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Title:

Sarah's birth. How the medicalisation of childbirth may be shaped in different settings: vignette from a study of routine intervention in Jeddah, Saudi Arabia

Abstract

• Background

The expansion of the medicalisation of childbirth has been described in the literature as being a global phenomenon. The vignette described in this paper, selected from an ethnographic study of routine intervention in Saudi Arabian hospitals illustrates how the worldwide spread of the bio-medical model does not take place within a cultural vacuum.

• Aim

To illuminate the ways in which medicalisation of birth may be understood and practised in different cultural settings, through a vignette of a specific birth, drawn as a typical case from an ethnographic study that investigated clinical decision-making in the second stage of labour in Saudi Arabia.

• Methods

Ethnographic data collection methods, including participant observation and interviews. The data presented in this paper are drawn from ethnographic field notes collected during fieldwork in Saudi Arabia, and informed by analysis of a wider set of field notes and interviews with professionals working in this context.

• Findings

While medicalisation of care is a universal phenomenon, the ways in which the care of women is managed using routine medical intervention are framed by the local cultural context in which these practices take place.

• Discussion

The ethnographic data presented in this paper shows the medicalisation of birth thesis to be incomplete. The evidence presented in this paper illustrates how local belief systems are not so much subsumed by the expansion of the bio-medical model of childbirth, rather they may actively facilitate a process of localised reinterpretation of such universalised and standardised practices. In this case, aspects of the social and cultural context of Jeddah operates to intensify the biomedical model at the expense of respectful maternity care.

• Conclusion

In this article, field note data on the birth of one Saudi Arabian woman is used as an illustration of how the medicalisation of childbirth has been appropriated and reinterpreted in Jeddah, Saudi Arabia.

Summary of Relevance

Problem or Issue	Globalisation of the bio-medical model of childbirth.
What is Already Known	The medicalisation of childbirth is expanding across the world.
What this Paper Adds	• The expansion of western birth practices involves a process of active reinterpreted • Religious beliefs in a context of inequality can intensify the medicalisation of childbirth

Keywords

Childbirth, ethnography, evidence-based practice, maternity, medicalisation, routine medical intervention, Saudi Arabia, Islam.

Introduction:

Much has been written about the medicalisation of childbirth in both the professional and social science literature. (1, 2, 3, 4) Undoubtedly, the worldwide expansion of new medical technologies in the management of birth, such as electronic fetal monitoring (EFM) and artificial hormones to induce and accelerate labour, along with the international displacement of birth to the acute hospital setting, has created unprecedented conditions for a socio-cultural shift towards a biomedical model of childbirth. Furthermore, this shift transcends national boundaries and is, as such, part of a wider globalisation of medicalisation. (5) A limitation in much of the medicalisation of birth literature is its failure to attend to how the process of medicalisation manifests in different socio-cultural contexts. The ethnographic evidence presented in this article concurs with van der Geest and Finkler's (6) observation that although the expansion of medicalisation may be described as being a global phenomenon, the worldwide expansion of the bio-medical model (of birth in this case) has not taken place within a cultural vacuum. Far from it, as van der Geest and Finkler point out:

> *'Medical views and technical facilities may vary considerably leading to different diagnostic and therapeutic traditions… and …biomedicine, and the hospital as its foremost institution, is a domain where the core values and beliefs of a culture come into view.'* (6)

Using a vignette of one woman's birth, drawn from an ethnographic study of childbirth management in Saudi Arabia supported by other ethnographic data

collected during the study, this article provides empirical evidence of the global medicalisation of childbirth but crucially also of the importance of the broader socio-cultural processes that play out within the context of this global process – in this case the Saudi Arabian context. We suggest that Sarah's birth provides a vivid and compelling illustration of the impact of medicalisation on the birthing experience to date, in what might be described as a 'fleeting moment of field work in dramatic form'. (7) Further, we propose that the particular socio-cultural setting of Saudi Arabia enables a reinterpreting and restructuring of the medicalisation process even though its core features of routine use of medical intervention remain intact.

The paper contributes to a growing body of literature interested in the socio-cultural shaping of medicalisation. (8) Van Hollen's study of childbirth in Tamil Nadu, for example, argues that culture is not reified, highlighting how poor rural women welcomed certain aspects of medicalisation while clearly rejecting others, in a manner that was concordant with local beliefs and traditions around health and childbirth. (9) Similarly, Donner (10), in a study of childbirth choices of middle class women in Calcutta, highlighted how a desire for caesarean section (CS) birth was linked with family and kinship dynamics rather than a preference for medical care per se, while Erten's study of rising CS rates in Turkey identified that women seeking CS birth viewed this as a means to assert reproductive rights in the face of a pronatalist government policy. (11) Through the close scrutiny of the finer details of the second stage of labour in one woman's birth in Jeddah, Saudi Arabia, this article shows how this particular cultural setting

operates to reframe the biomedical model of childbirth in ways that are consistent with the social and cultural context.

The study

Sarah's birth is the description of one of nineteen births observed during an ethnographic study of the clinical management of the second stage of labour in Jeddah, Saudi Arabia. The study took place between 2011 and 2014 and was planned following an earlier survey, which revealed a high prevalence of routine interventionist practices in Jeddah's labour wards. (12) The aim of the study overall was to answer the research question:

> What influences healthcare professionals' decision making during the second stage of labour in Jeddah, Saudi Arabia?

The main emphasis of the study (from which the story of Sarah's birth comes) was to examine health professionals' decision making during the second stage of labour, these findings have been reported by the authors elsewhere. (13) The observation data presented in this paper instead aims to tell a single story of a woman's birthing experience as observed by the researcher and as informed by the wider study analysis. This reflexive approach using thick description has been employed in order to portray the significance of clinician's actions and decisions, upon the management of women's birthing in this socio/cultural context. The particular birth story used in this paper was selected as illustrative as it successfully represents several of the most densely populated themes that arose from the research analysis (14). The story is presented in large part as it

appeared in the field notes, to preserve a sense of research reflexivity that we feel helps to capture the nature of all the births observed during the study. In other words, the story of Sarah's birth forms an exemplar of the wider findings from the study.

For the wider study observational field notes, text (such as the institutional hospital policies, organisational guidelines and religious text) and ethnographic interview data were collected by one of the research team during fieldtrips to the cosmopolitan city of Jeddah between 2011 and 2012. A total of 228 hours were spent collecting observational and text data during two separate field trips Jeddah. This fieldwork was carried out by one of the research team who speaks fluent Arabic and who is a qualified midwife. Jeddah is the largest seaport on the coast of the Red Sea and is the second largest city in Saudi Arabia after the capital city, Riyadh. Jeddah was selected as it offered a diversity of maternity care settings, allowing for a comparative component to the study. The maternity service in one of the settings was regulated by the military governing body (3,000 births per year); in contrast the second setting was regulated by the Ministry of Health (MOH) (6,900 births per year). These two settings represent the main providers of public maternal health services in Saudi Arabia, having a national average Caesarean Section rate of around 1/3 of all births, representing an 80% rise in between 1997 and 2006. (15) These public maternity service provides differ in their employment patterns, with one setting employing mainly Saudi professionals while the other employs a high proportion of expatriate professionals from a range of countries.

Research design and methods

Due to the paucity of empirical research about birth management in Saudi Arabia, an exploratory, qualitative study using an ethnographic design was deemed to be the most appropriate approach. An exploratory design using qualitative methods is ideally suited to exploring a phenomenon that has not been studied in depth before, (16) and is commonly used to explore problems about which reasonably little is known. (17) An inductive approach to the ethnographic method was adopted, as described by Charmaz. (18) Through a range of responsive and fluid ethnographic data collection techniques, that included participant observation, (19) ethnographic interview, (20) and text analysis, (21) we were able to gain a deeper and richer understanding of second stage decision making in this cultural context. The field diaries from which the data in this paper is drawn describes notes on one observation where the researcher offered help with practicalities if required (fetching things, bed-making and getting coffees, but not undertaking clinical duties) in order to 'fit' into the scene while trying to minimise the impact upon the clinical decision making. (22)

The study from which this article draws, builds upon an increasing range of ethnographic studies looking at childbirth in areas as diverse as the influence of birth setting, (23, 24, 25) labour room interactions between midwives and women, (26, 27, 28) midwives' body work (29) and the expansion of the discourse of risk, (30, 31) confirming the effectiveness of this research design for the investigation of this area of health care. Our aim with this article is to use field note entries describing one birth to provide an illustrative contribution to this literature by

offering a detailed account of how medicalisation of childbirth works in the Saudi Arabian context.

Participant recruitment

Because a significant amount of the data was collected using participant observation during the second stage of labour, service users (n=19) (like Sarah, whose birth is described here) were recruited to take part in this study. Service user involvement was exclusively via observation rather than interviews as the study focus was on professional actions and decisions. With the help of our participant obstetricians (n=10), midwives (n=12), obstetric nurses (n=6) and nurse/midwives (n = 1), we were able to identify nineteen labouring women who were deemed to be suitable to take part in the study. These women were all admitted in spontaneous labour at term of pregnancy, with a cephalic presentation (baby head down) and with no known medical complications and not deemed to be vulnerable by their carers.

Once a woman was identified by her health care provider, it was the staff member providing the intra partum care who initially approached her about taking part in the study. These women also were made aware of the study via a poster campaign and further verbal and written information was provided to them prior to the onset of the observation. The principal researcher spoke fluent Arabic, vital for ensuring informed consent. When a woman confirmed her consent for the observation, a signed informed consent form was taken by the researcher (RA). The midwife or nurse in charge of each shift was made aware of the observation

and professionals who had provided prior consent to the observation were approached to confirm or decline consent on the day.

Research ethics

Ethical approval for the study was obtained from the sponsoring University's Research Ethics Committee on the 29.06.2011. Following this, approval was sought from both hospitals sites where data collection was to be carried out. Consent to take part in the observational part of the study was sequential, (32) and all participants were re-approached after the events to check consent for the data to be used in the study. All data were transcribed and cleaned prior to analysis and pseudonyms used throughout. The Saudi Arabian Ministry of Higher Education, through a scholarship to the first author, funded this study.

Analysis

All participant observations, field notes, interviews, field diaries and documentation were recorded in English, translation was completed by RA, who was bilingual, using a word processing package (Word 2010) and then transferred into qualitative data analysis software Atlas.ti 7 to facilitate easy access and maintain analytical 'closeness' to the data. (33) The co-authors of this paper were continuously involved in the analysis process. Regular research meetings during the analysis allowed for discussion and refinement of results and identification and resolution of any analytical ambiguities.

A six phased of thematic analysis as proposed by Braun and Clarke were used for the data analysis as described below. (34)

Phase 1: Once all the data had been collected a period of data immersion commenced. This involved reading and re-reading the interview transcripts, observational field notes and text based data in order to gain a good level of understanding. This process followed the preliminary analysis that took place while the principal investigator was in the field.

Phase 2: Following the familiarisation phase of data analysis, systematic coding was undertaken using Atlas.ti. Initially this involved coding for descriptive codes.

Phase 3 and 4: Higher-order categories emerged from the descriptive analysis. The pre analysis data set was constantly revisited to check validity of the emerging analytical map. This dual approach allowed for the tentative grouping of categories into a thematic analytical framework. This was supported by a range of visualisation processes.

Phase 5: Refinement of the themes and testing of trustworthiness of the analysis was principally achieved through reflexivity and triangulation. Periodic reviews, conducted by each member of the research team, took place to confirm that data analysis met the aims and objectives of the study. Triangulation was achieved through the constant cross-referencing between the different data types and exploration of the contradictions and coherence within these.

Phase 6: Dissemination of this study is currently in progress and this article forms part of this. Other aspects of the analysis will be reported elsewhere.

Sarah's birth was selected for phase 6, following the reflexive refinement of the themes in the previous phases of analysis. Field notes of all nineteen observed births were scrutinized in the light of the final thematic framework, described elsewhere, (13) and after careful consideration Sarah's birth was selected as suitable to accurately represent the analytical framework that arose out of the data analysis overall.

The Vignette

Introducing Sarah

> *Sarah was lying on the bed on her left side, covered by a sheet. Since admission to the labour room, she had been attached to a continuous cardiotocography machine (CTG) by two wires, one to record the Foetal Heart Rate (FHR) and one to record the contractions. I could hear the foetal heartbeat coming from the CTG machine. (Researcher field diary)*

Sarah, a 21-year-old woman in her 38th week of pregnancy, was admitted in labour to a hospital maternity ward where she was not previously known. As a consequence, Sarah's arrival was unexpected (admissions of women whose antenatal care took place elsewhere is not uncommon in Jeddah's hospitals). Although she had no apparent risk factors that might complicate her birth, Sarah was categorised on admission as a high-risk case on the basis that she was not previously known to the hospital.

The management of Sarah's labour

Sarah was admitted through the Emergency Room (ER) as her cervix was 5–6cm dilated at around 6 am. She received her first intervention, a vaginal examination (VE), in the ER as she was having painful strong contractions. She had a second VE in the labour room at 7:20 am, which revealed that her cervix was 7cm dilated. Artificial rupture of the membranes (ARoM) was then performed by the doctor, resulting in clear liquor (amniotic fluid). The foetal heart rate showed (subsequently) variable deceleration on the CTG (this is when the baby's heart beat dips down but goes onto recover easily - a common physiological response to labour and birth), so the doctor decided to insert and attach an internal foetal scalp electrode (FSE) to the baby's head. At 7:30am, a Buscopan intramuscular (IM) injection was administered by the midwife to aid cervical dilation and shorten the duration of first stage of labour…

The Labour and Delivery Department was in the middle of the hospital, near the ER and operating room (OR). There were two doors in the labour room, one always closed and one usually open… I (the principal researcher) walked straight into the room as the door was wide open, while a curtain around the bed covered the entrance to ensure privacy of the woman. Sarah was wearing a green hospital gown (open from the back) and blue head cover, in a large, modern, clinical-looking room. The bed was in the centre of the room, and all the furniture was made of metal…

Artificial lighting was provided by recessed fluorescent tubes, and a large, mobile OR light (turned off) hung over the bed. There was oxygen and suction equipment on the wall, and a big clock above the bed. A baby resuscitation trolley stood at the end of Sarah's bed. There was one washing sink, two chairs, an ensuite bathroom and a computer for staff use… The room had no windows and was air conditioned and very cold. (Researcher field diary)

Within two hours of Sarah's admission to hospital she had undergone six medical interventions, over and above the routine medical investigations that were not recorded in the field notes. These included the routine measuring of Sarah's vital signs temperature, pulse and blood pressure. Sarah was put to bed in a cold, clinical looking room, was forbidden to eat or drink and was faced by a door that was left permanently open for ease of access for members of the multi disciplinary maternity care staff. Staff explained that the labour rooms had to be kept cold due to the central air conditioning being connected to the operating theatre. It was impossible to make the temperature more comfortable for the labouring women they said because then it would become "too hot" in the operating theatre. Sounds of hospital activity in Sarah's room were all but drowned out by the constant rhythm of the electronic fetal monitor.

Sarah had also one line of intravenous (IV) fluids (Ringer Lactate) running into her hand. She had an oxygen mask attached on her face due to variable deceleration (dips in the baby's heart rate). A blood pressure cuff was attached to her left hand. The midwife decided to insert a Foley

urinary catheter for continuous drainage of urine and for variable deceleration. Sarah's companion (her aunt, who was her father's sister) sat quietly in a chair on her right-hand side. (Researcher field diary)

Observations in both hospital settings accessed in this study showed that during labour and birth most women are 'not allowed' to mobilise. Movement away from the hospital bed was not considered to be conducive for the continuous application of medical technologies that were used routinely during all of the observation episodes. The labouring women observed in this study were predominantly confined to bed once they were diagnosed as being in active labour. Space limitations within the labouring rooms where women and their birthing partners (if permitted) competed for space with a range of technological machinery, also prevented women from mobilising freely. Some women were allowed to mobilise to go to the toilet, but in most cases (as was the case with Sarah) bladder catheters were attached routinely throughout rather than allowing women to walk to the ensuite toilet to empty their own bladder. As one midwife explained in an interview:

'Once she (a labouring woman) is in the second stage of labour, we will not allow it (mobilisation). She can sit, but she cannot walk. We can put her in a semi-sitting or sitting position and if the head is already crowning, we will put her in the proper position [referring to positioning the woman's legs wide open in stirrups attached to the side of the bed, which is used routinely]. But she is not allowed to walk.' (Ethnographic interview NMW-13)

The language of Sarah's birth

Two hours and twenty minutes after her arrival to hospital, Sarah was introduced to two doctors – Dr Nawal (female resident) and Dr Majed (male registrar)[i]. After making themselves known to Sarah in Arabic, Dr Nawal said **in English**:

> *'The CTG is not good. She has clear liquor. We have to call Dr Zaki, the consultant, for this lady'.*
>
> *Dr Majed said: 'In my opinion this lady needs a C-section'. (Researcher field diary)*

It should be noted that most women attending hospital for their births spoke only Arabic. Despite this however, in both the hospital settings observed in this study, English was the official language. Professionals communicated with one another in English, almost as if the women were not present in the room and certainly as if their input into the clinical decision-making was irrelevant. Interpreters and other Arabic-speaking healthcare professionals were readily available to assist the mostly expatriate healthcare professionals to communicate with the women but it was not actually language per se that limited the communication in the labour room; it was the staff's choice of language that acted as the major communication barrier. Even when staff members were predominantly Saudi Arabian, they still frequently chose to speak in English about the women in their care rather than talk to these women in a language they would understand. In some cases, healthcare professionals simply chose not to respond to women's questions at all, as was the case in when Sarah asked:

'*When will the pain go?*'

No one chose to answer this question.

After much to-ing and fro-ing in and out of the room by the midwife, the labour ward coordinator and the two doctors, Dr Majed said:

> *'Put her in the lithotomy (legs in stirrups) position,' to which the midwife replied, 'she is pushing'.*
>
> *Dr Nawal said to Sarah: 'I want you to be in a straight line'. Sarah was covered with disposable blue sterile surgical leggings…*
>
> *The doctor said: 'Let's wait for half an hour until the head is down. She is a very good pusher'. (Researcher field diary)*

Such objectifying language was commonplace in staff to staff communications in both the hospitals observed in this study. So much so, women were frequently talked about not only in ways that assumed passivity but that also denoted ownership. It was as if the women in their care somehow belonged to the staff members - my baby, my delivery, my patient. This linguistic objectification of women was so commonplace that when the word 'woman' was used during interviews with the maternity care staff, without the possessive adjunct attached, a sense of confusion would ensue, with the informants asking; whose women? Within the language of labour rooms of Jeddah, birthing women did not exist independently of those providing their care.

Staff activity as Sarah's birth approaches

The staff activity in Sarah's labour room intensified as she neared the birth of her baby.

> *The doctor and midwife said to the woman, 'Take a breath and push. Hold your thighs from behind and straighten your back'. Both doctors left the room.*
>
> *A nurse entered the room wearing a blue plastic gown. She talked with Sarah in Arabic and instructed her how to push: 'Without voice, hold your breath and then push like you are passing a stool'. The nurse prepared the newborn resuscitator, injections and file; Vitamin K and anti-Hepatitis B injections; and erythromycin (antibiotic) ointment for the baby's eyes. The nurse in charge brought the baby weighing scales into the room. The midwife recorded progress on the partogram…*
>
> *Dr Majed asked Dr Rana (the third doctor involved in Sarah's care) to put the patient in the lithotomy position.*
>
> *Dr Rana said: 'She is progressing',*
>
> *But Dr Majed replied, 'But the CTG (recording of the foetal heart rate) is not reassuring'… 'It is better to bring the ventouse (suction device for instrumental delivery) as her baby's heart rate is showing decelerations'.*

The nurse in charge in the room told Dr. Majed that another patient in Room 6 was having late variable decelerations. The midwife brought the ventouse into the room.

The doctor said to Sarah: 'Don't push'.

The midwife then said: 'Push'.

The doctor left the room to see the other patient.

The midwife examined Sarah again doing a VE and encouraged her to push…

Dr Rana left. The nurse in charge again came into the room and asked to borrow the ventouse for the other patient.

The midwife told her: 'Leave this, and take the other one'…

Dr Nawal entered the room and asked: 'Where is the head?'

The midwife said: 'Right here'.

Dr Nawal said: 'She should deliver.'

Sarah was still in the lithotomy position. Dr Nawal wanted to give her a Lidocaine injection (a numbing medication) in the perineum but the midwife told him: 'Dr Rana has already given her one'.

The nurse in charge entered the room and said, 'The other room is using the ventouse, and the other CTG is worse than this one'.

Dr Nawal said: 'Variability (a sign of foetal wellbeing on the baby's heart rate pattern) is now maintained'.

The midwife said: 'My baby is going to deliver first'…

Dr Nawal wanted to leave to attend to an elective Caesarean section for another patient, but before leaving she did a VE with a sterile glove…

The doctor said: 'The head is here!' and told Sarah: 'If you feel the urge to push, push'.

Sarah replied (screaming): 'It is enough. Take it out'.

The doctor left the room…

Sarah was bleeding when the doctor stretched her perineum… The baby's head was advancing when Sarah pushed, and the doctor kept the scissors ready by the bed. (episiotomy is a routine procedure in this hospital).

Dr Majed (now back in the room) said: 'The ventouse in the other room had failed'.

The midwife wiped Sarah's face with wet tissues.

The baby's head became visible. Dr Nawal said: 'No need for an episiotomy. The perineum is good'.

At 10:25am, a baby boy was delivered, he cried and was put on a dry towel. The cord was cut, and the baby was given to the nurse who was in

the room. The doctor took cord blood and the paediatrician checked the baby in the room. (Researcher field diary)

The constant and busy activity in Sarah's room revolved around the medical technologies of birth, not only for the management of her labour and birth but also for the management of labouring women in other rooms. Preparations for possible medical interventions were the main focus of this activity, for example scissors were ready to cut Sarah's perineum regardless of clinical indication for this surgical procedure.

Emotional support

During the commotion of her labour, Sarah sought emotional support from both staff and from her birthing companion who had accompanied her to the hospital, her aunt. As Sarah's labour became more intense she frequently turned to her aunt for reassurance.

Sarah was distressed and screaming. Her aunt calmed her down and asked her to pray to God. (Researcher field diary)

Despite the obvious importance of Sarah's companion to this story, both hospitals in this study took an ambivalent position to the idea of women being supported during their labour and birth by a friend or family member. Birth support companions were only ever permitted to be present with the doctor's consent. The companionship policy differed between the two clinical settings and while Sarah's hospital allowed one companion, the other hospital did not permit a companion to be present at all during labour and birth. Despite this difference in

policy, there was evidence from both clinical settings that companions were considered to be an inconvenience to staff. For example, despite having a policy that permits one companion during birth, some doctors actively discouraged the practice, as a midwife explained:

> *'It depends on the doctors. Sometimes the doctors don't want a relative to be present.' (Ethnographic interview, MW-06)*

The nature of the support that Sarah's aunt offered her during her labour and birth provides a glimpse of the spiritual context in which the medicalisation of childbirth is embedded within the Saudi Arabian context. Shortly after the arrival of the doctors at the beginning of her labour for example Sarah asked:

> *'When will I give birth?'*
>
> *The midwife replied: 'You are 7cm dilated. God willing, it will be soon'…*
>
> *Sarah's aunt then talked to her, telling her to be patient and to ask God for forgiveness…*
>
> *Although in pain, Sarah was quiet and followed instructions. (Researcher field diary)*

In common with Al-Shahri's observation that Islam consistently shapes Saudi Arabian life, starting with the flag of Saudi Arabia and the legal system through to the individuals' daily lives, (35) much of the data collected in this study illustrates how the medicalisation of childbirth in Jeddah coexists alongside beliefs around pain and suffering that are constituted through Islamic faith. It is customary for

Muslims to pray during difficult times; (36) importantly such prayers demonstrate absolute trust in God.

> *Indeed, Allah will not change the condition of a people until they change what is in themselves. And when Allah intends for a people ill, there is no repelling it. And there is not for them besides Him any patron."* (Quran, 13:11)

In Sarah's labouring room, both the midwife and her aunt encourage her to be patient and submit to Allah's will. It is only through His will that her suffering will come to an end.

> "*Only those who are patient shall receive their reward in full, without reckoning*." (Quran 39:10)

Although prayer involves submission to the will of Allah, it does not exclude a material reliance upon medicine and healthcare. Arguably in this cultural context it supports the acceptance of the medicalisation of childbirth. (36) During times of crisis it is customary for patients and their families to turn to religion for comfort, they are still required to make a sincere effort to strive and do their best and not simply sit back and let things take their course. While faith is sustaining, it leads to neither passivity nor the rejection of scientific knowledge and development. Medical intervention in childbirth is not only tolerated within this religious context, it would appear to be almost positively encouraged.

Sarah gave birth to a baby boy who cried at birth, was wrapped up and handed directly to a nurse. Although the child was born in apparently good condition, fetal blood was extracted from the umbilical cord and a paediatrician summoned to examined the baby.

> "*Sarah was shivering due to the cold air conditioning. I (the researcher) offered her hot milk with sugar. The baby boy was in the resuscitator under the heater, wearing a diaper. The patient's aunt was sitting in a chair. After suturing, (Sarah sustained a superficial tear of perineal tissue) Sarah was given her baby to breastfeed." (Research field diary)*

Discussion

Academic interest in the medicalisation of childbirth within the academy has stretched over four decades. (1) Within this largely feminist critique, the medicalisation of birth practices has predominantly been described as a universal and culturally static usurpation of women's control over their reproductive bodies.. While the evidence presented here and in the larger study from which this story is drawn (13) supports this supposition to a point - Sarah's birth, if nothing else is a gruelling tale of subjugation - what we hope to have added, is a unique description of how the medicalisation of childbirth manifest in Jeddah in such a way as to discourage women from questioning it actively. We concur with Oakley's claim that

'The reasons why a particular culture manages childbirth in a particular way are bound up with ideology predominantly in that culture about reproduction, about medicine and about the role of women' (38)

The aim of this article has been to provide a graphic example of how medicalised birth practices are never simply replicated in different parts of the world. As van der Geest and Finkler point out, biomedicine tends to reflect and reinforce local, dominant social and cultural processes. (6) According to this proposition, the medicalisation of childbirth is universal yet not globally uniform. Instead the cultural appropriation of medicalised practices and ways of knowing about birth across the world, involves an on-going and dynamic process of reinterpretation. Through the close scrutiny of Sarah's birth, we have been able to provide a detailed empirical illustration of how such broader social and cultural process are played out in the medicalisation of birth in the Saudi Arabian context. Here the reductionist approach of medicalised birth, is intensified through local understandings where pain and suffering is inseparable from religious beliefs, where womens' autonomy over decision-making is confined and where an interest in the application of technology prevails. In other words, it is the context in which the medicalised birth practices have been reinterpreted that accounts for much of the decision-making in the second stage of labour during Sarah's birth.

There are important limitations to the study, not least its small sample size. We cannot therefore claim our data to be representative of the diversity of birthing experiences in Jeddah. We acknowledge that the limits this puts upon the generalisability of the findings. Although this may be exacerbated by the single

ethnographic vignette approach adopted here, the vignette of Sarah's birth was selected for its ability to represent authentically the larger study from which it is drawn. Furthermore, we hope that by telling just this one birth story, we have provided a vivid and detailed picture of childbirth in Jeddah, adding new understanding to the dynamic nature of the appropriation of medicalised birth practices in the Middle East. As such the findings of this study have direct clinical implications for the maternity service provision in Saudi Arabia and could be used as a basis for further research on the second stage of labour in this part of the world.

Conclusion

The study from which this vignette is drawn sought to understand the reasons and drivers for routine use of interventions in Saudi Arabian labour wards. The findings were consistent with the medicalisation thesis, but they illustrate how social and cultural settings of care may shape the form this takes. In this case, Saudi Arabian social norms and interpretations of Islam do not only constrain women's agency; Islamic faith is also drawn on as a source of comfort in labour and acceptance of routine medical intervention. This has practical implications for

the task of developing more evidence-informed practice in Saudi Arabia. Future studies should explore women's experiences and agency within this context.

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