Worth of a Woman: The Power Politics of Childbirth

By

Allison McCloat

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_____, Sponsor
Professor Connie Lobur

_____, Second Reader
Professor B Aultman

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Introduction

The United States, arguably the keystone of scientific advancement and medical modernity, is reigning champion of the highest maternal mortality rate in a developed nation. Maternal mortality is classified as death due to complications of pregnancy during gestation, labor, or a year postpartum.[1]

Each year in the United States, four million mothers give birth to about the same number of babies. Between the years of 2000 and 2014, the maternal death rose from 18.8 out of 100,000 live births to 23.8 out of 100,000 live births.[2] To state it more simply, in 2014 alone almost 1,000 women died, and this number continues to grow. Black women are affected much more significantly than their white contemporaries by maternal mortality. The chances of a black woman dying due to complications of pregnancy are four time higher than a white woman.[3]

The question remains as to why the United States, with adequate medical technology, has such a high rate of maternal mortality? This question can only be answered once another question is posed, how does obstetric violence during childbirth affect the social and economic value of women within the United States, considering "mortality and morbidity statistics for women and infants... are standardly used to evaluate a given society's social and economic development."[4]

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[1] Maternal Mortality." 2018. *World Health Organization*. www.who.int/news-room/fact-sheets/detail/maternal-mortality.

[2] MacDorman, Marian F, Eugene Declercq, Howard Cabral, and Christine Morton. 2016."Recent Increases in the U.S. Maternal Mortality Rate: Disentangling Trends From Measurement Issues." *Obstetric & Gynecology* 128(3): 447–55.

[3] Ibid.

[4] Treichler, Paula A. 1990. "Feminism, Medicine, and the Meaning of Childbirth." In *Body/Politics: Women and the Discourses of Science*, New York and London: Routledge. 113-138.

Obstetric violence can be used as an indicator of maternal mortality rates because it is, "the appropriation of the body and reproductive process of women by health personnel, which is expressed as dehumanized treatment, an abuse of medication, and to convert the natural process into pathological ones, bringing with it loss of autonomy and the ability to decide freely about their bodies, negatively impacting the quality of life of women."[5] Obstetric violence, meaning is considered an institutional problem because of its widespread nature. Institutional problems cannot be solved on an individual basis and must be addressed through positive systematic changes.

Medical paternalism, meaning physicians who "interfere and overrule patient's preferences with the aim of securing patient benefit or preventing harm,"[6] has accounted for the rise in rates of obstetric violence and post-traumatic stress disorder for people who have just given birth. Women experience this type or trauma because of "inadequate quality of care,"[7] coerced procedures, and lack of proper consent during childbirth administered by attending professionals. Proper consent, by which I mean consent that is only granted with an informed yes, cannot be given in instances of coercion and manipulation. A main coercive tactic that physicians use against women during childbirth are court-orders. Physicians have the power to threaten a woman with a court-ordered mandate in order to force her to undergo a medical

[5] Borges, Maria T.R. 2018. "A Violent Birth: Reframing Coerced Procedures During Childbirth As Obstetric Violence." *Duke Law Journal* 67: 830

[6] Chin, JJ. 2002. "Doctor-Patient Relationship: from Medical Paternalism to Enhanced Autonomy." *Singapore Med J* 43(3): 152.

[7] Fernandez, Ibone Olza. 2013. "PTSD and Obstetric Violence." *Midwifery Today* Spring(105): 48

procedure, like a forced caesarean section,[8] through legal means. This removes the autonomy of a pregnant woman and her choices are no longer deemed valuable.[9]

These traumatizing births have significant and long-lasting impressions on new mothers. Due to the overwhelming sense of violation, coercion, and loss of autonomy felt by these mothers, many birth activists have categorized obstetric violence as rape or birth rape. This epidemic goes far beyond patient malpractice. Out of the 18% of women who are faced with PTSD in the United States, 35% of them are afflicted because of obstetric violence.[10] This type of violence during childbirth is classified under the broader epidemic of "gender-based"[11] violence, which is an "infringement of women's human rights to non-discrimination."[12]

Another reason why obstetric violence is prevalent in today's society is the perceived risk of fetal injury that is adopted by the attending physician. A physician may be more inclined to violate a woman's autonomy if they "rationalize the fetus as a second patient,"[13] despite being the physician of the person giving birth. This rationalization is based on the ideology that women should have little control over their own reproductive system. When physicians perpetuate obstetric violence, they assume the role of the state in balancing the interests of "potential life."[14] Not only do they remove autonomy from the child-bearer, but also of the state by becoming the judge and jury.

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[8] Charles, Sonya. 2012. "Obstetricians and Violence Against Women." *The American Journal of Bioethics* 11(12): 53

[9] Ibid. 54

[10] Fernandez, Ibone Olza. 2013. "PTSD and Obstetric Violence." *Midwifery Today* Spring(105): 48

[11] Diaz-Tello, Farah. 2016. "Invisible Wounds: Obstetric Violence in the United States." *Reproductive Health Matters* 24(47): 57

[12] Ibid.

[13] Ibid. 60

[14] Ibid.

Within this paper I will seek to prove there is little action on the states to decrease maternal mortality by ways of policy changes to the obstetric violence epidemic because of the economic and social devaluation of women. Women make up half of the world's population. Yet when they are in the midst of birthing new generations, they are treated with little humanity. In the United States "women are guaranteed equal protection under the law, but healthcare providers, institutions, and even courts are willing to 'read in' exceptions that do not exist, perpetuating a second-class status for women under the law."[15] Until this epidemic is addressed and solved through an acknowledgement of autonomy and reproductive rights, women will not achieve full equality.

[15] Ibid.

Chapter One

History of Childbirth in America

At seven years old, I was waiting in the lobby of the hospital's maternity ward as my mother was giving birth to my little sister. To say the least, it was a thrilling moment. My mother, being a nurse, had no reservations about keeping me involved with all the steps involved in carrying a fetus to full term. I had gone to multiple doctor's appointments with her and attended a baby safety classes designed for older siblings. When my mother was still early in her pregnancy, she wanted to know if I would like to cut the umbilical cord. I accepted my new and first responsibility as a big sister with a proud smile. So, the day my mother went into labor I waited in the lobby to perform my set-upon task. When my family was called into the labor room, the baby was already swaddled in a bright and bleached white blanket in a sterile bassinet.

Overcome with excitement, I forgot about the umbilical cord until later that night when I unceremoniously asked my mother about it. As she told it, before she gave birth, she had asked the doctor for me to come into the room so I could cut the umbilical cord. The doctor had refused to allow me in the room. He did not want me there during labor because he had thought it would be too scary and too messy for me to witness. His decision has a seemingly rational explanation at first glimpse, yet it is the subtleties behind his words that make for a situation that needs further investigation. Firstly, how did doctors become the sole authority during another person's labor? Secondly, how have views of childbirth shifted so drastically to be seen as an event too scary for a daughter to be a part of?

The modern scene of childbirth is set in a hospital, where doctors and nurses are never hard to find, and every machine seems to be emitting the same technical beep. For millions of

prospective mothers each year, hospitals are the only accessible and socially acceptable place for birth. Women in both pre-labor and in the midst of labor are emitted to a bed as an ill patient would be. There, simple procedures like sonograms and blood tests are companioned with invasive procedures like pelvic exams and cesarean sections.

Before hospital births were the normal, women were engaged in a practice of social birth. Social birth was a pre-revolutionary practice which involved the expectant mother literally lying in her bed a few weeks before and after while attended by "female friends and relatives came… to provide comfort and practical aid."[16] Birth at this time was strictly in the domain of those who had either already experienced birth or those who likely would. Most support shown by other women was given in the form of encouragement and solidarity. Birth was seen as a social event where other women would stay in the house to aid with the labor, before care, after care, and domestic affairs in the weeks that followed.

These social events were usually attended by midwives but were not addressed as strictly medical. Midwifery was a tradition that followed European settlers from England. Similarly, in America midwives were not classified as part of the medical tradition. They were instead viewed as social professionals, more like priests then doctors and as such were not licensed. The Age of the Midwife permeated colonial society. To be trained as a midwife, one needed to be apprenticed as any other learned skill of the time.[17]

On some occasions, usually for wealthy white mothers, a doctor would be involved with the lie-in party for emergency situations. Barring any said emergency, doctors had little sway in the care of the mother and the "relatives and friends oversaw the birth and exercised control over

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[16] Wertz, Richard W, and Dorothy C Wertz. 1989. *Lying-In: A History of Childbirth in America Expanded Edition*. New Haven: Yale University Press. 2

[17] Finnerty, G. 2013. "Charting the History of Midwifery Education." *The Practicing Midwife* 16(8): 23–25.

the physical aspects on the lying- in room."[18] Since doctors were only utilized during emergencies, the medical field began to perceive childbirth more as a sickness than a natural occurrence.[19]

At the turn of the 18th century and throughout the revolutionary era, this status of social importance was altered. The all-male New York government in 1716 mandated that midwives were licensed in order to practice. This law shifted the midwife from the social sphere to the civil sphere, no longer were they only answerable to the woman in labor, they were now "in the role of servant of that state."[20] This new legal status meant midwives were answerable to that state first and foremost, leaving lasting implications into the 21st century. Despite this new legal status, midwives were still called upon more frequently then doctors. There is one report of a single midwife by the name of Martha Ballard who was responsible for the safe births of 996 babies.[21] In 1762, Dr. William Shippen became the first physician to study midwifery. In turn, he started a school aimed at educating midwives. This became the first formalized school to study childbirth.[22]

It is important to note that women of colonial America used birthing stools rather than laying on their back, which is the modern tradition in developed societies. Birthing stools or chairs had been used as the main labor posture since the reign of Babylonia in 2000 b.c.e.[23] This instrument evidently spread to other cultures, such as ancient Egypt and Greece, as demonstrated

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[18] Op. Cit.
[19] Dundes, Lauren. 1987. "The Evolution of Maternal Birthing Position." *American Journal of Public Health* 77(5): 636–41.
[20] Wertz, Richard W, and Dorothy C Wertz. 1989. *Lying-In: A History of Childbirth in America Expanded Edition*. New Haven: Yale University Press. 7
[21] Ibid. 9.
[22] Kaplan, Laura. 2012. "Changes in Childbirth in the United States: 1750–1950." 4(4). np.
[23] Dundes, Lauren. 1987. "The Evolution of Maternal Birthing Position." *American Journal of Public Health* 77(5): 636–41.

by lasting artwork.[24] The birthing chair found its contender when King Louis XIV of France initiated a policy in his court mandating that all births be performed while the woman was lying flat on her back. According to historical rumors, the king enjoyed watching childbirth from the sidelines of the room. He found the birthing chairs and other natural positions obscured his view.[25]

The age of the midwife began its decline with an influx of the doctors and medical professionals in childbirth scenarios during the late 18th and early 19th centuries.[26] The men that had been studying medicine overseas returned to America with new scientific knowledge of anatomy. Magical and religious superstitions of childbirth were a thing of the past and childbirth was uncharted territory for these eager young doctors. This newfound knowledge led male doctors and male midwives to "rationalize" the birthing process and reclassify it as scientific.[27] The stance that childbirth was a medical ailment and needed to be treated as such, revolutionized common conceptions of birth. It was no longer seen as strictly natural but now warranted treatment and procedures. At this juncture in history, we see the seeds of paternalism and medicalization planted in the modern practices of childbirth.

The science of obstetrics having been established, new procedures were normalized by those in the medical profession. The all-male scientific community sought not to aid in childbirth, but to create an altogether new form of birth.[28] Forceps, which had been used privately and secretly by an affluent French family in the 17th century, became more widely

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[24] Fletcher, Sara. 2019. "Birthing Chairs." *Product Rankers*. https://www.productrankers.com/birthing-chairs/.
[25] Op. Cit.
[26] Wertz, Richard W, and Dorothy C Wertz. 1989. *Lying-In: A History of Childbirth in America Expanded Edition*. New Haven: Yale University Press.
[27] Ibid. 32.
[28] Ibid.

used.[29] Midwives began to use forceps more regularly at the end of the 18th century. They were used to expand the birth canal when the head of the fetus had descended "but not yet visible."[30]

Interestingly, the only midwives to use these dangerous and lethal instruments were the male midwives. There is no documentation of women using the instrument, nor is there any documentation of laws forbidding its use. What we do have is the views of a prominent mid wife who says, "A few, and very few indeed, of the midwives, dazzled with the vogue into which the instruments brought the men… attempted to employ them [but] soon discovered that they were at once insignificant and dangerous substitutes for their own hands, with which they were sure of conducting their operations both more safely, more effectually, and with less pain to the patient."[31]

William Potts Dewees, an influential obstetrician in the 1830's, popularized the position of the "flat dorsal birth position."[32] The position of an "individual [lying] on the back with the hips and knees flexed and the legs spread and raised above the hips often with the use of stirrups"[33] is known as lithotomy. Despite the newfound position of childbirth as science, no scientific thought was used when determining that lithotomy was a suitable position. Dewees main argument for the adoption of this position was that doctors and nurses had easier access to the vagina, similar to King Louis XIV insistence over one hundred years before. In actuality, this position is not natural for labor and can cause birth complications.[34]

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[29] Dunn, Peter. "The Chamberlen Family (1560–1728) and Obstetric Forceps." *BMJ* 81(3).
[30] Op. Cit.
[31] Ibid. 39.
[32] Dundes, Lauren. 1987. "The Evolution of Maternal Birthing Position." *American Journal of Public Health* 77(5): 636–41.
[33] "Medical Definition of Lithotomy Position." *Merriam-Webster*. https://www.merriam-webster.com/medical/lithotomy position.
[34] DiFranco, Joyce T, and Marilyn Curl. 2014. "Healthy Birth Practice #5: Avoid Giving Birth on Your Back and Follow Your Body's Urge to Push." *The Journal of Perinatal Education*

The anesthesia was discovered in 1847 when James Young Simpson and some friends were experimenting with the inhalation of chloroform.[35] Only days later did he administer it to a mother in labor for further experimentation.[36] So popular did this trend become that Queen Victoria requested it be used on her during one of her labors.[37] Eventually the use of anesthesia to ease the pains of childbirth paved a wide road for the common usage of caesarean sections, named after the Latin word to cut[38]. Caesarean sections had been practiced for millennia, though not very often and usually only in circumstances "when the mother was dead or dying, as an attempt to save the child for a state wishing to increase its population."[39]

Not only did anesthesia aid in the popularization of caesarean sections, but so did the urbanization and industrialization of the late 19th century. More women moved to cities rather than staying home with their family. Midwives and social birth were still prevalent in rural life but was an unattainable standard for city life since family was no longer close by. Hospitals, usually designated to treatment of illness, became the popular place to give birth.[40] Since women now *went* somewhere to give birth and were under constant medical surveillance, it was more accessible for doctors, eager to learn on living beings, to begin performing caesarean sections on a normal basis.[41] Despite these "medical advancements", almost all women who underwent this

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23(4): 207–10.

[35] Crenshaw, James F, and Elizabeth A.M. Frost. 1993. "The Discovery of Ether Anesthesia: Jumping on the 19th-Century Bandwagon." *Archives of Family Medicine* 2(6): 481–84.

[36] Ibid.

[37] Drife, J. 2002. "The Start of Life: a History of Obstetrics. (History of Medicine)." *Postgraduate Medical Journal* 78(919).

[38] Ibid.

[39] Eliot Sewell, Jane. 1998. "Cesarean Section - A Brief History." *National Library of Medicine*. https://www.nlm.nih.gov/exhibition/cesarean/index.html.

[40] ibid.

[41] Op. Cit.

procedure succumbed to death. It was not until the invention of penicillin did the mortality rate of cesarean sections decrease.[42]

Within a 30-year period from 1900 to 1930, the rate of hospital births increased by 85% though maternal mortality rate did not decrease until the 1940's. The belief at this time was hospitals were safer to give birth in, though the previous statistics prove otherwise. The 300-year shift of midwife to doctor had finally taken place. By this time, a full and expensive education was necessary to become a professional midwife. This mostly affected immigrant and Black populations because these groups continued to practice midwifery, rather than hospital usage, at greater rates than white women.[43].

People have been disillusioned with the hospital institution of childbearing since its inception. To combat the social and economic disadvantages of hospitals, birth centers increased in popularity during the late 20th century. Birth centers can be defined as "non-hospital child-bearing center[s] where a woman can give birth in a home-like setting surrounded by her family and go home with her baby within 12 hours of delivery."[44] The Maternity Care Association was the first of its kind in 1975[45], meant to combine the ease of at home births with the new safety of a hospital. The MCA was partnered with Blue Shield/ Blue Cross in New York to study the outcomes of this center, as well evaluate the risks and benefits. Despite this endorsement, established obstetricians began to demonize the MCA in the press, as well as to their patients.[46] It

[42] Ibid.
[43] Ibid.
[44] Treichler, Paula A. 1990. "Feminism, Medicine, and the Meaning of Childbirth." In *Body/Politics: Women and the Discourses of Science*, New York and London: Routledge.
[45] "Highlights of 35 Years of Developing the Birth Center Concept in the U.S." *American Association of Birth Centers*. https://www.birthcenters.org/page/history.
[46] Op. Cit.

is interesting to point out that care at the MCA came at a smaller expense than two-day hospital stays.

The MCA founded what would later become the American Association of Birth Center (AABC). By 1984, they began drafting standards of care for birth centers that were later adopted in 1988.[47] After years of studies determined only positive outcome for low-risk pregnancies, the New England Journal of Medicine is quoted as saying,

> Few innovations in health service promise lower cost, greater availability, and a high degree of satisfaction with a comparable degree of safety. The results of this study suggest that modern birth centers can identify women who are at low risk for obstetrical complications and can care for them in a way that provides these benefits.[48]

In 1979, there were 14 birth centers in 14 states. As of 2017, there are now over 345 birth centers in 34 states.[49] This growing figure perhaps represents yet another revolution in the childbirth narrative.

Along with increased hospital births comes a rise in obstetric procedures during birth, reaching its peak in 1979 when over 5 million obstetric procedures were performed a year. Since then it has continued to decrease, "but still comprise a large proportion of inpatient surgical procedures for U.S. women."[50] In 2015, just under four million babies were born in the United States.[51] A vast majority of these births took place in a hospital with 31.9% being caesareans.

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[47] "Highlights of 35 Years of Developing the Birth Center Concept in the U.S." *American Association of Birth Centers*. https://www.birthcenters.org/page/history.
[48] ibid.
[49] ibid
[50] Oliphant, Sallie S et al. 2010. "Trends Over Time With Commonly Performed Obstetric and Gynecologic Inpatient Procedures." *Obstetrics & Gynecology* 116(4): 926–31.
[51] "Birth Data." 2015. *National Center for Health Statistics*. https://www.cdc.gov/nchs/nvss/births.htm.

Among current literature, it is noted that unnecessary cesarean sections for low-risk patients take place frequently.[52] One study found that those giving birth with private health insurance have a greater chance of receiving a cesarean than those who are covered under Medicaid by 2%.[53]

Another increase of cesarean sections is based on the density of obstetric practices in the area. Those places with higher concentrations of obstetric doctors have higher rates of cesarean sections, while places with high densities of midwives have higher rates of vaginal delivery. [54] The past decade and a half has seen an increase to the amount of people giving birth in the comforts of their home with midwives and in childbirth centers. Statistics show that at-home births have a "lower-risk profile" due to the fact that at-home births typically see a decreased amount of preterm and underweight babies.[55] However, most home births in 2012 were had by white women.[56] Births attended by midwives "are comparable with and in some case preferable to those for patients with physician- led care"[57] and are less likely to result in emergency hospitalization, cesarean sections, and labor inductions. Because of this, midwifery is still depended on by birthing people as a necessary healthcare source.

The United States, unlike other developed countries, has the lowest midwife turnout of live births at 10%.[58] Midwifery is an expensive profession to enter. Besides the exorbitant fees a

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[52]Trends in Out-of-Hospital Births in the United States, 1990–2012." *National Center for Health Statistics*. https://www.cdc.gov/nchs/products/databriefs/db144.htm.

[53] Henke, Rachel Moser et al. 2014. "Geographic Variation in Cesarean Delivery in the United States by Payer." *BMC Pregnancy & Childbirth* 14(1): 1–10.

[54] ibid.

[55] "Trends in Out-of-Hospital Births in the United States, 1990–2012." *National Center for Health Statistics*. https://www.cdc.gov/nchs/products/databriefs/db144.htm.

[56] Ibid.

[57] Yang, Y. Tony. 2016. "State Scope of Practice Laws, Nurse-Midwifery Workforce, and Childbirth Procedures and Outcomes." *Women's Health Issues*. 1.

[58] Vedam, Saraswathi. 2018. "Mapping Integration of Midwives across the United States: Impact on Access, Equity, and Outcomes." *PLos One* 13(2): 1–20.

nursing student must pay for a bachelor's degree, midwives must also receive a costly master's degree, during this time they must also accumulate training hours. All this training is necessary, yet unavailable due to the financial burden of higher education.[59]

Another reason midwife density is low in the United States is due to decentralized regulations and licensing structures across the states. There are two categories of policy regulations for midwives, autonomous practice and supervised practice. In New York, midwives are "defined as management of normal pregnancies, childbirth and postpartum care as well as primary preventive reproductive health care of essentially healthy women, and shall include newborn evaluation, resuscitation and referral for infants allowed to practice independently" and are allowed to prescribe medication.[60] While midwives in New York are required to have a "collaborative relationships" with physicians who have hospital privileges and benefits, they are the primary caregiver to the birthing person.[61] States with supervised practice require midwives work with physicians as a secondary caregiver.[62]

[59] "Become a Midwife." *midwife.org*. http://www.midwife.org/become-a-midwife.
[60]"NYS Midwifery: Laws, Rules, & Regulations." 2010. *Office of the Professions*. http://www.op.nysed.gov/prof/midwife/article140.htm.
[61] Ibid,
[62]Yang, Y. Tony. 2016. "State Scope of Practice Laws, Nurse-Midwifery Workforce, and Childbirth Procedures and Outcomes." *Women's Health Issues*. 3.

Chapter Two

Medicalization of Childbirth

Hospitals births are the most popular place to give birth, just 1.36% of births were at home in 2012.[63] This scene transfer of home births to hospitals is the point in which the full force of medicalization can be witnessed. As demonstrated by the slow and hard-won success of birthing centers described in Chapter One,

> childbirth takes place in hospitals because there are few alternatives: yes, obstetrics has been successful-not in creating safe childbirth but in creating a monopoly; for its own professional gain, organized medicine in the United States has 'medicalized' childbirth, a process that in other cultures and countries frequently takes place outside of hospitals with little medical intervention. [64]

Medicalization, "the unintentional or intentional expansion of the domain of medical jurisdiction,"[65] has economically devalued women by removing them from spaces of medical discourse and, in turn, viewing them as biological factories for the future labor force. The rapid medicalization of obstetrics in the United States has led to a variety of unnecessary and

[63] "Trends in Out-of-Hospital Births in the United States, 1990–2012." *National Center for Health Statistics*. https://www.cdc.gov/nchs/products/databriefs/db144.htm.

[64] Treichler, Paula A. 1990. "Feminism, Medicine, and the Meaning of Childbirth." In *Body/Politics: Women and the Discourses of Science*, New York and London: Routledge. 114.

[65] Pauly Morgan, K. 1998. Contested Bodies, Contested Knowledge. In *The Politics of Women's Health,* Philadelphia: Temple University Press. 86.

risky procedures, putting women in extreme physical and emotional danger, while putting money in the pocket of a privatized health care system.

Obstetric and gynecological procedures in the United States accounted for 137 million procedures, or a quarter of all medical procedures performed in women by 2006.[66] The number has been decreasing, but at an incredibly slow rate which leaves many women still at risk.[67] As demonstrated in the previous chapter, the past few hundred years has changed the view society has on childbirth. "The entry of technology into the normal process of childbirth has fundamentally shifted our understanding of birth itself," [68] meaning that birth started off as a natural process and has developed to necessitate medical intervention. Pathologizing birth into a medical phenomenon "continue[s]to be translated into medically mediated harms, restricted choices, hostility, and negligence." [69]

[66] Oliphant, S. S. et al. 2010. Trends over time with commonly performed obstetric and gynecologic inpatient procedures. *Obstetrics And Gynecology*, *116*(4): 926–931.
[67] Ibid.
[68] Jacobus, Mary et al. 1990. "Introduction." In *Body/Politics: Women and the Discourses of Science*, New York and London: Routledge. 5.
[69] Pauly Morgan, K. 1998. Contested Bodies, Contested Knowledge. In *The Politics of Women's Health,* Philadelphia: Temple University Press. 85.

Theoretical Analysis

Medicalization of childbirth is a systemic issue that permeates the healthcare system, as well as social and economic life. It has undeniable sexist overtones, it is ingrained in language, "for women, whether viewed as objects rather than subjects of knowledge or defined as the meeting point of nature and culture, scientific discourse has been especially crucial in constructing reality as something they can embody but not know." Theoretical analyses will help to understand the machinations of medicalism and how it prospers in our country.

A reason for this pathologizing and concurrent medicalization of childbirth can be attributed to the overarching discourse of scientific and medical discovery. Science has been dominated by a male narrative since the time of alchemy. Women were excluded from these places of professional scholarship and even today most doctors are male. The largest concentration of practicing doctors is in California with 112,906 being active, of this number, 71,279 are men.[70] Language and action surrounding a medical event, consequently, will be dominated by male perceptions. Medicalization is not a consciously malicious movement plotted by physicians. It is, however, an ideal that is perpetuated with little accountability and is easily spread to "physicians already oriented toward scientific progress, decisive clinical action, and professional sovereignty, the representation of childbirth as 'natural' was simply a false and outmoded interpretation of reality."[71]

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[70] "Professionally Active Physicians by Gender" March 2019. *State Health Facts*. https://www.kff.org/other/state-indicator/physicians-by-gender/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D

[71] Treichler, Paula A. 1990. "Feminism, Medicine, and the Meaning of Childbirth." In *Body/Politics: Women and the Discourses of Science*, New York and London: Routledge. 118.

In 1970, “the United States performed twice the number of surgical procedures per capita than Great Britain."[72] The high costs of healthcare in the United States is seen as the vehicle of medicalization with sexism as the driver. Physicians have tangible incentive to perform excessive procedures in a private healthcare system. A fee-for-service payment, which pays the provider for each health service used, may persuade the physician to perform as many services as possible to get a bigger paycheck.[73] Appropriate care should never be determined by wealth yet that is the reality in the United States.

Despite it being the most common choice, giving birth in a hospital costs anywhere between four to ten thousand dollars.[74] A study conducting research on the variation of childbirth cost in hospital determined that hospitals with high-cost do not have significantly better care, and found that “there is potential to decrease cost of childbirth care at high-cost institutions without compromising patient outcomes."[75]

To better understand the impacts of medicalization, it can be conceptualized in five different components.[76] The first being the authority physicians have based on their medical knowledge.[77] Having this authority leads to the dismissal of treatments outside the scope of the knowledge, like the dismissal of birthing centers as legitimate options divergent of hospital births. The second concept of macro-institutionalization states that multiple institutions must

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[72] Bodenheimer, Thomas, and Kevin Grumbach. 2016. *Understanding Health Policy: a Clinical Approach*. 7th ed. New York: McGraw-Hill Medical. 119.

[73] Ibid. 33.

[74] Xu, X. 2018. “Hospital Variation in Cost of Childbirth and Contributing Factors: a Cross-Sectional Study.” *BJOG An International Journal of Obstetrics & Gynaecology* 125(7). np.

[75] Ibid.

[76] Pauly Morgan, K. 1998. Contested Bodies, Contested Knowledge. In *The Politics of Women’s Health,* Philadelphia: Temple University Press. 87.

[77] Ibid. 88.

exist to perpetuate medicalism. This includes "reproducing" authoritative knowledge and expanding the range of dominance.[78]

The third concept "micro-institutionalization through doctor-patient relations."[79] Doctors are viewed as the gatekeepers of our health and have the power to persuade patients for consent rather than receiving informed and affirmative consent. This concept will be further discussed in the next chapter. "Micro-institutionalization through self-management" is the fourth concept of medicalization. This concept relies on a person to embody the decisions of a physician or society as their own; for example, women who "are encouraged to feel apprehensive about the dangers of naive, unmonitored, technology unassisted childbirth."[80] The last concept of medicalization is the permeation into the "ordinary life worlds."[81] Medicalization can become a type of social control when it becomes a publicly accepted fact that excessive procedures are necessary.

Feminist critiques have recently been directed towards older concepts of medicalization based on what is "natural" and what is not. An intersectional study that researched the concepts of natural and medical birth between three groups of mothers found that the harsh distinction between natural and medical did not fit the ideals of ordinary modern women. What is deemed natural and medical is dependent on "the individual moments within which labor and birth are medicalized."[82]

In the modern age, most interactions have undergone technological transformations. Once, when a person needed to deposit money into the bank, they would communicate with a teller. Now money can be deposited with the push of a few buttons and no conversation with

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[78] Ibid. 89.
[79] Ibid. 91.
[80] Ibid. 96.
[81] Ibid. 96.
[82] Brubaker, Sarah Jane. 2008. "Re-Examining the Meanings of Childbirth: Beyond Gender and the 'Natural' Versus 'Medical' Dichotomy." *Advances in Gender Research* 12: 220.

another person. The technological process involved does not mean that transaction is not a natural part of daily life. Similarly, childbirth through cesarean can be deemed natural within the modern context. In her book outlining her experience with childbirth and pregnancy, Angela Garbes reflects on the dichotomy of natural and medical birth saying,

> We are told that giving birth is the safest and most normal human process there is. And yet, we are also told that babies who find themselves naturally in breech positions (bottom or feet first), or with larger than average heads, or not born by forty-two weeks, vaginal delivery isn't safe, and we'll need interventions to guarantee our health. The truth is that birth is both a normal, everyday occurrence and a significant medical event, it can be many things at once. It is, for some women, a spiritual experience that connects them with something divine. For others, the sheer feat of mental and physical fortitude offers a profound sense of bodily power and accomplishment. And for others, it scary and psychologically devastating. Birth is also, even at its smoothest and easiest, physically traumatizing.[83]

One definition of medical or natural birth does not always factor in for the individual experience's mothers have of childbirth, especially in regard to socioeconomic status. There are different perceptions of natural childbirth because of different realities experienced by different women. Medicalization when concerning childbirth is not wholly based on excessive procedures, but also on the usurpation of control and authority of a woman through the means medical procedures. There is no issue with someone requesting the use a pain management, the issue lies where a medical professional forces a patient to undergo a procedure during birth through

[83] Garbes, Angela. 2018. *Like a Mother: a Feminist Journey Through the Science and Culture of Pregnancy*. New York, NY: HarperWave, an imprint of Harpercollins Publishers. 99.

violence or manipulation. A woman should be able to decide what procedures she encounters during labor in birth without coercion or violence.

Empirical Analysis

Excessive procedures, meaning procedures that are performed when they are not necessarily needed or desired, during childbirth is the path to which obstetric violence is physically enacted. It is common knowledge that there is risk of complication when a surgery is performed; leaving people susceptible to complications, such as infection, when an unnecessary procedure is performed. The highest quantity of an excessive procedure that takes place during childbirth in the United States are cesarean sections. These procedures account for 1,232,339[84] births or 32.7%[85] of all births.

When dealing with excessive cesarean sections, it is important to differentiate between high-risk and low-risk pregnancies. A high-risk pregnancy is one that has been deemed likely to cause harm to the mother or the fetus. These include pregnancies where the mother has a chronic illness or has had previous pregnancy complications. What is deemed high-risk is can be in part attributed to the issues of the time. Tuberculosis was once a high-risk, while today it would be high-blood pressure. Cesarean sections that are needed for high-risk pregnancies are exceptionally important in helping women deliver. A low-risk pregnancy is one where there is a small chance for complication during childbirth. For the remainder of this paper, all mentions of critiquing the practice of cesarean sections are specifically concerning those performed on low-risk pregnancies.

Since health outcome of cesarean sections have risen, the World Health Organization has stated that once a nation's cesarean section rate exceeds 10% of all births, it is no longer

[84] "Births- Method of Method of Delivery." 2017. *National Center for Health Statistics*. https://www.cdc.gov/nchs/fastats/delivery.htm.

[85] Henke, Rachel Moser et al. 2014. "Geographic Variation in Cesarean Delivery in the United States by Payer." *BMC Pregnancy & Childbirth* 14(1): 1.

beneficial to the decrease of maternal or infantile mortality.[86] There is no state in America that has a cesarean section rate less than 20%.[87] New York, a state known for its comparably good healthcare, has a rate of 34.1% and is tied with Nevada as the 11th most likely state for a cesarean to occur.[88] A study found that obstetricians were more likely to look favorably upon intervention by cesarean as opposed to midwives.[89]

Within the United States, cesarean sections are no longer improving maternal mortality rates, instead they are now "associated with higher risk of maternal post-operative complications, including infection, blood transfusion, pain… and also increases the likelihood of future miscarriage, ectopic gestation, and cesarean delivery."[90] Once a cesarean is performed during childbirth, there is a higher chance of one being recommended and performed during a future pregnancy, continuing the cycle of increasing rates.

Medicalization has proven to affect the value of women's economic and physical health by the financial penalties one incurs after a medical intervention. Due to high costs, childbirth has become more profitable for hospitals and therefore more important than the needs of those giving birth. Viewing medicalization under the scope of exploitation, "the laborer who is a victim of objective, systemic violence under the everyday workings of capitalism often does not perceive the damage done."[91]

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[86] "WHO Statement on Caesarean Section Rates." 2015. *WHO International*. https://apps.who.int/iris/bitstream/handle/10665/161442/WHO_RHR_15.02_eng.pdf?sequence=1

[87] "Cesarean Delivery Rate by State." 2019. *Stats of the States*. https://www.cdc.gov/nchs/pressroom/sosmap/cesarean_births/cesareans.htm.

[88] Ibid.

[89] Van Gompel, Emily White. 2018. "Do Provider Birth Attitudes Influence Cesarean Delivery Rate: a Cross-Sectional Study." *MBMC Pregnancy and Childbirth* 18(84): 5.

[90] Henke, Rachel Moser et al. 2014. "Geographic Variation in Cesarean Delivery in the United States by Payer." *BMC Pregnancy & Childbirth* 14(1): 1–10.

[91] Shabot, Sara Cohen. 2016. "Making Loud Bodies 'Feminine': A Feminist Phenomenological

The price of hospitalized childbirth is varied throughout the country (the out-of-pocket cost of a vaginal delivery in Louisiana is $10,318 and the out-of-pocket a cesarean section in Massachusetts is $20,620) and "given the high healthcare spending in the USA, substantial costs associated with childbirth care, and nearly half of the births in the USA being financed by Medicaid, thorough understanding of how and why hospitals differ on cost of childbirth care is important."[92]

When a cesarean section is performed and billed, of the portion paid by a private insurance, "66% went to [hospital] facilities and 21% to maternity care providers, followed in descending order by payments for anesthesiology, radiology/imaging, pharmacy, and laboratory services."[93] Of payments towards vaginal delivery "59% went to [hospital] facilities and 25% to maternity care providers, followed in descending order by payments for anesthesiology, radiology/imaging, laboratory, and pharmacy services."[94]

On average, vaginal delivery costs $32,093 and cesareans sections cost $51,125 for those with private insurance.[95] Those with Medicaid, the prices are $29,800 and $50,373 respectively.[96] Private insurances pay, on average, 90% of the bill, leaving the other 10% ($2,669) as an out of pocket cost; Medicaid on the other hand covers over 90% of the hospital bill.[97] Based on the out-of-pocket expenses of vaginal delivery and cesarean sections, "both commercial and Medicaid payers paid approximately 50% more for cesarean than vaginal

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Analysis of Obstetric Violence ." *Human Studies* 39: 231–47.

[92] Xu, X. 2018. "Hospital Variation in Cost of Childbirth and Contributing Factors: a Cross-Sectional Study." *BJOG An International Journal of Obstetrics & Gynaecology* 125(7).

[93] Truven Health Analytics. 2013. "The Cost of Having a Baby in the United States." 6.

[94] Ibid. 33.

[95] Ibid. 6.

[96] Ibid.

[97] Ibid.

births."[98] Women with private insurance have a greater chance of receiving a cesarean section than those with Medicaid by almost 3%.

Racial disparities in the American healthcare system make it difficult for women of color to receive proper care. 55% of all uninsured people within the United States are people of color.[99] Those who are without insurance are much more likely to suffer from worse health outcomes than those who are insured because the out-of-pocket expenses are immense. [100]

From 2004 to 2010 there has been a significant increase of the cost of maternal care by 49% for vaginal births and 41% for cesarean sections.[101] Since private healthcare functions as a profitable business and since cesarean sections are more expensive, there is significant incentive for physicians to perform medical interventions even on low-risk pregnancies. Women who undergo a stillbirth are charged almost a thousand dollars more that women who have live births.[102]

This larger economic burden on mothers who have had a stillbirth is a way to make more money on a vulnerable situation. There have even been documented cases of parents being charged extra to hold their baby after a cesarean section. The cost of skin to skin proves that insurance companies and hospitals extract as much capital from childbirth as possible.[103]

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[98] Ibid. 6.

[99]Artiga, Samantha et al. 2016. "Key Facts on Health and Health Care by Race and Ethnicity." *Disparity Policy*. https://www.kff.org/report-section/key-facts-on-health-and-health-care-by-race-and-ethnicity-section-3-health-status-and-outcomes/.

[100]Truven Health Analytics. 2013. "The Cost of Having a Baby in the United States." 1–84.

[101] Gold, Katherine J, and et al. 2013. "Hospital Costs Associated with Stillbirth Delivery." *Maternal and Child Health Journal* 17(10): 1835–1841.

[102] Ibid.

[103]Earl, Jennifer. 2016. "Doula Explains Why Hospital Charged Parents $39 to Hold Newborn in Viral Post." *CBS News*. https://www.cbsnews.com/news/doula-explains-why-hospital-charged-parents-39-to-hold-newborn-baby-in-viral-post/.

Exploitation of the birthing person's body is evident as cesarean sections do not currently increase maternal health outcome, yet are performed a third of the time.

Chapter Three

Autonomy and Decision Making

I remember feeling odd going to my grandmother's house after having already been put to bed. The drive five blocks from my home was usually reserved for mornings when my mother was off to work and couldn't afford our usual babysitter. This time, I could tell, was different. Not just because night had already fallen, but because my stepfather was driving instead, and my mother was sitting uncharacteristically still in the front seat without saying a word. Once I was handed over to my loving and slightly worried grandparents, they sat me in the living room as if it was a normal day. I forgot all my previous sensations of confusion that had bubbled in the car and began to play with a toy I won from a gumball machine. I can still feel the brown leather chair underneath me as I threw my toy at the wall and waited for it to come back to me, just like my mom, over and over again. I must have fallen asleep on that brown leather chair because my recollection of the night stops there.

There was very little reason that my four-year-old mind would retain this memory, yet it did. About ten years later, after an embarrassing sex talk with my mother, I learned that over the course of her adulthood, she had six pregnancies and four miscarriages. I was first astonished that I wasn't her first try, but another attempt. My sister was born seven years after me and I knew well enough as a child that my mother had wanted another, in fact I begged for a sister as a child. The memory of night I was taken to my grandparents resurfaced in a wave of unexpected nostalgia. If she had four miscarriages, there was a very good chance that I had been around for at least one. "Did you have any miscarriages before Kylie was born?" I asked even though I

knew the answer. The night I thought was a random memory was the night my mother almost died from her fourth miscarriage.

I wanted to know more, but I was terrified of upsetting my mother. Mothers have a way of knowing what gears are turning in their child's mind, so seeing this burning curiosity being sated by my manners, and not wanting to hide any secrets, my mother shared her story. I received an abbreviated version of this story as a child and it stuck with me. I held onto the few details she had shared with me. Years later as a senior in college, having told my mother that I was focusing my senior project on the power politics of childbirth, she disclosed to me a version of the story that contained more of the gruesome details. I asked if she would allow me to share her story in my paper and she was more than happy to say yes.

She began by telling me that in her twenties, she had been pregnant twice, both times had proved to be unviable within the first few weeks. Despite the undeniable melancholy of sharing what she believed to be two deaths, I couldn't help but hear the unconscious relief that she would never again be connected to the man that didn't love her.

Her third miscarriage was a year before I was born. My mother and her sister-in-law, through her marriage to my biological father, were pregnant together. A strong sense of unity and support develops from experiencing alike situations, especially pregnancy, and this was not lost on my mother and aunt. Fantasies of shared childhoods and motherhoods developed between them in anticipation of the would-be cousins. My mother, unsure or unwilling to reveal the order of events, described an ecstatic and mournful family after my cousin was born and she remained childless for another year. My mother, never wanting to be seen as emotionally burdened, said to me, "I hope Aunt Diane didn't think I was upset she had a baby girl and I didn't, I was fine."

Five years, a child, a divorce, a new house, and a re-marriage later, my mother was ready to continue growing her family and became pregnant for the fifth time. A week after my mother took a pregnancy test, with her first doctor's appointment days away, she began having stabbing pains in her lower abdomen and began spotting. By the time I was put to bed, she was bleeding heavily. My mother, by now knowing the signs of miscarriage called her doctor. He advised my mother to go to the nearest emergency room to be seen by an attending physician and he would be there in the morning. My stepfather put me in the car to drop me off to my grandparents so he could stay with my mom. Finally, my misplaced memory of sitting alone in my grandparents living room, anticipating the return of my parents, had a home.

When my mother arrived at the hospital it was later enough in the night where you can be seen rather quickly by a doctor. The doctor who was assigned to my mother was a resident, in training to become an attending physician. The resident performed a physical exam and a sonogram. He discovered that yes, my mother was having a miscarriage because this pregnancy was ectopic. An ectopic, or extrauterine, pregnancy occurs when a fertilized egg is "[implanted] outside the uterine cavity," usually in the fallopian tube and are extremely rare.[104] My mother recalls the resident saying that he couldn't retrieve the attendant because he was sleeping. He then proceeded insert two fingers into her vagina and one in her anus. He applied a constant pressure between his fingers until my mother felt a pop and a horrible pain. The resident left.

My mother was now bleeding internally, she could see her abdomen expanding. She was unable to lie down and was in unbearable pain. Most of her pleas to her fellow nurses went ignored and no doctor saw her after the resident left. She thought she was dying. Her doctor, the one that sent her to the emergency room in the first place, arrived hours later in the early

[104] Taran, Florin- Andrei, and Karl- Oliver Kagan. 2015. "The Diagnosis and Treatment of Ectopic Pregnancy." *Deutsches Arzteblatt International* 112(41): 693–704.

morning. My mother remembers him looking at her with shock and saying, “what did they do to you?” The bleeding had been so bad that when she was laid down on a stretcher to enter the surgical suite, she stopped breathing. It took seven hours, but she finally had the surgery to correct the horrid mistake of that resident.

Hearing this story made my mother human, and no child wants to know that their parent is human because parents being human means that one day, they won’t be there to hold our hands and dry our cheeks. Unfortunately, my mother’s story is not unique. Loss of autonomy in situations of childbirth and pregnancy are all too familiar in the United States healthcare system.

Theoretical Analysis

In our gendered society, the bodily process of pregnancy ultimately leads to debates of sovereignty regarding who possesses control during birth. As a child visiting the pediatricians, my mother would always reassure me by reminding me the doctor was the one who delivered me as a baby. Yet, was she not the one to endure hours of labor? This simple misnomer is a glaring example of the praise and trust we grant physicians in the delivery room, while disregarding the mother. These conflicting desires of sovereignty between birthing people and external groups have deadly outcomes.

Lauren Berlant's theory of slow death is described as the physical deterioration, or "a condition of being worn out by the activity of reproducing life."[105] Slow death is a symptom of a population who seek comfort in habits that are deemed unhealthy to cope with the realities of exploitation and alienation in a capitalist society.[106] I argue this theory can also be applied to the exploitation of childbirth, as demonstrated by the excessive cost of childbirth and the unnecessary amount of procedures, because the maternal mortality rate has not decreased/

The exploitation of medicalized childbirth has deteriorated the birth giving body through a lack of decision making. Control loss during childbirth becomes the site of slow death when the life of a mother is put second to that of the fetus through the exercise of sovereignty of the State and medical professionals. The social value assigned to fetus and woman aids in the deterioration of material bodies.

Not only are cesarean rates at a point in which they serve no benefit to the woman giving birth of the baby, non-consensual cesarean sections are on the rise. Only 2.5% of all cesarean

[105] Berlant, Lauren. 2011. *Cruel Optimism*. Durham: Duke University Press. 101.
[106] Ibid. 1-20.

sections were planned by the birthing person.[107] These are procedures in which medicalization usurps the control and autonomy of the women and places the physicians in a role of dominance over her body. Forced procedures alienate women from their decision-making ability and from the physical process of childbirth.

Procedures that have been performed with coercive tactics have replaced the birthing person's autonomy with their own will is also tantamount to domestic violence. Both domestic violence and obstetric violence are based on gender and are products of "men who … have patriarchal and misogynistic attitudes."[108] Medical paternalism is embedded in the paradigm that the fetus must be protected from the mothers' choices. Physicians that view the fetus as their patient as opposed to the woman display a savior complex. Since the physician is willing to project citizenship upon the fetus, during childbirth, he sees himself as a savior. Usage of the term delivery indicates that the physician literally "delivered", as in saved, the fetus from the womb.[109]

Foucault defined sovereignty as the "right to take life or let live."[110] When the sovereign is not the birthing person during childbirth, then it has the ability to take the life of the mother and let the child live. This devaluation of women's sovereignty is the slow death of women through coercive procedures during childbirth. Cost and efficiency is seen as more important

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[107] "Cesarean Delivery on Maternal Request." 2018. *Committee Opinions*. https://www.acog.org/Clinical-Guidance-and-Publications/Committee-Opinions/Committee-on-Obstetric-Practice/Cesarean-Delivery-on-Maternal-Request?IsMobileSet=false.

[108] Charles, Sonya. 2012. "Obstetricians and Violence Against Women." *The American Journal of Bioethics* 11(12): 53

[109] Treichler, Paula A. 1990. "Feminism, Medicine, and the Meaning of Childbirth." In *Body/Politics: Women and the Discourses of Science*, New York and London: Routledge. 117.

[110] Foucault, Michel. 2008. "Eleven." In *Society Must Be Defended: Lectures at the Collége De France, 1975-76*, London: Penguin. Essay. 241.

than women's bodies secures that there is no recourse to protect women from physical harm during and after birth.

This power transformed biological happenings into a business model regulated by interests aside from those of the birthing person. The sovereign in the case of childbirth is the physician, as well as the government. Physicians are expected to act as the government's proxy in as gatekeeping the interests of the government, fetus, and, mother. Berlant states that "the current discussion of sovereignty as a condition of and blockage to justice recapitulates the widespread contemporary projection of sovereignty onto events of decision-making."[111]

Federal and state government have been involved with the issue of reproductive control for decades. Obstetric violence and coerced procedures need to be a part of that discussion more frequently as the same standards and laws apply to women who were violated during childbirth as those seeking abortions. The Supreme Court Case *Roe v. Wade* concluded that people have the right to privacy and to make choices regarding their own bodies when involving "the refusal of medical treatment, marriage, contraception, procreation, family relationships, and childrearing."[112] Obstetric violence removes choice and control from the person giving birth. It can be argued that it is unconstitutional to strip a birthing person of control during birth.

However, the same landmark case also enumerated in its conclusions that the state had an interest in the potential life of a fetus and in "preserving a fetus as it progresses towards viability." This has been used against mothers who are being threatened. In the case of *Pemberton v. Tallahassee Memorial Regional Medical Center, Inc.*, Pemberton was forced to

[111] Berlant, Lauren. 2011. *Cruel Optimism*. Durham: Duke University Press. 96.
[112] Davenport, Erin P. 2010. "Court Ordered Cesarean Sections: Why Courts Should Not Be Allowed to Use a Balancing Test." *Duke Journal of Gender Law and Policy* 18(79): 87.

have a cesarean section after "the hospital sought a court order to compel treatment."[113] Upon appeal, the courts concluded that the state interest in fetal viability outweighed the autonomy of a woman.

The states' and physicians' fetal projection of life being more powerful than the autonomy of an individual proves the social value of women have been devalued because they are "less politically represented than the fetus, which is in turn more privileged by law, paternity, and other less institutional family strategies of contemporary American culture".[114] Women are socially devalued by the state as being portrayed as incompetent regarding the regulation of their own bodies.

The projection of fetal life has redefined women's bodies as a space of future citizenship, undermining the rights of the mother. Women are not trusted to make the correct choice during childbirth, so the state and physician act as uninvited gatekeeper. This projection of life and perceived risk[115] of a fetus has jeopardized the type of care women receive during childbirth.

Recent critiques of autonomy in medical situations have discussed the subjectivity of autonomy in healthcare considering the different experiences of individuals. Relational autonomy takes into consideration present social and political stratifications that may influence control. Medical treatment is centered on the individual and does not take into account the "questions of power, dominance, and privilege."[116] This approach of choice in childbirth "recognize[s] how the forces of oppression can interfere with an individual's ability to exercise

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[113] Ibid. 85.
[114] Berlant, Lauren. 1994. "America, 'Fat', the Fetus." *boundary 2* 21(3): 147.
[115] Diaz-Tello, Farah. 2016. "Invisible Wounds: Obstetric Violence in the United States." *Reproductive Health Matters* 24(47): 60
[116] Sherwin, Susan. 1998. A Relational Approach to Autonomy in Health Care.. In *The Politics of Women's Health,* Philadelphia: Temple University Press. 31.

autonomy by undermining her sense of herself as an autonomous being and by depriving her of opportunities to exercise autonomy." [117]

[117] Ibid. 35.

Empirical Analysis

As previously stated, cesarean sections in the United States are currently beyond the threshold of increasing maternal health outcome by 10 % outcome.[118] If 1,232,339[119] births are cesarean sections and only 10% are necessary, about 123,124 women a year wrongfully receive cesarean sections under the authority of physicians.

Threats of legal action have been utilized by physicians to force women to undergo cesarean section against their will. A woman in Staten Island named Rinat Dray was pregnant with her third child, and after two cesarean sections wanted to have a vaginal birth. She found a hospital she believed would support her decision yet was still forced to undergo a cesarean. Rinat's doctor,

> 'told her she would be committing the equivalent of child abuse and that her baby would be taken away from her' if she did not consent to a cesarean. Dray and the doctor continued to argue about the need for a cesarean, at which point the attending physician sought the support of the hospital's Director of Obstetrics, who also pressured her to consent. The Director then consulted with the hospital attorney, who advised the Director that no court order was necessary to proceed with a cesarean. The Director noted in Dray's chart that she was competent to make medical decisions, but he was nevertheless overriding her refusal to consent and, over her continued objections, she was taken to the operating room and prepared for surgery. She recalls lying on the operating table and begging for more time, to which the doctor responded, 'Don't

[118] "WHO Statement on Caesarean Section Rates." 2015. *WHO International*. https://apps.who.int/iris/bitstream/handle/10665/161442/WHO_RHR_15.02_eng.pdf?sequence=1.

[119] "Births- Method of Method of Delivery." 2017. *National Center for Health Statistics*. https://www.cdc.gov/nchs/fastats/delivery.htm.

> speak.' In the course of delivering her baby--who was healthy and showed no signs of distress--the physicians cut her bladder, which required further surgery to repair. [120]

Another woman by the name of Lisa Epsteen was past the due date of her fifth child. As she was driving to her fifth ultrasound, she prepared herself that a cesarean section would be a possibility. She had scheduled one for later in the week "because of health factors including gestational diabetes."[121] When she arrived at the clinic, she was seen by a physician who,

> advised that she report to the hospital for surgery. Epsteen did not have anyone to take care of her two-year-old and had the family's single vehicle with her, so she opted to wait to have surgery a few days later as planned. The following morning, she woke to find an email from her obstetrician instructing her to report for immediate surgery, adding "I would hate to move the most extreme option, which is having law enforcement pick you up at your home and bring you in, but you are leaving the providers of [the hospital] no choice."[122]

Lisa went straight to the hospital.[123]Accounts like these are not rare and are accompanied by life changing effects. The woman having control of her situation during birth leads to a positive moment. Without control, it is more likely that the experience will be negative. Even if birth plans must be changed, it is essential for the mother to a have control over the choice in collaboration with the knowledge and experience of physicians. A common sentiment by those

[120] Kukura, Elizabeth. 2018. "Obstetric Violence." *Georgetown Law*: 8.
[121] Diaz-Tello, Farah. 2016. "Invisible Wounds: Obstetric Violence in the United States." *Reproductive Health Matters* 24(47): 58
[122] Ibid.
[123] Ibid.

who are victims of this act is a feeling of dehumanization and terror. Obstetric violence is traumatic and painful at a point in life that is supposed to be one of the happiest. When all control is lost during childbirth, women may develop post-traumatic stress disorder, which can include "flashbacks, nightmares, and irritability."[124]

The reduction of autonomy from women when they are pregnant or in childbirth proves that the social value of women is less than that of a physician, who is most likely male, because the physician's control is never removed or questioned from the scene. Lack of control may lead to unnecessary procedures which endanger the life on the woman. In the case of Serena Williams, lack of control may be materialized as dismissal of complaints. Williams, one of, if not the most, famous tennis player in the United States, had to have an emergency cesarean section. A day after the procedure Williams believed she was developing a blood clot due to her shortness of breath. This was a feeling she was attuned to considering she had health concerns all her life. She had to convince the nurse that pain medication wasn't needed but an ultrasound was. Once the clot was found in a CT scan, Williams was given a blood-thinner that eliminated the clot but "caused hemorrhaging at the site of her C-section."[125] She returned yet again to the OR to have a filter inserted into a major vein, in order to prevent more clots from dislodging and traveling into her lungs. [126]

Traumatic births like these have severe, long-lasting effects on the birthing person. Post-Traumatic Stress Disorder can develop in women "as a result of the action or inactions of

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[124] Fernandez, Ibone Olza. 2013. "PTSD and Obstetric Violence." *Midwifery Today* Spring(105): 48

[125] Haskell, Rob. 2018. "Serena Williams on Motherhood, Marriage, and Making Her Comeback." *Vogue*. https://www.vogue.com/article/serena-williams-vogue-cover-interview-february-2018

[126] Ibid.

midwives, nurses and doctors."[127] Birth becomes an experience of terror if a woman has "no control over the decision-making process."[128]

[127] Fernandez, Ibone Olza. 2013. "PTSD and Obstetric Violence." *Midwifery Today* Spring(105): 48

[128] Cook, Katie et al. 2012. "The Impact of Choice and Control on Women's Childbirth Experiences." *The Journal of Perinatal Education*21(3): 165.

Conclusion

Many cases of PTSD after birth due to obstetric violence are reported in the United States, such as "a seventeen-year-old who had a fourth degree episiotomy despite her express pleas that she did not want one,... and a mother of twins was forced into a vacuum-assisted delivery despite her uncomplicated vaginal labor because she was taking up the operating room."[129]

Obstetric violence has gone largely unnoticed by the criminal justice system, preventing any solution to this epidemic. As accounted, there are instances where the legal system determines a woman does not have autonomy during childbirth. These actions display how the state has prioritized its own interest above a mother. There is also little monetary gain for lawsuits won against medical professionals, dissuading many lawyers from accepting cases involving obstetric violence.[130] Coerced procedures are defined as gender-based violence and the lack of a monetary value assigned to the well-being of women proves there is little acceptance of women's autonomy in childbirth.

While the United States allows for obstetric violence to continue, Argentina and Venezuela have adopted a human-rights based legal framework to protect birthing people. Coerced and unconsented procedures are criminalized under Venezuelan law, including cesarean sections and "artificially accelerating labor".[131] Approaching this subject as a human rights issue allows us to "engage with the interpersonal relations, the institutional structures, and the normative patterns"[132] present in childbirth. One solution to the problem of obstetric violence in

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[129] Borges, Maria T.R. 2018. "A Violent Birth: Reframing Coerced Procedures During Childbirth As Obstetric Violence." *Duke Law Journal* 67(827): 832.
[130] Ibid. 837.
[131] Ibid. 830.
[132] Erdman, Joanna N. 2015. "Bioethics, Human Rights, and Childbirth." *Health and Human Rights Journal* 17(1): 46.

the United States would be to adopt a similar model as Venezuela. Legal structures put in place to protect women from this violence will ensure proper justice for its victims.[133]

It is legal for medical students to perform unconsented pelvic exams on women. Currently, the New York State Assembly introduced a bill that would categorize "professional misconduct" as "performing a pelvic examination without consent on an anesthetized or unconscious person" and would "prevent the performance of pelvic examinations on women whom have not consented to such an examination".[134] This is a significant advancement in the rights of women during childbirth and my own mother would have benefitted from it years ago.

Hospitals can reduce the cases of obstetric violence by implementing procedure policies for medical staffs. Research has shown that "hospitals that establish policies related to cesarean deliveries may be more judicious in their use."[135] Standardized policies indicating specific instances procedures are necessary to lower the rate of cesarean procedures in large hospitals.[136] To combat medicalization, privileged women can hire a midwife. Midwives are common option for those who can afford it because most "view pregnancy and birth as a natural process, rather than as a medical condition, and focus on providing prenatal care from a woman-centered perspective."[137]

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[133] Op. Cit. 830.

[134] New York Legislature. Assembly. 2019. A06325. https://assembly.state.ny.us/leg/?default_fld=&leg_video=&bn=A06325&term=2019&Summary=Y&Actions=Y&Committee%26nbspVotes=Y&Memo=Y (March 5, 2019).

[135] Kozhimannil, Katy B et al. 2016. "Relationship between Hospital Policies for Labor Induction and Cesarean Delivery and Perinatal Care Quality among Rural U.S. Hospitals." *Journal of Health Care for the Poor and Underserved* 27(4): 138.

[136] Ibid. 128-143.

[137] Shaw, Jessica C. A. 2013. "The Medicalization of Birth and Midwifery as Resistance." *Health Care Women International* 34: 530.

Socialized medicine in the United States could also lower the rates of obstetric violence. If there is not monetary incentive to perform unnecessary procedures, less would be performed. According to a CBS News article, the average cost of childbirth in Finland, a country with socialized medicine is $60. Whereas "commercial payers paid approximately 100% more than Medicaid" in the United States.[138] This shift would drastically reduce the hospitals ability to exploit patients and would refocus hospital births towards the autonomy of birthing people. The Finnish maternal care system's "policy has recently shifted away from a focus on efficiency to a re- emphasis on equity in primary health care provision."[139] Both Venezuela and Finland have adopted maternal care policies that emphasize autonomy and control during childbirth.

The social and economic value of women is currently low under the standards of medicalized American childbirth. The high hospital costs and lackluster legal protection negatively affect both the economic and social importance of women. This, in turn has created the epidemic of obstetric violence. Rectifying this problem is of the utmost importance due to its malicious nature. Adjusting laws to protect women from obstetric violence and implementing a socialized nation healthcare system will address this issue and make impactful change.

[138] Truven Health Analytics. 2013. "The Cost of Having a Baby in the United States." 1–84.
[139] Wrede, Sirpa et al. 2008. "Equity and Dignity in Maternal Care Provision." *Canadian Journal of Public Health* (99): 16–21.

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