How are we going to welcome the arrival of the newest members of our society? How will Catholics welcome their children into the “civilization of life and love” of John Paul II’s vision? And how should the women who bring children into the world be treated at the time of birth?

The mainstream obstetric management of normal childbirth in the United States is marked by an overuse of medical technology and medical intervention. This trend has increased in recent decades to the point where elective cesarean section—the replacement of natural vaginal birth with cesarean surgical birth for no medically indicated reason—is now officially considered “ethical” by the American College of Obstetricians and Gynecologists. This illustrates the extent to which the personal dignity of natural childbirth has become devalued in favor of a medicalized model which does not hesitate, in ACOG’s own words, to “replace a natural process—vaginal delivery—with a major surgical procedure.”

The widespread Catholic acceptance of the medicalized status of pregnancy and childbirth needs to be questioned, as it has been already by many feminist thinkers. Ethical discussions related to childbearing among Catholic moralists remain largely concerned with contraception, abortion, artificial insemination, in vitro fertilization, and other new reproductive technologies. Such discussions include the results of conception—pregnancy and birth—only when extreme medical situations require discernment about what medical decisions and technical procedures are morally...

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1 John Paul II, Evangelium vitae (March 25, 1995), n. 100.
3 Feminist criticism of mainstream childbirth practices is discussed below.
licit. Catholic ethics needs to critically examine the medicalization of normal, healthy pregnancy and childbirth, with the increased risks that such medicalization poses to both mother and child.

After describing the overuse of medical technology in birth management and noting its critique from feminism, I suggest the beginnings of a Catholic ethical critique of medicalized birth based on a personalist ethical framework. Personalist ethics and natural law have been used successfully to argue for Catholic doctrine on beginning-of-life issues such as contraception, artificial reproduction, and abortion. Given the fundamental interconnection between the unitive and procreative aspects of human sexuality and human generation (see *Humanae vitae*, n. 12), it is reasonable to apply this framework to an analysis of the aspect of procreation that occurs about nine months after the sexual union of husband and wife: childbirth. I will argue that a midwifery model of pregnancy and birth management that has as its goal mother- and child-friendly natural childbirth best respects the dignity of the persons involved.4 My intention is not to pit doctors against midwives, but rather to describe and critique the predominant medicalized model of perinatal care as opposed to the midwifery model.5

This project is important even though it does not concern the question of the life or death of the smallest of human beings as directly as do other beginning-of-life issues, such as abortion, in vitro fertilization, cloning, embryonic stem cell research, and embryo adoption. It is significant because the extent to which normal pregnancy

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5 Many doctors support natural childbirth, and many midwives can be overzealous in the use of medical interventions and technology. Two notable Catholic doctors who have made great contributions to prepared natural childbirth and who favor encouraging the natural processes over intervention are Robert A. Bradley, M.D. (1917–1998) and Herbert Ratner, M.D. (1907–1997). Dr. Bradley was the developer and promoter of the Bradley method of natural childbirth, a very successful method of drug-free birth preparation. Among women trained in the Bradley method, the rate of spontaneous, unmedicated vaginal births is 86 percent, according to the American Academy of Husband-Coached Childbirth, the resource center for the method (http://www.bradleybirth.com/WhyBradley.aspx). Dr. Bradley was also the author of *Husband-Coached Childbirth*, first published in 1965. It is largely thanks to his work that it is no longer illegal for fathers to be present with their wives and babies during hospital deliveries! Dr. Herbert Ratner was a mentor to the founders of the breastfeeding support group La Leche League and has published numerous articles on natural mothering practices based on an Aristotelian-Thomistic understanding of medicine. There are certainly many physicians who support natural birth and the minimal use of drugs and medical interventions. That said, midwives are more likely to actually support a woman by their personal presence through her entire labor and delivery, as the name (meaning “with woman”) would suggest, whereas a physician will typically check in only periodically (or have the nurses do so) and be present primarily for the actual delivery itself. This is probably in part because of the development of the different professions, as is discussed below, and in part because of physicians’ needs to take on more patients to help cover rising malpractice insurance costs.
and birth have been medicalized illustrates the deterministic manipulation that surrounds all aspects of sexuality and reproduction in contemporary American culture. The natural rhythms and processes of fertility, gestation, and birth seem not to be respected, honored, and carefully stewarded so much as “overridden,” thwarted in their natural ends, and often replaced.

To a certain degree, the overuse of medical technology in the management of childbirth illustrates the arbitrary nature of decisions made under a secular notion of autonomy—decisions which fail to take full account of the transcendent personal and even simply physical goods inherent in the natural process of birth. However, I contend that, given full access to information about the consequences of the overuse of technology in birth, most women would choose more natural methods, and would then enjoy more fully the physical, personal, and spiritual goods of giving birth.

**Overuse of Medical Interventions in Childbirth**

Most routine medical interventions during childbirth are of unproven merit, and their overuse on otherwise healthy women and babies often leads to iatrogenic (medically caused) complications and problems.\(^6\) Although modern medical science has saved the lives of many mothers and babies caught in true emergencies, it is the *common, routine* use of these procedures that causes harm. Since this seems counter-intuitive, this section is devoted to describing that harm and providing evidence for this claim.

A common assumption is that when the majority of births moved to hospital settings and physician management early in the twentieth century, fewer women died in childbirth and fewer babies were lost. In fact, the statistics tell a different story.\(^7\) Maternal death rates actually *rose*—from sixty per ten thousand births in 1915, before the general hospitalization of birth, to sixty-three per ten thousand births for women overall in 1932, and seventy-four per ten thousand births that year in cities,

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\(^6\) This article draws generously on Henci Goer, *The Thinking Woman’s Guide to a Better Birth* (New York: Perigee, 1999), which provides a comprehensive review of the relevant medical literature, including information on the rates and risks of common obstetrical procedures as well as information about natural alternatives. The *Cochrane Database of Systematic Reviews* (www.cochrane.org) also shows which routine perinatal procedures are supported by scientific evidence and which are not. See The Cochrane Collaboration, “Cochrane Review Topics: Pregnancy and Childbirth,” http://www.cochrane.org/reviews/en/topics/87.html. See also William D. Virtue, *Mother and Infant: The Moral Theology of Embodied Self-Giving in Motherhood in Light of the Exemplar Couplet Mary and Jesus Christ*, dissertation (Rome: Pontifical University of St. Thomas Aquinas, 1995), 180.

where three-quarters of women now gave birth in hospitals. Meanwhile, infant deaths from birth injuries increased 40 to 50 percent between 1915 and 1929.\textsuperscript{8} It was not until sulfa drugs and antibiotics were introduced to treat infection and “more stringent controls were placed on obstetric training and practices” in the 1930s that maternal mortality began to fall.\textsuperscript{9}

Contemporary studies comparing hospital births to attended home births (that is, births attended by either a trained midwife or a physician) and births in free-standing birthing centers show similar or better outcomes for out-of-hospital births, with fewer fetal and newborn complications.\textsuperscript{10} Even after controlling for levels of risk, studies comparing maternal satisfaction with standard hospital care to satisfaction with childbirth in a simulated home environment or birthing center show that women are less happy with the standard hospital experience than with a more home-like childbirth experience.\textsuperscript{11} A British study showed that “the perinatal mortality rate for high-risk births outside of the hospital (16 per 1,000) was lower than that for low-risk in-hospital births (18 per 1,000).”\textsuperscript{12}

\textsuperscript{8}Goer, Woman’s Guide, 202.
\textsuperscript{9}Ibid.
\textsuperscript{10}Goer reviews and treats the available research on these issues, all of which points to the above conclusions (Woman’s Guide, 314–320). A sampling of the forty-seven studies she references includes the following findings: J. T. Fullerton and R. Severino showed that women in hospitals were ten times more likely to have umbilical cord prolapse, a life-threatening emergency associated with artificial rupture of membranes, which was performed in half the instances in their study. “In-Hospital Care for Low-Risk Childbirth: Comparison with Results from the National Birth Center Study,” Journal of Nurse-Midwifery 37.5 (September–October 1992): 331–340. E. Feldman and M. Hurst reported an abnormal fetal heart rate in 25 percent of babies born in hospitals compared with 5 percent of those born out of hospital. “Outcomes and Procedures in Low Risk Birth: A Comparison of Hospital and Birth Center Settings,” Birth 14.1 (March 1987):18–24. The use of epidural injection and the electric fetal monitor, with its limitation of maternal mobility, and the tendency to read false-positives, which is associated with use of the monitor, might explain this. A. Scupholme, A. G. McLeod, and E. G. Robertson found that shoulder dystocia, a potentially life-threatening condition in which the baby’s shoulders are stuck in the birth canal, occurred in a greater percentage of babies born in hospitals than outside hospitals. “A Birth Center Affiliated with the Tertiary Care Center: Comparison of Outcome,” Obstetrics and Gynecology 67.4 (April 1986): 598–603. Hospital delivery procedures, including the use of forceps and the mother’s position on her back, may predispose the infant to shoulder dystocia. O. Olsen showed that, compared with babies born at home, about twice as many babies born in hospitals were born in poor condition. “Meta-analysis of the Safety of Home Birth,” Birth 24.1 (March 1997): 4–13.

\textsuperscript{11}Two studies showed that rates of satisfaction were much higher among women assigned to birth center environments or to simulated home environments than among those assigned to standard hospital care. Waldenstrom and Nilsson, “Women’s Satisfaction with Birth Center Care: A Randomized, Controlled Study,” Birth 20.1 (March 1993): 3–13, and MacVicar et al., “Simulated Home Delivery in Hospital: A Randomised Controlled Trial,” British Journal of Obstetrics and Gynaecology 100.4 (April 1993): 316–323.

\textsuperscript{12}Goer, Woman’s Guide, 203.
Routine episiotomies, in which the area surrounding the birth canal is cut during labor, are still common in hospital practice, despite research showing that they do not prevent further tissue tearing but often cause it, leading to a need for stitches after delivery and to other complications for the mother, such as pain during intercourse and longer recovery after childbirth. They also do not reduce the risk of incontinence, as was previously thought.\textsuperscript{13} Performing episiotomies during delivery has been a routine practice since the 1930s, but their effectiveness has only recently been critically evaluated and reported in major medical journals. The routine administration of enemas and pubic shaving of women about to deliver are further examples of common hospital practices that have been slow to fade away, despite lack of evidence to show that they improve birth outcomes.

Hospitalized labor and birth in the United States are now accompanied by continuous electronic fetal monitoring, which studies have shown is associated not with improved birth outcomes for mother and child, but rather with an increased rate of cesarean sections.\textsuperscript{14} In addition to restricting the laboring woman’s mobility, the monitors have been shown to turn the focus of attendants in the delivery room, those who should be helping the mother, away from the woman and onto the screen.\textsuperscript{15}


\textsuperscript{14} Goer reviews thirty-three studies on the use of EFM (Woman’s Guide, 244–249).

\textsuperscript{15} Goer observes that the monitor is “mesmerizing. Nobody pays attention to the mother who’s attached to one—not her partner, not the medical staff. Everything centers around the machine. You would think it was having the baby. Fathers sit intently gazing at … the machine … Nurses and doctors come in to tend and scrutinize the machine. One study analyzing medical staff behavior during the pushing phase of labor records that during one arbitrarily chosen five-minute segment of videotape, the nurse looked at the monitor nineteen times” (Thinking Woman’s Guide, 86). William Sears, M.D., observes: “Once or twice a week I enter a labor room to see a mother lying on her back with the EFM belt girding her protruding abdomen and attached to a video display terminal. Instead of watching the mother, the nurses watch the monitor, which ‘watches’ the mother. All too often these mothers ‘fail to progress’ in their labor and ‘need’ a cesarean section.” William Sears and Martha Sears, The Baby Book: Everything You Need to Know About Your Baby from Birth to Age Two (Boston: Little, Brown and Company, 1993), 22.
Women in hospitals still commonly deliver in the lithotomy position, lying on their backs with their legs up in stirrups. Unfortunately for the mother and child, this is the least effective and most painful position for delivery. It is, however, the most convenient position for an attending physician or midwife, and it is one of the few positions possible after the woman has been hooked up to a routine IV (for the administration of hydrating fluids, artificial hormones, and painkillers) and to the fetal monitor. As William Sears, M.D., and Martha Sears, R.N., write, “back birthing makes no medical sense.” The lithotomy position narrows the pelvic outlet, forces the mother to work against gravity by pushing “uphill,” against the natural slope of the vagina, and allows the heavy uterus to compress the blood vessels supplying the uterus and the baby, diminishing the baby’s oxygen supply—deficits that do not occur in vertical delivery positions such as standing and squatting. The lithotomy position also tenses the pelvic muscles, which need to relax to allow the baby passage. In addition to increasing pain, this position predisposes the mother to tears in the perineum and unnecessary episiotomies. It also slows labor, increasing the likely use of pain medication, forceps and vacuum extractors, and cesarean section.

Cesarean section represents the ultimate intervention, and is often the final outcome of the “spiral of interventions” common in mainstream obstetric practice, in which one medical intervention causes complications that necessitate other, sometimes larger interventions. Many practices can initiate this spiral: labor in the lithotomy position, the use of fetal monitors, and epidurals (the epidural administration of pain medication) all work together to slow labor’s progress and make other interventions necessary. Additional interventions include the administration of Pitocin (an artificial form of the hormone oxytocin) and rupture of the amniotic sac to “expedite” the slowed labor, and then the use of forceps or a vacuum extractor (which often requires an episiotomy) to deliver the child—or final resort to a cesarean section, which is major surgery. For example, an epidural slows labor, because it blocks sensation in the uterus; since the mother is not as aware of her contractions, she cannot participate in the labor as well, and her contractions are less effective. Pitocin

\[16\] Sears and Sears, Baby Book, 26.


is then administered to speed up the progress of labor. An IV is required to administer the Pitocin and maintain hydration, and since the mother now cannot feel her contractions effectively on her own, a fetal monitor is also required. The IV and fetal monitor also slow labor, reducing mobility and encouraging use of the lithotomy position. The membranes may be artificially ruptured to speed labor’s progress, but when infection is then feared (because the amniotic sac is no longer intact and cannot serve as protection against bacteria), an “emergency” cesarean section will take place.19

The rate of cesarean sections in the United States rose from 5 percent in 1970 to almost 28 percent in 2003,20 despite World Health Organization recommendations that it be no more than 15 percent.21 Many cesarean sections result from a “failure to progress,” brought about by counter-productive measures such as epidurals and the lithotomy position, as described above. Others result from false positive readings of fetal distress on the fetal monitor. Cesarean sections pose a risk to babies and mothers: A baby who is born surgically rather than vaginally is more likely to have asthma, other respiratory problems, and jaundice.22 The mother must deal with the pain associated with major abdominal surgery23 and the complications posed to bonding with her newborn. (Nursing, for example, which is a primary means of maternal-infant bonding, is much more difficult for a mother healing from an abdominal

19 Virtue describes a different possible series of events in the “cascade” or “spiral” of intervention: “For example, physicians who are in a hurry, instead of letting the woman’s cervix expand slowly, administer hormones (a Pitocin drip) intravenously. But this causes powerful and fast contractions … so the baby is pushed along faster than the woman can dilate. Then this ‘requires’ forceps to be used to extract the baby. And since she has not been allowed to dilate sufficiently, then one must routinely cut the perineum. Having put the woman on her back, she is less able to expel the child and so a cesarean is done. All these interventions in a normal birth disrupt the rhythm and functioning of her body and cause complications for which the next intervention is done. Thus the interventions become self-justifying. Yet few of these are needed in natural childbirth when the natural process is respected in the first place” (Mother and Infant, 180). Women should be aware that Pitocin causes unnaturally strong and often much more painful contractions that occur closer together than they otherwise would, so often drugs are needed to manage the pain if they have not already been administered.


23 Goer refers to literature that documents women’s reports of pain and impairment of their normal activities for weeks after cesarean deliveries (ibid., 22).
incision.)\textsuperscript{24} In addition, women undergoing cesarean sections suffer from greater risks of infection, fever, hemorrhaging, leg clots, paralyzed bowel or bladder, accidental injuries to surrounding organs, and death, which one study showed occurred at a rate of one in a thousand operations—ten times higher than the morbidity rate with vaginal births.\textsuperscript{25}

The scar tissue from a cesarian section poses risks to the subsequent reproductive life of the mother, from complete infertility to ectopic pregnancy or improper placental attachment in subsequent pregnancies.\textsuperscript{26} Later births are compromised. In a subsequent pregnancy, a woman who has had a low, horizontal cesarean cut can attempt a VBAC (vaginal birth after cesarean) if the scar tissue is judged strong enough and a willing birth attendant can be found, but this may be difficult, since many doctors would rather deliver a baby surgically than attend a VBAC, and midwives do not typically attend these high-risk births. Women who have repeat cesareans (whether elective or not) also face more technically difficult surgeries because of the scar tissue.

Epidurals, which often (but not always) effectively block the pain of childbirth, are also fraught with complications, risks, and adverse side-effects for the mother and child.\textsuperscript{27} Some of these include the slowing of labor, which leads to the use of Pitocin, causing unnaturally strong, fast, and painful contractions that usually lead to higher episiotomy rates; greater use of vacuum extractors and forceps, which cause a greater likelihood of anal tears; higher cesarean rates; and a greater likelihood of bladder catheterization, which can cause urinary tract infections.\textsuperscript{28} The administration of an epidural also requires that the laboring mother be hooked up to an IV and a fetal monitor, both of which entail additional risks. Another risk with epidurals is that the needle used to inject the analgesia may pierce the wrong place in the spine. Epidurals may compromise the health of the baby as well. Several studies show that epidurals, contrary to popular belief, actually cause fetal distress.\textsuperscript{29} Their use makes instrumental deliveries more likely, which can harm the child; the unnatural

\textsuperscript{24} Ibid., 24.


\textsuperscript{26} Goer, \textit{Woman’s Guide}, 25.

\textsuperscript{27} An introduction to many of the risks and side-effects to mother and baby associated with epidurals, documented with very recent research, is available in Sarah J. Buckley, “The Hidden Risks of Epidurals,” \textit{Mothering} (November–December 2005): 50–59.

\textsuperscript{28} Goer, \textit{Woman’s Guide}, 125–146.

contractions resulting from Pitocin use may be stronger than the baby can bear; and the first days and weeks of the child’s life are spent drugged. The epidural drugs pass through the cerebrospinal fluid into the maternal bloodstream, and from there cross the placenta to enter the baby’s circulation at rates of one-third of the maternal level for bupivacaine and one-third to four-fifths of the maternal level for fentanyl and sufentanil.30 Other effects of epidural drugs on the baby include increased instances of abnormal heart rate before birth (which, when perceived on the fetal monitor, prompt the use of a cesarean section) and impaired motor and neurological functions.31

Epidurals also compromise mother–baby interaction in the critical bonding period after birth: the child is more likely to have complications requiring that he or she be kept in a neonatal intensive care unit, and both mother and baby are drugged and less responsive. They may also have wounds or complications whose healing decreases their available energies—energies that might otherwise have been spent touching, holding, gazing, and nursing, key bonding activities. The effects of such mother–baby interactions on their bodies can be measured physically. For example, a mother’s contact with her baby stimulates the production of the hormone oxytocin, which makes the mother calmer and more responsive, helps contract her uterus, and stimulates her milk production and release; the baby benefits from being held more by gaining more weight and developing more neural connections through the skin-to-skin contact. But I suggest that the emotional, psychological, and spiritual effects are significant as well.32


Feminist Critiques of Medical Overuse

Feminist critiques of mainstream obstetric practice center on the loss of women’s power; they protest against a male obstetric model that controls women’s bodies and appropriates the mysterious, natural feminine world of childbirth into the orderly, predictable, masculine, hierarchical, patriarchal world of science.33 Women are isolated and disempowered. Adrienne Rich paints a poignant picture: “The loneliness, the sense of abandonment, of being imprisoned, powerless, and depersonalized is the chief collective memory of women who have given birth in American hospitals.”34 The importance of the support of other women in labor and delivery in non-Western cultures is highlighted by Germaine Greer, who notes that “in non-technocratic societies, except for remarkable accidents,” birth is always attended by other women who give support and encouragement, touching, helping, in some cases straining with the woman giving birth.35 This is the essence of midwifery, whose name means “with-woman,” as opposed to technical and medical obstetric intervention, which is not so much about presence and support as about technique. Rich’s observation of differences in birth-management styles in the seventeenth century is just as valid today:

One major difference distinguished the midwife and the male obstetrician. The midwife not only gave prenatal care and advice, but came to the woman at the beginning of her labor and stayed with her till after delivery. She gave not only physical assistance but psychological support. The male birth-attendant was historically called in only to perform the functions (podalic version, Caesarean, forceps delivery) which were forbidden to the midwife. He was a technician rather than a counselor, guide, and source of morale; he worked “on” rather than “with” the mother.36

While the difference in attending styles between continually present midwives and more distant physicians may have its roots in the origins of the different professions, the current litigious environment in which doctors practice exacerbates the situation. Many obstetricians need to take on more patients than they might like, in order to afford skyrocketing medical malpractice insurance premiums. Thus, even if they wanted to be more present, many doctors are simply unable to give each birth more time. Similarly, the pressure to avoid lawsuits may be a major factor in their

34 Rich, Of Woman Born, 176.
35 Greer, Sex and Destiny, 17.
heavy reliance on medical technology and their propensity to resort to cesarean section if, despite the evidence, they believe that increased intervention and use of technology leads to safer births.37

Physicians may be blamed for birth defects, in particular cerebral palsy, for allowing too much time for delivery, or for negligence during delivery. The theories behind these accusations are hotly contested, with doctors’ associations pointing to research claiming that the negligence theory is overstated, and lawyers claiming that the medical profession is producing “litigation literature” to help protect themselves in court.38 Because of lawsuits and the heavy price of malpractice insurance premiums in many states, one in seven members of the ACOG have stopped practicing obstetrics, leaving even fewer practitioners in the field to care for women and their babies during childbirth.39 Certainly, many malpractice lawsuits are justified, but the volume of cases has grown to crisis proportions and has become a major problem in health care, requiring legislative and cultural reform. In addition to heavy advertising on the part of many lawyers’ groups, which targets parents of infants with cerebral palsy and other neurological defects, perhaps an underlying mindset behind the increase in

37 See David M. Studdert, et al., “Defensive Medicine among High-Risk Specialist Physicians in a Volatile Malpractice Environment,” JAMA 293.21 (June 1, 2005): 2609–2617, quoted in “Defensive Medicine Widespread Among OBs,” Mothering (September–October 2005): 25. In this study, 93 percent of the surveyed physicians who practiced specialties that involve a high risk of malpractice claims (including obstetrics) reported practicing “defensive medicine,” or “assurance behaviors,” such as ordering imaging technology, diagnostic procedures, and referring patients for consultation. The widespread use of the electric fetal monitor in obstetric practice, discussed above, would seem to fit this pattern.

38 In the case of cerebral palsy, the theory is that taking too much time for delivery leads to asphyxia, or loss of oxygen to the brain, causing the neurological damage. The monograph Neonatal Encephalopathy and Cerebral Palsy, Defining the Pathogenesis and Pathophysiology, released by the American College of Obstetricians and Gynecologists and the American Academy of Pediatrics (Washington, D.C.: ACOG, 2003) points to a body of research by Karin Nelson et al. that disputes the causal connection between asphyxia and cerebral palsy and points to many other factors in the perinatal environment as causes. However, in “The Litigation Literature” (http://www.emeraldeducation.com/litigation-literature.pdf), lawyer Joel Cunningham claims that this research is out-of-date and has been disproved by research such as E. S. Draper et al., “A Confidential Enquiry into Cases of Neonatal Encephalopathy,” Archives of Disease in Childhood (Fetal and Neonatal Edition) 8703 (November 2002): F176–F180. See also Walter Olson, “Delivering Justice: Curing Health Care,” Wall Street Journal, February 27, 2003, http://www.manhattan-institute.org/html/_wsj-delivering_justice.htm.

39 Malpractice insurance costs are over $100,000 a year for obstetricians in some states, such as Maryland. See “Maryland’s Malpractice Mess,” editorial, Washington Post, July 6, 2004, A18. See also ACOG, “Medical Liability Survey Reaffirms More Ob-Gyns Are Quitting Obstetrics,” press release (July 16, 2004), http://www.acog.org/from_home/publications/press_releases/nr07-16-04.cfm. The Medical Liability Monitor’s annual rate survey reports the costs of medical liability insurance rates of all the major insurers of physicians in the United States (http://www.medicalliabilitymonitor.com).
lawsuits is the desire in our consumer culture for a “perfect product” and the inability for parents to accept a “flawed” child. This could relate to the belief, mentioned above, that all the processes of conception, gestation, and birth ought to be directly controllable to achieve the desired outcomes.

Whatever its causes, the current situation is that midwives tend to work with healthy women in low-risk pregnancies to empower them through the natural process of childbirth. In contrast, in contemporary mainstream obstetric practice, women are often not encouraged to labor and give birth through their own God-given powers, but are expected to lie down passively while the drugs, machines, and equipment allow the technico-medical team to separate the child from the woman’s body.40

**Personalistic Ethical Critique**

Catholic personalism focuses on the human being as made in the image and likeness of God, willed for her or his own sake, and possessing incommensurable worth and dignity. This ought to shape how we welcome our children into the world. Should a new person’s first impressions routinely be of glaring lights glancing off surrounding steel medical equipment, of instruments and monitors, of figures with masked faces? Should the child’s first touch be from cold metal forceps or a mechanical vacuum extractor, or from human hands—perhaps those of her mother or father? Almost three decades ago, Frederick Leboyer advocated a gentler welcome for our babies, a welcome marked by soft lighting, reverential voices, and gentle handling. “We must behave with the most enormous respect toward this instant of birth, this fragile moment,” he wrote, for “there is a grace which radiates in silence that crowns with a halo every child who arrives among us.”41 As Catholics claiming to see the image of God in each new child, we should offer them a fitting welcome.

And how ought the mother who brings new life into the world be supported? Goer points out that the adverse side effects of a medicalized birth are not only physical, but emotional and psychological as well. Here she describes the state of a woman who has been given an epidural:

By the time you are hooked up to an IV, an oxytocin delivery pump, a fetal monitor, an automated blood pressure cuff, an epidural pump, and have a bladder catheter, what was a perfectly normal labor has been transformed into a high-tech event. This has profound consequences for how you view yourself and your labor and how your partner, other support people, and medical caregivers perceive you and your labor as well.42

Agnes R. Howard opens her excellent reflection on the medicalization of pregnancy and childbirth with a striking image:

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Last Christmas our parish hall displayed a nativity painting by a local artist, showing a dark-haired woman in a wheelchair holding an infant, with a man in hospital scrubs standing solicitously behind them. The scene was instantly recognizable to anyone who has had a baby in this country in the last few decades. It was a typical hospital birth: the just-delivered mother bonding with her newborn, the father outfitted as birth assistant. Here was Madonna as *primipara*, what doctors call a woman delivering her firstborn.  

A medicalized birth event puts women in wheelchairs, viewing them as invalid patients.

The medicalization of birth loses sight of the reality of the *persons* at the heart of birth: the child, the mother, the father, and the community of the family which the child enters. Key aspects of personalism and Catholic personalist ethics (those of Pope John Paul II in particular) are an emphasis on the value of persons and on spiritual values rather than on technology, the centrality of free choice, the significance of the body, the “personalist” norm, and the centrality of Christ in revealing the person’s deepest vocation of self-giving love. These are very pertinent to childbirth practices.

*Personal and Spiritual Values over Technological Values*

Childbirth as practiced in the United States today is a technological rather than a spiritual and personal, familial event. It properly should be the latter, to respect the meaning of birth. Catholic opposition to artificial reproductive technologies and to abortion refers to the need for the human person to “retain his freedom and authentic spiritual character in the face of a massive technology that is more dominated by material considerations than by spiritual values.”

Pope John Paul II cites the valuation of technology over persons as a key component of the culture of death in a modern society which supports abortion. As the Holy Father articulated in *Evangelium vitae*:

Thus, in relation to life at birth or at death, man is no longer capable of posing the question of the truest meaning of his own existence... He is concerned only with “doing,” and, using all kinds of technology, he busies himself with programming, controlling and dominating birth and death. Birth and death, instead of being primary experiences demanding to be “lived,” become things to be merely “possessed” or “rejected.” Moreover, once all reference to God has been removed, it is not surprising that the meaning of everything else becomes profoundly distorted. Nature itself, from being “mater” (mother), is now reduced to being “matter,” and is subjected to every kind of manipulation. This is the direction in which a certain technical and scientific way of thinking, preva-

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lent in present-day culture, appears to be leading when it rejects the very idea that there is a truth of creation which must be acknowledged, or a plan of God for life which must be respected.47

The predominant model of American obstetric practices is based on “using all kinds of technology” for the purpose of “controlling and dominating birth,” obscuring the “plan of God for life,” which could be found in pregnancy and birth if these experiences were respected in their natural integrity. This can introduce fear and subservience to technical intervention rather than awe and wonder at the power God has entrusted to women in their bodies. The forces of a culture of death rob life of its joy and meaning right at the very entrance of new life into the world. The Catholic moral theologian Rev. William Virtue argues for a “normative natural childbirth,” which he describes as “essentially and achievable a natural physiological process rather than a pathological or surgical event, and a landmark personal experience with deep and lasting psychological consequences for both mother and child.”48

Mainstream obstetrics seems to be guided by the belief that “technology is superior to nature and machines are more reliable than people.”49 Or, as Virtue puts it, “physicians are under the spell of a philosophy of medicine as dominating or displacing nature.”50 This explains the readiness of the ACOG to say that elective cesarean sections are ethical. A gender bias that is distrustful of women’s bodies is at work as well: women’s bodies are thought to be “weak and defective and cannot be trusted to do what they are supposed to do.”51 The “obstetric premise,” as Goer describes it, is that “childbirth is a dangerous and difficult business and that the obstetrician’s role is to rescue the baby from the clutches of its mother’s untrustworthy body.”52 The language of obstetrics reflects this—the diagnoses of “failure to progress” and “incompetent cervix” appear pejorative. Ironically, these very conditions often result from heavy-handed obstetric practices!

The foundational beliefs of the Coalition for Improving Maternity Services are strikingly different, resonating with personal and spiritual values (rather than technological values) that affirm childbirth and the dignity of women and children. Birth is viewed as a normal, natural, and healthy process; women and babies have the inherent wisdom necessary for birth; babies are aware, sensitive human beings at the time of birth, and should be acknowledged and treated as such; birth can safely take place in hospitals, birth centers, and homes; and the midwifery model of care, which supports and protects the normal birth process, is the most appropriate for the majority of women during pregnancy and birth.53 Virtue agrees that giving birth is “a

47 John Paul II, Evangelium vitae (March 25, 1995), n. 22.
48 Virtue, Mother and Infant, 177.
50 Virtue, Mother and Infant, 180.
52 Ibid., 152.
53 These are taken from CIMS, “The Mother-Friendly Childbirth Initiative.”
natural and normal act for a healthy mother and child,” and should not be viewed as “an illness to be treated, but as an act to be respected and assisted by medical care on those occasions when nature is unable to achieve her end…. The majority of women and babies are capable of a normal birth, when mothers are free from dependence on technological intervention.”

The overemphasis on technology is also characteristic of in vitro fertilization, as William May has articulated.55 The laboratory generation of human life is governed by the “logic of manufacture”—efficiency, quality control and, I would add, mass production—and it views the child as a “product.”56 This logic governs medicalized birth as well. Labor and birth hurried along by the use of Pitocin, forceps, vacuum extractors, and episiotomies are often simply time-savers for busy doctors. Busy nurses can monitor the contractions of a whole wing of laboring women on fetal monitor screens at the nurses’ station, rather than personally attending the women. And cesarean section at the slightest hint of “fetal distress” on the fetal monitors ensures newborn quality-control in a doctor’s mind.57

Is the baby then a product? According to Wertz and Wertz, the “production metaphor”58 operative in the artificial techniques of reproduction with genetic screening and prenatal testing also extends to excessive obstetric intervention. All of these “indicate a mentality wherein childbearing and birth is dominated by the aim to ‘produce’ a ‘perfect baby’ who is ‘delivered’ during ‘labor.’”59 The sad irony is that these interventions on otherwise healthy mothers and babies do not, in fact, improve birth outcomes, but more often than not make the outcomes worse.

The laboratory generation of human life is fundamentally technical, thought of in terms of “making” rather than “doing,” an action rather than an act.60 However, babies are not “made” at birth by either the mother or her attendants; rather, as Virtue says, “birth is an act of the child and of the mother.”61 Virtue argues that this act has both a material and a formal aspect, or one might say, both a physical and a personal aspect. When the physical aspects are subordinated or integrated into the personal, the act becomes a truly interpersonal event between mother

54 Virtue, Mother and Infant, 181–183.
55 William May, Catholic Bioethics and the Gift of Human Life (Huntington, IN: Our Sunday Visitor, 2000), 81.
56 Ibid., 81–82.
57 Virtue, Mother and Infant, 180, note 7, observes that “obstetricians may be influenced by pressures such as modern women … who expect a perfect baby, and who may be potential litigants.”
58 This phrase is used by Wertz and Wertz, Lying-In, 257, 272–274, 325–326, 242–244, quoted in Virtue, Mother and Infant, 179.
59 Virtue, Mother and Infant, 179.
60 May, Catholic Bioethics, 81.
61 Virtue, Mother and Infant, 179.
and child. When the mother is able to consciously accompany her child during labor, birth is an act of welcoming her newborn in the way of love. It is also an act of the infant, who is “accompanied and warmly welcomed into the world by the parents and attendants.” Virtue proposes a practice of giving birth in which “the mother is able to reveal her love for her child before, during, and immediately following birth. Hence, the first signal the child receives is love welcoming him or her into the family, into the human community of persons.”

The Centrality of Free Choice

Pope John Paul II’s personalism emphasizes the freedom at the core of the person, by which “we make ourselves to be our unique selves by the actions that we freely choose.” A mother giving birth should be active, aware, and alert so that as she labors to bring forth her child, she also labors to make herself into the specific mother of this specific child. Her choices in birth shape the character of her motherhood. The mother is thus an active moral agent in giving birth to her child, not a passive medical patient. The methods of prepared natural childbirth developed in the twentieth century emphasize the active participation of the mother and appeal to her intelligence, competence, nobility, and character. Fernand Lamaze’s psychoprophylactic method, based on Pavlovian psychology, assumed that women could be educated to break what he thought was a culturally imposed association between childbirth and pain. Grantly Dick-Read’s 1944 classic, Childbirth without Fear, also counts on the intelligence and will of the mother, in his theory that pain is caused by a cycle of ignorance and fear, although he suggests that the mother be in a state of “dulled consciousness” in the second stage of labor. Bradley’s Husband-Coached Childbirth counts on the mother to learn to become a “relaxation expert,” using natural breathing and focusing on allowing her body to do its work. Sheila Kitzinger’s “psycho-sexual” method teaches the mother to “trust her body and her instincts, and to understand the complex emotional

62 Ibid., original emphasis.
63 Ibid.
64 Virtue, Mother and Infant, 179, original emphasis.
65 May, “Personalist Ethics,” 154.
66 Fernand Lamaze, Painless Childbirth: The Lamaze Method (Chicago: Contemporary Books, 1984). The Lamaze method has been criticized, however, for “greatly altering a woman’s natural experience of birth from one of deep involvement inside her body to a controlled distraction,” according to Suzanne Arms, Immaculate Deception, 145–146, quoted in Rich, Of Woman Born, 173. The unnatural breathing patterns he prescribes can also lead to hyperventilation of the mother and baby, dangerously depriving the child of much-needed oxygen. See E. K. Motoyama et al., “Adverse Effect of Maternal Hyperventilation on the Foetus,” Lancet 1.7432 (February 5, 1966), 286–288, quoted in McCutcheon, Natural Childbirth the Bradley Way, 11.
network in which she comes to parturition,” and insists on “the power of self-direction, of self-control, of choice, of voluntary decision and active cooperation with doctor and nurse.” 69 All these methods honor the freedom, intellect, and will of the self-determining mother, rather than viewing her as a passive object on which others operate.

That said, an important distinction should be made between a Catholic personalism, which recognizes the mother’s self-determination in the context of a God-focused teleology, and a secular autonomy, which views freedom of choice in an arbitrary manner. Catholic personalism works in tandem with a Thomistic, teleological view of nature and personhood: our bodies, our lives, and our personhood with all its inter-relational capacities to give, receive, and love are directed toward our ultimate end, a communal, self-giving, interpersonal, loving union with the Holy Trinity. The natural processes of birth ultimately have this as their telos (end) and are to be cooperated with as far as possible. The immediate goal in childbirth is the baby’s safe transition from the mother’s womb to her arms and breast, so that the mother–infant and infant–family relationships can grow and can be experienced in a fuller way. Ultimately, this reveals the image of the love of God to which we are all called.

Catholic personalism seeks the health of the mother and child to assist this end. If the mother and child are healthy and the process of giving birth proceeds as it should, the mother and child are already in a state of health, and medical intervention is unnecessary. There are times, of course, when birth does not proceed as it should, and medical intervention may be needed to restore the health of mother and child in such circumstances. On the other hand, from the perspective of secular autonomy, medicine is not limited to the restoration of health, but is widely used to fulfill our desires. It sees medical knowledge, technology, and intervention as means to use arbitrarily to enact the choices of an autonomous individual’s will, regardless of the true natural and personal goods inherent in human health or its ultimate, guiding end. 70 Replacing or disrupting normal, healthy processes with medical intervention is justified in this latter view in order to satisfy the arbitrary desires of the autonomous individual, with no judgment about whether the desires are ultimately for the good, for human personal flourishing, or for union with God. For example, contraception, abortion, and in vitro fertilization do not, in fact, promote the health or healing of a mother’s body, but rather disrupt or replace her natural processes of fertility and gestation in order to satisfy desires to prevent conception, end the life of an embryo, or produce a child “on demand.” These desires need to be judged in the context of human personal goods and our ultimate vocation of communal life in God. Authentic free choice, such as the freedom that a mother should enjoy during labor and delivery, does not consist in the ability to select an arbitrary preference (as in secular autonomy), but rather in the ability to make a choice for excellence, for goods like health and interpersonal relationships that are guided by the ultimate end of the human person.


The Significance of the Body

The significance of the body in John Paul II’s personalist argument against contraception is articulated in the “theology of the body” that he expounded in the Wednesday audiences given early in his pontificate. The significance of the bodies of the mother and child are such that they should be treated with respect according to their innate dignity. The bodily and physical aspects of childbirth are morally significant precisely because human persons are bodily persons.

The Personalist Norm

The fourth aspect of personalist ethics for John Paul II (as articulated by May) is the “personalist norm,” which holds that “the person is a good toward which the only proper and adequate attitude is love.” This should dictate the treatment of the baby and the mother by the birth attendants as well as the position of the mother toward her child. In childbirth the call to “discover the goods that are truly perfective of human persons, the goods meant to flourish in them and contribute to their being fully themselves” takes the form of childbirth practices that do not diminish the personal dignity of the mother as a competent, active participant in the process of birth or the dignity of the child to be born. In the second half of the twentieth century, an understanding of the awareness and capabilities of unborn and newborn babies helped enhance an awareness of the dignity of their personhood. The significance of prenatal experiences, birth, and the time immediately after birth for a person’s psychological development was described by Dr. Thomas Verny, who recounts how harsh obstetric practices can have adverse physical and psychological effects on a child even years after birth.

Just as personalist sexual ethics sees the sexual act in its integrity—and, indeed, the whole family—as a communio personarum, a communion of persons, so, too, natural childbirth practices highlight the communion of father, mother, and child at birth. As Virtue puts it,

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\text{normative natural childbirth thus is an interpersonal act in which the mother integrates her labor by her focus on her child ... [she thus focuses on] accom-}
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71 These have been compiled and are available as John Paul II, The Theology of the Body: Human Love in the Divine Plan (Boston: Pauline Books and Media, 1997).

72 May, “Personalist Ethics,” 154.

73 May, “Personalist Ethics,” 154.

74 I do not wish to claim that personal dignity is tied to awareness and ability, but the practical outcome of this new information is that the treatment of the baby is different when it is recognized that the baby “realizes” and is aware of what is being done to him or her. Dr. Frederick Leboyer’s classic book Birth Without Violence described the experience of birth from the baby’s point of view. Marshall Klaus and Phyllis Klaus brought new insights into the sensory perception and mind of the newborn with their book, The Amazing Newborn (New York: Addison-Wesley, 1985).

panying the infant. Thus mother and newborn are able to be present to one another throughout and immediately following birth, when they are both in an optimum state physically, emotionally, and spiritually, to begin forming a bond and to “initiate a lifelong reciprocal bosom friendship.”

The father’s presence is important in this as well. Just as the father has lovingly joined with his wife in sexual union to conceive the child, and has accompanied and supported her throughout the pregnancy, he ought to accompany and support her through her labor, as she bodily accompanies the child in his passage into the world, and join her in welcoming their new child at birth. Encouraging bonding between mother, father, and child in the important hour after delivery, when mother and child are both in prime condition for it—by not separating the baby from the mother at birth, by allowing the father to be present, by encouraging skin-to-skin contact with the baby, and by promoting breastfeeding—all serve the communion of persons in the family.

These, moreover, all help the mother and the infant flourish as persons and allow the mother, father, and child—and perhaps older siblings, as well—to begin their common life as a family together. The typical scenario for most first-time parents and their firstborn after a hospital birth is separation and isolation rather than interpersonal communion: the newborn spends his first nights in an “isolette” in the nursery with other crying, abandoned babies; the exhausted mother sleeps in a room that she most likely shares with another exhausted mother, both of whom are bereft of the fruits of their labor; and the new father goes home to an empty house.

In the current mainstream management of birth, the interventions and frequent separation of the newborn from the mother often lead to what Dr. Sears calls “poor start syndrome,” in which the mother must use her energy the first few days and weeks “healing her birth wounds instead of using that energy to get to know her baby … As a result, breastfeeding problems occur, the infant-distress syndrome (fussiness and colic) is more common, and the pair spends most of the time during the early weeks solving problems, many of which could have been avoided.” For the mother to spend the first hours, days, and weeks of her baby’s extrauterine life dazed, drugged, and cut does not contribute to the flourishing of a new person, or to her own flourishing as a mother.

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76 Virtue, *Mother and Infant*, 216, original emphasis.

77 Dr. Robert Bradley was the pioneer in bringing fathers into the labor and delivery rooms in the middle of the twentieth century. Even until recent decades, it has been illegal in many states for fathers to be present in the hospital rooms where their children are being born.

78 The importance of bonding has been scientifically studied in Marshall Klaus and John Kennel, *Maternal-Infant Bonding: The Impact of Early Separation or Loss on Family Development* (St. Louis: Mosby, 1976). The importance of skin-to-skin contact has been made known in Ashley Montagu, *Touching: The Human Significance of the Skin*. Skin-to-skin contact greatly enhances an infant’s physical, emotional, and cognitive development.

A personalist norm in birth management will seek effective comfort measures for the mother that respect her dignity and do not put her at risk: personal presence, support, encouragement (all of which can be offered by a doula, midwife, and most important of all, a prepared husband), freedom of movement and position, freedom to eat and drink at will, immersion in warm water, massage, soft music, and similar measures. These, along with the various methods of prepared childbirth, can all contribute to eliminating much of the pain of childbirth, or at least bringing it down to manageable levels:

Christ and the Christian seek to heal these wounds insofar as God permits. Yet ultimately we approach the difficulties of birth as we do all things in life: with the Christian attitude toward suffering as a redemptive work. Thus we will place the difficulties of birth in the context of the gift of one’s body as a sacrifice for the life of another.80

Two popes have voiced such sentiments as well: Pope Pius XII, in an address approving the use of the psychoprophylactic method (developed by Lamaze), reflected that “in the event of only partial success or of failure, [the mother] knows that the suffering can be a source of good, if it is borne with God and in obedience to His will,” in union with the sufferings of Christ.81 Likewise, Pope John Paul II praised the “brave mothers who devote themselves to their own family without reserve, who suffer in giving birth to their children and who are ready to make any effort, to face any sacrifice, in order to pass on to them the best of themselves.”82 Natural childbirth accepts and assures the natural labor, effort, and often discomfort and pain of childbirth and leaves it in its natural place, where it is productive, making of it a gift to the child. Heavy-handed intervention may block some pain before birth, but it effectively transfers it to the period of recovery, after birth, when it is not so productive, and impedes bonding. This calls to mind the Christian attitude of “first the fast, then the feast,” compared with the secular attitude of “first the feast, then the hangover.”83

Self-Gift

Christ’s revelation of God’s love to the human person in his gift of himself encourages persons to find their deepest meaning and vocation in self-giving. Just as spouses show each other their love by giving themselves fully to each other in non-contraceptive bodily union, the mother gives herself fully to her child during birth—a birth planned to be as free as possible from the damaging effects of drugs and medical intervention. Giving birth to her child using her own strength and will as
much as possible helps the body of the child to be strong. Virtue speaks of the “donative” qualities of birth.\textsuperscript{84} This would seem intuitive; in fact, we speak of “giving” birth, implying that birth is a gift the mother gives the child. This gift is “the gift of independence … as the body of the child’s presence goes out from the maternal body and into the world so that the child himself or herself can be present.”\textsuperscript{85} Christian childbirth is truly a loving, dignified event, and its personal qualities need to be brought to the fore to allow families to experience the deepest meaning of the arrival of each new child into the world. A midwifery model of birth management that patiently respects the natural order of birth and attends to the personal qualities of the mother and child clears the way for a more spiritual appreciation of birth that allows God’s hand to be more visible. “The womanly art of giving birth also is a creative act that imitates and shares in God’s creative work,” notes Virtue.\textsuperscript{86} Rather than fostering a subservient attitude in awe of the technology that delivers the child, as in mainstream obstetrics, gentler birth practices allow families to experience awe at the wonder God works in childbirth. This leads to human flourishing and can only contribute to building up the culture of life.

**Moral Implications**

What are the moral ramifications of this critique of medicalized birth in favor of the midwifery model? I suggest that the routine overuse of medical technology is wrong. I certainly do not claim that in itself the use of interventions is “intrinsically evil,” as are abortion, contraception, and many of the new reproductive technologies, but rather that it is *vicious*, in contrast to virtuous. Looking to the framework of virtue ethics, I propose that the use of medical technology, a good, needs to be measured by the virtue of prudence. Technology as currently used in birth is “too much of a good thing”; it is not used according to right reason (in the right amount, at the right time, in the right manner, and so forth). Just as the consumption of too much food is gluttonous, I propose that current overuse of medical technology is imprudent. Of course, the opposite extreme is also vicious—there can be an obstinate refusal to make use of available medical interventions when they would save or improve the lives of mother and child, and this would be negligent.

What are the criteria or principles by which the “right” amount of intervention can be determined? This is like asking what the “right” amount of food is for most people to eat; it will be different from person to person, but for most of us in affluent North America, it will probably be less than what we currently consume. Similarly, the “right” amount of medical intervention is a prudential matter, varying according to the circumstances of each pregnancy and birth, but definitely less than what is routinely employed in most births in North America today.

\textsuperscript{84} Virtue, *Mother and Infant*, 22.
\textsuperscript{85} Ibid., 177.
\textsuperscript{86} Ibid., 187.
Concluding Questions

I have attempted to show that the overuse of medical interventions in childbirth causes more physical harm than good to mother and child and constitutes a moral problem that needs to be addressed, and I have proposed an assessment incorporating Catholic personalism, Thomistic teleology, and virtue ethics. This theoretical treatment raises many practical questions, however: legal issues, insurance issues, Catholic health-care policy issues, and even child-rearing issues. Are there legislative measures that could be taken to promote more natural births, for example, by curbing malpractice lawsuits and by reversing laws in states that make home births attended by certified professional midwives illegal? What are the implications for health-care coverage? Should birthing centers and home births be options routinely covered by health insurance providers? (They are certainly less expensive to cover than hospital births.) Should doctors, rather than just midwives, be more open to attending home births if the parents wish it? Should Catholic hospitals in particular be especially sensitive to the natural processes at work, given Catholic theology’s understanding of the importance of the communion of persons in the family?

The Catholic tradition holds that marriage is ordered to the procreation and education of children. If the circumstances of childbirth are significant for procreation, what type of education for the children do they imply? What types of parenting styles can continue the physical, emotional, and spiritual bonding that normally occurs during a natural birth—what manners of child-rearing follow naturally from natural child-bearing? It seems that “attachment parenting,” made popular by William and Martha Sears, promoted by the Couple to Couple League for its child-spacing effect, and set in the context of a Catholic theology of the family by Gregory Popcak, would be an excellent place to begin to look.87