (and, it appears, especially) the loss of 'vaginal tone' and therefore of sexual pleasure. For obvious reasons, it is widely assumed that what is really at stake here is (some) men's preferences for more 'toned' vaginas. What if women feel pleased with or empowered by their choice to deliver surgically because they believe that this choice will ensure their partner's sexual pleasure? Should this experience be treated as evidence of the empowering potential of medical technology? In short, ignoring the grounds upon which women make their choices may not be compatible with feminists' commitment to minimizing the influence of patriarchy and other systems of inequality on women's lives.

It is somewhat ironic that those feminists who adopt the most radically constructionist position ignore the social construction of women's desires,

preferences and choices. As Hirschmann argues, social constructionism is not simply concerned with rhetoric, but 'requires us to think about the context in which choices are made' (2003: 39). This kind of 'deep constructionism' also goes well beyond the idea that women are simply socialized to accept and internalize 'dominant values'. Such theories of 'oppressive socialization' assume that patriarchy (and technocracy) pervert a prior and natural reality, and are frequently, and appropriately, criticized as treating women's choice to utilize technology as a kind of false consciousness. By contrast, deep social constructionism allows us to think about the complex ways in which women's assessments of risk, their hopes, and their aspirations are socially produced (Hirschmann, 2003: 80). There is ample reason to suspect that both the devaluation of women and medical interests are relevant to those processes.

The question then becomes how to assess women's choices, for if choice can never express an authentic or pre-social self, on what grounds can we assess women's choices to elect (or not) obstetric technology? Third wave critics are correct, I think, to argue that we cannot assess the validity of the idioms of 'the natural' or 'the medical' by ascertaining which of these idioms more closely approximates the 'reality' of women's bodies or childbirth; these are conceptual and cultural categories rather than empirically testable propositions. On the other hand, the historical context, political purposes, bodily effects, and material consequences of these discourses cannot be ignored. Consideration of these consequences allows us to begin to assess the validity of the 'high-tech' approach to childbirth.

Contextualizing medicine and medicalization

One of the most powerful aspects of the third wave critique is the recognition that 'the natural' is as much a cultural category as 'the medical', and that attempts to revive traditional birthing practices or legitimate new ones *on the grounds that those practices more closely approximate 'nature'* are misguided. Thus, we cannot choose between the notion that childbirth *is* natural or that it *is* disease-like on philosophical or abstract grounds. Rather, birth *is* natural for those who define and experience it as such; it *is* medical for those who define and experience it in that manner (Treichler, 1990).

On the other hand, the practices associated with treating childbirth *as if* it were medical or natural in nature can and should be evaluated. Many women want to know, for example, what the medical research shows about the risks and benefits of elective Cesarean section (the existence of which rests on the notion that C-section and vaginal delivery are alternative medical treatments), as well as pharmacological pain relief, induction, and other common obstetric procedures. Although inevitably partial and imperfect, the information that accrues from evaluations of these procedures is crucial to women hoping to make informed choices regarding the place and manner of their birth deliveries, as well as to the development of sound public health policy.

Yet there is ample evidence that this information cannot be communicated (or obtained) in anything approaching Habermas's free speech

conditions. Most women depend on their doctors for information about the risks and benefits associated with different birthing practices, but physicians and hospitals have their own set of interests (inconvenience, profitability, liability reduction) that shape the way this information is packaged and presented to birthing women (Armstrong, 2000). In addition, medical research is reinterpreted in highly selective ways to support current obstetrical dogma (Goer, 1995, 2001). The fact that much existing medical research suggests that high levels of obstetric intervention do cause a great deal of harm, and evidence that women are not informed of these risks, is not addressed by third wave critics of the alternative birth movement. In sum, although the rhetoric of 'the natural' and the notion that medical technology is inherently male are problematic, limiting the feminist critique to these discursive issues does not address women's quite practical need for information regarding various birthing options or the difficulty of providing women with access to that information in a disinterested fashion.

Similarly, the third wave critique fails to address the ways in which the idioms of 'the medical' and 'the natural' support and sustain quite different professional/political projects. Although third wave critics are prescient to point out that midwifery is not synonymous with feminism or birthing women's interests, it would be a mistake to therefore assume that there is no association between the two, for two reasons. First, in the United States and most other Western countries, physician-attended hospital birth is the norm, and the option of midwife-attended home birth is highly restricted by law as well as by health and malpractice insurance practices. Because definitions of 'normal' birth are comparatively narrow and the use of technology common in hospitals, medical knowledge derives from bodies that birth in more circumscribed ways (Rothman, 1982). The preservation of midwifery and home birth is therefore crucially important for the generation of an alternative body of knowledge that allows us to subject obstetrical knowledge to analysis and critique.

For example, doctors now routinely diagnose a woman who has been in labour for 10 to 12 hours as having 'dystocia' (i.e. prolonged labour), and this diagnosis has become one of the leading indications for Cesarean section. Midwives working in out-of-hospital settings can effectively challenge this diagnosis by pointing out that many women, and a majority of first-time mothers, labour 'successfully' for longer than 10 hours. Without this kind of comparative information, the ability to critically assess obstetrical knowledge and the way that it reflects both obstetrical practices and interests is severely compromised.

Of course, the preservation of midwifery and out-of-hospital birth is also important because women should have the right to choose the place and manner of their birth deliveries; this is an important dimension of reproductive autonomy. The need to protect this choice is all the more important for the epistemological reasons just outlined. In short, the preservation of midwifery and out-of-hospital birth is necessary to ensure reproductive choice and because these practices give rise to an alternative body of knowledge that enables us to critically assess the viability of medical

knowledge about women's bodies. In what follows, I discuss the importance of doing so.

Contextualizing medical technology

As has been discussed, third wave critics argue that medical technology is not inherently patriarchal or male, and can therefore be used by women for emancipatory purposes. Yet one need not make the argument that medical technology is *inherently* patriarchal or male to make the case that this emancipatory potential is, in the current social context, limited.

As many analysts have pointed out, the meanings, purposes, and effects of technology largely, though not exclusively, reflect the context in which that technology is developed and used. As one author put it, technologies 'do not fall from heaven . . . and they are not neutral. In other words, a "technology" is not objective: it carries embedded in it a vision of the world and of what is considered important and valuable for the particular society where it is developed' (Arditti et al., 1984: xii). Although users may alter technologies, their usage, their meanings, and their effects (Akrich, 1992; Winner, 1986), this indeterminacy is not infinite. In this case, the importance of reproductive technology in the re-emergence of 'foetal politics', to the establishment and perpetuation of medical authority and profitability, and to the inequitable allocation of health care resources necessarily complicate its emancipatory potential. Each of these constraints is considered below.

Noting that the image of the foetus as a person separate from the mother-to-be is a central component of patriarchal ideology, many feminist analysts have argued that recent advances in reproductive technologies have played a crucial role in reviving and strengthening this conception of women's role in the reproductive process (as well as the related notion that the primary threat to foetal health comes from its 'maternal environment') (Rothman, 1987). In the images generated by many of these technologies, the foetus is separated from rather than connected to the pregnant woman, and the split between the foetus and mother – so prominent in patriarchal ideology – is reified (Hubbard, 1990; Spallone, 1989). The conception of the foetus as a 'second patient' has, in turn, given rise to a conception of pregnancy as a conflict of rights between a woman and her foetus and the sense that the primary threat to foetal health comes from pregnant women (Arney, 1982; Blank, 1984; Hubbard, 1990; Rothman, 1987; Spallone, 1989).

The debate over elective Cesarean invokes much of this imagery. There is evidence that some women choose Cesarean section – either in anticipation of their labour or in response to unanticipated developments during it – because they are told that this choice ensures the safety of their foetus/newborn. Not only does this advice often overstate the risks of vaginal delivery and understate those associated with surgical delivery, it plays on, and contributes to, the sense that 'good mothers' are willing to assume the risks of a surgical delivery. As one obstetrician and mother wrote in a high profile women's magazine, 'Maternal deaths due to C-sections are two to four times greater than those due to vaginal

deliveries', but . . . 'when the rare problem occurs during a vaginal birth, it's the baby who's most likely to be harmed'. The choice of elective Cesarean section, she explains, 'gave her kids the best possible chance for a safe birth' (Freiman, 2000). The (quite controversial) study upon which Dr Freiman based her claims went on to calculate the number of infants who could be saved from 'birthing disasters' if more women elected to give birth surgically for the sake of their children. (Apparently, maternal death does not constitute a birthing disaster.)

Although controversial, this argument rests on a pervasive cultural logic; indeed, a recent editorial in a high-ranking medical journal argued that all women should deliver surgically in order to enhance the well-being of newborns. This proposal is not likely to be taken seriously, at least in the near term, but the message it reflects and conveys is both popular and powerful: good mothers make sacrifices for their children, and surgical birth may be one of those sacrifices. As Barbara Katz Rothman (1982) suggests in her discussion of prenatal testing, the increasing ubiquity of reproductive technology makes it more difficult to refuse it, for doing so is likely to be constructed and perceived as a 'selfish' choice that puts the foetus/newborn at risk.

The role of medical technology in the establishment and perpetuation of medical authority also complicates women's efforts to deploy obstetric technologies for their own purposes. Medical authority and control is partially sustained by doctors' expertise in the administration and interpretation of medical technology. As Jordan has argued, the medical 'ownership' of obstetric technology and technical procedures 'simultaneously defines and displays who should be seen as possessing authoritative knowledge, and consequently as holding legitimate decision-making power' (1997: 61; see also Rothman, 1989; Weir, 1996). To note the historical and political context in which obstetric technology is deployed does not imply that women cannot meaningfully choose and/or benefit from the utilization of obstetric technology. On the other hand, the recognition that technology is not inherently patriarchal does not mean that it is neutral. Medical technology may not be essentially male, but its development and use under existing historical conditions means that its use for feminist purposes is necessarily fraught with difficulty.

Perhaps the most important reason why an untempered emphasis on the emancipatory potential of obstetric technology is problematic is this: widespread use of this technology contributes significantly to the unequal distribution of health care resources, the existence of which is often overlooked in debates over the elective use of obstetrical technologies. For example, some supporters of elective Cesarean assert that the grounds upon which women choose to deliver surgically are irrelevant, and that their right to choose the mode of their delivery is absolute: 'In Brazil, C-sections are routinely done for aesthetic and sexual reasons . . . Many American women would dismiss this thinking as superficial, and maybe it is. But every woman has the right to make her birthing decision based on what's most important to her' (Freiman, 2000). This position overlooks the fact that many Brazilian women choose Cesarean for fear of the

consequence of highly interventionist care during vaginal delivery, the epistemological and political issues raised previously, and the fact that obstetric technologies, including elective Cesarean, are quite costly. As one prominent opponent of elective Cesarean explains:

A CS [Cesarean section] which is done because a woman chooses it requires a surgeon, possibly a second doctor to assist, an anesthesiologist, surgical nurses, equipment, an operating theatre, blood ready for transfusion if necessary, a longer post-operative hospital stay, etc. This costs a good deal of money and, equally importantly, a great deal of training of health personnel, most of which is at government expense, even if the CS is done by a private physician in a private hospital. If a woman receives an elective CS simply because she prefers it, there will be less human and financial resources for the rest of health care. (Wagner, 2000: 1679)

Researchers investigating the costs of unnecessary C-section have concluded 'The high cesarean section rate in the United States is a major public health problem, one that is having and will continue to have a major impact on health care delivery. If the \$800 million that could be saved by reducing the cesarean section rate by 5% were spent instead on prenatal care and preventative programs, dramatic effects on maternal and child health would be seen' (Sachs, 1989: 38). Not surprisingly, high rates of Cesarean section in Brazil are associated not only with escalating rates of maternal mortality, but also with increasing inequities in the delivery of health care (Wagner, 2000). The Brazilian case, though extreme, is quite relevant, as Western countries aggressively export the high-tech approach to health care and childbirth in particular, and many developing countries seek to emulate its example.

In short, even if, somehow, women's choice of/consent to obstetric intervention were based on full understanding of the attendant medical risks and on criteria consistent with the feminist commitment to women's integrity and autonomy, the cost of elective obstetric intervention would worsen the already unjust distribution of health care resources, a pattern that has very real and important consequences in both the United States and elsewhere. Recognition of women's capacity to experience technology as empowering ought not to preclude consideration of broader areas of justice and equity, and of the need for the judicious use of health resources.

Conclusion

Although offering quite disparate analyses, each of the three waves of feminist reflection on childbirth in the United States is aimed at empowering birthing women and destabilizing dominant understandings of childbirth. This preoccupation with challenging previously hegemonic assumptions and practices reflects the feminist commitment to enhancing women's capacity to make meaningful choices, and to increasing the likelihood that women will be supported in and empowered by those choices. Here, though, the feminist consensus regarding childbirth appears to end.

There is much to be said for recent feminist criticism of the alternative birth movement. That movement's invocation of 'the natural', while understandable in historical terms, is often essentialist, and critics are right to point out that its invocation reproduces the cultural categories and assumptions that have historically justified male domination. The related notion that the widespread use of pharmaceutical pain relief is a consequence of obstetric propaganda and women's attendant lack of confidence in their (natural) bodies clearly oversimplifies the matter: midwives have historically used many techniques to minimize the pain of childbirth, and women have long expressed a great deal of trepidation and anxiety about it (Leavitt, 1983, 1986; Leavitt and Walton, 1984; Wertz and Wertz, 1977). The insistence that women can/should/do find the pain of childbirth to be empowering neglects the diversity of women's bodies and experiences, and deflects rather than grapples with the possibility that medical technology may, in some instances, serve women's interests.

On the other hand, unreflective invocations of women's choice and positive experience of technology as a corrective to the idiom of 'the natural' are a fragile foundation upon which to build an alternative feminist politics of childbirth. As Alcoff (1994) argues, the emphasis on the importance of resisting and deconstructing the binary categories that have buttressed male domination is not sufficient, for, alone, it leaves us with only a 'negative' feminism, the capacity to deconstruct, but an inability to construct. Further, it is not just abstract discourses that cry out for deconstruction and analysis, but also the social and political contexts in which women make choices. Although the choice/positive experience of obstetric technology ought not to be construed as false consciousness or women's misrecognition of their true nature, it is clear that women often (though not always) make such choices based on inadequate and interested sources of information, as well as subtle and not-so-subtle invocations of women's obligation to make significant sacrifices on behalf of their sexual partners and children-to-be. The situations in which women make these choices therefore require analysis and critique; the failure to do so obscures the way in which the quest for profit, medical interests, and the legacy of patriarchy complicate women's efforts to use technology for their own purposes and continue to influence women's definition of what those purposes are and should be.

This argument does not imply that technology can never be used to advance feminist purposes. In fact, many women's appreciation of pharmaceutical pain relief, despite awareness of some of its less positive consequences, suggests that women are sometimes able to influence medical practice and technological development, and to deploy that technology for their own ends. But it is important to recognize that the actualization of this possibility is inevitably fraught with danger: the danger that women's positive assessment of their experience with medical technology is based in part on a lack of awareness of its risks, and that women's choices may be shaped by social relations and dynamics that subordinate women's needs and interests.⁶

Third wave critics of the alternative birth movement also overstate the

equivalence of medical rhetoric and the idiom of the natural. These discourses *are* analogous in the sense that they serve to render birth comprehensible and meaningful, and insofar as they reflect and sustain various childbirth practices. But as Foucault reminds us, discourses serve primarily to legitimate *practices* that have very real bodily and material consequences. Indeed, the discourses of 'the natural' and 'the medical' reflect and sustain different childbirth practices that generate different knowledges about women's bodies and have very different consequences for women and their babies, as well as for the distribution of health care resources. These consequences must also be considered, and if the available evidence is even partially correct, medicalization per se might be problematic after all. Indeed, there is overwhelming evidence that the social organization and practices of independent midwifery are more consistent with women's interest in their own health and well-being, the health and well-being of their babies, and, more indirectly, all consumers of health care resources that are affected by the injudicious use of those resources. Its existence also generates a body of knowledge that can be used to assess and critique obstetrical knowledge of birthing women; without it, the capacity to do so would be undermined.

Moreover, the notion that the alternative birth movement/culture has successfully challenged medical hegemony is misleading. Although the discourse and values of the alternative birth movement may have more cultural representation and appeal than its proponents aver (and may, as a result, induce guilt in some), the overwhelming majority of births remain highly medicalized, and even women who aspire to 'natural birth' experience significant medical intervention in the end (Declercq et al., 2002). In short, medicalization at the epistemological/cultural level is not the same as medicalization at the level of practice; in the realm of the latter, medicalization is stronger than ever.

Although childbirth has become comparatively safe for most women living in developed countries, some contemporary obstetrical practices pose serious threats to women and newborns and, by consuming significant medical resources, contribute to inequities in health and health care. Furthermore, Western obstetrical practices are aggressively promoted around the globe, and, if adopted, contribute to the injudicious use of health care resources in even more profound ways. While the essentializing and moralistic rhetoric of the alternative birth movement should be abandoned, its critique of contemporary obstetrics, commitment to women's and children's health, and thoughtful use of health care resources are essential to the reconstruction of a feminist politics of and theoretical approach to childbirth.

Notes

1. While some feminists focused their attention on women's right to pain relief during labour, other women's and public health organizations were more concerned about unequal access to obstetric services, and advocated increased government funding for maternity care to remedy this situation.
2. International comparisons also support this argument. At a time when the

British Cesarean section rate was half that in the US (12% versus 24 per cent), its prenatal mortality rate was lower than that of the US (8.0 versus 9.6 per 1,000). Even more dramatically, a 5 per cent Cesarean section rate in the Netherlands was associated with a perinatal mortality rate of 6.5 per 1,000 (Kubasek, 1997).

3. Medical research generally supports this contention: women who opt for an epidural have lower rates of spontaneous vaginal delivery, longer labours, and are more likely to have intra-partum fever; their infants are at increased risk of sepsis (Lieberman and O'Donoghue, 2002). Similarly, induction of labour increases the risk of uterine rupture and the likelihood of Cesarean section (Goer, 1995; Wagner, 2000; Walling, 2000).
4. Recently, a small number of renegade birth activists in the United States have identified unassisted birth as a more natural and empowering alternative to midwife-attended home birth (see <http://www.freebirth.com> and <http://www.unassistedbirth.com>).
5. Nearly half of all physicians surveyed believe that judicial force should be used to impose treatment of unconsenting pregnant women if persuasion is unsuccessful (Ouellette, 1994).
6. In making this argument, I implicitly accept hooks' (1989) contention that not every woman with a theory is feminist, and that 'the "anything goes" approach to the term [feminism] renders it practically meaningless'. See also Lublin (1998).

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