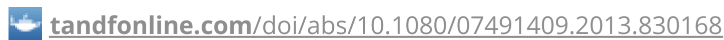
Framing Birth: Postfeminism in the Delivery Room


tandfonline.com/doi/abs/10.1080/07491409.2013.830168

Acknowledgments

The authors thank Barbara Sharf, Kristan Poirot, Wendy Atkins-Sayre, and the anonymous reviewers for their excellent advice on our manuscript. An early iteration of this essay, “What's Best for Me and My Baby? The Portrayal of VBACs on Four Websites,” was presented by Ms. Ramadurai at the National Communication Association convention in .

We recognize that the World Health Organization recommendations are not without some controversy. Some debate exists as to the validity of the studies used to formulate the 1984 recommendations. Nevertheless, recent studies have pointed in similar directions. According to Althabe and Belizan (), cesarean rates above 15% in industrialized countries are associated with increased mortality and morbidity for both mothers and babies.

Although studies about the rate of uterine rupture vary slightly, most studies offer rates between 0.5 and 1% (ACOG Committee, 2010; MacCorkle, 2002).

American studies scholar Lisa Duggan (2003) describes neoliberalism as the “brand name” for a series of seemingly apolitical economic policies, which emerged in the 1990s, that are largely pro-corporate, pro–free market, and anti–big government (p. 10). Neoliberalism is also theorized as a cultural phenomenon, one that emphasizes privatization and personal responsibility. For our purposes in this essay, we are particularly interested in how the economic goals and cultural values of neoliberalism are reflected in current medical practice and in patient subjectivities.

The definition of *postfeminism* we are using diverges from an understanding of postfeminism as merely a backlash against feminism. McRobbie's (2009) concept of postfeminism emphasizes postfeminism's relationship to feminism and postfeminist culture's ability to pick up and appropriate feminist politics in a largely depoliticized manner.

Given the emphasis on women's ability to decide their method of birth in the self-determination frame, some feminist scholars have advocated for the benefit of elective cesarean sections as one more choice for women. In opposition to this stance, many others decry the unreflective embrace of technology as problematic. Beckett (2005) explains: “the role of medical technology in the establishment and perpetuation of medical authority … complicates women's efforts to deploy obstetric technologies for their own purposes” (p. 267).

We accessed and analyzed 11 white papers on the ICAN Web site in 2010. Two of the papers, *Fighting VBAC-lash: A Critique* by Jill MacCorkle and *Critique of ACOG Practice Bulletin #5, July 1999* (no author) offered lengthy critiques of medical discourse about VBAC. Four of the white papers offered specific guidelines and pragmatic help for women seeking VBAC: “My Hospital is Currently Not Allowing VBAC” (no author); “Your Right to Refuse” (n.d.); *Vaginal Birth After Cesarean Checklist* (n.d.); and Katherine Prown's “Enforcing and Promoting the Rights of Women Seeking Vaginal Birth After Cesarean.” Four papers considered specific medical questions in the VBAC debate: “VBAC and Pharmaceutical Induction” by Jennifer Jamison Griebenow, “Issues and Procedures in Women's Health” by Ashley Hill, “The Suture Debate” by Gretchen Humphries, and “Uterine Rupture” (no author). Finally, one white paper was clearly labeled a position paper: “Position Statement: Elective Cesarean Sections Risker Than Vaginal Birth” by Jill MacCorkle. We analyzed the papers as examples of constitutive rhetoric, looking for the ways in which women were constituted in a specific narrative.

This bulletin is suitable for analysis as a representative of the medical establishment's rhetoric of containment because the College's bulletins are perhaps the most influential texts in guiding physician and hospital practice (Chauhan et al.,). Although the College draws from medical studies to support its claims, the bulletin is useful because it offers extensive and specific recommendations about VBAC.

Obstetrics and gynecology began as separate fields, with obstetricians focused on pregnancy and gynecologists focused on diseases of women's reproductive system. Because of the clear overlap between the two fields, in 1930 the American Board of Obstetrics and Gynecologists declared that the two fields were inseparable (Speert, 1980, p. 87). Medical schools combined their obstetrics and gynecology departments through the early and mid-twentieth century, and the board discontinued issuing separate certifications for obstetricians and gynecologists in 1965 (p. 88).

We informally surveyed threads about VBAC on discussion boards on the following Web sites: Parenting.com, Mothering.com, ICAN-online.net, storknet.com, mamapedia.com, and babycenter.com.