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Tip Sheet: Overmedicalization of Childbirth

What Is the Problem?

Childbirth has been a normal and natural life process for birthing people[i] and society for centuries. Yet today in the U.S., one-third of babies are surgically born, and interventions (e.g., episiotomy, fetal monitoring) are often used contrary to best evidence, when they are known to offer no benefit and have the potential to cause harm. Childbirth is the top reason for hospitalization in the U.S., with both maternity care providers (e.g. obstetricians, family physicians, midwives) and hospitals playing a significant role in childbirth.

Common actions that contribute to an overmedicalized pregnancy and childbirth experience include:

- Overuse of ultrasound scans during pregnancy
- Unnecessary IVs during labor and prohibition of routine oral hydration and nourishment
- Restriction to lying in bed versus mobility (which can enhance comfort and labor progress)
- Epidural analgesia, which can provide effective pain relief but dramatically changes the experience of labor and is often used without first offering other safe, effective pharmacologic options (e.g., nitrous oxide) or non-pharmacologic options (e.g., tubs, showers, birth balls, doulas)
- Unnecessary low-risk, first-born Cesarean section (C-section) births.

In particular, over the past decade, low-risk, first-birth C-section birth rates have dramatically increased by 50% across the country. Cesarean births are now the most frequent hospital surgery. Though C-sections are important and can be lifesaving in some cases, they are most frequently done for the often ill-defined stipulation of "a failure to progress in labor." Current national rates of low-risk, first-birth C-sections (from high 20% and up) are significantly higher than the U.S. Department of Health and Human Services goal of 23.9%. Because criteria are ill-defined and practice varies widely across maternity units, the facility where a birthing person gives birth greatly influences how she gives birth and her likelihood of a C- section and other birth-related procedures.

While necessary in limited circumstances, C-section surgeries bring with them serious risks, including but not limited to:

- For baby: respiratory complications, infection, neonatal intensive care stays, and lower breastfeeding rates
- For birthing people: hemorrhage, transfusions, infection, blood clots and postpartum depression; significantly increased chances of a C-section in subsequent births, with repeated uterine scarring posing hazards to both the birthing person and her future fetus/newborn.

Another key issue of overmedicalization is its economic impact; overmedicalization of pregnancy and childbirth leads to wasted resources in the system. For example, when the birth is Cesarean versus vaginal, total payments for the birthing person and newborn across the entire episode are about 50% higher. In California, for instance, a C-section averages $22,188 compared to a vaginal delivery at $15,162. Nurse-midwives who are trained to support the birth process and work as collaborative providers can help reduce the overmedicalization of pregnancy and childbirth. However, currently midwives only deliver about 8% of the births in the U.S.

What are the risk factors?

An overall challenge is the ***difficulty birthing people have obtaining access to essential maternity care practices that increase their likelihood of having a vaginal birth***. This challenge exists due to the loss of provider skills, knowledge, and support, and the relative ease of Cesarean birth for providers and facilities. Today, many providers are not trained to assist with: vaginal birth after cesarean ("VBAC"), vaginal breech birth and vaginal twin birth, versions (hands-to-belly maneuvers to turn a fetus to a head-first position at the end of pregnancy) and judicious use of vacuum extraction or forceps to assist a vaginal birth.

More specifically, ***birthing people who deliver their first child via C-section*** have nearly a 90% chance of subsequent births being C-sections with a higher risk of major complications, including surgical adhesions, fertility issues, placenta problems, hysterectomy and mortality. By contrast, a birthing person with an initial vaginal birth is highly likely to give birth vaginally with any future pregnancies. Other actions such as inserting IVs and continual fetal monitoring during labor mean a birthing people cannot be very mobile during labor; being able to walk around and be mobile during labor helps the birthing process.

Another challenge in addressing overmedicalization of childbirth is that ***today discussions between providers and patients focus on reasons for (not against) choosing a C-section and other medical procedures.*** According to a national survey, though only 1% of first-time people who have given birth would elect to have a C-section with the understanding that there is no medical rationale, yet:

- 1 in 4 birthing people felt pressured by health providers to induce labor or have an unnecessary C- section, and
- 1 in 4 birthing people felt pressure to repeat a C-section delivery for subsequent deliveries.

Where a birthing person-to-be receives care can have a tremendous impact on their care trajectory and the health outcomes of the birthing person and baby. For example, at one hospital the likelihood of getting an unnecessary C-section could be 15%, while at another hospital in the same city the rate could be 65%. In California, birthing people and their networks can find hospital-level quality metrics by named hospital at www.CalHospitalCompare.org, as well as on the Yelp hospital business pages. Birthing people can use this information to inform their choices about where they seek care and to enable them to ask more informed questions of their entire care team.

How Can Overmedicalization of Childbirth Be Prevented?

It is possible to reduce the rates of unnecessary medical procedures during pregnancy and childbirth by better informing patients and working with maternity care providers to improve clinical practice.

Patient engagement includes:

- Learning more about the drawbacks/complications of medical and surgical interventions such as: inserting IVs during labor; continuous fetal monitoring; episiotomies, and both low-risk, first- birth and repeat C-sections.
- Learning more about the benefits of the following: waiting to go into the hospital until labor is well-established ("active labor"), being upright and mobile as well as using handheld devices to monitor the well-being of the fetus, and VBACs.
- Researching the performance of hospitals on key quality of care measures like their C-section, episiotomy, breastfeeding and VBAC rates.
- Explicitly discussing care preferences with the care team, especially if performance data indicates that the hospital is not providing the highest quality of care. Consider switching the hospital or doctor if care quality is low and it is possible to do so.
- Engaging a midwife as a member of the healthcare team.
- Having the support of a labor doula, a non-clinical birth companion who helps birthing people avoid unwarranted cesareans, use less pain medicine and have more satisfying experiences, among other established benefits.
- Giving birth in a birth center, a limited but growing option.

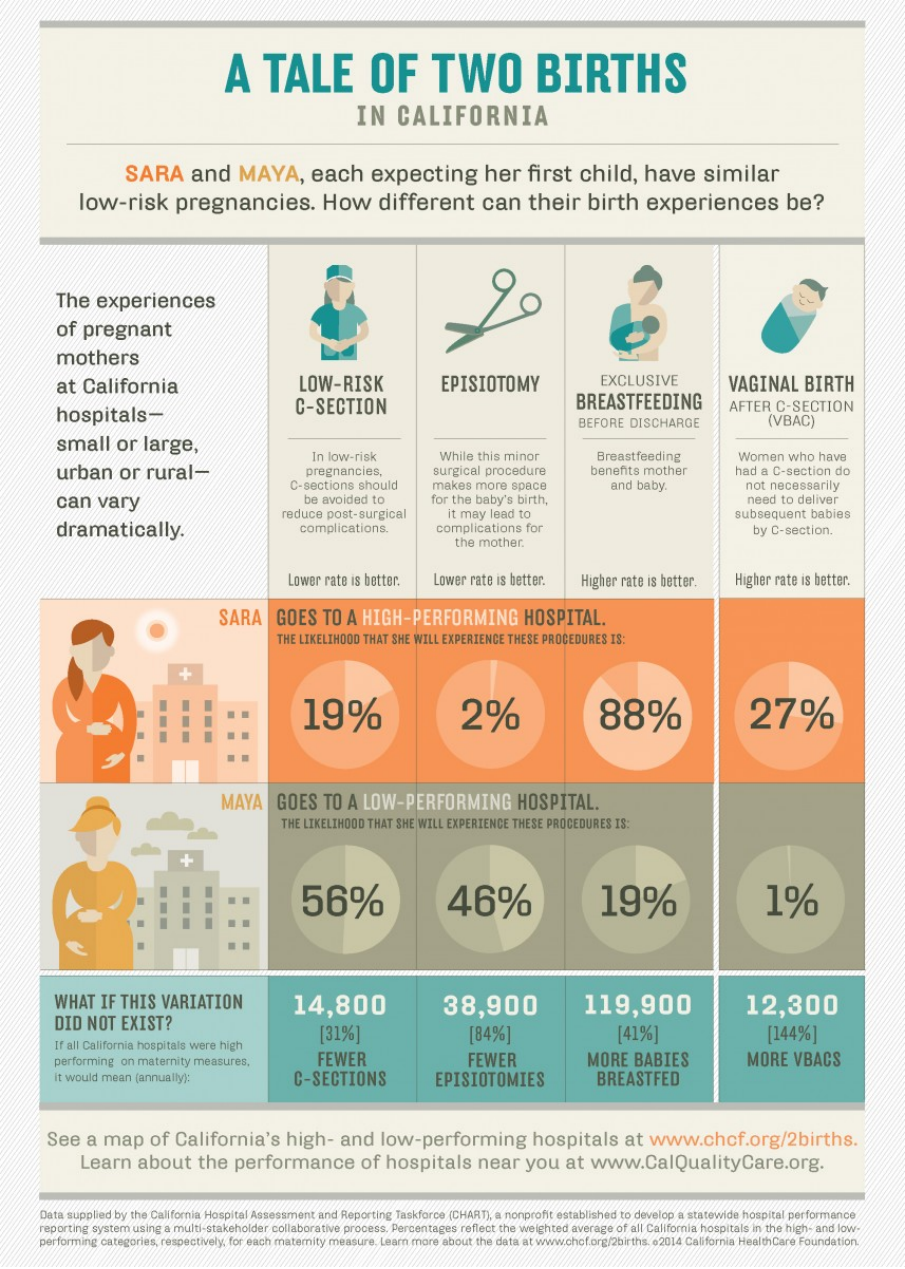
Midwives view birth as a normal life process. They are trained specifically in supporting birthing people through all stages of pregnancy, birth and the postpartum period. Studies have shown that they tend to use fewer interventions, provide high-quality care and know when to engage other health professionals. Doulas have often been found to lower the rates of unnecessary interventions. However, due to the COVID-19 pandemic, some hospitals have instituted a one visitor policy leading to difficult decisions on who can be present in delivery rooms, sometime leaving the birthing person left to choose between their partner and their midwife or doula. In response, some organizations have shifted to offering their doula services virtually.

In the statewide survey of people who gave birth in California ("Listening to Mothers in California Survey"), a majority expressed an interest (definitely would want or would consider) both a midwife and a doula should they give birth in the future, and four in ten similarly expressed interest in giving birth in a birth center. When the participants were asked whether they agreed or disagreed that "birth is a process that should not be interfered with unless medically necessary," about three-quarters agreed (half "strongly"), and just 8% disagreed. The care that birthing people receive in U.S. hospitals is out of step with the views and interests of the birthing people themselves and, all too often, with best practice.

Case Study

Valerie was excited to give birth to her first baby, a girl. Pregnancy was a breeze. All looked good—her baby was in the right position, and she'd carried her to full term. She and the baby were healthy. Valerie had eaten well and done everything right and looked forward to an uncomplicated childbirth. She arrived at the hospital partially dilated with her happy and nervous husband. But with the transition to this unfamiliar environment, stress hormones kicked in and her labor progress slowed. As the hours went by, the doctor visited to say, "I'm afraid you're experiencing a stalled labor. You're still only 5 centimeters. I'm sure you want to be home soon with your family to enjoy your new arrival." He recommended inducing labor and a Cesarean delivery.

Valerie wished she had followed her mother's advice to get a midwife who had techniques, such as using "peanut balls" to assist during the birthing process. She also didn't know that the hospital where she planned to give birth had a high rate of C-sections. When Valerie's mother arrived at the hospital, she was alarmed to hear her daughter was scheduled for a C-section and went in search of a nurse, asking, "Is the baby okay? Are my daughter's tests normal?" Their health was fine. Oddly but all too frequently, no one had provided any information about the many short- and long-term risks of the surgery. Valerie's mom, who had done her research, knew about the value of a vaginal birth and persuaded her daughter to wait a little longer, since the medical staff agreed it was safe to do so. She also suggested shifting positions, trying a few squats and took her on a brief walk with soothing assurances. The movement, change of scenery, a little rest and the calming effect of her mother and the new plan jump-started Valerie's labor and she was able to give birth vaginally.



Resources

- California Health Care Almanac (June 2016) "Maternity Care in California - Delivering the Data" - California Heath Care Foundation (CHCF): http://www.chcf.org/publications/2016/06/maternity-care-california
- Toolkit to Support Vaginal Births and Reduce Primary Cesareans (California Maternal Quality Care Collaborative): https://.cmqcc.org/VBirthToolkitResource
- California Hospital Compare Data Center: http://www.calhospitalcompare.org
- Trends in Low-risk Cesarean Delivery in the United States, 1990–2013: http://w.cdc.gov/nchs/da/nvsr/nvsr63/nvsr63_06.pdf
- Your Biggest C-section Risk May Be Your Hospital: http://www.consumerreports.org/c- section/your-biggest-c-section-risk-may-be-your-hospital/
- Midwifery: http://www.thelancet.com/series/midwifery
- Reducing Unnecessary C-Section Births, New York Times: https://opinionator.blogs.nytimes.com/2016/01/19/arsdarian-cutting-the-number-of-c-section-births/?_r=0
- California Hospital Ratings: http://www.consumerreports.org/health/hospitals/ratings
- Efforts to Reduce Black Maternal Mortality Complicated by COVID-19: https://www.chcf.org/blog/efforts-reduce-black-maternal-mortality-complicated-covid-19/

[i]We use the term "birthing people" to recognize that not all people who become pregnant and give birth identify as a woman or a mother.