The Struggle for Control in Childbirth Practices

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On my honor as a University Student, I have neither given nor received unauthorized aid on this assignment as defined by the Honor Guidelines for Thesis-Related Assignments

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Introduction

Childbirth practices changed rapidly over the early 20th century. Hospital births jumped from 5% of all births in 1900 to 50% in 1935, causing a rise in medical interventions such as bed rest, episiotomies, anesthesia, and c-sections (Jansen et al., 2013; Thomasson & Treber, 2008). Medical interventions offer birth security and are often viewed as the safest childbirth option (Jolly, 2010). However, medicalized childbirth has been critiqued for pathologizing a natural process (Martucci, 2018). The medicalization of birth impacts millions of pregnant patients in the United States who may accept the new paradigm or seek to regain control. Through what avenues have pregnant patients responded to medical interventions in birth? Pregnant patients interact closely with physicians and other birth attendants or advocates who are involved in the childbirth process. The ways in which these groups have evolved shows the interface between technology and society.

Methods

Relevant first-person accounts of birth, drawn from sources such as Mommy-blogs and midwifery websites are used. Blog accounts and perspectives published by midwives reflect evidence for birth priorities. There are fewer first-person interviews from advanced practitioner sources such as physicians. However, the American College of Obstetrics and Gynecology issues general practice standards that offer insight into the decisions and priorities of these specialized physicians. As the representative body for ob-gyns, these practice standards are considered as evidence. First-person sources existing at the intersection of perspectives, such as a physician choosing a natural birth are also highlighted.

Larger frameworks and theories regarding birth are drawn from medical sociology and anthropology journals. These articles are found in library databases with terms such as "medicalized childbirth," "childbirth interventions," and "historical childbirth perspectives." The focus of this analysis is on the interconnected priorities and decisions of each involved actor. This analysis is chronologically ordered as many of the shifts occurred over decades, largely starting in the early 1900's. It primarily focuses on American childbirth practices, with occasional historical sources drawn from Britain because of the influence of British midwifery practices on American practices. Lastly, within the analysis, the "medical model" or the use of interventions in childbirth are considered as the technologies of interest.

History of Childbirth

For much of history, childbirth was a social and exclusively female experience. Birthing patients were accompanied by friends, family, and local community members (Dye, 1980; Filippini, 2020). While the experience could be one of female bonding, it was also a time of fear (Dye, 1980). Birth and death were seen to be near events, as both the pregnant patient and child were at risk of death (Filippini, 2020). Therefore, seeking help from birth attendants and seeking community during childbirth was common.

In the mid-1800s, some upper-class, urban women began to turn to physicians for childbirth care (Dye, 1980). These American physicians had been trained in midwifery in Britain, and they marked the beginning of the shift away from a female-controlled experience, from midwife to physician. During the Enlightenment, a midwives' traditional knowledge was devalued (Filippini, 2020). Surgeons often deliberately devalued a midwives' experience in order to advance their own position in a traditionally female-dominated birth domain (Cahill, 2001).

Both physicians and midwives are relevant participatory groups in the birth process. During the early shift to physician-attended births, physicians and midwives were often in conflict. Although each group was interested in the safety of the birthing patient, they were also interested in advancing their own ends and positions.

The physician-controlled birth experience has been posited to be a medicalized model (Cahill, 2001). The medical model considers the birthing process as pathological and a clinical event that must be actively managed (Cahill, 2001). It is characterized by technological interventions used to facilitate birth. Researchers have argued that this model is based on power dynamics in which a female is seen as inferior and as a medical case to managed rather than supported (Cahill, 2001). Early physicians were entirely male, a change from the female-dominated field of midwives who supported a mother emotionally and physically.

Largely, the shift to a medicalized birth model was complete in the 1920's and persisted throughout the rest of the 1900's (Declercq, 2018). The cesarean rate reached a high in 2009 at 32.9%, showing the common modern use of c-sections (Declercq, 2018). Overall, the time frame from the mid-1800s to the modern day was a period of significant change for childbirth. Within this overarching timeline, it is relevant to study the ways in which participating groups, such as physicians, patients, and midwives, deployed tactics to further their own goals and generate change in childbirth norms.

Theories of Childbirth Practices

Prior scholars have used first-person accounts and theories of risk and gender to contribute to literature regarding childbirth practices. Evidence from participatory groups such as governing standards for physicians offer insight into the priorities for childbirth. Literature

considers the viewpoints of different participatory groups, including patients and unique members of the healthcare team.

Dr. Kellie Owens, a medical sociologist from NYU Grossman School of Medicine, has contributed to the discourse regarding childbirth interventions. In 2017, her article "Too Much of a Good Thing? American Childbirth, Intentional Ignorance, and the Boundaries of Responsible Knowledge" was published in *Science, Technology, & Human Values*. It examines the debate of continuous fetal monitoring within the framework of American risk culture and considers the perspective of both doctors and midwives (Owens, 2017). Continuous fetal monitoring is one form of technological intervention in childbirth, and the article includes two relevant participant groups. Dr. Owens draws from first-person accounts of obstetric providers and uses theories of knowledge and risk in modern society (Owens, 2017). These first-person accounts shed light into some of the decision-making procedures that guide the actions of healthcare providers. It also shows how physicians are seen by larger society to hold the most knowledge.

Dr. R Davis-Floyd is a cultural anthropologist focused on the anthropology of reproduction and childbirth. She has considered three paradigms of healthcare that heavily influence childbirth: technocratic, humanistic, and holistic (R. Davis-Floyd, 2001). Each paradigm was championed by a participatory group. For example, the technocratic childbirth paradigm was promoted by physicians. The humanistic paradigm was promoted by patients and doulas. She has also considered the dimension of cultural expression inherent to childbirth, exploring the birth choices of forty middle-class women (R. Davis-Floyd, 1994). She posited that the technocratic paradigm of birth is one in which the female body is viewed as abnormal and the demands of birth place it at high risk of malfunction (R. Davis-Floyd, 1994). Dr. Davis-Floyd's

analysis shows the significance of considering varying perspectives, different participatory groups, and first-person accounts.

Scholars have also used gender theory as evidence for changing childbirth procedures. Heather Cahill published an article in the *Journal of Advanced Nursing* entitled "Male appropriation and medicalization of childbirth: an historical analysis" (Cahill, 2001). She posits that the view of female inferiority has been cultivated through years of medical discourse and education. These internalized beliefs of the female body largely influences a male physician's treatment of women, leading to the aforementioned technocratic paradigm of birth (Cahill, 2001). This use of gender theory is especially significant when considering the shift from female to male dominated spheres of influences.

Another scholarly work signifies the importance of considering a pregnant patient's narrative. Madeleine Akrich and Bernike Pasveer point to this: " birth narratives, as we pointed out for other kinds of empirical data, are not considered as 'reflecting' reality but as constituting the reality we are interested in, that is, the woman's childbirth experience" (Akrich & Pasveer, 2004). This framework signifies that data or objectivity regarding a childbirth experience will only shed a limited amount of light on the full story. Considering childbirth narratives with regards to how pregnant patients perceive their experience and interventions is also significant. Each participant group operates with a unique amount of education and experience in comparison to others, and these narratives shed light on their internal decision making and their subsequent actions.

Early Medical Interventions

Childbirth is now a standardized clinical event, yet used to be a social, female-dominated experience. Prior to discussing advocacy for control in birth, it is important to understand the changes in the experience of birth, often championed by physicians. In the 1800s, there was a shift from community-based, social childbirthing experiences to more medicalized experiences organized by a physician. A fourth year OB-GYN resident stated, "We shave 'em, we prep 'em, we hook 'em up to the IV and administer sedation. We deliver the baby, it goes to the nursery and the mother goes to her room. There's no room for niceties around here. We just move 'em right on through. It's hard not to see it like an assembly line" (R. E. Davis-Floyd, 1987). The rise in the number of hospital births caused a rise in medical interventions such as bed rest, episiotomies, anesthesia, and c-sections. Medical interventions give control over the childbirth process to physicians as they are the primary provider for these technologies. Midwives, for example, are not qualified or trained to provide interventions such as c-sections.

Physicians were successful in establishing their authority over midwives. They were organized and received formal training, while midwives relied on experience (Cahill, 2001). There was also a difference in licensing: practicing midwives were often unlicensed and unregulated (Donnison, 2023). The ability of a physician to tout their advanced training, licensing, and organized efforts led to the increased use of physicians in the birth process. Obstetricians were perceived to have advanced and superior knowledge regarding birth (Hairston, 1996). The physician position was further advanced by the use of forceps, a grasping instrument that aided physicians in delivering a baby (Donnison, 2023). The advent of anesthesia also accelerated the rate of hospital births in comparison to home births (Donnison, 2023). The use of these medical interventions improved the status of physicians over midwives, who

traditionally did not rely on any type of instrument. Therefore, the inclusion of childbirth medical technologies into the physician practice advanced the societal shift to physician-attended births. Medical technologies allowed one participatory group, the physicians, to exert control over a process prior overseen by midwives.

Joseph DeLee was a prominent physician from Chicago who led early changes in obstetrics toward a more medical model (Leavitt, 1988). He published articles in medical journals such as *The Principles and Practice of Obstetrics* to advocate for the use of forceps, sedation, episiotomies, and medication (Leavitt, 1988)). He stated "instrumental delivery is safer than prolonged, hard, unassisted labor" and reminded of the dangers of labor: "I have often wondered whether nature did not deliberately intend women should be used up in the process of reproduction in a manner analogous to that of salmon, which dies after spawning" (Leavitt, 1988). DeLee has been both celebrated and criticized for advocating for routine interventions in birth. Some physicians, such as J Whitridge Williams, felt the interventions were "perniciously active" and placed pregnant patients at higher risk from complications than with no interventions in an otherwise normal birth (Leavitt, 1988). Others agreed with DeLee's concept of watchful expectancy and preventative measures (Leavitt, 1988). DeLee believed that his methods would improve the experience of pregnant patients but also would allow the practice of obstetrics to further develop (Leavitt, 1988). Later scholars have criticized DeLee's practices for perpetuating gendered stereotypes in the medical field. Majority male physicians, who saw the female reproductive process as problematic, pathologized normal reproductive functions that were prior considered to be natural. The framing of female reproduction in a problematic light has persisted to modernity via medical texts and knowledge. The example of DeLee's rhetoric, therefore, signifies that medical technologies could be used to switch the emphasis in childbirth from

natural cues to an instrumented, controlled delivery run by a physician. The focus on medical technologies in childbirth could also be used as a tool to perpetuate societal gendered stereotypes.

Patient Response to the Medical Model of Birth

All pregnant patients value a safe delivery, yet they disagree about the practices necessary to achieve this end. Some patients have advocated for medical interventions to improve the birth experience, for comfort and safety reasons. Another group of pregnant patients select education advocacy programs to take control over their birth experience. Others choose to forego the medical model of birth, and give birth at home, assisted by a midwife and doula. Patients seeking alternative childbirth options, opposed to the medical model described previously, comprised 1.26% of all births in 2020 (Gregory, 2021). Patient choices occurring in response to the changing childbirth norms are further described subsequently. Wherever possible, first-person accounts drawn from primary sources are included. These quotations shed light on the decision-making made by pregnant women prior to childbirth. These active decisions are a core component in advocating for the childbirth experience that they desire. The following sections are divided into the methods by which pregnant patients have sought to educate, advocate, or select a specific experience for themselves.

Twilight Sleep

During the shift toward a medical birth model, some pregnant patients sought medical interventions in birth. For example, in the early 1900s, “twilight sleep” or scopolamine-morphine, allowed pregnant patients to give birth without suffering the pain or experience of

childbirth. The medication dulled awareness and removed memory of the birth process (Wertz & Wertz, 1977). Twilight sleep allowed childbirth to be transformed "from a gross and primitive physical agony to normal unimpeded muscular process which can be entirely directed by the obstetrician" (Hairston, 1996). Pregnant patients given twilight sleep were semi-conscious and often had to be isolated and placed in beds to prevent injury (Leavitt, 1980). The drug was largely regarded as experimental and seen to be inferior to inhaled anesthetics by physicians (Hairston, 1996). However, American women contested this view, and criticized medical professionals for withholding the opportunity for painless childbirth (Leavitt, 1980). This fueled the creation of the National Twilight Sleep Association (NTSA) to advocate for the adoption of Twilight Sleep. The association held rallies and staged meetings in department stores (Leavitt, 1980). Women of the NTSA touted the birth experience with Twilight Sleep. Mrs. Francis Carmody of the cause stated, "I experienced absolutely no pain … The Twilight Sleep is wonderful … If you women want it you will have to fight for it, for the mass of doctors are opposed to it" (Leavitt, 1980). Mrs. Carmody's speech showcases the advocacy towards a less painful birthing experience. In the example of twilight sleep, pregnant patients encouraged physicians to adopt medical technology. They were active consumers and advocates in seeking to normalize a change in the childbirth process and improve access to twilight sleep.

Although twilight sleep had become more popular in the 1910's due to demand, the use of scopolamine-morphine was eventually discontinued. Reports of delirium and a fatality caused by the medication turned public opinion (Hairston, 1996). However, during its time, the medical technology of twilight sleep continued to give physicians active control over the birth process as patients were not fully conscious. Evidence was inconclusive and experimental during the popularity of twilight sleep, yet it continued to be championed by patients and administered by

physicians. By selecting twilight sleep, patients were able to choose a painless delivery option. The example of twilight sleep reflects the ability of society members to encourage and sustain the use of a certain technology. Although physicians held the technical knowledge and training, patients were able to deploy advocacy methods to sway these advanced providers to offer said technology option.

Childbirth Education Organizations

Pregnant patients who hope to gain control over the birth process have also sought education advocacy groups. Two prevalent birth education groups are Lamaze and Bradley. These education methods were developed in the mid-1900s and became increasingly popular in the 1970-80s. Each method plays a unique role in educating pregnant patients and their support system. Lamaze and Bradley promote reformed birth procedures with reduced medical interventions. Pregnant patients engage with these education advocacy groups to better advocate for themselves during the birth process.

Lamaze International is an advocacy group that believes trouble should not be expected in birth. Rather, providers should "respect and facilitate the normal, natural, physiological processes of labor and birth" (Lamaze International, 2007). Toward this end, they launched the Lamaze Institute for Normal Birth to create more resources about normal birth, or birth that is allowed to proceed naturally without the expectation for trouble. Lamaze techniques include a support system during labor, breathing exercises, and conscious relaxation (Monto, 1996). The system can be summarized as "prepared childbirth," with the goal of reducing pharmacological interventions (Monto, 1996). On why she chose Lamaze, one mother said, "I have a background in Research Methodology and am highly skeptical of anecdotal rationales. Learning that

Lamaze's practices are based on good/reproducible research means a lot to me" (blake, 2017). These quotes show that some pregnant mothers select Lamaze international for their evidence-based procedures. By selecting Lamaze education, pregnant patients learn to operate within and understand the existing procedures of childbirth. In the hospital, while accompanied by physicians, they may deploy the methods learned in Lamaze classes.

The Bradley method originated from the idea that through training and preparation, pregnant patients would be able to give birth without medication. It was developed by Dr. Robert Bradley who observed natural farm animal births and contrasted it to the medical birth environment of humans (Walker et al., 2009). The method focuses heavily on a coach supporting and advocating for their partner. In a 1996 observational study of both Lamaze and Bradley classes, Bradley classes more explicitly advocated against the medical model of childbirth (Monto, 1996).

These classes allow pregnant patients to receive care in a hospital setting yet retain more control by being an active participant in the hospital room. In the hospital, physicians will operate as they have been trained to do. However, with the knowledge and support system created in Bradley education classes, pregnant patients may advocate for their own care in a more informed manner. Overall, these education advocacy groups were created in response to the increasing amount of technology and medical interventions used in childbirth. They equip pregnant patients with the tools to navigate the system and tools used by physicians. The classes represent a degree of participant acceptance of the prevailing technologies, while also offering a semblance of autonomy and control for patients within said medical model.

Home Birth Movement

Another avenue through which pregnant patients have responded to the medicalization of birth is by forgoing a hospital birth. At home, pregnant patients can control the environment, the attendants and people present, and the experience. Home births are a minority of all births that occur in the United States, only accounting for one percent of births since 1990 (Gregory, 2021). The home birth movement is often classified as the "alternative birth model," or one that contradicts the medical model of childbirth (O'Connor, 1993). The tenets of this birth model are that birth is non-pathological and safe in most cases, each labor is unique, family bonding is essential, and interference might provoke additional problems (O'Connor, 1993). One early figure in the natural birth movement was Dr. Grantly Dick-Read who published *Childbirth Without Fear* in 1942, in which he argued the difficulty of birth might stem from social attitudes and culture (Shapiro, 2012). Social attitudes of fear in childbirth and the pathological nature of childbirth often stemmed from ideas perpetuated by figures such as DeLee.

Ina May Gaskin is a prominent figure of midwife-assisted, home birth. She has published the book *Spiritual Midwifery*, writing:

> this book is revolutionary because it is our basic belief that the sacrament of birth belongs to the people and that it should not be usurped by a profit-oriented hospital system … we feel that returning the major responsibility for normal childbirth to an abundance of well-trained midwives, rather than have it rest with a profit-oriented medical establishment, would lower rates of premature birth, infant mortality, induced births, and cesarean section, not to mention skyrocketing costs (Gaskin, 1975).

Beyond her book, Gaskin has also created a spiritual community, called the Farm. The Farm Midwifery Center offers instructional workshops and classes to provide continuing education to midwives (*Our History – The Farm Midwifery Center*, n.d.). Pregnant patients seek care from midwives who will support them "to have a natural birth safely and with as much control as possible" (Missouri Midwifery Service, 2016). The choice for a natural, home birth shows that

some pregnant patients have selected against medical technology in their delivery. The natural birth option conflicts with prior physician opinions. For example, Dr. DeLee advocated for active monitoring and frequent interventions. As a result, pregnant patients who appreciate the tenets of the alternative birth model may seek midwives as a provider rather than physicians. The active choice to avoid the medical model of birth reflects societal opposition to standard technologies. Although a certain technology such as medical interventions in childbirth may be widely accepted, there will remain a subset of societal members who will resist.

Considering the experience of a doctor who selected a home birth might also shed light on the personal reasons fueling the decision for a natural birth. One OB-GYN chose a home birth because:

> "I wanted to experience physiologic childbirth with limited medical intervention. To be at home, snuggled afterward in my own bed where I felt most safe, surrounded by the family that my husband and I created together, was a feeling like no other. I wanted to feel empowered by the experience, not belittled by it. I finally got to experience the birth I had envisioned was possible" (Goldstein, 2015).

The quote illustrates that some pregnant women might feel belittled by the loss of control during a hospital birth and select to have more autonomy during their birth. Another blogger writes, "while we are all grateful that inductions, epidurals, and c-sections are available when needed, they often work to rob a woman of the experience of childbirth and the empowerment that comes with going through that experience as much as she can on her own strength" (Verhaeghe, 2012). Overall, pregnant mothers have sought other avenues in response to the technical interventions that may accompany hospital births. Midwives and home births can be intervention-free options for pregnant patients who would rather not pursue a potentially technological experience in the care of a hospital physician. Natural birth represents opposition to the prevailing technical model of childbirth.

Birth Advocates

Birth advocates are another resource women have selected to use for their birth. Prior to understanding the use of advocates such as doulas, it is necessary to address racial disparities in pregnancy and childbirth. In the United States, the maternal mortality rate for Black women is three times higher than white women (CDC, 2023). Factors such as implicit bias in healthcare providers and structural racism contribute to this disparity (CDC, 2023). As a result of bias in the healthcare system and the affected quality of care, some pregnant patients have selected to use doulas. Doulas are trained professionals who provide support to their pregnant patients prior to and during the childbirth process. On the verywell family blog site, Jessica Florio writes about her decision to have a doula as a Black pregnant woman:

> The presence of a doula during childbirth has been shown to have numerous favorable outcomes for both mom and baby … Besides wanting an advocate (besides myself), I wanted someone to help me through the pain and anxiety I would face. I needed an anchor to keep me calm and focused during the giant waves of labor, and I didn't want to put that kind of pressure on my husband … I am so thankful that I learned about doulas early in my pregnancy, and that I was able to have one by my side when giving birth to my son, especially as a Black woman. As doulas become more and more popular, I hope that the gap in maternal mortality between races closes, and all women are able to have more positive birth outcomes (Florio, 2022).

Florio's experience illustrates that trained birth advocates can be a useful resource for pregnant patients when navigating a medical birthing process. "A skilled doula empowers a woman to communicate her needs and perceptions and actualize her dream of a healthy, positive birth experience" (Gruber et al., 2013). Doulas are used alongside another healthcare provider such as a physician or midwife. The inclusion of an additional provider reflects the ability to craft a new experience while also operating within the prevailing technical model. For example, pregnant patients can seek more comfort and autonomy when interacting with physician providers. Doulas may ensure interventions are necessary and seek to preserve a patients' desires as much as

possible with a medical model. The use of doulas reflects acceptance of some technical interventions while also preserving patient priorities.

Medical Model Participants

Although various oppositions to the medical model of childbirth have been discussed, it is important to note that the majority of pregnant patients support and seek medical interventions. They may choose this for safety or comfort (Weymouth, 2018). Emilee Janitz writes on the The Everymom blog: “I got the epidural. And now, reflecting on the experience, I can happily identify as one of the women who will credit the miracle of modern medicine with saving her birth experience. I always expected childbirth to be quite awful. I didn’t anticipate I would actually get to enjoy welcoming my son into the world” (Janitz, 2022). Kristen Middleton writes on the baby chick blog, “And don’t worry if you need medical intervention. Childbirth is about the process, not perfection!” (Middleton, 2021). These pregnant patients who accept the modern medical model of birth are the majority and reflect larger society’s views on the safety of birth technologies. Much of society views birth technologies as the lowest-risk option and trusts the expertise of physicians, who have traditionally held the bulk of medical knowledge.

Within the participatory group framework, pregnant patients who seek medical interventions do not fall within the “natural birth experience” championed by midwives and home-birthers. Rather, they remain closer to the viewpoint of physicians regarding the use of birth interventions. The majority participation in the medical model of birth reflects how society members often accept and engage with technologies that have been championed and endorsed by experts such as physicians.

Limitations

This paper discusses the avenues through which pregnant patients have responded to medical interventions in birth. Future research in this field should examine relative rates of each choice. Often, choices such as the use of a doula, home birth, or unmedicated birth are not tracked on a country-wide scale. Therefore, it may be challenging to showcase how frequently each response is used. Further research should also seek to be more inclusive. Most commonly, the experience of white, middle-class women is examined. There is less data or scholarly articles on the experience of diverse populations. These limitations should be addressed should future researchers select to study a similar topic.

Conclusions

In the United States, healthcare expenses account for 19.7% of gross domestic product, equivalent to $4.1 trillion (CMS, 2020). Yet, the United States is a consistent low performer in healthcare outcomes such as maternal mortality (Khazan, 2018). The discrepancy between healthcare spending and performance illustrates the need for improvement in the modern medical model of care. While considering avenues to improve, it is worthwhile to study how patients have sought to create a better experience or advocate for themselves within the existing system. The childbirth experience is a common medical experience, and as a result, is a valid avenue to examine criticisms of the healthcare industry. As shown, there are several avenues by which patients have sought to craft the childbirth experience that they desire. Most commonly, the existing medical model of care which involves the employment of technological interventions is selected. However, other options have included selecting midwives and doulas, enrolling in education classes, or opting out of the medical model entirely.

Medical interventions in childbirth have continued to be a subject of controversy. Providers today debate the efficacy of methods such as continuous fetal heart monitoring vs. less frequent monitoring technologies, especially for low-risk deliveries (Owens, 2017). These recent conversations, framed within the larger context of maternal mortality, showcase the relevance of studying technological interventions in childbirth.

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