The Medicalization Of Childbirth
A necessary system for safety or a lack of evidence-based practice?

ABSTRACT
There has been an alarming trend in Canadian hospitals to over-medicalize the process of childbirth. The attribution of pathology to childbearing has led to an increased use of medical interventions that elevates healthcare costs and postoperative risk without improving the birthing experience for mothers and newborns. Nurses occupy an optimal position for addressing this problem because of the significant duration of contact they have with patients and their professional competency in non-pharmacological approaches. This is reflected in the positive outcomes linked to the use of continual labour support, an intervention largely performed by nurses and midwives.

INTRODUCTION
Medicalization is the process of defining a human condition as a pathology that should be managed with a medical framework consisting of diagnosis and treatment. However, pregnancy and the process of delivery are neither inherently pathological nor a disease state. Prior to the 18th century, childbirth was entrenched within the realm of midwifery. As critical health issues related to labour were identified, physicians became more involved in the childbearing sphere. Medical interventions provide life-saving measures for childbirth that should not be devalued. For example, from 2003-2009, over half of maternal deaths worldwide could be attributed to preventable complications such as sepsis, hemorrhage, or hypertensive disorders. However, situations that warrant medical services rather than natural birthing strategies have not been firmly established, contributing to the overuse of medical interventions.

The incorrect attribution of pathology to childbirth fosters the overuse of medical interventions including inductions, vacuum-assisted deliveries, and caesarean sections (CS). The rate of CS in Canada has risen 10% since 1995 to a current total of approximately 25% of all births. A cross-sectional analysis concluded that labour is induced in 10% of all first-time mothers without appropriate medical indication. Additionally, vacuum-extraction deliveries have increased by 56% in Canada since 1991. Excessive use of medical interventions during delivery are justified on the pretext of safety but are associated with decreased maternal autonomy, increased negative clinical outcomes, and escalating healthcare costs. Canadians should call for systems-level action to provide care that prioritizes the well-being of women and newborns.

OVERUSE OF THE SUPINE POSITION
The practice of placing mothers in a supine position during delivery is commonly used despite its association with negative clinical outcomes. The supine position offers optimal accessibility for the healthcare provider which has contributed to its popularity amongst clinicians. However, since maternal position during labour impacts the process and outcomes of childbearing, the decision therefore should be based on evidence rather than convenience. A number of studies demonstrated lower length of labour, self-reported pain, amount of assistance needed, and risk of abnormal fetal heart rates when delivering in the upright position. In comparison, women who labour in a supine position report higher rates of dissatisfaction with their birth and increased perineal trauma. Given these results, the standard position for delivery should be reconsidered and mothers should be made aware of the numerous positions amenable to birth.

BARRIERS TO MOVEMENT
The use of medical interventions often restricts movement, confining women to the supine position. This practice conflicts with the World Health Organization’s recommendations for intrapartum care which suggests that mobility is a critical factor in shaping a positive childbirth experience. Hormonal studies have found that increased time spent in the supine position increased release of catecholamines, which are...
hormones associated with emotional responses of stress and fear. Two commonly used interventions that restrict movement are electronic fetal heart rate monitoring (EFM) and induction. EFM is widely used with the aim of identifying fetal deterioration. However, its capacity to detect true fetal distress remains quite low. Since its installation in hospitals, there has not been a substantial decrease in fetal mortality. The usage of both methods in cases where the fetus is viable and capable of surviving carries significant ethical considerations, as they may lead to the premeditated termination of life.

Induction is intended to promote labour in women past 41 weeks of gestation to prevent complications associated with carrying a fetus past term. However, surveys from developed nations have found that up to 25% of deliveries were induced despite not surpassing gestational term. Pharmacological induction of labour often requires the insertion of an IV, which complicates movement and promotes stasis, further inclining women to labour in the supine position.

**INCREASING CS RATES IN CANADIAN WOMEN**

When necessary, CS can save the lives of mothers and babies and minimize the risk of serious complications. As previously discussed, the rates of CS in Canada have recently escalated significantly. The World Health Organization has identified a CS rate greater than 15% to be futile; this threshold raises concerns that many CS are medically unnecessary. A CS can result in severe acute and chronic complications. Acute complications include intra- and post-operative bleeding, wound infections or sepsis, and even death. Long-term complications include menstrual irregularities, ectopic pregnancy, abnormal placentation, and pelvic adhesions that generate recurrent pain. The escalating usage of CS suggests that clinicians are not fully considering the gravity of this procedure and its ramifications for mothers.

Economic burdens must also be considered in the scrutiny of increasing CS rates. In fact, a CS in Canada can be 45% more expensive than a vaginal delivery. The current CS practices place increased economic stress on the already strained Canadian healthcare system.

It is recognized that CS rates in Canada have been steadily rising; however, causative factors have not been widely identified. Fear of malpractice lawsuits engendering a culture of defensive medicine has been implicated in this trend, as it inclines physicians to perform CS on complex birthing situations. Further, declining birth rates among North American women could be encouraging financially-motivated physicians to supplement their incomes by providing excessive care in the form of unnecessary CS.

**THE ROLE OF THE NURSE IN THE BIRTHING PROCESS**

Evidence demonstrates that continuous support for labouring women from nurses promotes high rates of satisfaction in women and decreases the need for mechanical or surgical interventions. Women who received continuous care support were more likely to experience spontaneous vaginal births, experience less pain, feel more active in the decision-making process, and deliver babies with higher APGAR scores.

Nurses are often at the patient bedside during delivery and therefore play a critical role in encouraging women in labour to assume more control in the birthing process. Nursing education around the benefits of upright birthing positions and continuous labour support during the intrapartum period could help improve the birthing experiences for mothers and newborns.

**CONCLUSION**

The process of pregnancy and childbirth should not be considered inherently pathological or high-risk. The medicalization of childbirth is an unnecessary trend that is increasing in Canada without medical indication. Over-medicalization of childbirth creates negative subjective experiences and clinical outcomes for mothers and newborns and places an economic burden on the Canadian healthcare system. Ultimately, medical approaches to childbirth must be re-evaluated to allow current care practices to reflect evidence-based research. Canadians should call for systems-level action to encourage care that facilitates the well-being of women and newborns.

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