

# The Medicalization of Childbirth: Ethical and Legal Issues of Negative Childbirth Experience

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## Abstract

As a potentially harmful process, medicalization should be analyzed in contrast to reproductive autonomy. We argue that it is crucial to advance women's control over reproduction, especially over childbirth, since disregarding autonomy could cause negative childbirth experience even without maternal or foetal morbidity or mortality. We present the results of a questionnaire-based research of our own regarding negative childbirth experiences among Hungarian women (n=506). We found that comprehensive medical information, active participation in medical decision making, freedom of movement during labour and delivery had positive effects, while the loss of control was correlated with negative childbirth experiences.

## Keywords

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## **Abstract**

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## **I. The medicalization of women' bodies**

The term 'medicalization' is often used to describe an intrinsically negative phenomenon that is closely related to the philosophical problem of *power*. According to Peter Conrad, by medicalizing a phenomenon, we are describing

a problem in medical terms, using medical language to describe a problem, adopting a medical framework to understand a problem, or using medical intervention to

‘treat’ it. This is a socio-cultural process that may or may not involve the medical profession, lead to medical and social control or medical treatment, or be the result of intentional expansion by the medical profession [1] (p. 211).

The exponentially growing medical knowledge and medical technology can be interpreted as a form of power as well, which led to a seemingly irresolvable asymmetry between doctors and lay people. In his work, *History of Sexuality I* and *History of Madness*, Michele Foucault argues that *power* at first is a ‘multiplicity of force relations’ that is not fixed, changes constantly, and influences our self-understanding and interpersonal relationships to a significant extent. “One needs to be nominalistic, no doubt: power is not an institution, and not a structure; neither is it a certain strength we are endowed with; it is the name that one attributes to a complex strategical situation in a particular society.” [2] (p. 93). By accepting and supporting the nature of the Foucauldian definition of power, we first need to review the cultural and philosophical heritage that determines Western societies. First, regarding the issues of gender equality; and second, as a negative result of the first, the features of the paternal doctor-patient relationship.

Regarding the medicalization of women, it is essential to explore to what extent technical development affected the history of science, especially that of psychology and psychiatry. The development of medical technology and the scientific method turned the medical attention predominantly towards the *empirical* aspects of life. Somatization, as the primary concept of the Western medical approach, provided precisely the necessary epistemological background since it turned doctors’ attention to the physiological side of the human being. This shift was also crucial for the survival of psychiatry, as it had to prove its objective, scientific roots.

The medicalization of women is based on several presumed ontological differences between males and females. These differences are significant for our explanation of how the Western civilization and its philosophical background created an *unequal and hierarchical* relationship between women and men – also in the delivery room.

As Foucault wrote in the *History of Sexuality*, there is a large difference between the 19<sup>th</sup> century’s medical discourse of ‘reproductive biology’ and the ‘medicine of sex.’ The connection between the two is rather problematic:

The role of the first with respect to the second was scarcely more than as a distant and quite fictitious guarantee: a blanket guarantee under cover of which moral obstacles, economic or political options, and traditional fears could be recast in a scientific sounding vocabulary [2] (p. 54).

In fact, the blanket guarantee that Foucault mentions prolonged the Aristotelian tradition into the 18<sup>th</sup> and 19<sup>th</sup> centuries, which sustained the idea of some essential differences between women and men. By the end of the 19<sup>th</sup> century, medicine served as a tool, whose truth and reliability was hardly disputable.

In Aristotle's Ancient Greek *polis*, women were not part of political decision making, and thus they could not be *zoon politicon*. Although the feminist interpretations of Aristotle are quite diverse, it is likely that on the ontological level, he presumed a substantial difference between women and men. Such differences are also reflected in his *hylomorphic* views. The well-known Aristotelian description of women as '*deformed men*' suggests that the sexes do not possess the same amount of form and matter. There is strong evidence to suggest that being male and female are expressible on the level of matter and form as well, hence the two are gendered notions [3]. The explicit misogyny of the Aristotelian texts stems from the Aristotelian presumption that, biologically and ontologically, the two sexes are not equal. Feminist thinker Cynthia Freeman analyzed Aristotle's texts that characterized the relevant features of women:

Aristotle says that the courage of man lies in commanding, a woman's lies in obeying; that 'matter yearns for form, as the female for the male and the ugly for the beautiful'; that women have fewer teeth than men; that a female is an incomplete male or 'as it were, a deformity': which contributes only matter and not form to the generation of offspring; that in general 'a woman is perhaps an inferior being [4] (p. 145-156).

## II. The medicalization of childbirth and reproductive autonomy

Despite the interiorized social attitudes and the religious and philosophical tradition, civil rights movements started to demand *reproductive autonomy* in particular for males and females in the middle of the 20<sup>th</sup> century by advocating self-determination and human dignity for people in general. The term *reproductive autonomy* conceptualizes a universal and gender-neutral principle – this is especially important for women because of a simple biological obviousness: no matter how advanced medical technology is, the control over reproduction still belongs to women. Regarding medicalization, Laura Purdy argues that respecting the reproductive autonomy of women is the tool which could advance most women's welfare. So it is, since the term relates to all existentially crucial questions of reproduction, over gaining or losing control, thus highly influencing human freedom [5]. First, autonomy in this regard concerns the freedom to choose between contraceptive methods, as well as the timing of pregnancy, if the person wants to bear a child at all. Second, during their pregnancies, women must be allowed to decide on the location of delivery, the people whom they wish to be present, the diagnostic tests during each trimester, etc. Third, during labour, the woman must have the chance to maintain control over the process; that is, to receive comprehensive information from the Obstetrician, to be able to decide on the most comfortable birthing position, and so on.

In the Aristotelian perception, women were highly associated with their procreative function, which resulted in an obstacle to assertiveness. According to feminist bioethical literature, this tendency still existed in the 20<sup>th</sup> century. From this point of view, Nicolette Priaulx criticizes Abraham Maslow's theory regarding the basic and higher needs of women and men. According to her argument, by identifying basic (psychological, safety) and higher (belongingness, love, esteem) needs, Maslow prolonged the ancient Greek philosophical tradition. A deeper reading of the Maslowian texts shows, says Priaulx, that striving to boost self-esteem as a higher need for women still meant the primacy of childbearing [6].

The first document to include these rights for women was prepared at the 1994 International Conference on Population and Development under the coordination of the United Nations [5].

Following this milestone, the theory of respecting reproductive autonomy not only appears in philosophical and legal texts, but the number of obstetrics and gynaecology guidelines which integrate reproductive autonomy as a tool to reduce the vulnerability of birthing women is constantly increasing.

The International Federation of Gynecology and Obstetrics (FIGO) also acknowledges the importance to respect self-determination regarding reproductive issues:

The principle of autonomy emphasizes the important role women should play in decision-making in respect to their health care. Physicians should try to redress women's vulnerability by expressly seeking women's choices and respecting their views [7] (p. 21).

However, the medicalization of childbirth is fed by many lay beliefs that suggest that it is better for pregnant women to renounce their agency. In a Hungarian study, Emma C. Molnár questioned over one hundred pregnant women on pregnancy-related issues [8]. The participants were asked whom they thought they should pay attention to when giving birth, and who would help them. The participants ranked the doctor as the first one, followed by the midwife and the husband, themselves ending up last [9] (p. 293). Patient control and women's involvement in decision making regarding childbirth have several psychological benefits: it reduces depressive and posttraumatic stress symptoms, and increases the overall patient satisfaction and self-esteem. [10] Considering the potentially-harmful consequences of women's passive role during labour and delivery, it is essential to abolish the paternalistic doctor-patient relationship from maternity wards. Informed consent and shared decision making are crucial for securing women's reproductive autonomy in this context.

The recommendations of the World Health Organization (WHO) emphasize women's self-determination during the different stages of delivery. In the latest edition of WHO recommendations regarding intrapartum care, over 50 recommendations were included to foster a positive childbirth experience [11] (p. 19-168). The list captures the potentially-harmful or unnecessary medical interventions that are still routinely applied in the obstetrical practice in many countries.

Despite the fall of maternal mortality rates, the WHO estimates that immediate medical intervention to prevent lifelong disabilities is still

necessary in 10 to 15% of childbirths [12]. When criticizing the medicalization of childbirth, we believe that it is important to stress that medical technology and medical interventions on their own are completely value-free. The often criticized obstetrical practices such as episiotomy, Caesarean-sections or the administration of oxytocin have no inherent meaning from a moral point of view. However, applying them routinely could lead to negative outcomes by undermining the sense of human dignity. Therefore, the personalized intrapartum care should be a moral standard, since the misuse of medical interventions could subjugate women to doctors and the medical authority [13-14].

### **III. The Hungarian patient rights and reproductive autonomy**

The Hungarian legal regulation also includes several patient rights which foster reproductive autonomy in practice. According to ‘The Right to Health Care’ women have the right “to choose attending a physician, with the agreement of the healthcare provider” (Title 2, Section 7(1)). Furthermore, ‘The Right to Have Contact,’ explicitly states that

A woman in childbirth shall have the right to designate a person of age to stay with her continuously during labor and delivery, and after delivery, to have her new-born baby placed in the same room with her, provided it is not excluded by the mother’s or the new-born baby’s health condition (Section 11, 5).

According to ‘The Right to Information’ it is essential to provide complete information in an ‘individualized form’ even in the intrapartum period [15]. Hungarian Law accepts the limitation of this particular right and informed consent, if the patient does not have the capacity to decide. Nevertheless, there is no consensus in the literature whether women who experience high levels of pain while in labour have the capacity to decide, which raises medical, legal, and ethical debates [16]. The same issue applies to ‘The Right to Self-determination’ and ‘The Right to Refuse Healthcare,’ since both may only be exercised by those who have full capacity of decision.

Therefore, allowing a woman to refuse a seemingly effective medical treatment, such as an episiotomy, without being convinced of the

capacity of the woman to decide, could lead to medical moral dilemmas. The situation could become even more problematic, if the couple provides the doctor with a directive (birth plan) in advance, in which the woman refuses an intervention that would be in her best medical interest in actual given situation.

Altogether, respecting patient rights rooted in the principle of reproductive autonomy is essential in order to achieve a positive childbirth experience and to avoid or minimize the occurrence of certain medical interventions.

#### **IV. Non-medical reasons of negative childbirth experience**

##### *A. Objective and hypothesis*

As argued so far, respecting women's reproductive autonomy is essential in obstetrics and gynaecology. However, the literature suggests that women are still rather vulnerable in the prenatal and perinatal stages in terms of self-determination [16-17]. Our starting hypothesis was that limiting reproductive autonomy and patient rights could lead to negative childbirth experiences, even if no maternal or foetal morbidity/mortality occurs. We also assumed that the medicalization of childbirth could cause the loss of control because of the medical practitioner's role – the guardian of safety –, which may easily overrule reproductive autonomy. We hypothesized that the following non-medical factors would have a significant connection with negative childbirth experiences: lack of information; restriction of women's movement during labour and delivery; loss of the sense of control; limitation of self-determination. We wanted to explore what women consider a negative childbirth experience and how medicalization and reproductive autonomy appear (or fail to appear) in the hospital setting.

##### *B. Methods*

We created an online questionnaire and sent it to the administrators of major Hungarian Facebook groups for women who have experienced childbirth. We collected 506 childbirth instances from women who gave birth in Hungary since 1997 and had negative experiences. We then analyzed the participants' answers to open-ended questions which asked them to describe their negative childbirth experiences. Following

this stage, we processed the data gathered from closed-ended questions regarding childbirth preferences.

The questionnaire started by asking participants to score their childbirth experience in a 1 to 10-point scale, in which the lower scores represented negative experience, whereas the higher ones were linked to positive experiences. Before analyzing each childbirth instance, we filtered out the participants whose negative experiences were the result of clear medical problems. The cases of foetal and maternal morbidity or mortality were also excluded from the analysis. Furthermore, we also excluded the participants who scored their overall experience by more than 6 points. We thus reached a number of 435 childbirth experiences which we then reviewed.

### *C. Qualitative and quantitative analysis*

Before the qualitative analysis, the main attributes of medicalization in regard of childbirth should be listed: (1) unnecessary, unwanted, or unexplained medical interventions; (2) the violation of the principle of reproductive autonomy and paternalistic doctor-patient interactions; (3) the violation of particularly important rights for women in labour, namely the right to information, the right to human dignity, the right to have contact, the right to self-determination, the right to refuse health care.

The Spearman correlation was applied to assess the relationship between negative childbirth-experience and non-medical traumatizing factors (the amount of sufficient information; the freedom of women's movement during labour and delivery; the sense of control). Participants were asked to score various statements regarding the previously-described features of reproductive autonomy (the amount of sufficient information; the freedom of women's movement during labour and delivery; the sense of control) on a 1 to 5 point scale (1 = completely agree; 2 = partially agree; 3 = not really agree; 4 = completely disagree; 5 = do not know). The respondents who could not decide were excluded from the statistical analysis. Multiple linear regression analysis was used to identify significant predictors of negative childbirth experience among the non-medical traumatizing factors. Frequency distributions were determined through Google Docs. Correlation and multiple linear regression analyses were performed in IBM SPSS Statistics 23.

## D. Results

Closed-end questions suggested that comprehensive medical information ( $r=0,25$ ;  $p<0,01$ ), active participation in medical decision making ( $r=0,22$ ;  $p<0,01$ ), freedom of movement during labor and delivery ( $r=0,21$ ;  $p<0,01$ ) had positive effects, while the loss of control was correlated with negative childbirth experiences.

The multiple regression model ( $F=9,26$ ;  $p<0,01$ ;  $R^2=0,1$ ) explained 10% of the variance of negative childbirth experiences. The lack of sufficient information ( $\beta=0,13$ ;  $p<0,05$ ), the restriction of women's movement during labour and delivery ( $\beta=0,11$ ;  $p<0,05$ ) were marked positive, while the loss of the sense of control was a significant negative predictor ( $\beta=0,13$ ;  $p<0,01$ ). Collinearity and autocorrelation were not observed.

Hierarchical differences between practitioners and women are not favoured by women. This was further reflected in the responses given to the question on the preferred quality of doctor-patient relationship: 83% ( $n=348$ ) of the respondents indicated a preference for a partner-like relationship over a paternalistic one.

While reviewing the childbirth instances ( $n=435$ ), various forms of violation were identified. One of the most important one referred to the patient rights based on reproductive autonomy such as the Right to Self-determination (41%;  $n=181$ ), the Right to Information (37%;  $n=161$ ), the Right to Dignity (19%;  $n=82$ ), the Right to Have Contact (10%;  $n=42$ ), the Right to Refuse Treatment (5%;  $n=21$ ).

## V. Discussion

### A. The Right to Self-determination

The Right to Self-determination is one of the essential patient rights, based on the well-known bioethical principle of reproductive autonomy. We collected the main freedoms and options in which this right is embodied during the intrapartum period: the possibility to choose between therapeutic options and medical interventions (artificial rupture of membranes; pelvic exam; enema; pubic shaving; episiotomy; IV-fluids; artificial oxytocin administration; vaginal birth/Caesarean-section, etc.), and the possibility to determine the position and place of labour and birth). 181 women experienced an unnecessary, unwanted, or disproportionate limitation of this right, despite that the right to self-

determination and autonomy is the essential requirement of the partner doctor-patient relationship. One participant wrote: *"The doctor examined me again and without telling me or asking me anything, he ruptured the membrane!!!! He smiled and told me that now we would give birth. I know, but why couldn't he discuss with a frightened mother what and why he plans to perform on my body?!?!?"* Not only doctors were criticized, but also midwives. As another participant tells: *"The midwife had a completely medicalized approach, she only came to give me something, to examine me, but treated me as if I was just an object, she did not speak one word to me."* Many respondents expressed how much the burden of the loss of self-determination affected them. Indeed, the loss of self-determination is an alienating factor, hence violates the principle of autonomy and results in a paternalistic relationship. For the majority of the participants, the violation of self-determination represented the single negative aspect of childbirth, which shows how important safeguarding this right is during the intrapartum period. As another woman wrote, *"It was not the natural pain of birth which made my experience negative. But rather the medical interventions, of which I was not informed, such as membrane stretch and sweep, the Kristeller manoeuvres and other painful manoeuvres. Saying that these manoeuvres are really bad is just an understatement."*

### *B. The Right to Information*

Personalized, objective, and understandable medical information is needed in order for women to gain control and practice patient autonomy in the delivery room. FIGO and WHO guidelines emphasize informed consent, considering it a highly effective tool in reducing the vulnerability of women during pregnancy. Providing continuous information in the intrapartum period is not only important on its own, but it also facilitates the agency of women when giving birth. Respecting the reproductive autonomy of women during childbirth can only be fulfilled if the hospital team allows them to articulate their wishes according to their preferences. Generally, women are competent during labour, therefore *any form of unnecessary or disproportionate limitation of informed consent should be recognized as a harmful by-product of paternalism as a form of medicalization.*

We reviewed the childbirth instances focusing on complaints based on the lack of communication and insufficient medical information. The results showed that the Right to Information was also frequently

violated. 167 stories explicitly referred to a perceived violation of proper medical information. One of the respondents wrote: "No one informed me, or asked for my permission to perform any examination. I was given medications without being informed or giving consent. They did not treat me as a competent individual while giving birth." Another woman also reported loss of control because of lack of information: "Having insufficient information was the most difficult part of the experience, I felt like a lost child." These complaints offer a dramatic insight in the situation of women who are forced to give birth without being informed. Limitation of information and autonomy lead to a paternalistic relationship -- which is the opposite of what women need during childbirth. Throughout the instances we reviewed, the following seems to be a typical scenario: "I had a clear concept of how I would like to give birth. It just did not happen, they brought me the consent forms when I was having contractions, so I could not even assess what I was signing while I was urged that I need to sign here and there." Many instances showed that women were not informed, despite the fact that they wanted to be. The following example shows how vulnerable one can become if the minimum information is refused to them: "If I asked something, the midwife only replied in two-word sentences. Then she yelled at me derisively: 'How curious can one be...you'd better do what is your business, just like I do.' But I knew neither what to do [i.e. what was my business], now what was happening to me and why."

The 'Right to Self-determination' and the 'Right to Information' are proper tools to enhance reproductive autonomy for women who give birth. However, medicalization often results in unequal relationship in delivery rooms. The information asymmetry between the medical team (doctors, midwives, nurses, etc.) and the women, sometimes brings unnecessary and causeless deprivation of control and reproductive autonomy. We believe that a partner-like doctor-patient relationship, shared decision making, and informed consent are the only morally acceptable tools to fill the information gap, hence paternalism as a form of medicalization must disappear from obstetrics and gynaecology. Withholding information and limiting self-determination is potentially harmful. Their violation can lead to terrible childbirth experiences, as one of the respondents emphasized: "I feel like I was deprived of the most important event of my life; it was not the most beautiful, but the

most terrible. I am sure it would not have happened that way, had I been informed, prepared, and supported.”

### *C. The Right to Human Dignity*

Protection through the ‘Right to Human Dignity’ is crucially important for patients who are vulnerable in hospital setting. The fragile position of women in labour must be recognized, as they may feel exposed to medical practitioners due to information asymmetry. Some examples of violations of the Right to Human Dignity, identified by the respondents, include disrespectful or rude behaviour of the healthcare practitioners, as well as unnecessary, unwanted, or unexplained restrictions.

82 respondents expressed some form of human dignity violation. Objectifying, that is, reducing patients to objects in need of ‘repair’ is a frequent feature of medicalization. The partner-like doctor-patient relationship should be the exact opposite, as the cooperation between the two parties should be based on a simple recognition: people who seek help from medical practitioners must be perceived as subjects, not as objects, thus deserving respect and appropriate communication.

One of the respondents explained objectification in the following manner: “No one cared about my feelings, my fears. I felt humiliated and vulnerable. I was just a ‘piece of work,’ while giving life to my baby.” Another frequent instance of human dignity violation, as expressed by the respondents, was related to alienation. Many respondents said they felt like a ‘piece of meat’ or an ‘object’: “I was just one piece of meat among the others. Not a human being. Not a woman.” Such experiences were more common for patients with Caesarean-sections: “I felt like I had nothing do with the birth. I felt wretched and incompetent. [...] It was just like a slaughterhouse. Rigid, metallic. And above all, inhuman. When I cried, I was told that I was not a three-year-old anymore.”

### *D. The Right to Have Contact*

The Hungarian healthcare legal regulation provides women with the right to designate someone to assist them during labour and delivery. Nevertheless, in 42 cases the Right to Have Contact was limited through a questionable manner. There were several obvious cases of

misinformed women: “We arrived to the hospital at the end of an absolutely problem-free pregnancy. After that – although our doctor had previously confirmed (multiple times), that my husband can be with me during labour – we were unreasonably separated from the beginning.”

Unreasonable limitation of the Right to Contact could lead to vulnerability and loss of the sense of control, therefore decreasing reproductive autonomy. “My husband was not allowed to be with me, he was sent home, and I was left alone during labour. I was not informed about anything, I felt vulnerable.” Women’s mental health is positively affected not only by physical and informational support, but also by emotional support [18]. As already emphasized, the emotional support during labour reduces the number of childbirth complications and postpartum depression, therefore it is crucial to allow women to choose a close person to assist them, this being an essential part of reproductive autonomy during the intrapartum period.

### *E. The Right to Refuse Treatment*

This right ensures that competent women at birth can refuse any medical intervention that is not life-saving. A frequent issue signalled by the respondents regarded respecting women’s active role in the decision-making process. The responses included cases where women were not allowed to refuse an otherwise not life-saving medical intervention. 21 participants felt that health care practitioners deprived them of practicing this form of self-determination. “They did not inform me on the upcoming examinations, somebody just came in (no introduction, nothing, he could have been a maintenance worker), touched me, and left. The midwife and the doctor neglected my requests. I was given oxytocin without information and against my will.” “I had indicated in advance, that I did not want any medication to accelerate my labour, but they eventually gave me oxytocin in fear of prolongation.” Disproportionate or unnecessary limitation of the Right to Refuse Treatment is potentially harmful if the right only exists on the theoretical level. If competent women are not allowed to make informed consent during labour, it opens the ground for paternalism. As the WHO and FIGO guidelines warn, it is not recommended to routinely perform medical interventions at birth, such as episiotomy. Nevertheless, some of the respondents claimed that the limitation of

the Right to Refuse Treatment was due to “hospital protocol.” If this is the case, health care providers must protocols and recommendations on labour and delivery.

*F. Paternalism: an unnecessary, disproportionate limitation of reproductive autonomy and patient rights*

As argued above, the medicalization of childbirth manifests in various forms. However, the results are similar, since paternalism is an obvious consequence of the misuse of medical power. Unnecessary or disproportionate limitation of reproductive autonomy is a result of paternalism. Nevertheless, the intention of the healthcare practitioners could be intrinsically good in most situations if the limitation of autonomy is based on a medically-sound reason. Overriding self-determination could serve the patient’s best medical interests, since immediate medical help can prevent life-long disabilities or even maternal or foetal death. Paternalism, as the suppression of patient autonomy and self-determination is not immoral in itself. However, it is crucial to emphasize that it is problematic to disregard the will of an otherwise competent individual.

Within the respondents’ answers, paternalism was also a major complaint. 141 women to have felt vulnerability, self-abandonment, and infantilization because of the medical environment: “When I arrived at the hospital, I became a puppet. I seemed to not be competent at all; they arranged everything without my will. They did not inform, ask me anything, and I was laughed at if I asked something.” Alienation, as another result of paternalism, was also a complaint: “The doctor’s and midwife’s lack of communication and empathy made it horrible. They discussed important issues without me, issues in which I should have been involved, and they asked each other questions that I should have been asked as I was the one who knew the answer. They did not explain what was happening and I felt ordered around.”

Paternalism and its forms were the most common complaints of the respondents. Again, parentalism has many features, but has similar consequences: alienation from birth, vulnerability, and the medicalization of an otherwise natural physiological process: “I felt like someone who is not capable of assessing her own condition and feelings, just like an incompetent patient.” Transforming healthy people

into sick ones, using medical technology to expand control over the unpredictable features of birth (duration of labour and delivery, the emotions of the woman in labour, the need of birth-experience personalization) are essential parts of medicalization.

Our results are in accordance with the findings of other studies which explore the ethical and legal aspects of obstetric care. Similarly, a recent study also found that the Right to Information and Self-determination are often violated in obstetrics practice in Hungary [19]. The impact of reproductive autonomy in the sense of women playing active roles during labour and delivery in order to facilitate a positive childbirth experience is also confirmed by recent studies [20, 21, 22].

## **VI. Conclusion**

This essay gave an insight to the medicalization of childbirth. The most well-known guidelines regarding pregnancy and childbirth (such as those of the FIGO or WHO) emphasize the importance of reproductive autonomy. However, both the FIGO and WHO warn that there are countries in which medicalization is an issue to be resolved, because of the unprecedentedly high prevalence of medical interventions such as Cesarean-sections or episiotomies.

Our survey explored the manners in which childbirth experiences are affected by medicalization. The results showed that a significant number of types of medicalization are potentially responsible for negative childbirth experiences. By reviewing the respondents' answers, several non-medical reasons were found which affect women's satisfaction at birth. Unwanted, unexplained, or unnecessary medical interventions, disproportionate limitation of self-determination are the most common ethical and legal issues of childbirth. It should also be highlighted that the majority of the respondents prefer a partner-like doctor-patient relationship and shared decision making instead of paternalism. Since hierarchical differences between healthcare practitioners and women increase vulnerability during labour and delivery, it is essential to allow reproductive autonomy and self-determination dominate the intrapartum care. Therefore, in line with informed consent, women must be involved in the decision making process after being given comprehensive medical information in an understandable manner. Practitioners must consider women's preferences regarding the nature and timing of medical interventions,

position during labour and delivery, and choosing a person/family member to assist them during labour.

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