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"Call the Midwife": An Argument Against the Medicalization of Pregnancy and Childbirth

In the moments preceding labor, a Rhesus monkey calmly finds a quiet and isolated shrub away from the rest of her group. As labor begins, she squats down, reaches below, and safely pulls the infant out of her birthing canal. She is able to free up the infant's airway herself by holding him in one hand and the umbilical cord in the other. The infant immediately clings to the mother, the mother licks the infant, and the whole birthing process is over in less than an hour. Unfortunately for human mothers, things are not quite so simple.

Due to the pelvic constraints brought on by bipedalism, human mothers have exceedingly more arduous and complicated birthing procedures than monkeys, leaving both the mother and the infant prone to adverse health consequences. To reduce mortalities, prehistoric humans developed obligate midwifery, in which laboring mothers were assisted by members of their kin, primarily other women. Over time, birthing responsibilities were handed from relatives to trained midwives to eventually physicians. The industrial revolution normalized hospital interventions for childbirth, prior to which home births had been the conventional standard. Today, 88% of all childbirths in the United States take place in a hospital setting. The introduction of medical interventions, such as antiseptics, has revolutionized pregnancy and childbirth. Maternal mortality rates have rapidly declined since the 20th century, due in fact to both advancements in technology and medical knowledge. The rise of obstetrics—a branch of medicine dedicated

specifically to childbirth—has made it easier for physicians to prevent and treat complications that arise during high-risk pregnancies. Additionally, diagnostic tools such as ultrasounds have enabled physicians to better predict and plan for the outcomes of any pregnancy.

Given all of these improvements, it is surprising then that the United States consistently ranks worst among all developed countries for maternal mortality. The emphasis on medical intervention has not only eliminated much of the pre-existing midwifery practices but has also led to the medicalization of normal pregnancy and childbirth. Though medical intervention is necessary for high-risk pregnancies, the medicalization of all pregnancy and childbirth practices has resulted in increased complications. Infusing midwifery techniques with modern-day hospital practices could drastically improve health outcomes for both the laboring women and their families.

"Rise of Obstetrics and Fall of Midwifery"

To improve current-day medical practices, the historical context in which they were conceived must first be understood. In the case of childbirth, the "fall of midwifery" and the subsequent "rise of obstetrics" have a complicated history (Johanson et al., 2002). A good starting point is acknowledging the factors that make childbirth so challenging. All human childbirth operates under the pelvic constraints imposed by the obstetric dilemma. Coined in 1960, the obstetric dilemma hypothesis suggests that the structure of the female pelvis is under the control of two selective pressures: bipedalism and increased cranial capacity (Haeusler et al, 2021). When hominids began to stand upright and develop bipedal locomotion, their hips faced evolutionary pressures to grow more narrow. However, female pelvises still required birthing canals wide enough to give birth, especially as evolutionary forces favored large-brained

offspring (Haeusler et al., 2021). The competing effects of bipedalism and increased cranial capacities have resulted in a birth canal that is just wide enough to give birth and support locomotion, but not without compromise; human neonates must assume a non-traditional position in-utero that best aligns with pelvic constraints and requires internal rotation before birth (Haeusler et al., 2021) Given these difficulties, assisted childbirth—known more formally as obligate midwifery—was developed to reduce complications and provide encouragement to laboring mothers. For much of human evolution, obligate midwifery was a female-dominated sphere. This is historically evidenced by the appearance of female birth attendants in ancient Egyptian drawings, Greek mythology, the Old Testament, and various studies conducted on contemporary hunter-gatherer tribes (Drife, 2002). Around the 15th century, trained midwives were formally established to handle complications, but still, labor was considered a domestic affair. As such, natural home births were the preferred modem up until the 20th century.

In comparison, the medicalization of childbirth through obstetrics is a relatively recent phenomenon. Even as late as the industrial revolution, home births were still preferred due to the high rates of infection and disease present in hospitals (Johanson et al., 2002). Obstetricians were only called into the home if the pregnancy was expected to be high-risk or if complications arose during labor (Drife, 2002). Additionally, early instrumental intervention involving forceps carried high mortality risks (Johanson et al., 2002). The introduction of antiseptics and other medical inventions in the 20th century finally made hospitals a formidable option. Other medical interventions such as ultrasounds, epidurals, and surgical tools further standardized hospital practices into what they are today (Johanson et al., 2002). While standardization may have reduced certain complications, it also removed the personable aspects of childbirth that had been

intrinsically tied to its success for so many years prior. Often, the simple existence of a medical practice is taken as proof of its necessity. However, as the history of childbirth indicates, this is not always the case.

Consequences of Medicalization on Physical Health

For most pregnancies, the medical model results in adverse physical consequences such as unnecessary medical intervention and worse labor outcomes. First, a misalignment between hospital standardization practices and female anatomy can potentially worsen labor outcomes. One prime example of this is birthing positions. For centuries, the most common birthing position had been the upright position, as it allows gravity to aid the infant's journey through the birth canal (Liu et al, 1979). Other positions such as squatting, sitting, and kneeling have a similar benefit. Common among other non-human primates, such as monkeys, these positions increase the size of the pelvis and thus provide a biomechanical advantage (Liu et al, 1979). However, the most common birthing position in hospitals is the recumbent position, in which the mother reclines on a bed in a supine manner. The primary benefit of this position goes not to the laboring mother, but rather to the obstetrician, as it allows for better visualization of the cervix and easier access for forceps (Huang et al., 2019). Though the recumbent position is the most widely used, studies have demonstrated that it is more prone to long labor and potential vaginal tears (Huang et al., 2019). Ultimately, these preventable outcomes can have long-term consequences on women's reproductive health.

Additionally, the medicalization of childbirth has increased the prevalence of instrumental and surgical operations, such as caesarian sections. These interventions are invasive and can have long-term effects on women's health (Elnakib et al., 2019). These risks

worsened with age. Though caesarian sections are vital in certain situations, such as high-risk pregnancies and unexpected complications, the disproportionately high C-section rates in the United States indicate that many of these procedures lack medical justification. Rather, the characterization of normal childbirth as a "disorder" or "something to be treated" has driven physicians to consider extreme medical interventions at earlier stages than perhaps necessary (Elnakib et al, 2019). Like birthing positions, the consequences of unnecessary medical intervention are long-lasting.

Societal Consequences of Medicalization

The adverse physical consequences of the medical model are deeply rooted in the incongruence between biomedicine and societal perception. A prominent example is the rising practice of defensive medicine by healthcare professionals. Given the vast advancement of biomedicine throughout the twenty-first century, patients have adopted a "zero tolerance" policy on bad outcomes (Johanson et al., 2002). Though some bad outcomes are indeed due to mistakes or malpractice, the reality is that a much larger percentage simply cannot be avoided. Yet, an assumption that all bad outcomes can be prevented through proper medical intervention has prevailed across society. This is an especially commonly-held belief when it comes to childbirth. As a result, an increasingly litigious environment has been created around the field of obstetrics, forcing physicians to adopt a defensive approach (Johanson et al., 2002). Rather than being accused of withholding treatment, physicians prefer performing all available diagnostic tests and medical interventions—even when not medically necessary—to avoid litigation. If a bad outcome occurs, it is much easier to claim that all treatment possibilities were exhausted before the patient died than to admit that a patient was purposefully left untreated.

The commonplace use of technology in today's world has also affected women's perception of what biomedicine should look like. This has created a paradox in which women believe limiting the use of technology during both their pregnancy and labor would be detrimental to their quality of care (Johanson et al., 2002; Sabetghadam et al., 2022). In truth, the use of technologies such as ultrasound beyond a certain extent offers no competitive advantage.

Finally, increased reliance on instrumental and surgical interventions may be due to a fear of natural childbirth, known as tokophobia **(**Prosen & Krajnc, 2019). Since childhood, women have been primed to believe that pregnancy and labor are difficult processes subject to unbearable levels of pain. The characterization of childbirth as a pathological condition, rather than a natural process, further perpetuates this belief. Medicalization practices place control in the hands of the physician and limit women's reproductive autonomy (Vedam et al., 2019). Given that hospitals are already associated with death and disease, this could potentially instill fear in place of confidence. As such, those fearful of childbirth are more prone to seek quick, surgical alternatives (Johanson et al., 2002). Changing public perception of both the limitations of obstetrics and the normalcy of childbirth is the first step in empowering women to be active participants in their own birthing process.

The Benefit of Combining Models

A combination of the midwifery and medical models would provide the best standard of care for birthing mothers. Though the medical model has its faults, many of which remain unaddressed, it is important to acknowledge the advantages it provides as well. The existence of the obstetrics field allows medical complications to be thoroughly researched and accounted

for. Additionally, medical interventions such as epidurals are effective in managing pain (Anim-Somuah et al., 2018). However, a majority of childbirths do not require the level of benefits that the medical model provides and thus are only affected by its disadvantages (Kundisova et al., 2019). A cross-sectional study performed on a neonatal intensive care unit in Italy found no positive correlation between more controlled pregnancies and neonatal health recovery (Kundisova et al., 2019). This indicates that adverse childbirth consequences must be alleviated by some mechanism other than additional medicalization efforts.

An infusion of midwifery practices, such as birthing positions and familial support, into hospital settings, may be able to reduce some of the negative consequences of modern practices. In the midwifery model, women can give birth in the comfort of their own homes. Emerging evidence points to the correlation between normal birth outcomes and positive beliefs about the birthing process (Johanson et al., 2002). The highest rates of normal childbirth are associated with community-based approaches. For instance, the presence of loved ones has been shown to reduce cesarean section rates. Educating women on all of their birthing options and recentering obstetrics to focus on the birthing women's perspective may also reduce the fear associated with childbirth.

Alternatively, some anthropologists recommend the creation of birthing centers, which work in tandem with hospital physicians to coordinate the care of low-risk pregnancies while still maintaining an "at-home" ambiance and providing women with more birthing options (Rice & Williams, 2022). The benefit of reducing unnecessary hospital visits offers a financial advantage to both patients and hospitals alike. In reducing unnecessary complications, hospitals on future expenses. Through the creation of birthing centers, mothers benefit by not having

expensive medical bills at the end of their hospital visits. accredited birth centers are accepted by the American College of Obstetricians and Gynecologists (ACOG) as a suitable form of care.

Conclusion

The problems in modern healthcare stem from the need to turn childbirth into a repeatable, clinical procedure. Unfortunately, human childbirth comes with its own set of rules and regulations. Thousands of years of human evolution, along with evidence from non-human primates, have demonstrated what techniques provide the most efficient births. Just as humans have vestigial organs—such as the appendix—left over from ancestral environments, the same is true of the modern healthcare system, which has outdated remnants of the industrial revolution's influences. However, unlike appendixes, these remnants can have lasting effects on millions of lives. It is important to not only consider how certain practices came to be established within the modern healthcare system but to also consider what their consequences are on current populations. It is impractical to believe that all low-risk pregnancies will be rerouted back into the midwifery model. It is also impractical to continue showing partiality solely towards the medical model, given the strong empirical evidence against certain aspects of it. Thus, the best approach would be to offer a combined medical and midwifery approach, as well as educate women on what options are available to them.

For a rhesus monkey, labor lasts at most three hours. For human mothers, labor can last upwards of eight hours or more, followed by long periods of immobility, pain, and sometimes depression. On top of that are the added stresses of balancing careers, managing medical bills, and arranging child care while at the hospital. If returning to a primal method of childbirth means few adverse effects and better health outcomes, then it is in society's best interest to try.

References

American College of Obstetricians and Gynecologists. Obstetric Care Consensus: Safe prevention of the primary cesarean delivery, reaffirmed 2019. 2019a. https://www.acog.org/Clinical-Guidance-and-Publications/Obstetric-Care-Consensus-Series/Safe-Prevention-of-the-Primary-Cesarean-Delivery

Anim-Somuah, M., Smyth, R. M., Cyna, A. M., & Cuthbert, A. (2018). Epidural versus non-epidural or no analgesia for pain management in labour. *The Cochrane Database of Systematic Reviews*, *2018*(5), CD000331. https://doi.org/10.1002/14651858.CD000331.pub4

Drife, J. (2002). The start of life: A history of obstetrics. *Postgraduate Medical Journal*, *78*(919), 311–315. https://doi.org/10.1136/pmj.78.919.311

Elnakib, S., Abdel-Tawab, N., Orbay, D., & Hassanein, N. (2019). Medical and non-medical reasons for cesarean section delivery in Egypt: A hospital-based retrospective study. *BMC Pregnancy and Childbirth*, *19*(1), 411. https://doi.org/10.1186/s12884-019-2558-2

Haeusler, M., Grunstra, N. D. S., Martin, R. D., Krenn, V. A., Fornai, C., & Webb, N. M. (2021). The obstetrical dilemma hypothesis: There's life in the old dog yet. *Biological Reviews of the Cambridge Philosophical Society*, *96*(5), 2031–2057. https://doi.org/10.1111/brv.12744

Huang, J., Zang, Y., Ren, L.-H., Li, F.-J., & Lu, H. (2019). A review and comparison of common maternal positions during the second-stage of labor. *International Journal of Nursing Sciences*, *6*(4), 460–467. https://doi.org/10.1016/j.ijnss.2019.06.007

Johanson, R., Newburn, M., & Macfarlane, A. (2002). Has the medicalisation of childbirth gone

too far? *BMJ : British Medical Journal*, *324*(7342), 892–895.

Kundisova, L., Nante, N., Cuccaro, C., Mariottini, E., & Alaimo, L. (2019). Does the over-medicalisation of pregnancy help to improve neonatal outcomes? *European Journal of Public Health*, *29*(Supplement_4), ckz187.127. https://doi.org/10.1093/eurpub/ckz187.127

Liu, Y. C. (1979). Position during labor and delivery: History and perspective. *Journal of Nurse-Midwifery*, *24*(3), 23–26. https://doi.org/10.1016/0091-2182(79)90077-6 Prosen, M., & Krajnc, M. T. (2019). Perspectives and experiences of healthcare professionals regarding the medicalisation of pregnancy and childbirth. *Women and Birth*, *32*(2), e173–e181. https://doi.org/10.1016/j.wombi.2018.06.018

Rice, K. F., & Williams, S. A. (2022). Making good care essential: The impact of increased obstetric interventions and decreased services during the COVID-19 pandemic. *Women and Birth*, *35*(5), 484–492. https://doi.org/10.1016/j.wombi.2021.10.008

Sabetghadam, S., Keramat, A., Goli, S., Malary, M., & Rezaie Chamani, S. (2022). Assessment of Medicalization of Pregnancy and Childbirth in Low-risk Pregnancies: A Cross-sectional Study. *International Journal of Community Based Nursing and Midwifery*, *10*(1), 64–73. https://doi.org/10.30476/IJCBNM.2021.90292.1686

Vedam, S., Stoll, K., Taiwo, T. K., Rubashkin, N., Cheyney, M., Strauss, N., McLemore, M., Cadena, M., Nethery, E., Rushton, E., Schummers, L., Declercq, E., & the GVtM-US Steering Council. (2019). The Giving Voice to Mothers study: Inequity and mistreatment during pregnancy and childbirth in the United States. *Reproductive Health*, *16*(1), 77. https://doi.org/10.1186/s12978-019-0729-2