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Childbirth

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The Landscape of Childbirth in the United States

While childbirth is certainly a biological event, it also has a socio-cultural component that has changed over time to reflect particular historical moments. At varying times childbirth has been a private affair undertaken by a woman alone, an intimate experience shared by two partners, and a grand social event involving friends and family. This shift over time can be seen to correspond to changes in society; the status of childbirth is closely linked with dominant views on how a society sees women and to some degree reflects the overall social standing of women at that time. In the context of the US, the changing nature of childbirth is apparent. During the 1920s, childbirth became increasingly medical, moving from the home to the hospital. Many have cited the 'assembly line' style of care that attended this move, and birthing women became a major commodity in the healthcare industry. This shift mirrored women's widespread move from the home to the workplace and captured the overall tenor of the time—commodification of women's labor. A similar phenomenon can be seen during the 1950s, when idealized white, middle-class women were embracing domesticity and were striving for lives of suburban disengagement. During this time, hospital birth became centered on complete pain management. With the advent of 'twilight sleep'[1] and other such interventions, childbirth became a non-event, one that women were literally 'put to sleep' for, perpetuating the cultural myths of the time—modesty, privacy and isolation. The ways that a society conceives of and approaches childbirth reflects its broader conception of women and speaks to the social standing of women at the time.

Since the turn of the century, childbirth has become increasingly medicalized. Beginning with birth shifting from home to hospital in the 1920s, medical management and oversight has become the paradigm of western birth. Over the decades, the delivery room has become a site of advancing technologies and laboring women have witnessed a birth process that reflects these rapid changes. As the field of obstetrics has grown more closely intertwined with developing medical technologies, childbirth itself has become more technological. Such technological advancement has allowed for the routine surveillance of women's birthing bodies through myriad devices. This ability to constantly monitor a woman's labor has fostered the entry of a growing number of medical interventions and has legitimized doctors' increased involvement in the birth process.

And today, with the overall social consensus being that hospital birth is safest, this rising rate of obstetrical intervention is viewed as evidence of birth security. Particularly when attended by an obstetrician, a safe birth is seen as virtually guaranteed within the high-tech environment of the hospital delivery room. As a result, the vast majority of women continue to choose physician-attended (91.4%) or certified nurse midwife-attended (7.6%) hospital birth over other non-hospital alternatives (<1%). These

[1] Gaining popularity during the early to mid-twentieth century, women were given scopolamine (an amnesiac) together with morphine (an opiate) to numb the body to the pain of childbirth. The resulting state was popularly known as 'twilight sleep.' This narcotization of birth fell out of favor as evidence was produced demonstrating its negative impact on mothers and babies (ranging from women's nightmare birth recollections to infant and maternal death) and as medicalized birth advocates championed the reclamation of unmedicated birth.

statistics have remained relatively stable over recent decades. Today, over 99% of births take place in a hospital environment, and are subject to the procedures and treatments that accompany medicalized care.

Most commonly, medical technologies are used to monitor the birthing woman and manage the delivery of the baby. It is routine practice for women to be constantly monitored through the use of an Electronic Fetal Monitor (EFM) (an instrument that measures the heartbeat of the baby) during the course of her labor. Over 85% of birthing women, or more than 3.2 million live births, were monitored during labor using EFM in 2003, and this rate has climbed steadily since 1989. EFM is the most frequently reported obstetric procedure, and may in fact be used to monitor an even higher percentage of births.[2] In addition to the EFM, it has become increasingly popular to employ Internal Fetal Monitoring (IFM) (where an electrode is attached through the vagina directly to the baby's head) to ensure constant monitoring of the baby's heart rate during labor. Both of these surveillance technologies necessitate that the woman be connected to machinery through wires, electrodes and sensors. This technology is quite sensitive, and often requires the birthing woman to remain immobile to ensure a stable reading.[3] Labor monitoring is also carried out through detailed charting to ensure that cervical dilation is progressing along expected lines.[4] Slow or stalled labors are thereby quickly noticed, and more stringent courses of medical management are then adopted.

A woman in labor is routinely supervised and her medical caregivers regularly intervene into her labor and delivery. One-fifth of all birthing women will have their labor induced, a rate that has more than doubled from the 9.5% rate in 1990. This rising rate has been linked to a growing number of elective inductions (inductions with no medical or obstetric indication) and 25% of today's induced labors are the result of these 'patient-choice' inductions. Labor contractions are also increasingly amplified with a variety of chemical stimulants, and 16.7% of labors in 2003 were augmented in such a way. This represents a 59% increase from the 1989 stimulation rate of 10%. And even when there is evidence that certain medical interventions are in decline—processes such as vacuum extraction and forceps delivery have decreased in recent years, dropping by 41% to only 5.6% in 2003, down from 9.5% in 1994—there is often a more complicated explanation for these trends. This decrease in assisted delivery has been linked to a drastic increase in cesarean births, making these vaginal delivery techniques unnecessary.

Today the US cesarean rate is above 30%—the highest rate ever reported. Driven by both the rise in primary cesareans (particularly for low-risk women) and the steep decline in the Vaginal Birth After Cesarean (VBAC), this represents a 5% rise from 2002 and a 25% rise from 1996. The rate of women having a vaginal birth after a previous cesarean (VBAC) fell 16% in the last year and has dropped 63% since 1996. Because the majority of medical liability insurance providers no longer cover the procedure, it is increasingly difficult for women to choose a VBAC in a hospital environment. Thus, women who have an initial cesarean delivery must now deliver all subsequent babies via

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[2] According to their National Vital Statistics Report, the CDC has suggested that EFM statistics are often vastly underreported on birth certificates.

[3] Because of the growing evidence of false positive reports of fetal distress as a result of EFM, greater attention has been focused on curbing women's movement during labor and encouraging their immobility.

[4] It is a common obstetrical assumption that women will dilate according to the Friedman Curve, which stipulates 1.2 cm dilation for each hour of labor. Though many women do dilate in such a manner, as many as 20% of otherwise low risk women do not progress at this rate.

cesarean section. Also leading to the growing rate of cesarean deliveries is the rising number of women with very low risk pregnancies delivering by cesarean, a trend that has risen 67% since 1990. A number of these are elective cesareans—surgical deliveries that were requested and scheduled by the woman herself rather than recommended by her medical team.

Pain management plays a central role in childbirth today. The vast majority of women elect to use some sort of medication to alleviate the pain of childbirth. Most common is the epidural, a local or regional anesthesia or painkiller medication that is injected through a tube-like catheter into the birthing woman's lower back. This technique of pain management numbs the body from below the waist, and as a result women feel very little of the pain associated with childbirth. Analgesics, which are also common, are pain medications that are given intravenously and are also used to mitigate the pain of childbirth. In addition, tranquilizers are administered (often in conjunction with analgesics) to calm and sedate birthing women who are unsuccessfully navigating the pain of childbirth. Another pain mitigation technique, one that has persisted since the beginning of the last century, is the administration of nitrous oxide (laughing gas) to laboring women. In some situations, birthing women are injected with opioids (narcotics), which can also be given intravenously to manage pain. In the hospital, enduring the pain of childbirth is believed to require a number of different medications, all of which are available and administered by the birthing woman's medical team. Even when women anticipate an unmedicated birth, many of them eventually request to one of the above-mentioned interventions for pain relief.

The Critique of Childbirth Today

The medicalization of childbirth has not arrived without a small but vocal critique. Critics of medicalized birth have suggested that recent trends in the birth process are in many ways inhospitable, and are frequently hostile to the bodies and the experiences of birthing women. Growing out of the 'natural birth' tradition of the 1960s, their critique extols the virtues of midwifery care, unmedicated labor and even homebirth. They have claimed that the increase in technological dependence and medical intervention have not resulted in the expected levels of safety and security, and may in fact be partially to blame for the US's embarrassingly high rates of both infant and maternal mortality.[5] And though their ranks remain relatively small and their influence rather minimal, their rhetoric has empowered a growing group of discontents concerned with the current trajectory of medicalized childbirth. Their critical appraisal has occasionally garnered mainstream attention—particularly around the recent controversy over cesarean section—where it has led to a more general critique of obstetrical practices and the medical management of birth.

Ongoing childbirth activism has primarily focused on the character of medical care today. Particularly around issues of labor and delivery, their criticism has made a number of significant interventions into the nature of women's health care. This work has been instrumental in pointing out the fact that some medical practices are unfriendly (and sometimes harmful) to birthing women, and are part of a larger tendency to see

[5] The US ranked twenty-six in the world in term of infant survival in 1999, far below the rank of other developed (and a few less developed) countries.

childbirth as a medical malady rather than a normal biophysical process. Practices such as the pubic shave and enema were contested as inhumane and medically unnecessary, and have gradually faded away after years of protest. Partners and relatives are now welcome to attend the birth. Studies demonstrating the correlation between soaking in water and a decrease in pain during labor have been used to fuel a push for the installation of tubs in delivery wards. Childbirth advocates and birthing women have long promoted the efficacy of sitting, standing and squatting during delivery and have mounted an ongoing campaign to allow birthing women off their backs and into more comfortable positions. Though these critiques have offered (and continue to offer) some amendment to the current birth idiom, the more general course of medical intervention and management continues unabated.

More recently, critics have wondered if medical practitioners can reasonably expected to follow their Hippocratic Oath of 'first do no harm' in today's medical environment. Many childbirth activists and critics have suggested that healthcare workers (including labor and delivery nurses and obstetricians) are influenced by a variety of pressures that can complicate decision-making. In a litigious field such as medicine, the specter of malpractice hangs heavy and, coupled with the capitalistic desires of hospitals and HMOs, encourages a healthcare system that tends toward 'intervention at any cost' rather than employing a more tempered approach. It is this intrusive approach to medicine that critics cite as leading to a style of care that pathologizes and commodifies every aspect of pregnancy and childbirth.

Yet despite these critiques, the medical community continues to enjoy a high degree of legitimacy. The overall social consensus is that hospital birth is safest, particularly when attended by an obstetrician. As a result, the vast majority of women (99%) continue to choose a medically managed hospital birth over other less medical alternatives. Medical intervention is seen as a normal part of the birth process and medical technologies play a central role in the monitoring and management of labor and delivery. In fact, the increase in elective cesarean delivery demonstrates that today more women than ever before are opting for a highly medicalized and indeed surgical birth. All of this occurs parallel to the mounting evidence suggesting that such a highly medicalized course of action may not offer the highest level of safety and security in childbirth. Many have begun to wonder why women continue to choose care that may compromise their goal of a smooth birth and a healthy baby.

Early critics of medicalized childbirth believed that women choosing such care for their pregnancy and birth were operating without full knowledge of the data and research. It was believed that once women learned that medicalized (including surgical) birth may not represent the pinnacle of healthcare, a paradigm shift would occur and more women would denounce medical birth in favor of a more "natural" experience.[6] Instead, even as more research is released demonstrating the uncertain safety of medicalization during childbirth, women continue to choose hospital and even surgical birth in growing numbers. As these rates continue to rise, it becomes apparent that women are making decisions about their birth based on a number of different factors—overall safety of any given procedure may play only a minor role in the decision. Women are not, in fact, operating under a sort of 'false-consciousness' assumed by early

[6] The dichotomy of natural vs. medical is common in the alternative birth movement, as is a variety of other language that feminists and others have found essentializing and problematic.

alternative birth critics but are responding to a complex set of forces both external and internal that shape their decisions and inform their choices.

Much ink has been spilled debating the consequences of this trend towards rising cesarean section rates and increased levels of medical intervention. Some believe that the growing number of cesareans is the result of a medical community driven by profitability and fear of litigation. Others have responded that the pressure has not come from doctors, but instead from birthing women themselves who are actively requesting surgical birth and other medical interventions.[7] By couching the debate in terms of *choice*, medical practitioners assert that women have the option to choose whichever delivery method they prefer, and obstetricians merely comply, even if medical evidence may contradict patient choice. Critics suggest that such a *choice* is often fraught with social pressures that re-inscribe gender inequality—particularly when women opt for surgical birth to avoid the potential consequences of vaginal birth, including possible loss of vaginal tautness and the "honeymoon vagina." Others have wondered if birthing women find the moral superiority that often permeates the alternative birth movement alienating. The language and tone of the alternative childbirth movement is often laced with condescension towards those who do not adhere to the tenets of 'natural childbirth,' including unmedicated delivery, breastfeeding, co-sleeping, etc. As a result, women who may have benefited from the critiques that the alternative childbirth movement offers do not spend time exploring its critical appraisal of medicalization and surgical birth. It has also been observed that women are oftentimes pleased with the pain reduction and convenience of surgical birth and choose surgical birth knowing its possible attendant consequences, troubling the assumptions of 'false-consciousness' made by proponents of the alternative childbirth movement. What is clear is that women's decisions about childbirth are influenced by a variety of social, economic, medical and personal forces, all of which need to be closely examined in order to understand how each shape the conclusions that are drawn about childbirth today.

The Politics of Childbirth

The trend towards higher levels of surgical birth, and indeed the rising rates of medical intervention more generally, has generated much commentary over the nature of childbirth today and the consequences of this ever more medicalizing practice. Many have suggested that this pattern stems from the increased influence that health maintenance organizations (HMOs) have on the practice of medicine. These organizations have certainly changed the way that health care is managed and have shaped both the procedures that are chosen and the ways that they are orchestrated. The complex relationship between HMO, medical insurance, and liability has no doubt altered the practice of medicine, making it more susceptible to the pressures of the market. And while there is evidence to suggest that such medicalization of childbirth has resulted in dramatic economic gains for HMOs, hospitals and doctors, it is dangerous to assume that this is the only force pushing the trend towards surgical birth and an interventionalistic model of care.

The medical community has been quick to respond to these claims. They have asserted that, in fact, this trend is not the result of obstetricians advocating for surgical

[7] Indeed the language of 'elective' interventions and 'on-demand' or 'patient-choice' procedures is common.

birth and medicalization, but instead grows out of the demands made by birthing women themselves. Indeed there has been substantial evidence to support the argument that a growing number of women are choosing cesarean, induction, epidural, etc. before even interacting with their medical team. Women who have low-risk pregnancies and who show no signs of needing advanced intervention are requesting medical procedures such as cesarean sections and labor inductions even before their waters break. Such trends are particularly common among pop idols (Madonna, Brittany Spears, Jamie Lynn Spears, Angelina Jolie, Christina Agulara, Jennifer Lopez, etc.) who have been dubbed "too posh to push" and are increasingly opting for a *celebrity cesarean*. Many doctors feel compelled to provide women with medical interventions whenever they are requested, even if such a demand puts woman and baby at a higher risk for complications. This debate has been presented as a matter of *choice* on the part of the woman, which some (particularly alternative birth movement activists) have critiqued as being quite distorted. Critics have responded that the medical community has rarely been concerned with respecting a women's right to choice[8] and have demonstrated the long history of restricting the options that women have, including harshly penalizing women who *choose* to birth at home, in a birth center, with a midwife, etc.

A more careful deconstruction of the elective cesarean section as an issue of *choice* has revealed that this *choice* may reflect a deeper social inequality that encourages women to make decisions that privilege others over themselves. Feminist work has long illustrated the myriad ways in which decisions made within a patriarchal society are rarely free, and instead reflects the power differential between men and women. A woman's choice to birth via cesarean section to—for example—preserve vaginal tautness or to prevent late pregnancy weight gain reflects just such tendency. Others have claimed that such reasoning strips a woman of her agency and undermines her autonomy. And while both sides may have merit, it is clear that a debate around *choice* over-simplifies the complexity of the issue at hand. This tendency to generalize the nature of these debates has led to escalating tension between the medical community, childbirth activists and birthing women, all of whom find themselves defending a caricatured position in the face of mounting criticism.

The alternative childbirth movement has certainly played a role in the overgeneralization and occasional misrepresentation of the medical opposition. Since the 1960s, childbirth activists and concerned citizens have advocated for greater social awareness around elective cesarean section and a variety of other birth interventions. And yet while their critiques often have substance, they have rarely managed to alter the direction of medicine in any sustained way. Childbirth activists have suggested that this silence reflects the power held by the medical community, which they believe has worked to systematically discredit and undermine critical opposition. Feminist critics have espoused a more internal critique and have pointed to both the moralistic tone and the essentializing language employed by the alternative childbirth movement. Feminist critics have speculated that birthing women feel alienated by the intense and often polarizing views espoused by childbirth activists—many of whom hold strong counter-culture attitudes on a variety of different issues.

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[8] Women have frequently been pressured into cesarean deliveries and other forced interventions by their doctors and thus had their 'choices' limited by medical practitioners.

Furthermore, childbirth activists' universal denunciation of any and all medical intervention does not leave room for the reality that many women find the use of pain-relieving drugs such as epidural and other medical interventions and even cesarean birth empowering and fulfilling. However, while there is substantial research demonstrating the risk associated with a number of these practices, this ubiquitous denunciation does little to bring new women into the alternative childbirth movement. And with the rising rates of medically intervened births, many women today are finding the discourse of the alternative childbirth movement alienating and didactic. So while the alternative childbirth movement may have many well-substantiated arguments against the medicalization of childbirth, their divisive rhetoric distances a majority of women and keeps many from exploring the legitimacy of their critique.

And yet, the kernel of their criticism remains valid—medicalization is often not the best practice in childbirth. Twenty-five years of radical childbirth activism has managed to demonstrate that the philosophy of obstetrical practice today is interventionist and over-medicalized and does not promote the health of mothers and babies. Increasing levels of medicalization in obstetric care have resulted in shrinking midwifery units within hospitals and the decimation of out-of-hospital midwifery (also called direct-entry) care. In many states[9] practicing midwifery outside of a hospital environment is illegal, and direct-entry midwives operate through an informal underground network without medical or legal support. In recent years, midwives have been tried and convicted of practicing medicine without a license, of manslaughter, and even of murder by district attorneys who represent a state-sanctioned effort to limit out-of-hospital options for birthing women. Such efforts have been largely successful and the number of out-of-hospital births in the US has dropped to less than 1% today. This drastic shift in the landscape of childbirth has not only normalized hospital births for nearly all women. It has also acted to diminish the oppositional voices that have long critiqued the medical establishment and has truncated the rich supply of evidence and documentation that supported such a critique.

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[9] 15 total, including Illinois where the American Medical Association is headquartered.

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