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# **Caesarean or Vaginarean Epidemics? Techno-birth, Risk and Obstetric Practice in Turkey**

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## **Caesarean or Vaginarean Epidemics? Techno-birth, Risk and Obstetric Practice in Turkey**

Caesarean sections (C-sections) have become a substitute for vaginal birth in a number of developing and emerging economies. Often in these contexts, the promotion of caesarean delivery as a safe or even zero-risk and zero-pain alternative to vaginal birth continues to serve as a powerful discursive tool, despite growing international evidence on its iatrogenic effects. These caesarean ‘epidemics’ are often explained in terms of obstetricians’ individual preferences for C-sections. Drawing on ethnographic research conducted in one private and one public hospital in western Turkey, I argue that there are a wide range of factors influencing obstetricians’ risk conceptualisations, discourses and practices. I also contend that the medical justifications for C-sections and their public popularity can best be understood by looking at the ways in which both caesarean and vaginal births are organised. In the settings examined, the processes around caesarean and vaginal births were blurred to such an extent that vaginal delivery was, in its technicised and closely monitored nature, transformed into what I propose to call ‘vaginarean’ birth. Recent state regulations in Turkey aiming to prevent ‘caesarean abuse’ had only had limited effects. The notion of risk continued to operate as a major driving force in that an institutional risk colonisation came to compete with medical risk framings, while deficiencies in the national obstetric care system were made invisible. I conclude that regulations aimed at eradicating a caesarean epidemic, such as those implemented in Turkey since 2012, are unlikely to be effective unless they also combat the vaginarean epidemic.

Keywords: caesarean sections; Turkey; construction of risk; institutional risk; vaginarean birth; public and private hospitals

## **Introduction**

In this article, I draw on findings from an ethnographic study conducted in two Turkish maternity hospitals (one public and one private). The research focused on the factors that shape obstetricians' framing of the C-section as a safe mode of birthing, even for non-pathological pregnancies. This safety discourse, which has been dominant in Turkey for the last 15-20 years, had been challenged by the public authorities shortly before my fieldwork began. In both maternity units studied, however, most of the health professionals still considered vaginal birth to be risky by definition and caesarean birth to be the safe, 'ideal' even, mode of birth (Mello e Souza, 2004). While government authorities problematised the necessary shift from caesarean to vaginal birth mainly as a physical one (from the abdomen to the vagina), and settled a set of sanctioning mechanisms for 'caesarean abuse', the obstetricians elaborated diverse strategies to cope with these new demands and threats to their professional autonomy.

I draw on these data to explore the various ways in which the safety of caesarean delivery and the risks of vaginal birth are dynamically constructed, managed and re-evaluated by obstetricians on a day-to-day basis. I also look at the diverse and sometimes unexpected fallouts from the recent regulatory measures targeting 'caesarean abuse' in the public and private sectors. Drawing on social studies of technology and gender, and on sociocultural conceptualisations of risk, I argue that obstetricians' risk discourses and practices are orientated by a large set of intertwined factors at the intersection of economics, politics, medical knowledge and technologies. I contend that contexts of controversy offer fruitful grounds for the analysis of such factors as well as of medical and institutional constructions, deconstructions and reconstructions of risk (Lupton, 1993; Rothstein, 2006). I also highlight a major paradox: In the settings examined, the safety of caesarean delivery was often acknowledged in reference to the riskiness of vaginal birth, despite vaginal birth having been made just as technicised and safe as caesarean birth. Finally, I argue that the best way to understand this paradox is to approach risk as a discursive tool that obstetricians draw on in their daily practices and when exerting their medical power.

### **Caesarean epidemic: governing childbirth *by* risk**

The omnipresence of risk discourses and the central concern of risk management in obstetric care is no longer specific to industrialised Western countries, where risk has largely shaped

the contemporary conditions of giving birth (Akrich & Bernike, 1996; Davis-Floyd & Sargent, 1997; De Vries et al., 2001; Armstrong, 2008; Scamell & Alaszewski, 2012; Coxon et al., 2014; Scamell, 2014). Risk has now become a tool for governing childbirth in emerging and developing countries too (Chadwick & Foster, 2014; Lane, 2015), where the aim has been to better manage maternal and new-born mortality and morbidity. This was framed as a global problem in the late 1980s (AbouZahr, 2003) and led to an intensive recourse to technology and technical instruments. The result has been that C-sections have increasingly replaced vaginal births as the most common form of childbirth in countries such as Brazil, Mexico, Chile, Iran, China, and Turkey.

Quite often in such ‘caesarean epidemic’ settings (Morris 2013), the widespread use of C-sections is justified by a concern for zero risk in the medical arena and zero pain from the woman’s perspective (McCallum, 2005; Bahadori et al., 2013; Kuan, 2014; K1sa et al., 2017). Such national and medical justifications for the normalisation of abdominal births are deployed despite warnings over the past three decades from the World Health Organisation (WHO, 2015a) of the need to make proper use of caesareans and despite expanding scientific evidence and guidance regarding not only the greater mortality and morbidity risks of C-sections for women but also the possible side effects for their newborns (Wagner, 2010; Sarda, 2011). It can thus be safely argued that the zero-risk discourse deployed for caesarean births operates as a means of ‘producing ignorance’ (Gros & McGoey, 2015) surrounding the iatrogenic risks of routinised caesareans. This zero-risk discourse on C-sections also masks a larger set of factors that often play a role in the normalisation of C-sections. These include deficiencies in a country’s health system (McCallum, 2005; Lauer et al., 2010; Diniz & Chacham, 2004), social or ethnic inequalities in access to healthcare and technology (Behague, 2002; Roberts, 2012), the advantages of C-sections for healthcare providers (Morris, 2013) and established national medical norms (e.g. the rule of ‘once a caesarean always a caesarean’) that result in an increased use of C-sections (K1sa et al., 2017). Women’s ‘preference’ for C-sections is another common argument for both justifying caesareans and producing ignorance on it. This argument hides the ways in which women’s choices are socially, culturally and medically constructed (Mello e Souza, 1994; Hopkins, 2000; Leone et al., 2008; Jomeen, 2010; Coxon et al., 2014).

Despite the multiple mechanisms of ignorance production that medical discourses incorporate, the redefining of caesarean birth as the safest mode of delivery should be taken seriously rather than being considered an ‘illusion of certainty’ (Manca, 2016) given that it still serves as a powerful tool for managing childbirth and its risks in many contexts.

Doctors' influence in a woman's decision to opt for a caesarean delivery is well documented (Hopkins, 2000; Wagner, 2000). However, notwithstanding the medico-legal aspects of the issue (Morris, 2013), there is less literature on why doctors consider or continue to promote caesarean delivery as safe (despite the controversies), what safety or risk means to them, and how they make use of risk in their day-to-day practice. The aim of this article is to go beyond the analytical approaches and public critiques explaining the clinicians' role in the normalisation of C-sections merely in terms of individual action or professional choices and preferences (Mello e Souza, 1994; Hopkins, 2000; Wagner, 2000)<sup>1</sup>. The notion of normalisation refers here to the routinised use of caesarean delivery in contexts in which it has more or less become a substitute for vaginal birth. I propose to examine the clinicians' role in this process by widening the analytical scope to a large set of factors (cognitive, technological, managerial) that they do not always choose or control, and which influence the way they frame, perceive and make use of (medical) risk. I also propose to analyse the way clinicians modify (or not) their relationship with childbirth and its risks in situations in which regulatory bodies introduce new – organisational – risks, with the aim of monitoring and making accountable professional practice. In developing this approach I draw on the concept of 'institutional risk' forged by Rothstein (2006). In particular I propose to look at the ways the institutional threats – such as economic sanctions or 'reputational risk' (Power, 2004) for hospitals, loss of performance points and premiums both for doctors and their organisations – enter in competition with 'medical risks' defined and mobilized by clinicians. I propose to shed light, in this frame, on two competing movements of 'risk colonisation' (Rothstein, 2006) – medical vs. institutional<sup>2</sup> – the first being driven by obstetricians-gynaecologists (OGs) and the second by public authorities. I aim to examine to what extent and under which circumstances the 'new' (institutional) risks engender, reinforce, or modify the 'old' (medical) ones – at the heart of obstetrical discourses and practices. I propose to tackle this question by paying attention to trends in public vs. private sector, and by taking seriously the dynamic interactions between risk colonisation and what I will name technology colonisation.

The phenomenon of 'technology colonisation', which can be described as the increasing control and even domination of childbirth by medical technologies, machines and pharmaceutical products in the hospital settings, has much narrowed the spectrum of birth

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<sup>1</sup> For a similar discussion, see McCallum, 2005.

<sup>2</sup> Rothstein (2006) mainly deals with the former. He defines 'risk colonisation' as a configuration in which institutional risk has gradually occupied a central place in the definition of objects, methods and rationale of governance

options both for women and for the health professionals in many hospital settings. In her recent study on caesarean epidemic in US, Jacqueline Wolf (2018) relevantly argues that the available ‘choice’ for American women has now been reduced to a one between elective caesarean birth vs. epidural birth. I will go one step further and show that in certain technicised birth environments, even the existence of such a limited ‘choice’ is not obvious. The reason is that the boundaries between caesarean and vaginal birth may sometimes be blurred to such an extent that vaginal birth is, in the name of safety and efficiency, managed just like caesarean birth, or what I propose to call ‘vaginarean’.

Vaginarean is a term that I introduce here for the sake of conceptual clarity<sup>3</sup>. It refers to vaginal birth that is organised in such a medical-technocratic (Davis-Floyd, 2003) manner that the maternal body is not only immobilised (and the woman’s autonomy and agency blocked), but also subject to routinized pharmaceutical as well as surgical interventions. Such a disciplining of the maternal body is considered inevitable for assuring birth safety. In comparison, the advocates of natural birth claim the opposite: woman’s agency and liberty are considered the ‘key’ for the good functioning of the woman’s body (such as the opening of the cervical sphincter that lets the baby move into the birth canal), for preventing medical interventions (and their iatrogenic risks), and thus for a successful, safe and happy birth (Odent, 1992; Gaskin, 2008; Sarda, 2011). Interestingly, in the two settings analysed in this paper, despite vaginal birth remaining very much under the control of clinicians, products, machines and surgical cuts, it was paradoxically discredited as risky or undesirable. I argue that this, in turn, played an important role in the normalisation of caesarean birth by the practitioners – at least until competing versions of risk (that is the institutional risk resulting from caesarean abuse) entered into scene.

### **From silent epidemic to national controversy: caesarean birth in Turkey**

With the highest caesarean acceleration rate among the member countries, Turkey is the OECD (Organisation for Economic Cooperation and Development) country with the highest percentage of C-section births. The normalisation of C-sections is only a recent phenomenon in Turkey in comparison, for instance, with Brazil, where it became a public problem in the

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<sup>3</sup> A counterexample to vaginarean birth would be ‘natural caesarean’ delivery (see Maffi, 2013). It should be noted that the health professionals and women who were the subjects of this field study never used the term ‘vaginarean’. A similar term has only been used once and that was in a journal article by a gynaecologist from Istanbul. See Özer, S., 2015, Vajeryen olacagina sezaryen olsun ! (‘Go for caesarean rather than vaginarean!’), *HT Hayat (online newspaper)*, 9 November 2015.

1990s. In Turkey, the C-section rate rose from 13.9 per cent in 1998 to 21.2 per cent in 2003 and then to 36.7 per cent in 2008 (Hacettepe Institute of Population Studies, 2009: 153) and then continued to rise significantly thereafter (46.6 per cent in 2011, 48 per cent in 2012, 50.4 per cent in 2013, 51.1 per cent in 2014 and 53.1 per cent in 2015 and 2016, according to Turkey's Ministry of Health [2017]). In 2016, 98 per cent of births took place in hospital compared with only 75 per cent in 2002. The total volume of (live) births was 1,390,771, with a fertility rate of 2.1 per woman. While not low, this rate has decreased regularly over recent years<sup>4</sup>. Also in 2016, the average C-section rates in private hospitals, university hospitals (i.e. those belonging to either private or public universities), and public hospitals were 70.5 per cent, 69.1 per cent, and 38.2 per cent, respectively.

During the 2000s, the rapid rise in C-section rates was closely related to a boom in private hospitals, where the normalisation of caesarean birth was most pronounced. Between 2002 and 2015, the number of private hospitals more than doubled (from 271 to 562) – with a significant concentration in big cities such as Istanbul, Izmir and Ankara – while the increase in the number of public hospitals was only modest (from 774 to 865) (Ministry of Health, 2016: 93). These changes resulted from the health sector reforms (the so-called 'Health Transformation Programme', or HTP) launched by the government in 2003 with support from the World Bank. The HTP was an important pillar of the strong 'neoliberal turn' that Erdoğan's JDP ('Justice and Development Party' – in government since 2002) was aiming to mobilise (Ağartan, 2012).

In the Turkish obstetric system, obstetricians – who are also gynaecologists and surgeons – play a dominant role in childbirth (for a historical analysis, see Balsoy, 2013). At the end of 2013, 5,128 obstetrician/gynaecologists (OGs) plus 72,405 specialist physicians were in practice (Council of Higher Education of Turkey, 2014: 50). While no official data are available on the gender distribution of the OGs in practice, a quantitative study conducted in 2011 showed that 42.62 per cent of university lecturers in the field of gynaecology and obstetrics were women (Davas Aksan et al., 2011).

The total number of midwives in practice in 2013 was 52,351 (Council of Higher Education of Turkey, 2014: 95). The majority of the midwives were employed in public hospitals (91 per cent in public versus 8 per cent in private hospitals and 1 per cent in university hospitals), where C-section rates have generally speaking been lowest (Council of

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<sup>4</sup> Previous fertility rates were 2.73 per cent in 1993, 2.61 per cent in 1998, 2.22 per cent in 2003 and 2.15 per cent in 2008.



Higher Education of Turkey, 2014: 95). It should be noted, however, that even in public hospitals, midwives play a secondary role in childbirth to OGs. Furthermore, many of them did the work of nurses rather than of midwives.

Before the HTP was implemented, OGs worked mainly at the public hospitals, but they would also have their own private practice. The HTP put an end to physicians' small, individually-run private practices, which led to a massive migration of OGs to the newly established private hospitals. Late 2013 saw a large rise in the rate of OG recruitment in private hospitals, which resulted in 51 per cent of OGs being employed in the private sector against 40 per cent in the public sector and 9 per cent in university hospitals (Council of Higher Education of Turkey, 2014: 50). The HTP also introduced a system of benchmarking, called the performance system, according to which different performance points are attributed to each medical act and each point corresponds to an increase in personal as well as institutional premiums.

The present research was conducted within a specific context in which the caesarean boom had recently been challenged by government authorities. On 27 May 2012, during the 3rd General Congress of the JDP's Women's Groups, the then prime minister Erdoğan declared that both caesarean births and abortion were 'murders'. Until then, caesarean deliveries had not been subject to any significant public or media debate, although the exponential rise in C-section rates had been discussed within the medical arena. Suddenly, the prime minister was accusing the OGs of being 'murderers', and this stood in stark contrast to the public prestige they were accustomed to. In order to regulate the C-section epidemic, the government modified the law (dating from 1930) in July 2012 by 'preconditioning C-sections to medical reasons only' (Bill no. 6374, Article 1, published in Official Gazette no. 28351). This legal modification was renamed the 'caesarean law' by the media and interpreted as a ban on C-sections.

'Caesarean abuse' is an institutional category forged by the Turkish Ministry of Health after 2012. It refers to the violation of a set of medical criteria (that are supposed to either authorise or ban its use) identified by the ministry. The ministry declared that any OGs or hospitals who 'abused' C-sections<sup>5</sup> would be sanctioned (see Letsch, 2012). It also added, however, that 'a woman's fear of giving birth' would be considered a viable medical reason *per se* for opting for a caesarean delivery. In economic terms, the sanction was made concrete both through the reduction of health insurance coverage for caesarean deliveries (which

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became slightly lower compared with that for vaginal births) and through the lowering of performance points attributed to caesarean births, which were re-categorised as ‘basic’ operations. Organisational benchmarking was also put into practice. Since 2012, each caesarean act has been accounted for within maternity hospitals, and C-section data have been reported to the Ministry of Health on a monthly basis. Doctors exceeding the average rate are likely to bear sanctions, which consist mainly of short-term training sessions in Ankara.

The reason the prime minister viewed caesarean births as ‘murder’ was that they victimised, in his view, a very specific population, namely all the babies that would not be conceived as a result of the repeated scars on the mothers’ abdomens. In Turkey, the medical norm of ‘once a caesarean, always a caesarean’ stands (Kısa et al., 2017), and professional practice believes that C-sections should not be repeated more than three times. Hence, during a third surgical birth, OGs will generally also carry out a tubal ligation. The conservative government therefore alleged that the caesarean delivery acted as a family planning tool and even a geopolitical weapon in a period when its pronatalist policy had become quite aggressive. In 2008, Erdoğan began to promote a family model of ‘at least three children’ in order to combat Turkey’s ageing demographic (Yazıcı, 2012). Families with three children or more were gradually provided with tax reductions. The JDP also enthusiastically promoted IVF, with the result that only three years after the state and social security funding for IVF treatment had been introduced (in 2005), Turkey became the world’s seventh largest IVF market (Gürtin, 2016). Finally, in 2011, Erdoğan’s JDP adopted a clear position opposing abortion, which has been legal in Turkey since 1983. Most JDP officials justified their position on both moral and pronatalist grounds. In the face of massive opposition from feminist groups, professional medical associations, intellectuals and a number of journalists, however, the JDP’s attempt to ban abortion failed (Badamchi, 2014). In 2012, the prime minister launched a controversy on C-sections as well, by at the same time designating the OGs as a public enemy. According to Erdoğan, OGs who imposed surgical birth to women (and who thereby prevented them from having more than three children) were contributors of a conspiracy to freeze the country’s population growth, to prevent the rise of a young and strong Turkey, and thus to eradicate the Turkish nation from the world stage (Sümer & Eslenzia, 2017: 30).

The empirical data presented in this paper were collected during this period of conflict between the OGs and the government. This was a time also marked by the launch of a new slogan by feminist groups: ‘My uterus is my own. I will have an abortion or a caesarean if I want to’. Until 2012, abortion, contraception and making birth safe had been the priority

causes of Turkish feminist organisations. As a result, the problem of the medicalisation of childbirth (including caesarean deliveries) had been largely missing from their agenda. The rise of the natural birth market and the dissemination of the denunciations of obstetric violence in the international arena in the late 2000s could have seen this trend reversed. However, feminist groups were focusing most of their energy on violence against women following an increase in such crimes, including rape and murder, under the JDP government. In addition, although C-section deliveries were considered by many feminists in this 2012 political context to entail medical control over women's bodies, they were also forced to prioritise other aspects of political control exercised by the JDP and its pronatalist and anti-feminist discourses and practices (Sümer & Eslen-Ziya, 2017: 28-29).

### **Methodology**

The findings and analysis presented below are based on extensive ethnographic observations conducted in two hospitals, one public and one private, located in an average-sized town (number of inhabitants: 80,000) in the Istanbul region. Caesarean section rates in this region (54 per cent in 2016) had been very close to the national average over the few years preceding the study (Ministry of Health, 2017). I carried out my observations over two full months (June-July 2014). These were complemented by shorter visits to both hospitals in February 2015, July 2016 and July 2017. In addition to regular discussions with the health professionals concerned, which were noted in a 200-page field journal, 12 in-depth interviews were conducted with the OGs and midwives working in the two maternity units during summer 2014. I conducted 10 in-depth interviews (per maternity unit) with pregnant women met in the labour rooms and the ultrasound scan services, as well. In February 2015, I also recorded 6 interviews with OGs from the managerial boards of the TJOD (or the Turkish Society of Gynecology and Obstetrics) and the ITO (or the Chamber of Doctors of Istanbul). Finally, I carried out a systematic review of journal articles related to the caesarean debate published in Turkey during the whole research period and consulted archive documents in both maternity hospitals, which mainly comprised birth register books, statistical data relating to monthly caesarean rates per OG and institutional software outputs relating to salary premiums and performance points.

Authorisation and ethical approval for access to the maternity units was provided by the managerial boards of both hospitals following written requests and meetings with the respective chief executives. Interviews with the expectant mothers and observation of their deliveries were conditional upon their consent.

The private hospital was fairly typical of private hospitals generally in Turkey in terms of what it charged for childbirth procedures (at the time of the fieldwork, the costs of a C-section and subsequent hospitalisation (based on an average two-day stay) were close to average rates, at around US\$400 each, while a caesarean operation in a luxury hospital in Istanbul could cost up to US\$5,000). Its clientele during the fieldwork was composed mainly of medium socio-economic-status (SES) with some high-SES women. In the public hospital, the patient profiles were more diverse, comprising low-SES or precarious women, recent migrants (mainly women from Syria and Russia), single women and some middle-SES women. In the year to 2014, the number of births per month was around 100 in the public hospital and 40 in the private. There were 3 OGs and 6 midwives practising in the public hospital, and 2 OGs, 2 midwives and 1 nurse practising in the private. All 14 health professionals contributed to the key data. However, because this article mainly focuses on OGs, it is their discourses and practices that will be described and analysed in detail in the ‘Findings’ section. In Table I present the profiles of the OGs that were the focus of the study. I use pseudonyms for all individuals included in the study.

Table 1: Profiles of the OGs included in the ethnographic study

	Age	Sex	Public/Private hospital	Years of practice at the hospital
Dr Cesur	55	M	Public	15
Dr Volkan	40	M	Public	7
Dr Ayda	51	F	Public	20
Dr Tarik	53	M	Private	5
Dr Azade	46	F	Private	3

## Findings

Below I present the findings of this study grouped into two parts. In the first part, I analyse the OGs’ conceptions and management of childbirth and its risks from a technological and gender perspective. I describe, in this frame, the contours of a double phenomenon of risk and technology colonisation. In the second part, I explore the ways in which OGs’ discourses on and use of C-sections were revisited (or not) when the national norms and regulations were subject to change, and when ‘institutional’ risks started to compete with ‘medical’ ones.

### *Deconstructing Obstetricians' Risk Discourses and Practices*

Although work and space were organised differently in the two maternity units in this research, childbirth in both hospitals relied on fairly standardised protocols, instruments and practices. For example, as soon as a pregnant woman was admitted to either hospital, she was given an enema, a blue hospital gown to put on and settled in her bed in a labour room. This labour room was an individual room in the private hospital and a room containing three beds in the public hospital. The rapid administration of oxytocin was frequent in both hospitals. Foetal heart monitoring was continuous in the public hospital and regularly carried out in the private. In both hospitals, all the women gave birth on a gynaecological table. Episiotomies were systematically carried out in the case of first births and were common in the case of successive births. In C-sections, general anaesthesia was always used in the public hospital, and local anaesthesia was an option in the private setting. In the case of vaginal births, the midwives managed the deliveries themselves in the presence of the on-call OG in the public hospital, while the OGs themselves took charge of the deliveries in the private hospital.

Three intertwining sets of factors, which can be categorised as cognitive, technological and managerial, appeared to play a role in the OGs' conceptualisation and management of childbirth risks. The cognitive factors refer to the practitioners' lifeworlds – that is their mental schemes, beliefs and imaginaries (including those acquired during their medical training) including their often gendered representations of the maternal body. The technological factors concern the whole range of machines, instruments and products that the OGs and midwives employed on a daily basis. The managerial factors refer to both the organisational (workload, available competencies, distribution of medico-legal responsibility) and regulatory settings (demands for accountability, quality and performance tools, administration of incomes and premiums) that framed their activity. The three notions best suited to addressing the dynamic deployment of these intertwining factors and their inertia or change are abnormality, extractivism and performance.

#### Abnormality: the Gendered Reframing of Childbirth

Christaens and Van Teijlingen (2009) described recent forms of the medicalisation of childbirth as part of a search for the optimisation of the body and its functions at a micro level that involves redefining the normal as abnormal at a population level and which consequently serves to boost a consumer (or technology) market. In accordance with this observation, the medicalised governance of childbirth through risk and technology in both maternity units in

this study consisted, above all, in theorising, managing and experiencing childbirth, whether vaginal or abdominal, as something that was abnormal. In a sense, abnormality of birth was a ‘professional good’ for OGs, meaning, in line with Scamell & Alaszewski (2012: 214), that it served as an interpretative framework through which they redefined and even praised their professional role and skills.

During the interviews, some OGs, especially in the public hospital, insisted on ‘Turkish women’s lack of proficiency in the field of childbirth (...) compared to European women, for instance’ (Extract of interview with Dr. Volkan and Dr. Ayda). The ‘Turkish woman’ appeared in these discourses as a total category. She was seen as a risk factor in her own right or as the typical layperson of early modernity (Wynne, 1996), particularly in the way she managed labour and the push. Too ignorant, too fearful or too weak to manage birth pain autonomously, the ‘unruly mother’ (Kukla 2005) could, according to OGs, ‘throw herself away, cry too much, lose consciousness, push when she should not, thereby putting her baby in danger’ (Extract of interview with Dr. Cesur). For these reasons, she is *de facto* considered to be obliged to *delegate everything* to the specialists and the machines.

Partly as a result of such gendered and ethnicised representations of expectant women, which have historically been widespread and are still in existence in many contexts (Rothman, 1991; Kukla, 2005), the labour process, particularly the dilation phase, was discredited by the professionals as a difficult, disordered and painful event that should be over as quickly as possible and generally unaccompanied. Labour induction had therefore become normalised in both hospitals. Labour also appeared to be a taboo process. It was even censored linguistically.

The term for ‘labour’ exists in Turkish medical terminology, but it has been borrowed from French (*travail*) and given a slightly different spelling, *travay*. The labour room is thus called *travay odası*, but not all the women in either the public or the private hospital understood what the term meant. Furthermore, in both hospitals, when a woman arrived with intensified contractions, she was not registered as a ‘pregnant woman in labour’ but rather as a ‘pregnant woman with pain’ (*sancılı gebe*). Labour was reduced to the need to tolerate the contractions in bed, either alone in the public hospital or with her partner or family members in the private. In the private hospital, the women could also ask for an epidural. The clinic had only recently started to advertise epidural births on a large scale, calling them ‘princess births’ (*prenses doğum*) in its 2017 flyers. Here, again, there was a similar central idea that labour (pain) is chaotic, impoverishing and old-fashioned and that technology (epidural) can eliminate it and make birth luxurious, modern and peaceful.

Concerning the delivery itself, OGs mostly worked under the assumption that the ‘expulsion’ of the baby should happen not as a result of the active participation of the mother but *despite* her and her psychological and cognitive state. This once again reinforced the belief that birth should take as little time as possible. Accordingly, in both hospitals, some labouring women were transferred to the birthing room shortly after they had dilated to 6 centimetres (according to the vaginal examination carried out by the midwives). Once in the delivery room, the push and expulsion often lasted around 10-15 minutes. For primiparous births in particular, the midwives often performed episiotomies within 5-10 minutes of the pregnant women’s arrival on the birthing table.

In the Turkish language (both popular and medical), vaginal birth has been renamed ‘normal birth’ (*normal doğum*), while ‘abnormal birth’ automatically refers to caesarean birth. Beyond this terminological dichotomy, however, no formalised or national definition exists for ‘normal birth’ to distinguish between the different versions of vaginal birth, unlike in Britain, for instance, where the ‘Normal Birth Consensus Statement’ (2007) defines it using a series of negatives such as ‘without induction, without use of instruments, not caesarean section and without general, spinal or epidural anaesthesia before or during delivery’ (Scamell & Alaszewski, 2012: 215). Furthermore, despite the dichotomic nature of the common terminology, the normality of normal birth, the abnormality of caesarean delivery and the differences between the two did not seem obvious in practice in the two hospitals studied. Vaginal and caesarean births were shaped by similar assumptions (about the riskiness of maternal bodies), restrained by the same imperatives (the necessity of medical management and time optimisation) and reframed by the same types of practices and tools (cuts, machines, pharmaceutical products). Accordingly, both C-sections and episiotomies were widespread and interchangeable – which marks an important point of similarity with other countries with high percentages of C-section births, such as Brazil (Diniz & Chacham, 2004).

In short, the two competing childbirth options were caesarean and vaginarian. Interestingly, whether by vaginal or caesarean birth, a large number of women described their birthing experience as abnormal or disappointing (for similar findings, see Cindoğlu & Sayan-Cengiz, 2010). Notions of ‘ugliness’ and ‘dirtiness’ (which was frequently related to the blood resulting from the episiotomies) and the affirmation of the ‘unpresentable’ nature of the vaginarian in front of the husband or medical staff were frequent in their descriptions of vaginal births.

### Extractivism: the Techno-Masculinist Reframing of Childbirth

One of the OGs in the public hospital explained why the maternity service neither trained nor encouraged women to do respiration exercises in order to better manage their contractions:

I don't think physical exercises facilitate the management of contractions. Birthing is a biological matter. All this stuff can help a woman from a psychological point of view, but it's just psychological. A baby coming into the world is like an apple you have to pick off a tree. You can shine the apple up a bit with the psychological stuff, but in the end, an apple's an apple, isn't it? (Extract from interview with an OG in the public hospital)

According to this OG and indeed most of the OGs and midwives interviewed, childbirth was an extractivist activity that *they* performed. The medical staff's main concern was to extract the baby from its mother's body, as if they were extracting a resource from a mine, in the safest possible way. The rest, the 'psychological stuff', was seen as merely accessorial. Attention was thus focused on the baby, on the moment the 'seed' is pulled out of the 'soil', as Delaney (1991) put it, while the woman's lived experience and her very role and place in the birthing process was denied or overlooked.

In such a framing of childbirth as an almost techno-industrial activity, the proficiency of those in charge of extracting, as well as the tools they used, mattered a great deal. Most women who chose to give birth in the private hospital did so because they wanted to be under the care of an OG rather than a midwife. For those OGs who satisfied such a demand, caesarean delivery appeared to be not only the most modern tool but also the tool that they best knew to manipulate given they were mostly trained for surgery and heavy interventions. Such an explanation was openly provided by a renowned OG in Istanbul, who was also a representative of the Turkish Society of Gynecology and Obstetrics (TJOD). When asked why, in his opinion, caesareans had become so common in Turkey, he replied wide-eyed:

It's obvious! Women want us doctors to enable them to give birth. And we Turkish obstetricians, we are, above all, surgeons. You know this. So it's normal that we cut! (Extract from interview with an OG from the TJOD)

Denial of the physiological dimension of childbirth and the classical vision of childbirth as a top-down medical management issue (Scamell, 2014) were also omnipresent in the midwives' views and practices. Nevertheless, they felt less comfortable with the situation than the OGs. Some of them explained that they would love to practice differently, to make



birth 'more beautiful'. None however challenged the utility of episiotomies that they routinely performed, nor did they criticise the continuous use of foetal heart monitoring. There had been no mortal accidents during birth over the previous couple of years in either hospital. This medical progress (as well as maternal mortality rates having reduced six-fold over the previous 25 years - from 97/100,000 in 1990 to 79/100,000 in 2000, 23/100,000 in 2010 and 16/100,000 in 2015 – see WHO, 2015b, Annex 19) was attributed to the fact that childbirth risks were totally under control thanks to medicaments and machines.

Even after the national controversy about caesarean deliveries was launched, it was seen as a point of no return. At the same time, the medical staff were aware that safety alone could no longer be considered a sufficient criterion to ensure women were satisfied with the treatment they received. A midwife from the public hospital explained:

I've been working here for 14 years now. (...) There's not been a single mortal accident during childbirth since I started here. We don't take any risks. Whenever there's an emergency, an abnormal situation, the doctors intervene, and it ends with a caesarean (...) 99 per cent of women leave the hospital satisfied with their treatment. We do our best so that everything goes well. But there is a phenomenon that we don't understand. Once they've left, apparently the women don't tell people they were satisfied with their treatment. And we've heard rumours that some were not at all satisfied. We've heard people say, 'Apparently you midwives here beat women. Is that true?' Some women arrive at the hospital with this kind of prejudice. Obviously, there's no such horrors. The worst thing that can happen is that, during delivery, we will need to raise our voices to prevent any damage but also because of stress, because the patient doesn't listen to us and pushes when she shouldn't, exposing her and her baby to danger. That's all. So, this prejudice is very demoralising. (Extract from interview with a midwife in the public hospital)

### Performance: the Professional-Managerial Reframing of Childbirth

In both hospitals, the socio-cognitive work to frame childbirth as a process that should be normalised through extractivist cuts operated at different levels. The act of cutting was of course physical (bodily) first and foremost, but it was also temporal in terms of (short)cutting the time it took to give birth. This appeared to be a key precaution. The less time the birth took, the lower the risks would be. The use of oxytocin was therefore very common in both hospitals and was often administered within an hour of the expectant mother arriving in her bed. However, it did not seem to accelerate vaginal delivery as much as expected. According to the private hospital's 2013-2014 daily birth register, which recorded the reasons for opting

for a C-section, the second most common medical reason for caesarean delivery after a previous C-section was ‘prolonged labour’.

The act of cutting, which seemed to be central to the OGs’ and midwives’ practices, was also related to a demonstration of virtuosity and performance. Not only could childbirth duration be reduced but so could the time it took to make the cut itself. Several OGs described, or even boasted about, their speed in performing a caesarean, alongside that of Turkish OGs in general. One of the public hospital OGs explained:

During my training, I worked as an intern in a private German hospital in Istanbul. There was a culture clash. The midwives were German, they had been trained in Germany. Once, I was going to do an abortion; they (the midwives) all panicked. For us, abortion’s really commonplace. And very quick. But apparently, in Germany, they do it with a lot of ceremony attached. First, the woman has to meet a psychologist, who tries to discourage her really. Then, apparently the woman has to stay in hospital the night before the intervention to get used to the environment, so she’s not traumatised. She also has to stay the night after the abortion. Here though, we don’t ask any questions. The woman makes an appointment. We go into the surgery. I finish the job quickly. The woman leaves the room and walks back home. There’s no ceremony! (Laughs) I also carried out C-sections in this hospital. The midwives were astonished. They were saying, ‘How do you manage to do it so fast?’ Apparently, we Turkish doctors are fast at cutting. I actually wonder how you can do it less quickly. Those ladies were telling me that I was really really quick. (Extract from interview with an OG in the public hospital)

Rapidity and virtuosity rather than reflection and rites (which require time and attention) thus seemed to prevail in the OGs’ daily practices. In line with Rosa’s theorisation (Rosa, 2015), acceleration was perceived both as an imperative and a sign of modernity, whereas (according to this OG) German midwives were held to represent a conservative and archaic group who instrumentalised rites in order to dissuade women from abortion. That C-sections were mostly performed under general anaesthesia is another illustration of the injunction for rapidity and efficient time management. In both the public and private hospitals, the OGs preferred general anaesthesia over spinal and epidural anaesthesia because it takes effect more rapidly. Finally, the episiotomies performed by the midwives (public hospital) and OGs (private hospital) can also be seen as a means of cutting down not only delivery time but also suturing time in the case of spontaneous tears, because tear suturing generally takes longer than episiotomy suturing (Schantz et al., 2015).

The central place that acceleration seemed to occupy in the clinicians' day-to-day lives should however also be considered in relation to their intensive workload. In the public hospital, some OGs had an average of 60-70 consultations in the polyclinic every afternoon. They had under two minutes to examine each pregnant woman. The OGs in the private hospital had different working conditions. They met the pregnant women at monthly consultations, which were always long enough for the women to have a 3D ultrasound scan if the family could afford it. In return, the OGs had a formal obligation to be present during delivery.

### ***Rethinking the obstetricians' relationship with childbirth risks in a context of controversy***

The findings presented above suggest that, generally speaking, in the post-2012 period, the medical representations of caesarean delivery as a safe mode of birth were not subject to any significant change or collective reflection among the clinicians in the study. Furthermore, childbirth, whether caesarean or vaginarian, continued to be managed within a double configuration of (medical) risk and technology colonisation. However, the caesarean law and the new regulations and the institutional risks it had introduced did have an impact in the two hospitals. They were received, interpreted and dealt with in two quite different ways.

### **Re-hierarchising risk in the public hospital**

In the public hospital, all OGs initially affirmed that they 'did not care at all about the caesarean law'. The law was clearly seen as a political-conservative manoeuvre to exert pressure on OGs and to further control women's bodies. The fact that caesarean delivery was associated with 'murder' was, in their eyes, the best illustration of the violent attacks that they were being subject to. One OG explained:

We do what we think is right. Politicians shouldn't meddle in our work. In any case, we only perform a caesarean when there's a medical reason for it. That's how we've always worked.  
(Extract from interview with an OG in the public hospital)

Nevertheless, the C-section rates had decreased in the public hospital from 40 per cent in 2013 (average rate for the year) to 33 per cent by May 2014. One of the reasons for this drop was that under the new caesarean law, OGs were no longer able to schedule elective caesareans. Furthermore, that each OG's C-section rates were now published monthly also

seemed to have an impact. New risk hierarchies and identities had thus emerged among the OGs. They still considered C-section to be the safest mode of delivery for women and their newborns, but it was no longer seen as the safest tool. Although caesarean delivery protected OGs from medico-legal risks, it now exposed them to a new risk, namely the institutional risk — government sanctions, loss of performance points and loss of premiums in the case of ‘caesarean abuse’. However, the OGs were also aware of the contradictions in the government’s new regulations concerning the ongoing pressure for improved efficiency and performance combined with demands for higher quality. Their main concern was ‘too high a workload’, because they all believed that they were already over-performing. Hence, each of them made use of caesarean delivery in the way that best fitted their day-to-day practice.

Dr Cesur (all clinician names reported in this article are pseudonyms) had registered the lowest C-section rates in previous months. In May 2014, his score was 8.1 per cent, much closer to WHO recommended norms, while his two colleagues had registered 45.9 per cent (Dr Volkan) and 18.9 per cent (Dr Ayda). Dr Cesur applied different protocols to the established ones. For example, he was the only OG to use forceps in emergency cases, to opt for a vaginal birth for breech babies and to perform VBACs (Vaginal Birth After Caesarean). Both his clinician colleagues and the midwives described Dr Cesur as a ‘risk-taker’ and even a ‘risk-lover’, while they considered that it was not worth embarking on such ‘adventures’ themselves. Dr Cesur affirmed that he had already been practicing in this way before the caesarean law was introduced. Despite the fact he was head of the maternity unit, the other OGs did not follow his lead. An ‘abnormal presentation of the foetus’ and a ‘scarred uterus’ were part of the fourteen medical indications for a caesarean, as defined by the Ministry of Health (Ministry of Health, 2010). Hence, the OGs who opted for a caesarean in these cases were not violating the rules. Dr Cesur had his own rules, not only because he had been trained in a different medical culture abroad but also because he was the head of department. Given his administrative workload, he needed to delegate more births to midwives, but this did not deprive him of performance points. On-call doctors received points for each delivery even if it was entirely taken charge of by midwives, because births were ultimately considered to be their responsibility. Indeed, they received extra performance points if they intervened in the delivery room, for example to use forceps.

While Dr Volkan had the highest C-section score, neither the midwives nor the pregnant women talked about this tendency in negative terms. On the contrary, he was considered as ‘the public hospital obstetrician who treated women the best’, according to

several women that I met. The fact that Dr Volkan ‘didn’t take any risks’, as he stated it to me during our interview, when it came to breech babies, scarred uteruses, twins or IVF babies (which he considered ‘too precious to try a vaginal birth’) certainly weighed on his C-section record. The category of ‘precious baby’ exists formally and was registered as one of the medical reasons justifying a caesarean in the post-2012 period. Dr Volkan was also proud of his rapid performance in surgery, which certainly fuelled his preference for C-sections. However, beyond that, he frequently said that he was fed up with working in the public sector. ‘My letter of resignation is ready. I was very close to resigning a few weeks ago,’ he told me twice. He ultimately did not resign because ‘many (doctors) have already left the hospital (to work in the private sector). The hospital needs me, the pregnant women need me’. Because the hospital ‘needed him’, he did not seem to be bothered by the recent politico-administrative risk regarding ‘caesarean abuse’. Hence, he did not boost his performance points very substantially because ‘a caesarean operation was no longer worth more than an appendicectomy’. This was an observation made by all the OGs. However, Dr Volkan was happy with the situation as far as his remuneration was concerned. He had the highest number of consultations in the polyclinic, and the premiums he gained in this way were satisfactory. He thus said he did not need to take any medico-legal risks by imposing self-censorship or self-discipline regarding caesarean births. Caesarean delivery was part of the reason why he was so efficient and so popular.

Dr Ayda was the only female OG in the public hospital maternity unit. The midwives felt they were under a more affirmed hierarchy with her than with the male OGs. They also commented that Dr Ayda was ‘serious’ and ‘cautious’ in comparison with Dr Cesur. The medical team did criticise her, however, for taking last-minute leave with no regard for the burden she was putting on her colleagues. Everybody expected her to leave the hospital soon for a private one. Dr Ayda defined herself as a secularist and openly criticised the JDP government’s caesarean law as grotesque. She said that the law had not impacted her work and that she would change nothing about her medical practice. She also did not seem to care about the performance system and the premiums. She was wealthy enough and missed the ‘good old days’ when she had a private practice. Like her colleagues, she frequently complained about the high workload in the unit. Regular holiday escapes from the hospital were Dr Ayda’s way of coping with the bad working conditions and of stabilising her caesarean rates.

To sum up, in the post-2012 period, the public hospital OGs either revisited or reaffirmed their caesarean delivery practices in relation to the newly emerged economic-

institutional risks that weighed on them. The clinicians' evaluation of the risks of vaginal birth extended far beyond the dominant 'medical' criteria of risk to incorporate issues such as diverse as organisational responsibility, public recognition, performance demands and related economic and institutional interests.

### The private hospital: from risk to chance

In the private hospital, the caesarean law had a different impact on the health professionals' day-to-day practice. The two OGs that worked there did not seem to be as concerned about the economic and institutional sanctions regarding 'caesarean abuse' as their colleagues in the public hospital. They only marginally reconsidered their risk discourses and practices. With the post-2012 regulations, they also increasingly promoted caesarean delivery as a choice to 'sell'.

The private hospital's manager affirmed, 'You know, caesareans have been banned since 2012', during our initial interview implied that the hospital's C-section rates would have seen a spectacular decline. This, however, was not the case. The monthly rates were generally around 85 per cent in 2014, which was higher than the 2012 (79 per cent) and 2013 (83 per cent) rates.

According to the hospital manager, these high rates were due to the irreversible nature of caesarean delivery. Women with a scarred uterus automatically had a caesarean in future births. The system was thus self-generating. The problem was unlikely to be solved for another generation at least. However, the manager also mentioned something unexpected:

Since elective caesareans were banned, the women who really want a caesarean knock on the doors of the private hospitals (Extract from interview with the private hospital's chief executive).

Indeed, the caesarean law, which was intended to regulate a problem that had mostly been produced in the private sector, had begun to have an unforeseen effect. In the public hospital, pregnant women received a formal refusal if they requested an elective caesarean immediately after being admitted to the maternity unit. In the private hospital, such cases were dealt with differently. A doctor-patient relationship was established over 9 months, so it was difficult for the private hospital to refuse requests for elective caesareans, even after

2012. These requests were legitimated according to neoliberal notions of ‘choice’ and of individual/parental ‘responsibility’ (Macvarish, 2016). The conversation below with one of the two OGs working in the private hospital maternity unit illustrates this point:

Dr Tarik: The caesarean rates are maybe higher here than in the public hospital. That’s because we have a lot of women who already know at the beginning of their pregnancy which doctor they want for their antenatal care and caesarean. They’re not necessarily 100 per cent informed, but they’ve heard, for example, that Dr X in hospital X does a better bikini-line cut, that it’s smaller and more aesthetic, etc.

Author: Do you continue to accept requests for elective caesareans even when there’s no medical reason justifying it?

Dr Tarik: Yes, we do, but we ask the women to sign a form confirming that they won’t be covered by the SSK (social security agency).

The two OGs who held office in the private hospital were described by the midwives and expectant women as ‘proficient doctors who take good care of women and don’t take any risks’. However, according to the midwives and some of the women who gave birth there, the male OG, Dr Tarik, was more inclined to ‘give normal birth a chance’ than his female colleague, Dr Azade. Dr Tarik was not described as a ‘risk-taker’, however, but as ‘open-minded’ and as taking into account senior midwife Fatma’s opinions in her attempts to strike a balance between essential medicalisation and what she viewed as excessive medicalisation, which is a common struggle in midwifery practice (Scamell & Stewart 2014). He also sometimes agreed not to do an episiotomy if it was not a first birth. There was no significant difference between the C-section rates of Dr Tarik and Dr Azade. The rates were around 80 to 85 per cent for both, with a range of 70 to 90 per cent. However, these figures remained discreet, that is they were not displayed on the walls like they were in the public hospital.

Indeed, despite the recent changes in OGs’ discourses and attitudes concerning vaginal birth, caesarean delivery was far from being an autonomous choice elaborated by the pregnant women alone. According to the interviews conducted with the expectant mothers, the OGs had continued to prepare them for the idea of a caesarean delivery during their pregnancy, even when they had stated from the start that they wanted a vaginal birth. The OGs put forward ‘the risk for the baby of an over insistence on vaginal birth’. The women’s preference for a vaginal birth was thus not treated as a birth plan to be prepared together but rather as a

request that the OGs would perhaps authorise if everything went well. The case of a young mother who was expecting her first baby illustrates this point:

When Dr Tarik first gave me a vaginal examination, he said that it would be difficult for me to have a normal birth, because I wasn't relaxed, I was stressed. So he said I probably wouldn't manage it, that it could be risky for my baby. But in the end I was able to, and apparently my pelvis was suitable for it (Extract from interview with a woman aged 25, on her second day in the private hospital).

Finally, the private hospital OGs' preference for caesarean delivery was apparently fuelled by different organisational-managerial factors from those in the public hospital. Both before and after the law was introduced, the management of childbirth seemed to be closely related to time and performance management. According to the data recorded in the private hospital's birth register book, the majority of its vaginal deliveries took place in the morning, while most of its caesareans took place towards the end of the afternoon. These findings suggest that the authorised time of birth was likely to be determined by the OGs' working hours (09:00-18:00). If the vaginal delivery had not happened by 13:00 or 14:00, both OGs would often opt for a C-section. The midwives played a specific role in this. If the delivery was likely to take place before the OG's arrival in the morning or before he or she could arrive during the night to manage the emergency, then the on-call midwife would play the role of 'firefighter'. In the private hospital, only Fatma was considered proficient enough to replace the OGs in deliveries. The other two midwives had more of a nursing role. Fatma was 62 years old and therefore of 'the old generation'. She had a lot of experience both in the public sector and in Eastern Turkey, where she had coached home births in the 1970s. She explained:

There are fewer and fewer midwives. The hospitals desperately need more of them. There aren't enough new graduates, I believe. (...) The hospitals are now looking for older midwives, because there aren't enough experienced midwives. When a doctor tells me, 'I've got more qualifications than you, so I make the decisions', I reply, 'I've got a 40-year-old qualification'. (Extract from interview with a midwife in the private hospital)

The midwives in the public hospital were all between 25 and 35 years old. The only senior midwife, who was in her 60s, had left a few years previously, frustrated at trying to impose practices (such as letting the labour continue at its own pace) considered incompatible with



the established medical norms. While the presence of at least one senior midwife appeared to be crucial at the private hospital, there seemed to be little room for senior midwives at the public hospital. Their presence was even seen as a threat, because they could disregard the modern childbirth standards in favour of ‘old-fashioned’ practices and beliefs.

Moreover, the economic risk of ‘caesarean abuse’ did not seem to carry the same weight in the two hospitals. In the private hospital, the performance system operated on a more individual basis than in the public hospital. The supplementary premiums for the private OGs were negotiated with the hospital’s management on an annual basis during the renewal of work contracts and were based on various medical interventions and their ‘values’ in the performance system. Some OGs preferred to have a high fixed salary (of around 25K YTL, i.e., \$US8,000 per month at the time of the research), while others opted for profit shares (which could mean 30-40K YTL in the case of ‘good performance’) plus a base salary (of around 10K YTL). Dr Tarik, for instance, chose the second option in 2014 and agreed in his contract to an average premium level of 13 per cent for his activity. He also negotiated a premium rate for each medical act. He received 22 per cent of the total cost of a caesarean, 20 per cent for a first vaginal birth, 22 per cent for a second or third vaginal birth, 40 per cent for an elective caesarean, 10 per cent for an ultrasound, 5 per cent for a Trisomy 21 test, and so on. Hence, beyond making his job and his obligation to organise his own working hours easier, elective caesareans also appeared to be profitable for Dr Tarik.

In short, in the private hospital where C-section rates continued to rise, the caesarean law did not engender any significant change in professional practices apart from encouraging OGs and midwives to be ‘more open-minded’, to ‘give normal birth a chance’ and to provide elective caesareans as a private service.

## **Discussion**

In the analysis presented above, I have explored the OGs’ relationship with risk, technology and the maternal body in the context of a ‘caesarean epidemic’ (Morris, 2013). I have sought to deconstruct the dominant risk discourse that governed their day-to-day practice by taking into account the wide range of epistemological, cultural, technological, economic and regulatory factors that shaped their conceptualisations of caesarean and vaginal births.

Unlike the critical approaches that generally view OGs’ routinised recourse to C-sections as an individual preference and an ethical (ir)responsibility, I adopted a more institutional and constructivist, less moralising approach to capture their medical

understandings of risk and safety. The ‘preference’ approach (Mello e Souza, 1994; Hopkins, 2000; Wagner, 2000) presumes that an individual’s actions are conscious and controlled, but this overlooks the part played in decision-making processes by taken-for-granted lifeworlds (such as beliefs or established ignorances) and the uncontrollable (such as organisational constraints). The ‘preference’ approach references three main advantages of C-sections for OGs, namely time, money and safety (see, e.g., Wagner, 2000). C-sections are quicker to perform and easier to plan. They are often more profitable, and they protect OGs from medico-legal risks. While such concerns are important, my findings suggest that they should be nuanced and/or complemented by other factors. Some of these clearly appeared to be constraints rather than preferences or choices in this study, or else they corresponded to both. For instance, several OGs suggested (and some even admitted) that they felt they were more proficient at caesarean deliveries than vaginal births. Most of them had never assisted or observed a birth with no interventions, hence why such a process was less thinkable amid their lifeworlds. They thus denied the competencies of the labouring women and the maternal body (Kukla, 2015), they disregarded the probabilities of catastrophic events in their framing of childbirth as ‘pathological’ and they ignored alternative practices and a large body of research indicating that the labour process does not have a standard duration and that not all primiparous women need an episiotomy (Diniz & Chacham, 2004).

If these findings globally converge with those from the vast literature on biomedical birth models or on pathologization of birth (Davis-Floyd & Sargent, 1997; Chadwick & Foster, 2014; Scamell & Alaszewski, 2016), their original contribution is threefold. First, they highlight several techno-cultural determinants specific to the national context studied here, including OGs’ belief that they are ‘fast cutters’ (or their obligation to be so in a context of intensive workload) and their disregard of the labour process, which is even *censored* linguistically. These determinants necessarily influence their risk conceptualisations and practices. More generally, technology plays as central a role in the management of childbirth and its risks in emerging economies like Turkey as it does in developed economies, if not even more. From an Enlightenment perspective, technology is viewed as a means of controlling nature and its unpredictable potential dangers, while the iatrogenic risks engendered by unjustified technological interventions – or ‘man-made risks’ (Beck, 1992) – are overlooked. The risks and the deficiencies of the maternal body (‘natural risks’) are highlighted as a major justification for medical interventionism, to such an extent that an OG-driven ‘(medical) risk colonisation’ (Rothstein, 2006) reigns, parallel to an institutionally driven ‘technology colonisation’.

Relevantly – and this is the second original contribution of this paper – this study provides an updated perspective to the literature on technocratic birth by showing that in the most contemporary period, women in many contexts are basically left with two simultaneously disempowering and safe options – caesarean vs. vaginal birth in Turkey; caesarean vs. epidural birth in USA (Wolf, 2018) – and that ‘avoiding a C-section thanks to one’s perseverance’ has become the only imaginable horizon for many women. The ‘caesarean delivery is the safest option’ discourse is paradoxically reinforced in such settings (especially when epidural anaesthesia is not available) because it is faster than vaginal birth, it is ‘high-tech’ and it eliminates the painful labour process. Vaginal thus serves to facilitate the ‘selling’ or adoption of caesareans, which is another important factor that explains OGs’ widespread use of C-sections. These findings on the dual birth model (caesarean or vaginal), which was dominant in the settings examined, should however be nuanced at a macro level. In the last few years, women’s demand for natural birth has increased in Turkey in parallel with the rise of an as yet marginal alternative birth market. In the large cities, a small number of OGs who have recently converted to natural birth or to ‘birth without regrets’ (a label proposed by one of them) provide a less medicalised birth service, but it is only affordable by upper-middle class women. Natural birth therefore often takes place in a private hospital ward that the OG has hired for their client’s delivery. Childbirth in Turkey, whether normal, caesarean or natural, thus continues to be very hospital- and OG-centred. This probably says a lot about the future trajectory of risk in the Turkish childbirth system. More research is, however, needed for a detailed and dynamic exploration of these recent changes.

Last but not least, this article adds to the literature on constructivist and institutionalist theorisations of risk by providing data on recent reforms and their impact on obstetric practices. Noteworthy here are the changes engendered by the health system restructuring programmes launched in many developing and emerging economies under the supervision of international organisations such as the World Bank. In Turkey, the recent regulations regarding ‘caesarean abuse’ have been part of such a programme, the HTP. Because these regulations were mainly aimed at generating a shift away from caesarean to vaginal delivery and because they did not leave room for a collective reflection on the technicisation and pathologisation of childbirth as a public problem, most OGs only marginally revisited their risk categorisations regarding caesarean vs. vaginal births. While the public sector OGs viewed the caesarean law as an additional constraint that forced them to re-hierarchise medical risks in relation to the newly emerged institutional risks, the private sector OGs

seemed less affected by these new risks. They even sought to turn them into new opportunities.

These data should, indeed, be consolidated by future research exploring the fallout of the caesarean law in a greater number of public vs. private maternity units. They nevertheless allow us to note that, unlike what Rothstein (2006) observed in other cases, the ‘colonising effect’ of institutional risks (once they are theorised and introduced by the state as a means of regulating professional and managerial practice) is ambivalent. These new risks do not have the same impact or power everywhere; they rather seem to be sector-sensitive, in the sense that their influence is highly dependent on the sector (public vs. private) over which the regulatory state aims to (or succeeds to) exercise its power. Furthermore, such institutional risk colonisation, and the related regulatory measures, may be more difficult to implement in contexts in which other types of risk colonisation (such as medical risk colonisation, orchestrated by OGs) pre-exist and have strong material or technological support (technology colonisation).

The Turkish case analysed here also appeals to researchers to go beyond conceptualisations that are merely framed in terms of risk or technology management or colonisation, however. The C-section controversy, and the related developments and changes examined here at a micro-level, reveal the importance and the dynamic character of the battles over who governs (or should govern) the women’s bodies at different (private, public/organisational, population control) levels, and among different actors (here, between OGs and the conservative government). Risk (medical vs. institutional) appears to operate in this frame as a central locus of contestation between the powerful actors, while pushing the women’s voices and enlightened choices to the backstage.

## **Conclusion**

In emerging economies such as Turkey, risk plays a major performative role not only in the technicisation of birth but also in the elimination of vaginal births in favour of caesarean deliveries. Far from being grounded in evidence-based medicine, the dominant obstetric discourses that denote the riskiness of vaginal birth, in favour of the safety of caesarean delivery as almost ontological truths, are constructed under the influence of a wide range of epistemological, technological, economic and political factors. The notion of risk operates in this context as a major driving and organising force that allows clinicians to conduct their day-to-day practice and thus to exert their medical power while the deficiencies, the authoritative character and even the violence of the obstetric care system are rendered

invisible. If caesarean and vaginarian births are technological co-constructs of the risk society and of patriarchal medicine in Turkey, they are also co-products of its contemporary health restructuring reforms, which are increasingly centred on quantitative performance. Regulations aiming to eradicate the caesarean epidemic, such as those introduced in Turkey in 2012, are unlikely to be effective unless they also attempt to combat the vaginarian epidemic.

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