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A Reinterpretation of Maternal Requests for Cesarean Sections in Taiwan

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ABSTRACT

This paper examines the gender politics of Cesarean sections (C-sections) in Taiwan, the country with the third highest Cesarean rates (C-rates) in the world. Public discourses attribute the high C-rates to the demands of women. According to my fieldwork, the Taiwanese medical system itself is responsible for high C-rates. Taiwanese hospitals enforce a significant amount of medical interventions that increases C-sections through social, psychological, and biological processes. Aware of these intervention practices, women request a C-section out of fear of "suffering twice", or in other words, trying to deliver vaginally but ending up having to have a C-section. I will re-interpret maternal requests of C-sections within this context.

Keywords: Cesarean sections, Taiwan, gender politics, manufactured risk, reflexive response.

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台灣“選擇性剖腹產”之重新解讀分析

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摘 要

本文檢視台灣剖腹產現象背後的性別政治。台灣剖腹產率高居世界第三，公共論述傾向將高剖腹產率歸罪於婦女的選擇。根據我的民族誌研究，醫院生產制度乃是造成高剖腹產率的主要因素。台灣醫院對於生產的高度醫療介入，在社會、心理與生理等面向上，皆增加了剖腹產的可能性。面對如此高剖腹產率，“痛兩次” (陰道產失敗後，接受剖腹產)成為台灣孕婦普遍的擔憂，部分婦女因而直接選擇剖腹產。本文將藉由分析台灣醫院生產系統，重新詮釋所謂的“選擇性剖腹產“。

關鍵字：剖腹產、台灣、性別政治、人為風險、反身性回應

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INTRODUCTION

This paper examines the gender politics in Cesarean births in Taiwan, a country with extremely high C-rates. In 2005, the C-rate in Taiwan was 32.4%—more than twice the 10% to 15% range that the World Health Organization (WHO) defines as normal (Department of Health of Executive Yuan 2005).

Public concern about Cesarean births in Taiwan emerged from a very specific socio-political context. In this country, Cesarean sections did not become an issue until C-rates were reported as the third highest in the world. The emerging concerns are not so much about the health of mothers and newborns, but also partially originate from the Taiwanese politics. Besieged by Mainland China diplomatically, the Taiwanese government has searched for all possible means to enter international organizations. One such method has been to strive to conform to standards set by international organizations, including the WHO's normal range of C-rates. When Taiwanese C-rates were reported as twice the normal range as defined by WHO, the Taiwanese government felt pressure to reduce C-rates. In this context, the reduction of C-rates became a political means for the Taiwanese government to receive recognition from international organizations.

In this context, Taiwanese society's understanding of C-rate reduction has been tied to the pursuit of national reputation. In "Understanding C-sections", the author explains the need to decrease C-rates stating, "recently every developed country in the world has been striving to reduce C-rates" (Wu 2004). This argument reflects the ideology behind the new policy of C-rate reduction—reducing C-rates is a demonstration of the progress of a country, so Taiwan should follow the trend if it wants to become a developed country.

However, the Taiwanese government finds itself unable to offend physicians—a politically and economically powerful group—in its efforts to reduce C-rates. Consequently, while much research argues that physicians play a significant role in the high rates (Wu 2000), the government has been quick to blame mothers when global trends started shifting negatively against prevalent C-sections. A medical official explains:

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> *Because of fears of labor pains or possible complications to future sexual pleasures from natural birth, Cesarean rates have become extremely high…some physicians tell us that women will still turn to other hospitals to have a C-section if they [physicians] try to dissuade them…[therefore] we need to come up with new polices in order to reduce national Cesarean rates to what the WHO defines as a normal range.* (ET News 2006)

In an effort to engage with this problematic argument, I analyze how high C-rates have been driven by Taiwan's medical system via ethnographic findings. In this paper, I first examine medical discourses in the Taiwanese mass media. These discourses not only construct the idea of vaginal birth as an inherently risky event, but also normalize the use of C-sections. These kinds of messages have been influential in women's reactions to C-sections. Second, I analyze how Taiwanese hospitals implement a significant amount of medical interventions that increase C-sections in social, psychological and biological aspects. Within this context, I explore how women's concern about "suffering twice"—attempting to deliver vaginally but ultimately having a C-section—has become a reflexive action responding to prevalent C-sections, and the unfriendly system as well.

CONTEXT

In order to reduce C-rates, the Taiwanese government set up certain policies in the past decade. First of all, C-rates have been included as an indicator of hospital accreditation since 2000 (Wu 2007). This aims to regulate obstetricians' implementation of C-sections. Furthermore, in order to encourage obstetricians to perform vaginal births, the National Health Insurance raised payment to an obstetrician for a vaginal birth to the same level as that for a C-section in 2005. But these policy interventions did not effectively lower the C-rates (Hsueh 2006).

The failure of these policies implementation was consequently viewed as evidence that women, instead of obstetricians, were the cause of high C-rates.

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However, research has shown that factors behind physician's preference of C-sections over vaginal births are far more complex and persistent (Hopkins 2000; Wendland 2007). For example, since the 1980s the Brazilian government also changed its reimbursement of vaginal births to equal that of C-sections and added C-rates into hospital accreditation. The new policy did not successfully decrease C-rates because C-sections remain more cost-effective for the physician, considering the hourly rates of return (Faundes and Cecatti 1993; Potter, et al. 2007). Without considering the complex factors behind obstetricians' preferences for C-sections, the argument that women demand C-sections has been gaining credibility as an indisputable "fact" in Taiwan.

Based on this problematic assumption, the newest policy in Taiwan regarding Cesarean births is to reduce women's "demand" for C-sections from the economic side. The Bureau of National Health Insurance made an announcement in April 2006 that, starting on May 1st of that year, anyone who requests a C-section without any medical indication has to make an extra out-of-pocket payment of between NT$12,000 to NT$18,000. Policy makers argue that this approach can effectively lower C-rates because they believe that "many C-sections are not performed based on medical reasons, but rather based on women's request due to their fear of birthing pain" (Hsueh 2006).

This changed official attitude toward C-sections has brought forth a set of discourses that emphasize the risk of C-sections. The government funded a report by the Taiwanese Ob-Gyn Association which emphasizes that C-sections "cause higher infant mortality and morbidity" (Syu 2004). On a hospital website which provides pregnant women information about C-sections, an obstetrician argues that "most women think C-sections are better because at least newborns can be safe[…]In fact, a child born through C-section is more likely to have respiratory problems because he or she is not pushed out through a parturient canal" (Wu 2004). To respond to this new trend, maternal magazines have also invited obstetricians to write about the negative impact of C-sections on both newborns and mothers, such as article titled as "Five Main Concerns on the Side-effects of C-sections" (Chung 2008).

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In the following, I will show how these recently emerging policy and discourses interweave with other social forces and constitute a very dynamic context which significantly influence women's experiences of childbirth in Taiwan.

THEORETICAL FRAMEWORK

To address the power relationships surrounding Cesarean births in Taiwan, I base my analysis on the framework of "three bodies" proposed by Nancy Scheper-Hughes and Margaret M. Lock in their important work "The Mindful Body: a Prolegomenon to Future Work in Medical Anthropology" (Scheper-Hughes and Lock 1987). Scheper-Hughes and Lock define three analytical levels by which body can be understood "(1) as a phenomenally experienced individual body-self; (2) as a social body, a natural symbol for thinking about relationships among nature, society, and culture (3) as a body politic, an artifact of social and political control" (Scheper-Hughes and Lock 1987: 6).

Based on this framework, at the level of individual body, I will look at how individual women experience pregnancy and childbirth in Taiwanese society. Particularly, how their experiences, especially those in the prenatal screening process, shape their perceptions of child delivery. At the level of social body, I focus on discourses surrounding C-sections that have been constructed in a specific socio-political context, and become influential in women's understanding of surgical births, and childbirth overall. To address the body politics, I examine how women's options and resources regarding the mode of child delivery have been confined within a specific system in which they still actively negotiate with the medical professionals and try to gain control over their own childbirth.

Furthermore, the idea of risk has been crucial to how women and obstetricians react to C-sections in contemporary Taiwan. As such, I also draw on the theory of "risk in modernity" proposed by Anthony Giddens and Ulrich Beck as well. Both of them point out that the concept of risk has been integrated into every aspect of everyday life in the modern world (Beck 2000; Giddens 1990). Giddens reminds us

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that “it is not true that world is more risky than it used to be. Rather the notion of risk becomes more central, as does trust because of the existence of more active trust systems” (Giddens and Pierson 1998: 103). This is reflected in the fact that the monitoring of trends, and collection and analysis of data, is a distinct feature not only for the modern state administration but of modern life more generally (Cassell 2003).

This also involves the increasingly technological intervention in nature and everyday life which is another central aspect of modernity. Tradition and nature used to structure actions. As things increasingly become non-natural and non-traditional, the more decisions have to be made about them (Giddens and Pierson 1998). In this regard, Giddens and Beck discuss a “manufactured risk” that is not associated only with human intervention in nature, but also with social change in an information society based upon high reflexivity (Beck 2000; Giddens 1990). By opening up more and more new spheres of action, science creates new types of risks as well (Beck 2000). This is particularly evident in medicalized childbirth. In the following, I will show how the Taiwanese obstetric system implements intensive interventions in childbirth that consequently increase risks. Moreover, when technologies are increasingly used to detect, predict and manage birthing risks, women and their family are “trained” to be concerned about potential risks that may occur in their childbirth.

Furthermore, when it is central to modernity that risks can in principle be accessed in terms of generalizable knowledge about potential dangers, this actually increases, rather than reduces, people’s anxiety about risks. To recognize the existence of a risk or a set of risks is to accept not just the possibility that things might go wrong, but that this possibility cannot be eliminated. The phenomenology of such a situation is part of the cultural experience of modernity in general (Cassell 2003). This perspective to a large extent explains defensive surgery and certain maternal requests for C-sections based on women’s and their families’ fear of the potential risks of vaginal births. In other words, women’s seeking for further insurance through technology is in fact part of the modern risk culture.

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Most importantly, according to what Mary Douglas and Aaron Wildavsky argue in their book *Risk and Culture*, the ideas of 'risk' should be viewed as culturally and historically embedded (Douglas and Wildavsky 1982). Therefore, we have to look at the changing perceptions of childbirth in Taiwan. In traditional cosmology and Chinese medicine, harmony between body and nature is emphasized and intervention discouraged. Nowadays the medical model of childbirth emphasizes the risks inherit in the natural process of birth, and view medical interventions as necessary and beneficial. I will show how this changing viewpoint of childbirth has affected women's decision regarding the mode of child delivery.

METHOD

I conducted ethnographic fieldwork in Taiwan from June 2008 to June 2009. My research sites include three medical institutions in Taipei, including a private teaching hospital and two Ob-Gyn clinics. Ethnographic observation focused on prenatal and postnatal care, as well as the process of hospital childbirth. I also attended six maternal classes titled "How to choose between vaginal birth and C-section" to examine the messages conveyed to pregnant women. Additionally, I analyzed maternal booklets and magazines from websites, popular bookstores, and hospitals to look at assumptions about motherhood and gender relationships that underlie the "scientific" discourse regarding C-sections in Taiwan.

I have interviewed eight obstetricians, two nurses, and fifty-six women. Three of the doctors interviewed work in private Ob-Gyn clinics while the rest of them work in teaching hospitals. Through interviews with obstetricians, I came to know how they determine whether a woman should have a C-section. This data contributed to my critical analysis of how the reproductive body is conceptualized through these "medical rationales." Moreover, I examined structural factors that determine whether obstetricians themselves prefer C-sections over vaginal births, including the educational training of obstetricians and their work load. My interviews with women focused on their experiences and understanding of C-sections. As such, I learn how

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women respond to C-sections based on immediate situations and also on their long-term thinking about their status in the family, their career, and their overall social status. The informed consent of each interviewee was obtained and in the following sections, I use the real names of interviewees only if permission was given on the informed consent form. For those who did not give permission for this research to use their real name, I use pseudonyms instead.

CESAREAN AS AN OPTION: INDIVIDUALIZED RISK

In response to the claim that women's demand is the main reason for high C-rates in Taiwan, risk discourse regarding child delivery has been developed as a primary mechanism to discipline women's reproductive practices. While C-sections used to be described as being able to protect the infants' health (Lane 1995; Martin 1987; Wang 2005), this new claim has brought forth a very different set of discourses of risk regarding Cesarean births in the mass media. In order to advise women not to thoughtlessly choose elective C-sections, predominantly motherhood magazines invite obstetricians to explain the risks of C-sections for newborns and mothers as well. For example, in "Five Main Concerns on the Side-effects of C-sections," an obstetrician writes about the risk of anesthesia, dysfunctional uterine bleeding, and pelvic adhesion caused by surgery (Chung 2008). By citing statistics, this obstetrician states that newborns are more likely to have respiratory complications with Cesarean births compared to those delivered vaginally. The rhetoric in these articles strongly implies that mothers' demand for C-sections stems from their "scientific illiteracy," the lack of an appropriate understanding of medical events (Georges and Mitchell 2000:192). For example, in another article an obstetrician "advises" women not to "simply think about the convenience of C-sections, but to understand the possible risks and side-effects" (Gao 2008).

However, while the risks of C-sections are outlined in these articles, the obstetricians do not seem to take the side effects into serious consideration. In "Five Main Concerns on Side-effects of C-sections"—based on an interview with a senior

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obstetrician Zeng Mao-rong in *Mombaby*--women are reminded, on the one hand, of possible complications associated with Cesarean births. On the other hand, though, they are told not to worry about these complications "since medical technology is quiet advanced, [and] obstetricians and anesthetists will do their best to maintain the health of mothers and newborns" (Chung 2008: 67). Regarding the side-effects of pelvic adhesion, the obstetrician mentions that "there are already anti-adhesion materials developed to separate surgical cut and membrane. As such, the problem of adhesion will be significantly reduced" (Chung 2008: 68). This sort of medical opinion reflects the technocratic view inherent in the obstetric profession. In other words, in spite of warnings about its medical repercussions, women are also simultaneously told to understand C-sections as relatively safe operations.

Consequently, messages regarding child delivery became highly complex and ambiguous when technocratic values and official attempts to reduce C-sections coexist in Taiwanese popular discourse. This complexity can be seen, for example, in an article in *Mami-Baobei* by an obstetrician on the ten main reasons for having a C-section. While the author noted that vaginal birth is in theory the best mode of child delivery, he also recognized a higher possibility of serious accidents in a vaginal birth that could be avoided through having a C-section. Despite that, he also claimed that the mother-to-be "should consider adopt vaginal birth since it is a better choice for your baby" (Wang 2007: 33-35).

C-sections are continuously described as a modern and reliable approach of child delivery. Wang states: "based on the advanced medical technology and hospital equipment, C-sections have become a quite common and safe medical intervention" (Wang 2007: 172). In other words, C-sections began to be conceptualized as a harmless "option" available for pregnant women. A health education article from a hospital website reads:

> *As everybody knows, there are two ways of giving birth: C-sections and vaginal births. So which is the better choice?...Based on the advanced techniques both in anesthesia and surgery, the mortality of women in*

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> *C-sections has become very low. A C-section can avoid problems of vaginal relaxation, urinary and rectal incontinence, and accidents in a vaginal birth. It also makes it possible to schedule the time of birth. However, at the same time, it may cause dysfunctional uterine bleeding, infection, adhesion, and complications related to anesthesia. It also takes longer for postnatal recovery, and leaves a surgical scar. As such, both a C-section and a vaginal birth have their own risks and benefits. Which one to choose depends on one's personal needs and health conditions.* (Obstetrics in Guang-tian Hospital 2008; emphasis added)

The conceptualization of Cesarean and vaginal births as two "options,"equally with risks and benefits, is achieved via two premises. On the one hand, C-sections, which used to be an emergency surgery, now becomes a newly innovated birthing approach available even in non-emergancy situations. On the other hand, a vaginal birth, which should be the natural course, begins to be described as a medical event with "complications." For example, Chi-mu Jhuang, an obstetrician, states in a magazine article:

> *What complications do a vaginal birth and a C-section cause? Overall, the complications caused by a vaginal birth are definitely less than those caused by a C-section. However, regarding the problem of urinary incontinence and the injuris of pelvis, many researchers have pointed out that the harm on the pelvis from a C-section will be less serious compared to that from vaginal birth.* (Jhuang 2005, emphasis added)

In these articles, the authors identify themselves as information providers for individual women who make "choices" about the kind of delivery they want. One doctor states, "in the end of the ten-month pregnancy, every mother-to-be will confront the decision of whether to have a Caesarean or vaginal birth" (Obstetrics in Guang-tian Hospital 2008). Dominated by the rhetoric of women's choice, these articles are full of comparisons of the risks and benefits of vaginal births and C-sections. Furthermore, the idea of "choice" has become so pervasive that prenatal

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classes also offer talks like: “Which one to choose: a Cesarean or vaginal birth.” The lecturers usually hold the rhetoric of consumerist choices. In an extreme example, the lecturer concluded the class by offering a power point slide with the title of a popular Japanese cooking competition show. In doing so, he strongly implied that modes of child delivery are like food people choose based on preference.

C-sections implemented without any medical indication used to be controversial, but elective C-sections are increasingly seen as a right of women who pursue surgical births as consumers. As such, some research argues that consumer rights are a main reason for the increasing acceptance of elective C-sections (Anderson 2004). However, it is problematic to attribute high C-rates in Taiwan to consumer choice when women remain voiceless when confronted with medical authority. It should also be noted that there is not much room for individual preference in the Taiwanese medical system regarding childbirth. For example, some grassroots groups have strived to introduce the idea of pregnant women creating a birthing plan with her family. This practice, however, is viewed as infeasible in many hospitals, as I will demonstrate in the following section. Even so, the idea of child delivery as an individual consumer’s choice has been increasingly internalized by some women. This is apparent in online discussion boards where pregnant women seek advice and share experiences with each other. For instance, in one discussion forum, a user describers her dispute with her in-laws about a plan for a C-section. A respondent says: *“*the problem with a C-section is pelvic adhesion. Some people vomit while having anesthesia. Everything has its good and bad points. You just need to analyze them [to make your own choice]”. [1] In brief, while the policy attempts to promote vaginal births via health education, it is hard to do so when confronted with the deeply rooted technocratic culture within the obstetric profession. Consequently, health education articles reinforce the idea that C-sections are an option for child delivery.

This sort of conceptualization involves how “risks” are being defined. Defining what are and what are not risks, and what risks are acceptable and unacceptable,is also a part of politics (Beck 2000; Douglas and Wildavsky 1982; Giddens and

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Pierson 1998). Viewing a C-section as safe as, or even safer than, a vaginal birth also reflects the technocratic viewpoint that overstates the risk of vaginal birth and understates those associated with surgical birth (Beckett 2005). [2] This viewpoint ignores the harm to the maternal body inherent in the surgery itself. For example, through my ethnographic observation, I have seen several cases where women have suffered serious health threats due to multiple C-sections. One woman had a life-threatening gynecological problem, and the best way to deal with it was a hysterectomy. However, according to the obstetrician, the surgery became too difficult to conduct because of serious adhesion after multiple C-sections. Another example is a situation where a woman hoped to have another child, but too many C-sections had made it impossible. She had a C-section in her second birth, and then was forced to have two more since no obstetricians were willing to do VBAC (vaginal birth after C-section). The obstetrician told me that it was dangerous for the woman to have another pregnancy. If the placenta lands on the weak point caused by the C-sections, the placenta would penetrate the very thin uterine membrane and grow into the bladder. The situation would be life-threatening. He added that this scenario was highly possible since a previous C-section usually leads to placenta previa. These issues are, however, unaddressed in the mass media. As a result, C-sections are continuously portrayed as a safe surgery due to technological advancement, and complications with a C-section, such as adhesion, are viewed as minor and manageable.

Moreover, it should be noted that the risk of birth is produced by precipitous medical intervention (Lane 1995). Both Emily Martin and Brigitte Jordan find that so-called normal birth is redefined according to specific timeframes based on medical expertise (Jordan 1997; Martin 1987). The umbrella term “lack of progress in labor” becomes a commonly-used reason for medical intervention (Lane 1995). In other words, the increasing use of technologies narrows the range of women and babies who qualify for a “normal” vaginal delivery. C-rates significantly increase when the notion of high-risk pregnancy becomes refined (Souza 1994). By not taking these structural factors into account, the management of birthing risks “are becoming

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individual moral responsibilities to be fulfilled through improved access to knowledge, self-surveillance, prevention, risk assessment (…)" (Clarke, et al. 2003: 162). In the following section, I will illustrate how birthing risks have been institutionalized in the hospital system and increased due to excessive intervention.

MEDICAL INTERVENTIONS AND INCREASED CESAREAN SECTIONS

The Taiwanese obstetric system is organized to respond to risks in childbirth. Consequently, childbirth has become a project of quality control that is reflected in prenatal screenings and child deliveries. Responding to the policy to reduce C-rates combined with the concerns about birth risks, Taiwanese prenatal screens include an evaluation of the probability of a successful vaginal birth for each pregnant woman. This sort of practices increases what Giddens and Beck call "manufactured risk" (Beck 1990; Giddens 1990). A vaginal birth used to be the mode of child delivery for everyone unless there was an emergency. Nowadays, throughout pregnancy, technologies are intensively used to collect information in an effort to decide the most appropriate mode of child delivery. This transforms the view of vaginal births from a natural occurrence to a medical event that is technologically monitored. In addition to detecting if there are any current indications of the need for a C-section, other information is collected to carefully evaluate the probability of a successful vaginal birth. When the data implies a difficult labor, other medical interventions, such as preventive labor induction,[3] are implemented to prevent a C-section in an effort to reduce C-rates in accordance with the current policy. However, as I will show below, this technological-oriented approach inevitably leads to more C-sections.

I conducted observation in prenatal screens with five obstetricians. Two of them own private ob-gyn clinics while the rest work in a teaching hospital. Fetal weight is the most important information during prenatal screenings. It is not only important for tracing the growth of the fetus, but also for monitoring the fetal weight through the mother's diet practice. Obstetricians tell women to control their weight to avoid

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difficult labor: “Your baby already weighs enough. Do not eat too much. Only by doing so, can you have relatively easy labor”. This rhetoric of risk management reinforces the worry and fears about child delivery among pregnant women. Women are taught to be concerned about labor difficulties. During the prenatal screenings, they often ask the obstetricians or sonagraphers to check the fetal weight: “Can you tell me the weight of my baby? I am so afraid that I will have a difficult labor”.

Based on the idea that a large fetus causes a difficult birth, obstetricians believe they can foresee a difficult labor using ultrasound screening and pelvic checks. A mother-to-be came to a prenatal check at her thirty-seventh week of pregnancy. While checking the size of her pelvis, Dr. Wang reminded her not to let her baby get too big. Hearing this, she asked: “So do you know yet if I can have a vaginal birth?” Dr. Wang answered: “The only thing we can know is whether your labor will be easy or not.” The woman asked: “Will it be easy for me?” Dr. Wang replied: “It seems all right. Your baby is not that big.” After the woman left, Dr. Wang turned to me and said: “We have relatively low C-rates here because we don’t suggest a C-section just based on a large fetal weight. We do more evaluation [about the probability of a vaginal birth being completed] ”. When C-rates became part of hospital accreditation, due to the new policy, obstetricians began carefully monitoring fetal weight in the hopes of reducing C-sections. Under Taiwan’s national health insurance directives, a C-section is needed only when fetal weight is over 4000 grams.[4] However, obstetricians get suspicious whenever fetal weight is higher than the standard. As such, they routinely check fetal weight and give medical intervention such as preventive labor induction when they suspect a difficult or a prolonged labor, which is an indication for a C-section. During my ethnographic observation in the birthing room of a teaching hospital, I asked an ob-gyn resident about the timing of giving a preventive labor induction. She told me that they tend to conduct preventive labor induction whenever a fetus is larger than average. She said, “The medical textbook does not say it, but large fetus weight causes a higher possibility of CPD.[5] As such, this is something that most Taiwanese obstetricians do, but we do not explicitly talk about it.”

臺灣大學學術期刊資料庫

Within this mode of childbirth, a vaginal birth is viewed as not only risky, but also hard to achieve. Dr. Wang once said to a pregnant woman: “The fetal weight is all right, and your pelvis is big enough. According to this, you do have a chance to complete delivery vaginally. But we can never be sure about it beforehand.” This shows that obstetricians themselves are aware of the uncertainty of their diagnosis and predictions of the possibility of a successfully completed vaginal birth. However, this sort of medical advice still conveys a strong message that not everyone can complete a vaginal birth even when nothing goes wrong before labor begins. These prenatal practices lead to an emerging cultural concern of difficult birthing. Moreover, the rhetoric used is sometimes very threatening: “Your baby is a little larger than average. A large baby can lead to a difficult labor, even a shoulder dystocia”. “You have to watch the weight, because fetal overweight can cause danger during birth”. Researchers have argued that prenatal care plays a crucial part in shaping women’s perceptions and experiences of childbirth (Faundes and Cecatti 1993). Unfortunately, within the medicalized model of birth, prenatal preparation often increases women’s fear of childbirth and reduces their confidence in completing a vaginal birth.[6]

In addition to fetal weight, pelvic size is another item routinely checked when evaluating the possibility of a successful vaginal birth. A small pelvis is considered by some obstetricians to be a sign of a highly possible (if not necessary) C-section. They even abandon their principle of not accepting maternal requests for C-sections due to their concern that difficult births may be caused by small pelvises. Dr. Wang told me that he does not accept maternal requests for a C-section unless the mother-to-be has a small pelvis: “that [having a small pelvis] means she will suffer for quite a while, and still fail to push the baby out.” He went on to explain that he checks pelvic size for every pregnant woman in order to reduce C-rates. Once he finds that a woman has a small pelvis, he suggests preventive labor induction. He says, “She may be able to complete vaginal birth in the thirty-eighth week, but fail to make it if she waits until the fortieth week. You know…a baby grows really fast”. Preventive labor induction, prevalently used in Taiwan, is viewed not only as an ideal approach to manage birth risk, but also as a harmless intervention. Taiwanese

臺灣大學學術期刊資料庫

obstetricians suggest labor induction even for non-medical reasons. In one prenatal screening, Dr. Hu told a pregnant woman to arrive at the hospital earlier since this was her second birth, and thus would proceed relatively fast. “Or you can consider inducing labor now.…It’s just another way to do it”.

Taiwanese obstetricians are more ready to apply medical interventions and are less concerned with the possible side effects. For example, the ACOG guideline states that “results from recent reports indicate that induction of labor at least doubles the risk of cesarean delivery without reducing the risk of shoulder dystocia or newborn morbidity” (Chatfield 2001). The negative impact of this intervention is not yet being discussed among Taiwanese obstetricians. This technocratic value of Taiwanese obstetric profession has also been reflected on the implementation of C-sections.[7] ACOG created a guideline that states that an elective C-section should not be performed before the 39th week of pregnancy or without verifying fetal lung maturity (ACOG 2006). Yet, Taiwanese obstetricians are not concerned about this.. They tend to schedule surgery before the 39th week to ensure that it is scheduled in advance. They tell mothers-to-be that “it is more troubling to schedule the surgery after the thirty-ninth week because your labor may have begun by then. That means you will have an unplanned C-section. But you know…well-prepared surgery is always better”. This conduct, again, shows the technocratic value by which Taiwanese obstetricians prioritize planned surgery over the wellness of a newborn.

Uncertainty has been the central issue regarding technological management of risk in modern society. Since there is no perfect knowledge available that allows us to effectively avoid risk, people have to continuously adjust to newly emerging evidence and the immediate circumstances (Beck 2000; Giddens 1990). Obstetricians, for example, have to manage for the limits of technologies, such as bias in estimated fetal weight through ultrasound screen. In one case, Dr. Wang suggested a C-section even when there was no medical indication of its necessity. He explained to me that he did so because the ultrasound screen had indicated fetal weight to be one to two weeks larger than the average throughout the pregnancy. However, when the woman asked if NHS would cover the fee for surgery, he answered: “For now, we will just put it

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down as an "elective C-section" [on the official document]. It will be changed when we make sure that the baby is really too big."[8] Apparently, this was not a situation that definitely required a C-section. The obstetrician suggested one mainly to reduce risk. The mother did not show any disagreement probably because she had been warned and became worried about the potential danger to the fetus. As such, she might take Dr. Wang's suggestion as authoritative advice as to the best way to avoid an unwanted outcome. This example shows that, first, even when obstetrians notice the limits and biases of technologies, they tend to worry about the risks in the natural process of birth, rather than those inherent in the technologies. Secondly, the decision to have a so-called elective C-section does not solely come from the mother and her family. Her obstetrician may be directly involved in this process.

Furthermore, as in many other developing countries, Taiwan has experienced rapid medicalization that results in crowded hospitals. There is always a waiting line both in prenatal screenings and in birthing rooms. On average, obstetricians spend two to five minutes on each prenatal check in a large hospital. In local obstetric clinics, women will have relatively more time, from ten to fifteen minutes, for their prenatal check. This crowdedness in prenatal and birthing rooms has been exaggerated by the "superstar effect"—the phenomenon that most Taiwanese pregnant women go to certain famous obstetricians.[9] For example, Dr. Hu, one of the most famous obstetricians in Taipei, has to take care of one hundred childbirths per month on average. Moreover, the work schedule for obstetricians is very stressful, as they usually have to run back and forth between their ob-gyn clinics and the birthing room. This constant movement makes the nurses in the birthing room confront time pressure in another way. Ms. Liu, the head nurse in birthing at a teaching hospital, told me that every nurse has to be good at deciding the best time to call the obstetrician. "If you make the phone call too early, the obstetrician complains. But if it is too late, the patient will blame the nurse." The tension among obstetricians, nurses, and patients are caused by, and also reflects, the stressful working environment within the Taiwanese hospital birthing system.[10]

Under these highly stressful circumstances, long labor becomes a taboo. When

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Dr. Lee conducted a prenatal screen with a mother having her third child, he asked about her previous child delivery experiences. The mother told him the births had been very tough; it even took her three days for the second birth. Hearing this, Dr. Lee replied with shock on his face: "Don't tell me that. That really scares me." To women, increased labor time means the endurance of more pain. To obstetricians and hospitals, longer labor means an addition to their already stressful work load, and also to the risks based on the medical model by which labor should be completed withiin a certain period of time.

When time management becomes a main concern, hospitals apply a significant amount of medical interventions, including routine augmentation and artificial rupture of the membrane, to accelerate the labor process. More importantly, these medical interventions are viewed by medical professionals as inherently harmless to mothers, and applied to births on a regular basis. Dr. Chen is a resident who works in the birthing room of a teaching hospital in Taipei. She is very proud of the "correct attitude" of her colleagues with respect to the avoidance of unnecessary C-sections. However, according to her, births at this hospital have been regularly and intensively intervened:

> *Kuan: It seems like this hospital encourages natural births.*[11] *As such, you would reduce medical interventions, right?*
> *Dr. Chen: Like what [kind of intervention]?*
> *Kuan: Such as augmentation or artificial water breaking…*
> *Dr. Chen: No, it has nothing to do with promoting natural births. Regarding the use of augmentation or artificial water breaking…we observe the labor progress, we certainly hope labor can progress more quickly. It is not necessary to wait for labor to be prolonged [to apply the medical intervention].*
> (Interview with Lily Chen 2008/12/24)

Interestingly, Dr. Chen, like most other obstetricians, does not define "natural birth" as a type of delivery with little technological intervention. Rather, she sees it merely as a mode of delivery without a C-section. With this idea in mind, it is no

臺灣大學學術期刊資料庫

wonder that Taiwanese obstetricians' response to the policy of decreasing C-rates is to increase medical interventions (such as preventive labor induction) rather than avoiding them.

Dr. Chen mentioned that medical interventions are sometimes applied to manipulate the labor process based on the obstetricians' personal considerations. She says, "For example, say a mother was having good progress, but it was almost 1 AM and the obstetrician did not want to come to the hospital in the middle of the night. He or she would I ask us to add more augmentation drugs. Or when the obstetrician is having a meeting and unable to come, we will try to slow down the labor progress. This is in fact something we can manipulate." (Interview with Lily Chen, 2008/12/24)

Labor augmentation is very commonly used in Taiwan. Yu-ying, one of the very few doulas in Taiwan, told me that Taiwanese hospitals apply intravenous drips to women in birthing rooms, and add induction drugs without permission (Interview with Yu-ying Lin, 2008/10/5).[12] Dr. Lee, who has experience working in both Taipei and the United States, also thinks that labor augmentation is over-used in Taiwan mostly because obstetricians do not want to wait, or because they try to "clean out" the birthing rooms (Interview with Fang-Yi Lee, 2008/12/3). When I asked him if over-augmentation causes any problems, he answered: "Of course, it will lead to more complications. For example, the fetal heart beats too quickly.[13] That increases the possibility of a C-section." Artificial rupture of the membrane is also commonly practiced in a birthing room in order to speed up labor. However, this intervention does not always accelerate labor, especially when the maternal body is not ready for labor. In this situation, the woman is more likely to end up having a C-section. As the doula explained to me, hospitals will count from the moment of rupture, and send the woman into surgery room when she doesn't deliver within a certain period of time (Interview with Yu-ying Lin, 2008/10/5). To some extent, this may explain why "fetal distress" and "dysfunctional labor" are two of the most commonly seen indications of C-sections in Taiwan.

臺灣大學學術期刊資料庫

In addition to intensive interventions, hospitals have developed a very strict and inflexible model of hospital births in response to the crowdedness in birthing rooms. An obstetrician once complained to the doula: “I have to take care of 300 births per month. How can I deal with their different needs?” (Interview with Yu-ying Lin, 2008/10/5) Consequently, every woman is asked to fast or have an enema regardless of whether she needs a C-section to shorten the time needed for surgical preparation, as medical professionals assume a C-section may be needed at any point. By the same token, women are asked to stay in bed and not to walk around. Dr. Chen told me:

> *Women are allowed to walk around during labor in other countries, but not in Taiwan. Because we got a highly tense physician-patient relationship. As, such, we do not want mothers to do that…They have to stay in bed throughout the whole time. It would be easier for us to just push the hospital bed into the delivery room when an emergency occurs. In this way, the monitor can also stay attached. Monitors are not so routinely used in other countries, but in our hospital they are required for every woman. (Kuan: Throughout the whole time?) Yes. If you look at this kind of thing in medical research papers, they would tell you that it is unnecessary to use a monitor throughout the whole time, or limit the women’s walking around during labor. But in our hospital we think it is neccessay.* (Interview with Lily Chen, 2008/12/24)

According to Dr. Chen, this conduct is not really required for medical reasons, but rather for the convenience of the hospital and better work management. Dr. Chen further attributes the strict control over women in labor to the high rate of lawsuits in Taiwan. In order to prevent accidents that may lead to lawsuits, the hospitals make sure each woman is connected to a fetal monitor the entire time. In other words, these controls are also part of the hospital’s regime of risk management. Avoidance of lawsuits, according to Dr. Chen, is also a crucial factor in Taiwan’s high C-rates:

> *We do not really have particularly high prevalence of physiological factors for Cesarean births here in Taiwan, such as placenta previa and*

臺灣大學學術期刊資料庫

> *malposition. So the high Cesarean rates must come from elective Cesarean sections. Of course, it has a lot to do with the avoidance of lawsuits among obstetricians…For example, I read about painless childbirth in medical literature these days. The epidural may sometimes affect the fetus. But they [obstetricians in other countries] will just wait for a while to see if the fetal heart-rates come back normally. But here in Taiwan, probably due to the tense physician-patient relationship, we cannot be so bold. We may just send the woman to a Cesarean section if the fetal heart rate does not come back within two or three minutes…This is also why nurses in surgical rooms sometimes question us, particularly when the newborn's Apgar-score is good. But you never know what the real situation is. You just send the mother directly to surgery when things going wrong on the monitor. We do not talk about whether there is any bias built into the monitor even when it turns out that surgery was unnecessary. Because we need to avoid lawsuits.* (Interview with Lily Chen, 2008/12/24)

Dr. Chen's comments reflect Taiwanese obstetricians' relatively low tolerance for birth risks, which, in turn, leads to defensive surgeries. More importantly, these problematic practices should not be interpreted as the selfishness of individual obstetricians, but structurally driven responses considering the industrialized system of birth and the technocratic culture in obstetric profession.[14] As I have illustrated, in addition to medical theory, obstetric practices in Taiwan are also structured in response to the concerns of risk reduction and industrial management. As such, medical practices sometimes contradict the purpose of enhancing labor progress. For example, medical professionals I have talked to are all aware that limiting women's activity during labor will slow down the progress. They, however, cannot change the practice because the whole system has been set up to prioritize risk management.

This medical conduct not only increases suffering during a vaginal birth, but also the possibility of a C-section. This can be first shown through statistics. According to my interviews with obstetricians, maternal requests account for only

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3% of C-sections while the overall C-rates are around 32%. This means that Taiwanese C-rates are still much higher than normal rates as defined by WHO even without maternal requests. This can be seen by comparing Taiwanese C-rates to those in Japan. Japan, our very close neighbor, has significantly low C-rates.[15] Japan's low rate relates to the fact that Japanese people view childbirth as a primarily normal physiological event and conduct less intervention in childbirth (Fiedler 1997). It is common for Japanese women to eat and drink during labor and to walk from the labor room to the delivery room. They do not routinely have analgesia or operative intervention during birth. With this in mind, when public discourses tend to blame women for high C-rates, it is important to examine the problematic hospital birthing system in Taiwan.

MATERNAL REQUEST AS A STRATEGIC RESPONSE

Women in countries with high C-rates are usually blamed for being the culprits behind the over-use of this surgery. When C-rates in South Korea approached 40%, newspaper reports suggesting that women might be choosing to have cesareans for nonclinical reasons fueled the debate on contributory causes (Lee, et al. 2004). However, it was found that over ninety-five percent of Korean women preferred vaginal delivery during pregnancy. The rapid rise of C-rates in South Korea in fact had its origins in the privatization of health care systems in which medical institutions prefer C-sections over vaginal births. A similar situation occurred in Brazil, the country with the highest C-rates in the world. It was found that more than one-third of those who expressed a preference for vaginal birth ended up acceding to a scheduled C-section (Potter, et al. 2007). Joseph Potter and other researchers argue that under a stressful working environment,[16] the unpredictability of spontaneous labor would result in interrupted office hours and academic or social activities almost daily. Scheduling C-sections allows doctors to schedule the deliveries of several women on the same day, and gain some measure of control over their lives. In other words, Brazilian women are persuaded to having medically unnecessary Cesareans.

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Based on this perspective, while the Taiwanese mainstream discourse attributes high C-rates to women's demand, I argue that the relations between maternal requests and the high C-rates should be reexamined. Based on my ethnographic findings, most Taiwanese women prefer vaginal birth to a C-section, even those who request an elective Cesarean section. In the following, I reinterpret maternal requests based on the Taiwanese hospital birthing system. By so doing, I aim to provide a feminist reinterpretation of the deeply stigmatized "women's demand for Cesarean sections."

First of all, medical intervention in childbirth often increases problems that people think are necessary consequences of vaginal birth. For example, one of the most commonly mentioned "complications" of vaginal birth is its negative impact on sexual life. However, it should be noted that the rupture of vaginal tissue has been intensified due to the prevalence of episiotomy[17] and push-on-abdomen[18] during child delivery. Moreover, the practice of episiotomy has dramaticized birthing pain. Nico, who decided to have a Cesarean section, told me:[19]

> *I was hesitant about whether to have a C-section or vaginal birth. But then I decided that it would be better to have a C-section. Birthing pain can be so horrible that you will not even feel anything when the obstetrician cuts you. That is so cruel.* (Interview with Nico, 2008/7/28)

In other words, the conduct of episiotomy directly reinforces women's fear of vaginal birth. My interview with Wen[20], who had both vaginal and Cesarean births, also indicates how prevalent episiotomy influences women's preference of mode of child delivery:[20]

> *[In vaginal births] we have episiotomy which causes pain lasting up to a couple of days after labor. (Kuan: So…even though you have vaginal birth, you still feel pain after labor?) Yes, [the pain came] also from your abdomen because your uterus was contracting. For some people, it can be really painful. (Kuan: What about you?) It was ok. To me, the pain from the perineum [caused by episiotomy] was more terrible. On the third day after my vaginal birth, I still needed a wheelchair because*

臺灣大學學術期刊資料庫

> *it hurt so much whenever I walked. My husband was laughing at me. But what was I to do? It really hurt a lot. (Kuan: If you compare your recovery after the vaginal birth and the C-section, which one was easier?) That would be the vaginal birth for sure. But for the extent of pain, I would say it hurts more when you are cut on the perineum than on your belly because it hurts whenever you walk. For the belly, you feel ok as long as you don't touch it.* (Interview with Wen, 2006/6/29)

High rates of episiotomy reinforce women's negative feelings about vaginal births in two ways. First, as Wen points out, it does cause pain, especially when there is no other medical facilitation for pain-relief. Second, episiotomy is viewed as a surgical cut occurring during vaginal birth, thus blurring the distinction between vaginal birth and a C-section. In other words, for these women, choosing a vaginal birth does not really avoid medical intervention. For example, Nico once mentioned that she was worried if her in-laws would be unhappy about her decision to have an elective C-section:

> *Many in-laws do not like the idea of C-sections. They question why you want to go through the surgical cut if it is unnecessary. But the fact is that you either have a cut on the belly [from a C-section] or a cut on the perineum [caused by episiotomy in a vaginal birth]. Does it make any difference?* (Interview with Nico, 2008/7/28, emphasis added)

Moreover, birthing pain is exaggerated when women have to give birth in an isolated, dehumanizing environment like a hospital. Dr. Chen told me that more than one-third of women in labor, particularly those who are in their first birth, ask for a C-section in reaction to their panic. This reaction emerges from panic, which is common in an environment like a birthing room: "You know, everyone is screaming there." (Interview with Lily Chen, 2008/12/24) It also involves women's feeling of helplessness when they are alienated from the medical processes they experience, for while medical interventions are intensively implemented in Taiwanese birthing rooms, women are seldom informed about beforehand. Mothers-to-be also feel it

臺灣大學學術期刊資料庫

inappropriate to ask questions, or are unable to understand responses framed in medical language even if they did ask. During my observation in a birthing room, a young obstetrician went to check a women's amniotic fluid with sonography. While looking at the screen, the obstetrician told her that she did not have sufficient amniotic fluid. The woman could not really understand but got very nervous anyway:

> *Woman: Does that mean that the situation is not good?*
> *Obstetrician: It should be fine. You are giving birth very soon. Or do you want me to explain (with his finger pointing to the screen)?*
> *Woman: That's ok. I wouldn't understand anyway* (with disappointment on her face).

Most of the time, women in the birthing room are just told to put up with the uncomfortable feelings caused by medical interventions. I have seen a scene in which a woman became exhausted after a long and painful vaginal birth. A young obstetrician came to do a per-vaginal check and then the nurses pushed hard on her abdomen. The woman then cried out: "What are you doing? That really hurts." A nurse simply replied, in a very impatient tone, that "this is routine process to make the lochia comes out. Just put up with it."

Under these circumstances, a C-section, on the one hand, is seen by women in labor as the only way to end their suffering. On the other hand, within this birthing system, having a C-section is also treated among medical professionals as a privilege for the woman.[21] For example, one obstetrician told me that C-sections are sometimes conducted for obstetricians' acquaintances who do not want suffering. This is also apparent in conversations among medical professionals in the birthing room. Once a nurse found out that a women had a C-section that was apparently unnecessary: "A3 got a C-section![22] Why is that?!" A resident answered with disdain: "Because she kept asking for one. And more importantly, she is sister of his [the obstetrician] college." This conversation demonstrates how having a C-section is regarded as a privilege for women, or a favor an obstetrician does for her. This idea originates from a problematic medical system that makes the birth experience so impersonal and

臺灣大學學術期刊資料庫

painful that a C-section becomes a favor to women.

As Pranee Liamputtong's research on Cesarean births in Northern Thailand shows, self-perception of "risk" plays the most important role in deciding the mode of child delivery (Liamputtong 2005). However, understanding and reacting to risk is not so easy in modern society. As Giddens and Beck point out, when risk becomes so central to modern society, there can be no perfect knowledge in predicting or ruling out risks (Beck 2000; Cassell 2003). As a result, individuals cannot really rely on experts. By the same token, women have to actively interpret the information they access and make a decision for themselves. Women are socialized into the medical model of childbirth both through mass media and through prenatal practices, and thus view vaginal births as extremely risky. Consequently, some of them become even more suspicious about birthing risks than their obstetricians and request a C-section whenever they feel uncertain about their pregnancy and delivery. Lian-yin was in her thirty-second week of her pregnancy when I interviewed her.[23] She was thinking about having a C-section because she was told that her baby was larger than normal. Even though her obstetrician did not suggest a surgery, she was still considering having one because she was overwhelmed by the possibility of risk:

> *I am concerned that she will be really large at the moment [of delivery]. Besides, I heard so much [of accidents in birthing]. For example, there will probably be a shoulder dystocia, and many other problems. All of these make me want to talk to my obstetrician about whether or not to have a C-section.* (Interview with Lain-yin Huang, 2009/2/11)

Lian-yin is one among many other mothers-to-be who were worried about their baby's possible harm during a vaginal birth. Their fear does not come from nowhere. They articulate the medical information they hear with what their obstetricians or sonagraphers tell them during prenatal screens. With birth risks so emphasized in Taiwanese obstetric culture, women can easily feel threatened. They feel like they have to actively seek out technology to ensure the safety of their baby.

Some may assume that it is just irrational fear of possible risk among people

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who do not have sufficient knowledge about C-sections. For example, one study compares C-rates between two groups: female physicians or female relatives of physicians, and other Taiwanese women with the same educational level and economic income (Chou, et al. 2006). It concludes that the Cesarean delivery rate was lower among physicians and their relatives because they have greater access to medical knowledge.[24] However, based on my ethnography, physicians are also worried about the potential risks of vaginal birth and try to ensure their childbirth through technology. One female obstetrician—whose husband is also an obstetrician—decided to schedule a Cesarean birth when she found a sign of minor placenta praevia that was not yet an indication of the necessity of a C-section:

> *To be honest, I simply do not want to deal with an emergency C-section even though the possibility is not high. If the same case was found with my patient, I might tell her that it is not that serious. No need to have surgery. But I tend to be more conservative when it happens to me. As obstetricians, we are scared by the serious situations we have seen. Sometimes the outcome of prenatal screens were all right, but then serious uterine bleeding occurred during delivery. What was worse was that the baby was suffering from anoxia. We do not want any of that. Think about it…it is easier to deal with the problem of infection or adhesion, but you definitely do not want any accidents with your baby*. (Interview with Wen-wen Chou, 2008/11/25)[25]

The technocratic value—which demonizes the unpredictability of a vaginal birth—has crossed the boundary of obstetric profession to influence lay people. This is reinforced by the fact that obstetricians ask pregnant women to sign an affidavit when they refuse a C-section. But at the same time, obstetricians often accept requests for an elective C-section. The newly emerging technological model of childbirth in Taiwan has changed cultural ideas about childbirth. Based on traditional cosmology, surgical intervention in childbirth was not socially acceptable in Taiwan decades ago. A Taiwanese woman, who had her C-section twenty-six years ago, told me that a Cesarean was not an acceptable option at that time. Her mother-in-law tried

臺灣大學學術期刊資料庫

everything to steer her away from having "surgery" during childbirth. (Interview with Chou 2006/6/29) But today women, especially in the younger generations, claim that vaginal birth is much more frightening than a C-section.

Furthermore, the woman's decision to have an elective C-section may be strategic response to the medical system, rather than a reflection of their personal preference. For example, "suffering twice" is one of the most central concerns among pregnant women in Taiwan. This term refers to a woman who begins with vaginal birth, and thus experiences birthing pains, but ends up having a C-section. On an online discussion board, one woman writes:

> *"I am struggling between having a C-section or a vaginal birth. This is my first birth. But I am so afraid of birthing pain…what if I lose my strength after a potentially long and painful birthing process? The doctor will then send me to have a C-section. This means I will have to suffer both kinds of pain…?"*[26]

This message seems to reflect this woman's weakness. However, we may see another meaning behind this massage when reinterpreting it within the context of high C-rates driven by the Taiwanese obstetric system. Hearing many stories of "suffering twice" combined with the prevalence of C-sections in Taiwan, women are aware that they may be sent to the surgical room at any point even if they first decided to have a vaginal birth. In this sense, the direct request for a C-section becomes a way for Taiwanese women to decrease suffering in childbirth and avoid "suffering twice." This kind of worry is also reinforced by Taiwanese prenatal practices that strongly imply that vaginal birth is difficult to complete:

> *During my last prenatal screen, my obstetrician told me that my baby was three hundred grams larger than the standard. As such, my baby may reach four thousand grams by the moment of birth. I heard that it will be really difficult [for a vaginal delivery]. My friends told me that there is too much suffering if you are sent to a C-section after you fail in a vaginal birth. That is why I am thinking of scheduling a C-section*

臺灣大學學術期刊資料庫

> *anyway even though I always preferred vaginal birth.* (Interview with Lian-yin Huang, 2009/2/11)

Similarly, Ko-shin requested a C-section as soon as she was told she had a relatively small pelvis:[27]

> *I had intended to have a vaginal birth until I was told that my pelvis is relatively small in my last prenatal screen. The obstetrician told me that I could still have a vaginal birth. Then I asked her if that meant that I will suffer for a very long time. She said: 'You just keep trying, and it is still possible that you can make it.' I asked: 'Possible?! Are you saying that I may suffer for a long time, but still fail and need a C-section?' Knowing this, I immediately scheduled a C-section.* (Interview with Ko-shin Tsai, 2008/11/18)

Both Ko-shin and Lian-yin's experiences illustrate how women are "trained" during prenatal screens to be sensitive to every possible sign predicting their "suffering twice." In order to avoid that, they choose a C-section even though they would prefer vaginal birth. This involves the reflexive response to risk in modern society. Knowledge of risk in the modern world becomes very uncertain and open to revision (Cassell 2003). People can no longer fully depend on experts. This leads to the double-edged character of expert systems in the modern world. On the one hand, the actor is "deskilled" by the globalization of abstract systems. People are told they have to rely on various professionals to live their life. On the other hand, these expert systems have the potential to "reskill" people by providing an information base that can be selectively drawn on to control important aspects of daily life (ibid: 32). Technical expertise is continuously reappropriated by lay agents as part of their routine dealings with abstract systems (Giddens 1990). Reflexivity can be seen in Taiwanese women's reaction to C-sections, particularly when public discourses are very diverse, complex, and ambiguous. In order to actively manage the risks in birthing, other than medical advice from their obstetricians, women constantly draw on information from other sources including magazines, websites, and their friends

臺灣大學學術期刊資料庫

and family. In this process, knowledge claimed by the obstetricians rejoins women's subjective interpretation of many other kinds of information. Consequently, even though their obstetrician tells them fetal weight or pelvic size is acceptable for vaginal birth, women still feel suspicious when they look at it in relation to the potential threats emphasized by other information.

In order to rule out the risk, women, as reflexive actors, then choose to go directly for C-sections. More importantly, their reaction to risk should not be seen as irrational (Giddens and Pierson 1998). Recent studies have pointed out that the public response to risk is rational, but based on factors different than those used in technological calculations of risk (Stoffle, et al. 1991). So, what many technology specialists dismiss as irrational and fearful public responses to risk is actually a result of concrete and complex sociocultural issues that transcend mathematical calculations of the probabilities (Stoffle, et al. 1991). Based on this viewpoint, women are rational actors who base their decision on medical information, both from their obstetricians and other sources. Their decisions should be seen as a result of active interpretation of medical advice and reflexive action that responds to the existing highly prevalent C-sections and an unfriendly medical system as well.

CONCLUSION

Giddens argues that the dynamism of modernity is partly explicable in terms of the power generated when capitalism combines with industrialization. As such, when industrial technology and practices are applied to surveillance, and so on (Giddens and Pierson 1998). The development of modern social institutions and their worldwide spread have created vastly greater opportunities for human beings to enjoy a secure and rewarding existence than any type of pre-modern system. But modernity also has a somber side that has become apparent in the present century (Cassell 2003). Cesarean births are an example of this. While this surgical intervention saves the lives of mothers and babies, it also causes some negative consequences that mainly come from its over-use.

臺灣大學學術期刊資料庫

When the obstetric system is structured based on capitalism combined with industrialism, stressful work conditions of physicians tend to make them perform C-sections more often than vaginal births (Souza 1994). Due to the policy of reducing C-rates, Taiwanese obstetricians seldom directly suggest a C-section. Yet, out of concern for efficient time management, doctors apply a significant amount of medical interventions that eventually leads to the higher possibility of C-sections. Moreover, in reducing C-rates without questioning their medicalized practices, obstetricians ironically increase medical interventions, such as labor induction, in childbirth. However, these preventive approaches are still controversial. To some extent, they may even increase the possibility of a C-section (Chatfield 2001; Horrigan 2001; Klein 2009). This seems to be an inevitable outcome of a technocratic system of childbirth. Meanwhile, these medical actions decrease women's confidence in their ability to complete childbirth vaginally. This situation has been exacerbated by crowded Taiwanese hospitals, which in turn, results in very little time for mothers-to-be to talk to their doctors or ask questions. This somehow reinforces the authority of obstetricians and narrows women's understanding of childbirth in the medicalized model. This may explain why my interviewees tended to express confusion and fear of childbirth, rather than criticizing these medical practices.

Unfortunately, even though high rates are driven by the system, women have been viewed as the "culprit" responsible for high C-rates. As Georges and Mitchell argue in their research on reproduction in Greece, the modernization of motherhood has been used as "a call [on women] to take responsibility for their roles in favorably representing themselves and the Greek nation to the "civilized world" (Georges and Mitchell 2000)193). By the same token, with the changed official mindset, Taiwanese women have become associated with "weak" mothers who demand the seemingly easy options of C-sections, and hence, hinder their country's development in the process.

Based on the above claims, one can easily conclude that women are the victims here. However, using maternal requests as an example, I have shown that women are neither simply the victims of medical authority, nor empowered by technology.

臺灣大學學術期刊資料庫

Instead, women's relations with Cesarean births have developed from a more pragmatic context including their negotiation with the immediate medical system and with broader socio-cultural structures as well. Based on my reinterpretation of maternal requests for C-sections, I argue that even though women have been marginalized in the system, they are in fact reflexive actors who constantly adjust to the system by using whatever means available.

Moreover, this reinterpretation of maternal request of Cesarean sections illuminates the intersections of the individual body-self, social body, and body politics. When C-sections become an issue of public debate, socio-political forces surrounding this issue remarkably influence clinical practices of childbirth. For example, faced with the policy of reducing C-sections, Taiwanese obstetricians did not address the over-use of technological interventions which may lead to a prevalence of Cesarean births. Instead, these doctors apply even stricter technological estimates of the possibility of vaginal birth, and give intervention (such as preventive labor induction) when they think the possibility is low. This type of prenatal screen directly shapes women's idea of childbirth. Since the messages given by doctors during prenatal screens usually highlight the risk and difficulty of vaginal birth, women start to worry that they may fail in vaginal delivery. To avoid what they call "suffering twice," some women request a Cesarean section even when they would prefer vaginal birth. In terms of body politics, this shows that while women are trained to view vaginal birth as risky and difficult both by their doctors and by risk discourses in the mass media, maternal requests of Cesarean section become a strategy to negotiate with the medical system. Most importantly, based on the fact that requesting a Cesarean section becomes the only available approach for women to negotiate with the system, it becomes clear that it is the hospital birthing system itself should be examined and addressed while attempting to lower C-rates.

NOTES

1. Please see the post by "LifeChangesWithMind" (2008) on the web "BabyHome": http://www.babyhome.com.tw/mboard.php?op=d&bid=8&sID=2099684&r=13. Emphasis added.

臺灣大學學術期刊資料庫

2. This is also reflected in documents offered in Taiwanese birthing rooms. The list of risks associated with a C-section is much shorter than that with a vaginal birth.
3. Preventive labor induction is performed to increase the likelihood that labor occurs before the fetus has grown too large for the maternal pelvis or before the placenta has grown too old to support the fetus during labor.
4. The indication for Cesarean section is named as "macrosomia," used to describe a newborn with an excessive birth weight. The definition of macrosomia varies with countries. The American Congress of Obstetricians and Gynecologists (ACOG) define it as 4500g when Taiwan and Japan define it as 4000g.
5. CPD refers to Cephalopelvic Disproportion which is also an indication for a Cesarean section based on Taiwan's National Health Insurance program.
6. Please see interviews quoted on page 29-30.
7. By "technocratic values", I draw on Davis-Floyd's (1992) analysis of how the medical model of childbirth becomes an ideal birth in American culture which values and pursues technological control over nature.
8. This means that they have to wait for the baby is born. The document can be changed only when the baby weight over 4000 grams at the moment he or she is born.
9. This phenomenon first increases the time pressure in prenatal screen and labor as well. Second, this is a way through which lay people seek to increase control over their hospital births.
10. Another example that illustrates the stressful working environment is that during an interview, an obstetrician picked out pineapple from her salad. She explained to me that this is her ritual before attending to her resident duty hours in the birthing room, as pineapple in the Taiwanese dialect is similar to the term "abundant." This sort of ritual practice reflects that the birthing room is often crowded, and most obstetricians want to avoid that.
11. Where "vaginal birth" is used to refer to non-surgical birth in the West, Taiwanese instead use the term Ziran-chan, which means "natural birth." Obstetricians sometimes use another term "NSD" (natural and spontaneous delivery). Both terms imply the ideal of a child delivery occurring naturally without any intervention. Ironically, child delivery in Taiwan is often technologically intervened.

臺灣大學學術期刊資料庫

12. A doula is an assistant who provides various forms of non-medical support (physical and emotional) during the childbirth process. Based on a particular doula's training and background, the doula may offer support during prenatal care, during childbirth and/or during the postpartum period. A birth doula provides support during labor.
13. It usually indicates a fetal distress which is an indication of a Cesarean section.
14. Obstetricians themselves also got trapped when, as I will show later, they find themselves unable to dissuade women, who have been socialized into this model, from requesting a C-section.
15. According to the research of Fiedler (1997), the Cesarean section rates for hospitals and obstetrician-operated clinics in 1990 were 11 percent and 8 percent.
16. According to the author, busy obstetricians often attend 15 or more deliveries a month.
17. The rate of episiotomy in Taiwan is 93%. Please see news article "93% Episiotomy Rates" by Lee (2007).
18. This is a frequently seen intervention in delivery rooms in Taiwan. Instead of waiting for a woman to push the baby out herself, medical professionals push hard on her abdomen to force the baby out.
19. Nico was thirty-three years old, and a white-collar worker in an international trade company.
20. Wen was a housewife whose husband works as a technician in the information center of an electronic company.
21. Based on my observation during prenatal care, an elective Cesarean section became to appear as a kind of privilege in the sense that obstetricians accept requests from their friends or colleges right away, while other women have to try various ways to get their request accepted, particularly when the obstetrician is concerned with hospital policy.
22. Medical professionals tend to refer to a woman by the number of the hospital bed she is in.
23. Lian-yin was twenty-eight years old and a teacher in elementary school.
24. It should be noted that this research also points out that “however, the lower rates observed among female physicians and physician relatives in Taiwan are still considerably higher than the national averages of many countries” (Chou, et al. 2006: 195).

臺灣大學學術期刊資料庫

25. Wen-wen was thirty-five years old during interview, and just gave birth to her first child.
26. Please see: http://www.dadupo-bbs.com.tw/phpBB2/viewtopic.php?t=36406&highlight
27. Ko-shin was thirty-three years old, and working in a private company as a white-collar worker.

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