MEDICALISATION

- Is contemporary maternity care heading in the rigth direction?

Robson Möte, Göteborg, 13 Mars 2026

Eva Rydahl, Midwife, MHS & Ph.d

KØBENHAVNS PROFESSIONS HØJSKOLE

A bit about me…

- Midwife
- Master in Heath Science,
- Ph.d. in Clinical Epidemiology:

”Medicalisation in Pregnancy and Childbirth” (2020)

- Researcher / lecturer
- Health Authorities, guideline on induction of labor 41+

Content for the next 1hour

1: State of maternity care

- Increase & variations

2: Improving birth outcomes?

- Status of mothers and newborn health

3: Medicalisation

- Theory
- Signs in clinical practice

4: Promotors of medicalisation

- Changing the threshold
- Intervening on risk factors

5: Are we heading in the right direction?

In line for elective cesarean, Equador

Point of departure:

Current labour practices have seen a rapid escalation in the application of interventions to initiate, accelerate, monitor, or terminate the physiological process of labour, all with the aim of improving birth outcomes

The increasing medicalisation of childbirth tends to undermine the labouring woman's own ability to give birth as well as impact negatively on her labour experience

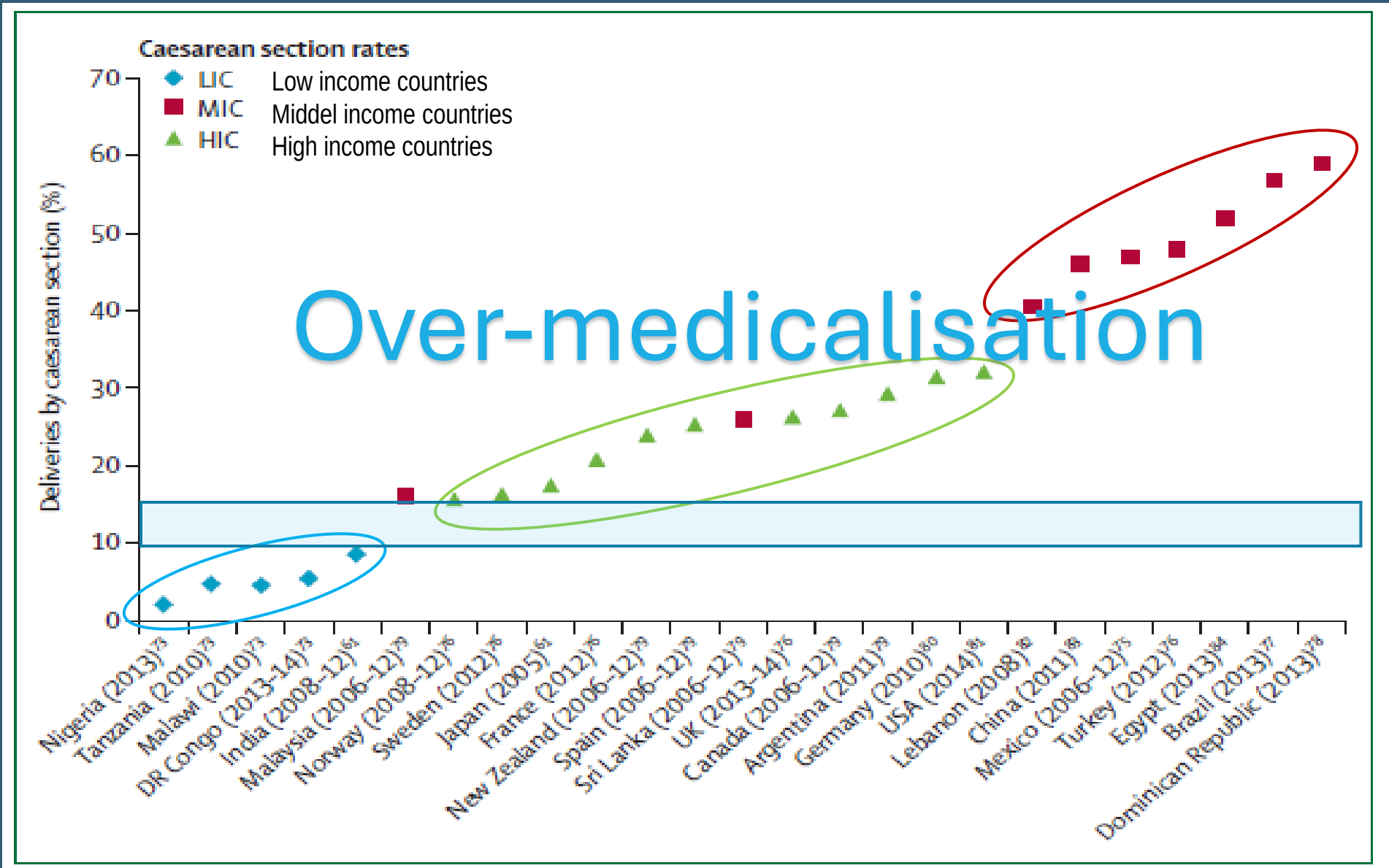
(WHO, Intrapartum care, 2018)

THANK YOU
for the medical science

- Antibiotics
- Cesarean sections
- Ultrasound
- Induction of labour

But….when to be used?

Why talk about medicalisation?



Miller, 2016

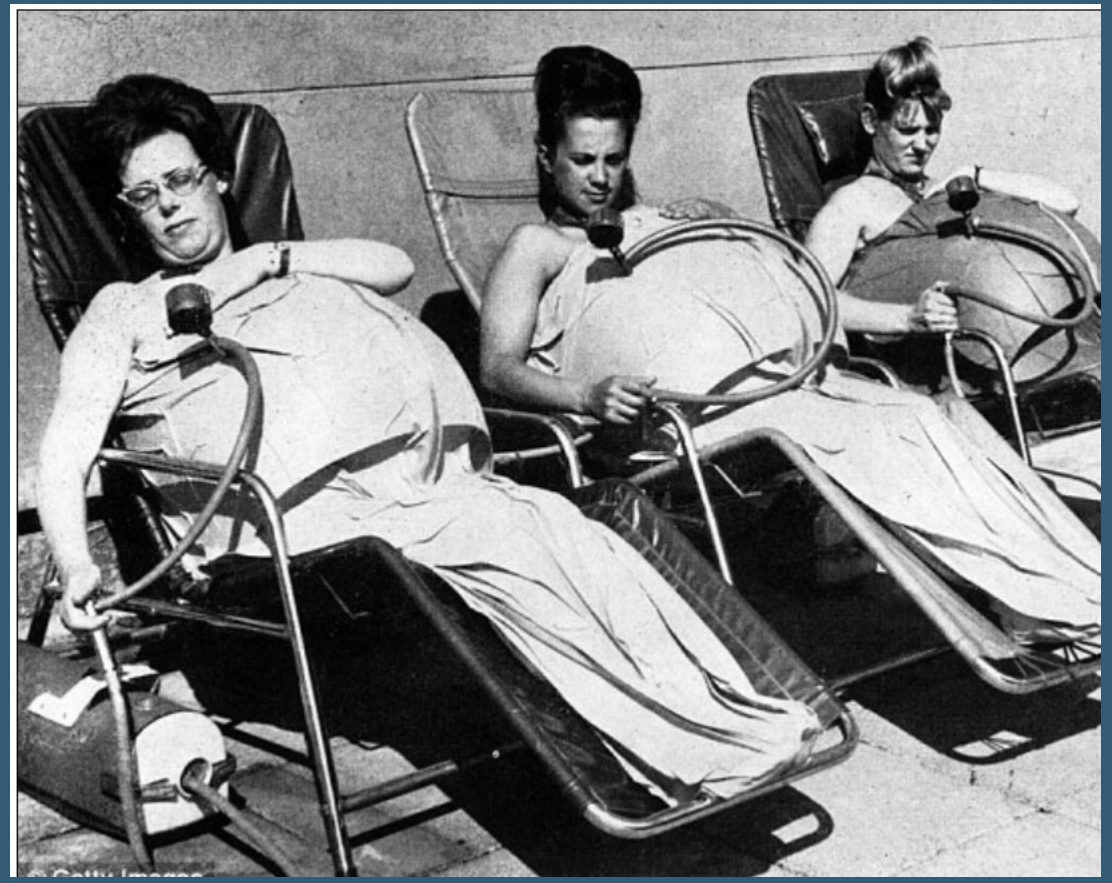
“Over-medicalisation”

Too much, too soon

- Excessive or improper use of interventions
- Unnecessary use of non-evidence-based interventions
- Possibly even harmful

Cascade of intervention

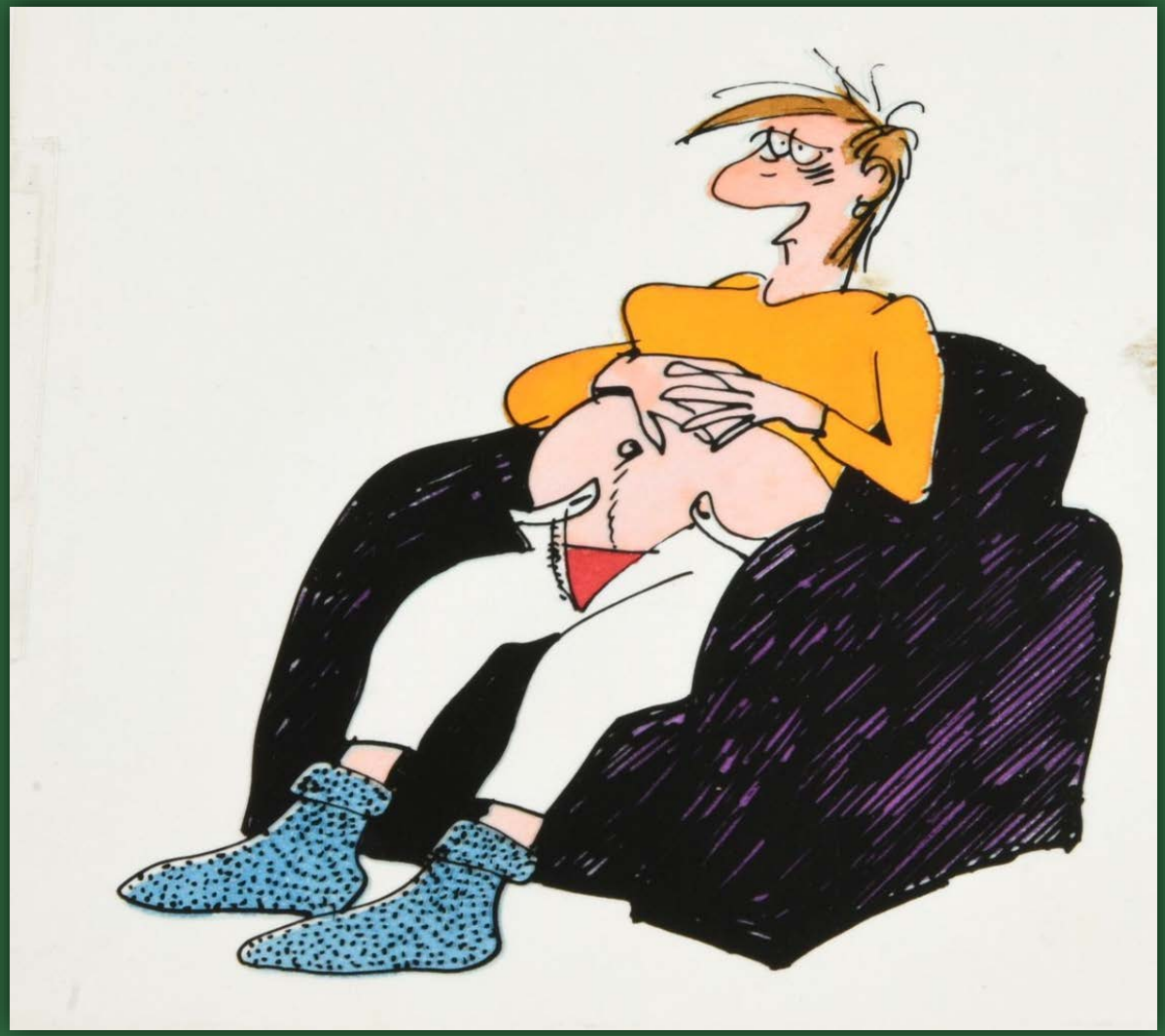
Not wisely use of resources



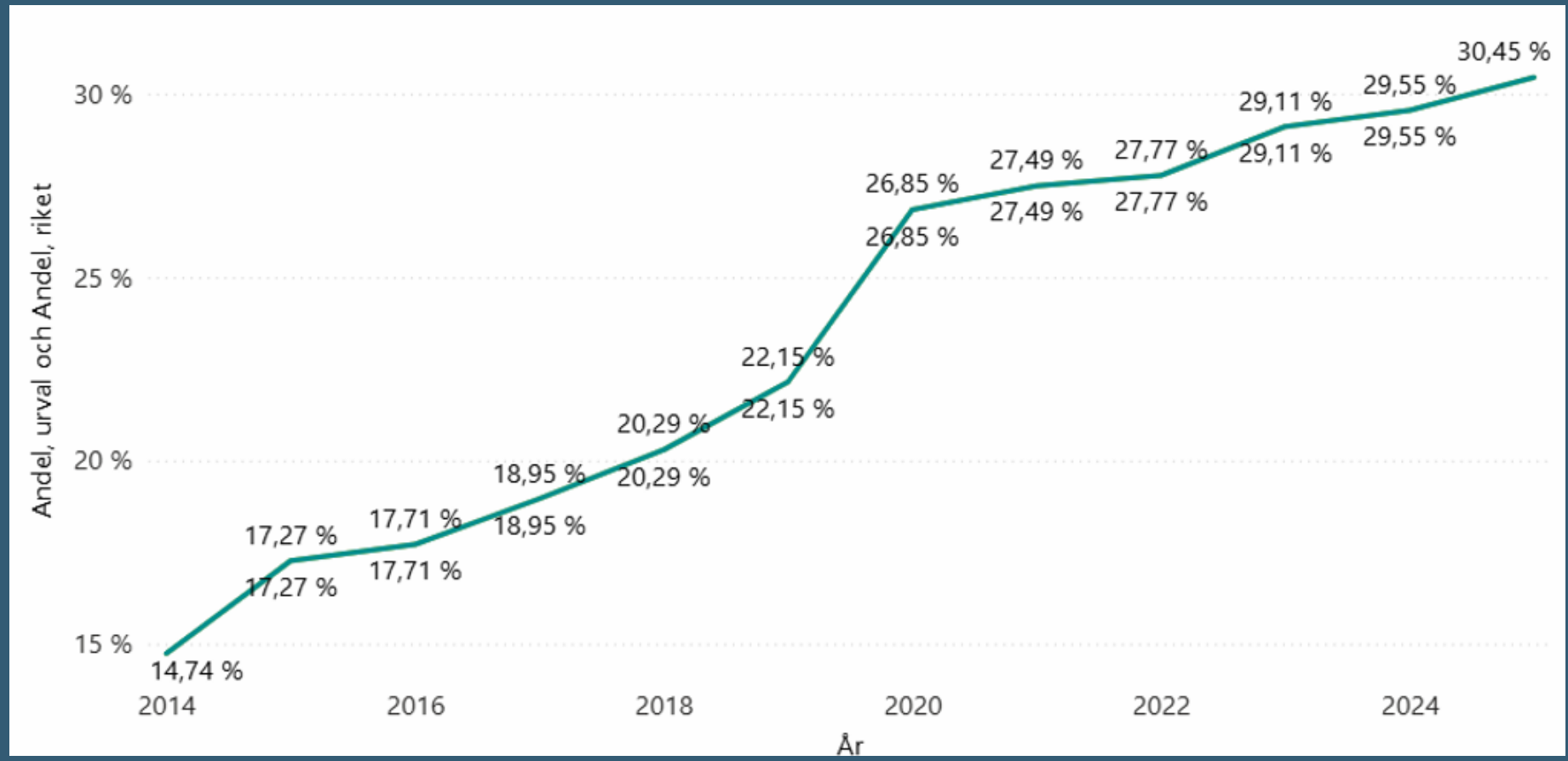
1965: Suction machine to improve brain development

Miller 2016; Rossignol 2014

1: State of maternity care

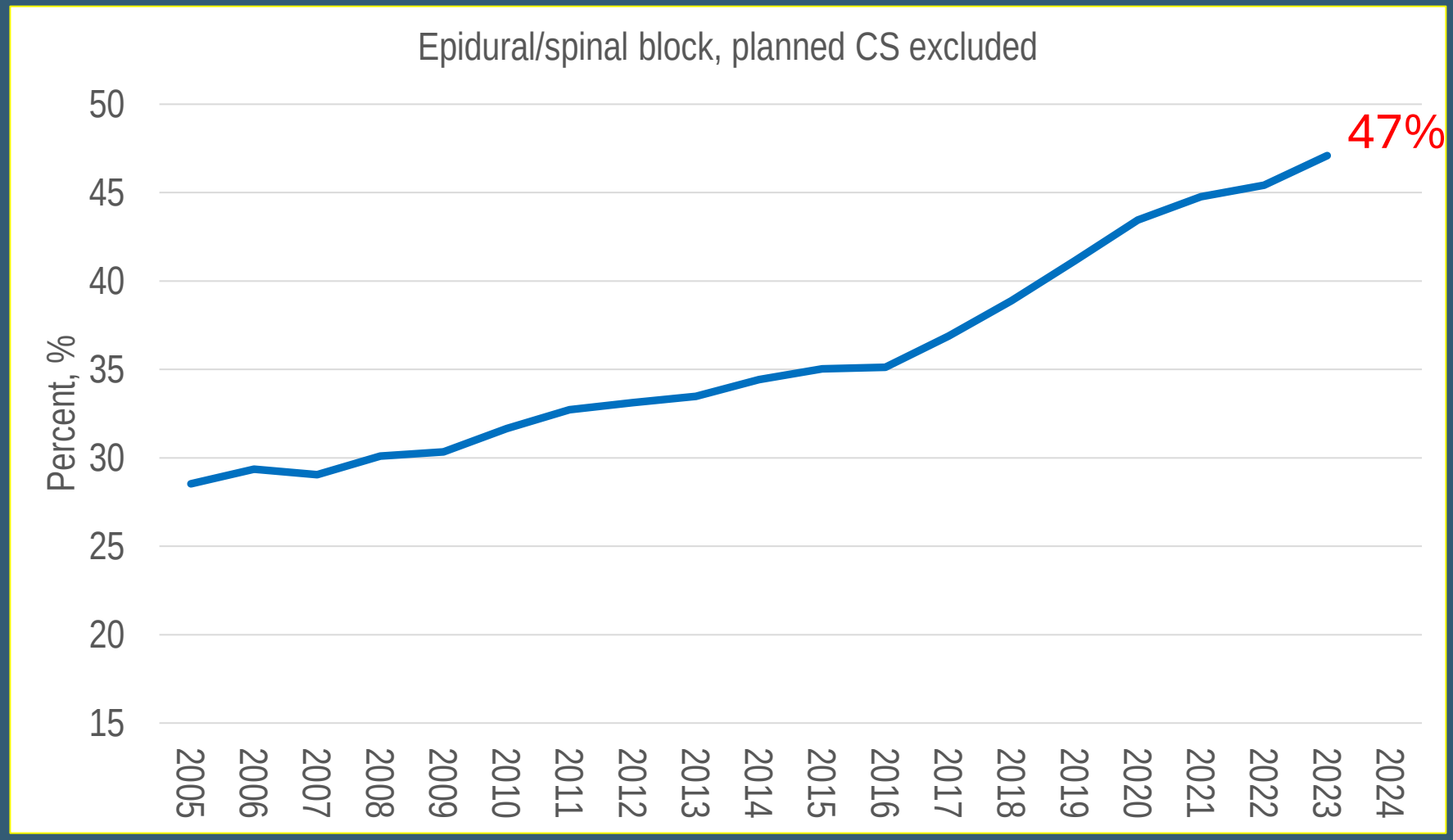


Induction of labor, Sweden



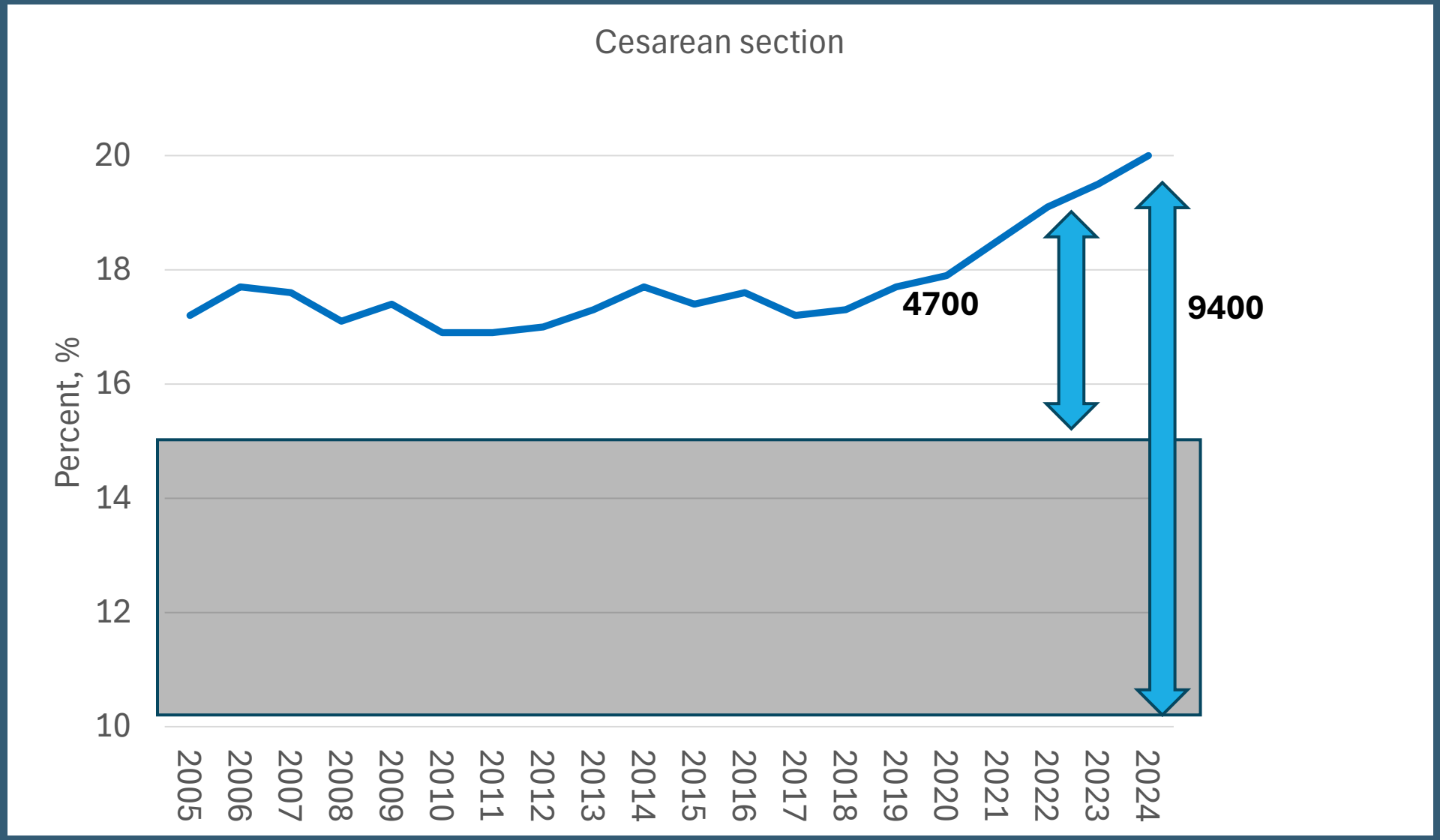
Graviditetsregistret.se

Epidural analgesia, excl. planned CS, Sweden



Socialstyreslen.se

Cesarean section, Sweden

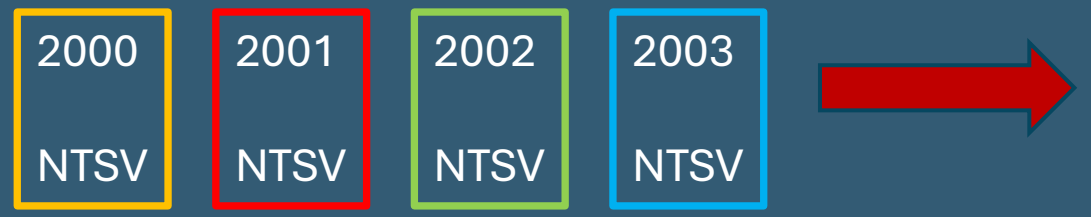


FHI.no/ Socialstyreslen.se/ eSundhed.dk/ Thl.fi

Significant change in interventions over time? , Denmark

Induction of labor
Augmentation
Epidural
-& combinations

Nulliparous
Term
Singleton
Vertex position
2000-2017
N= 380 326 births



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ELSEVIER

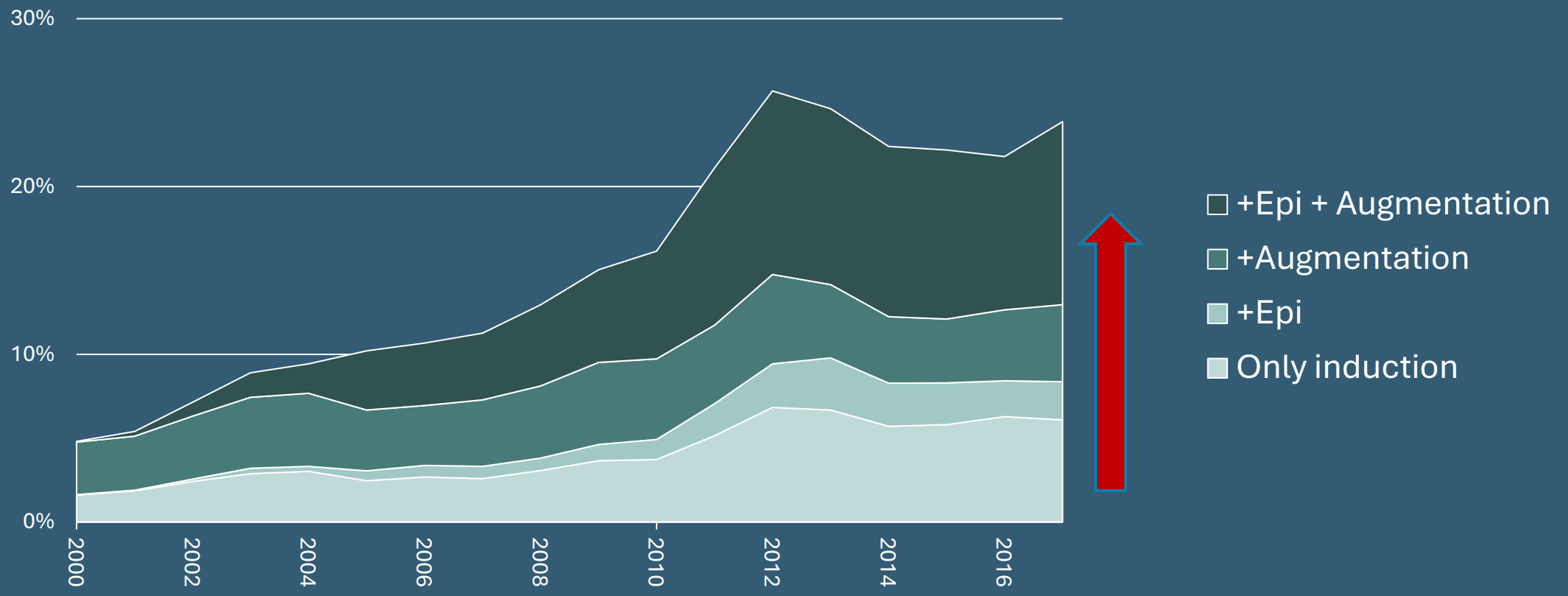
Check for updates

Disruption of physiological labour; – A population register-based study among nulliparous women at term

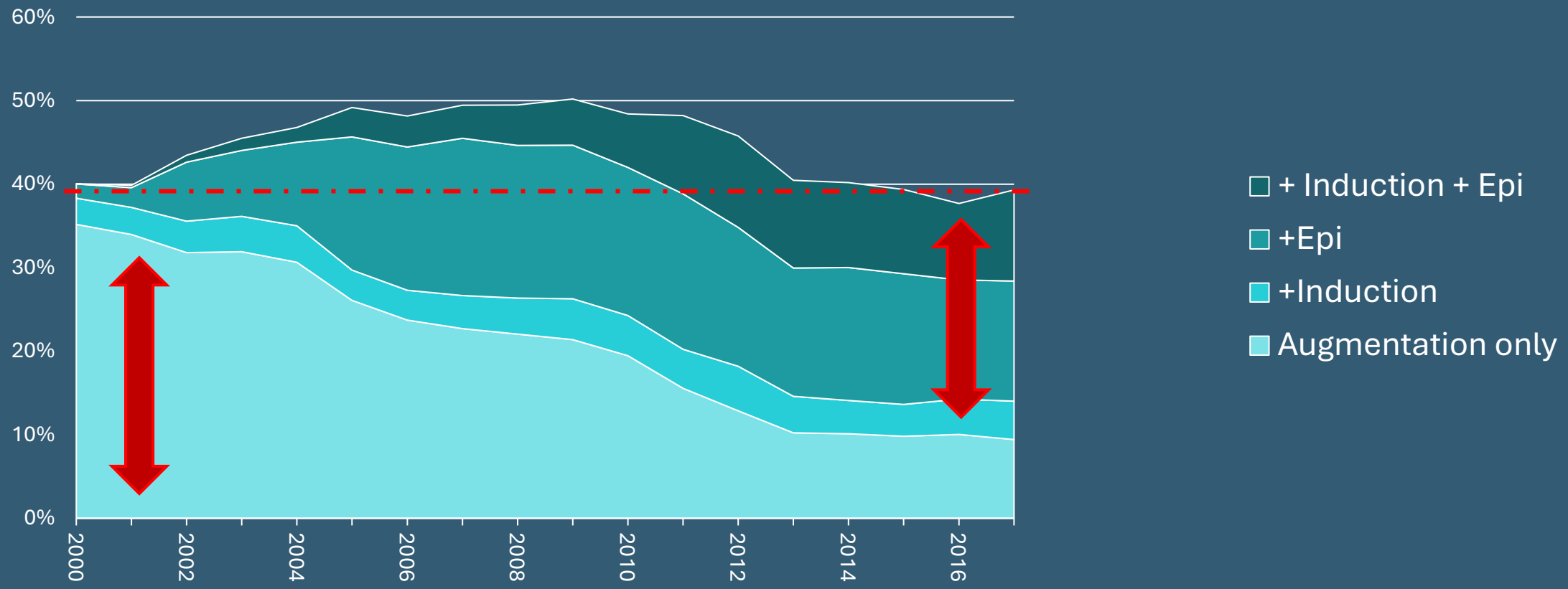
Eva Rydahl [a,b,*], Mette Juhl [a], Eugene Declercq [c], Rikke Damkjær Maimburg [b,d,e]

[a] Department of Midwifery, University College Copenhagen, Copenhagen, Denmark

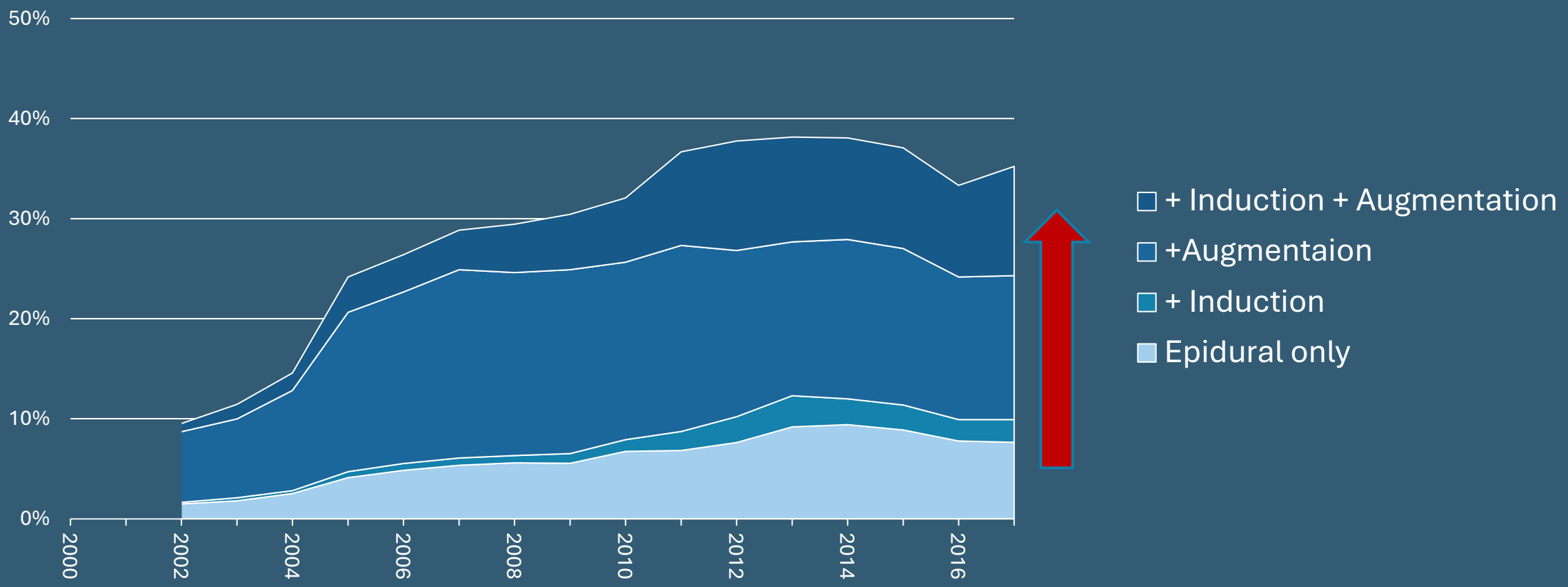
Induction of labour, foley / prostaglandins



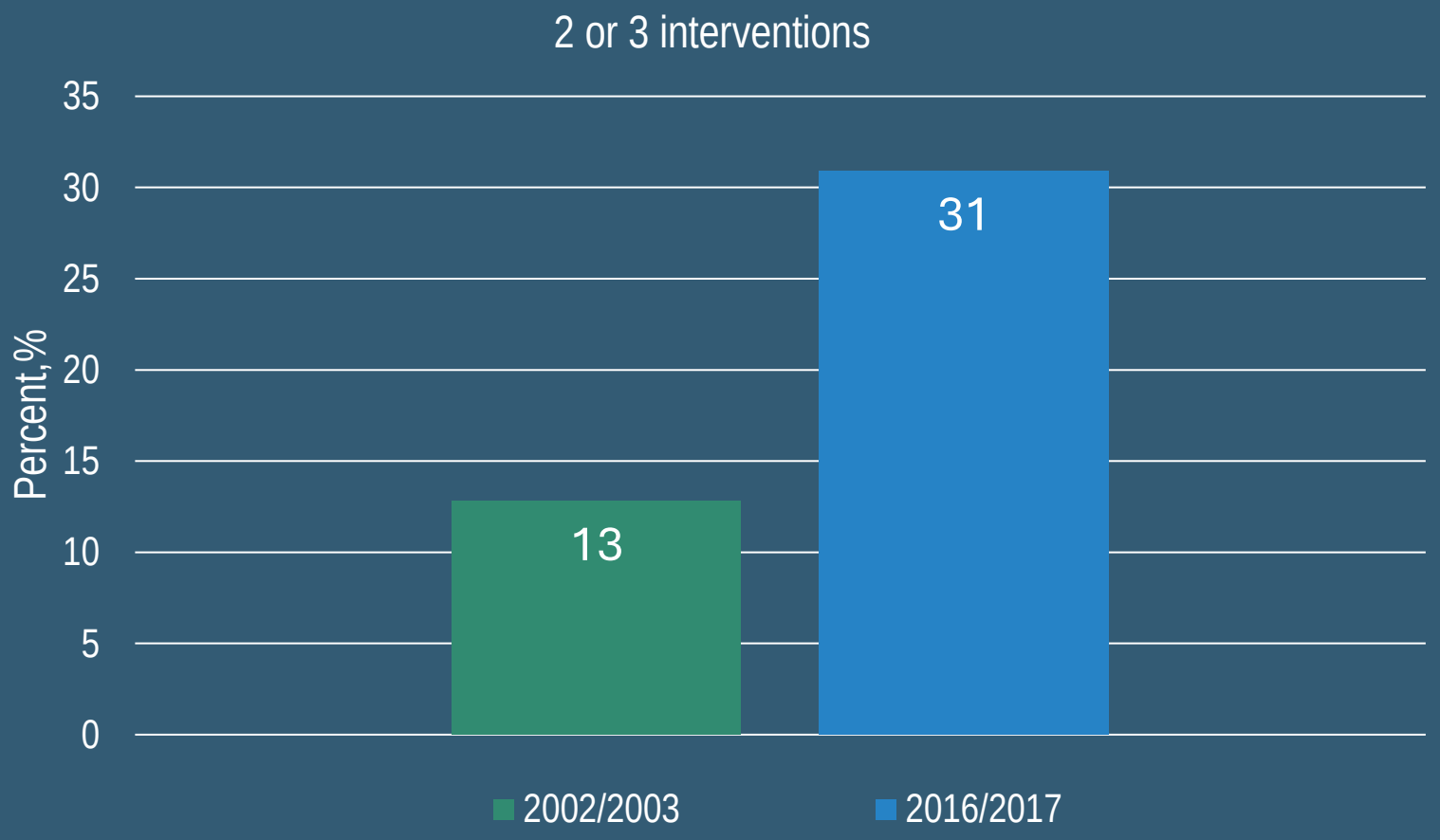
Augmented labour, by Synthetic Oxytocin



Epidural analgesia



Results: A change towards more interventions



Can this be a matter of culture?

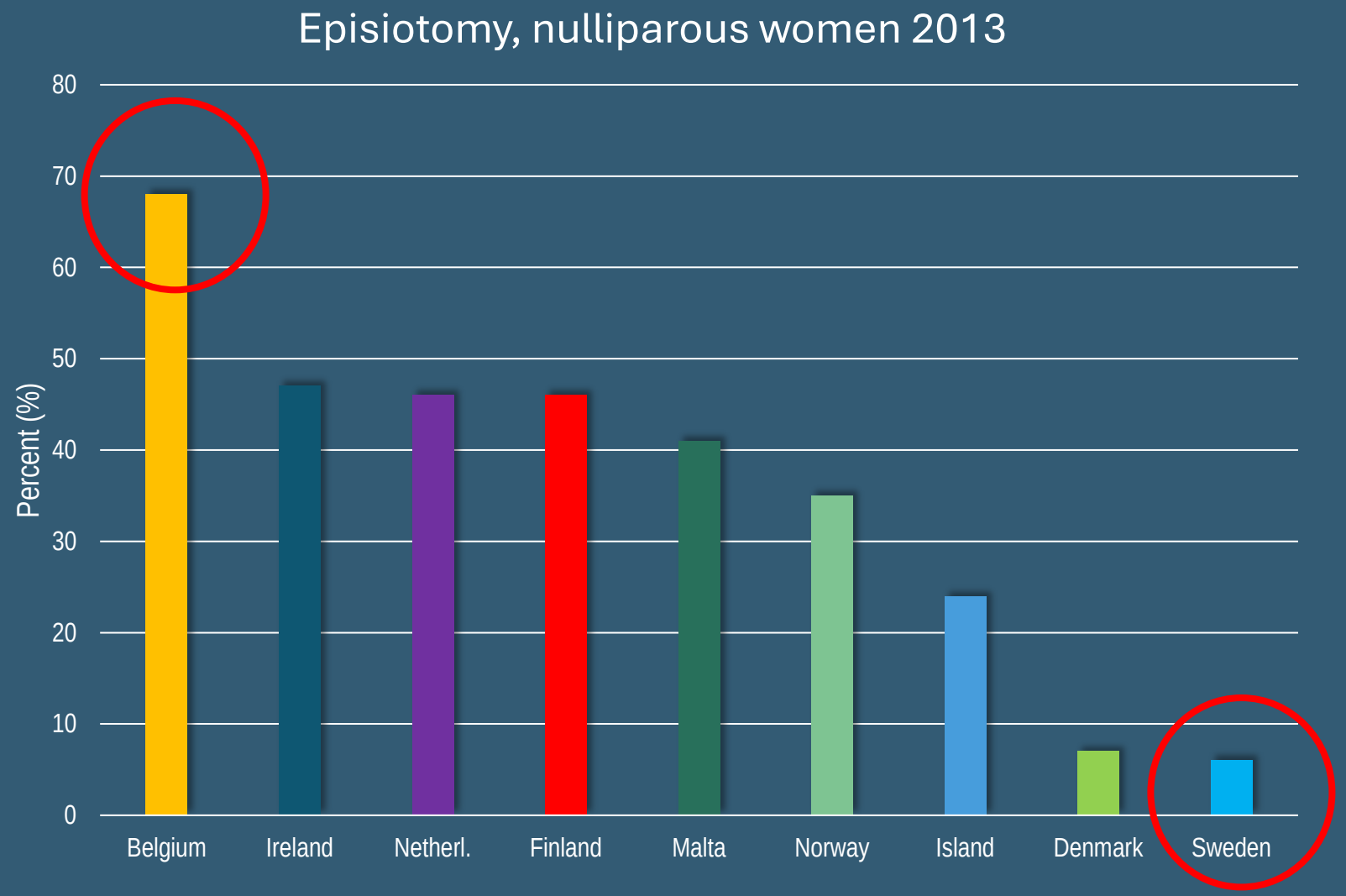
- Increases substantially over time

  (populations change slowly)

- Huge interregional variation

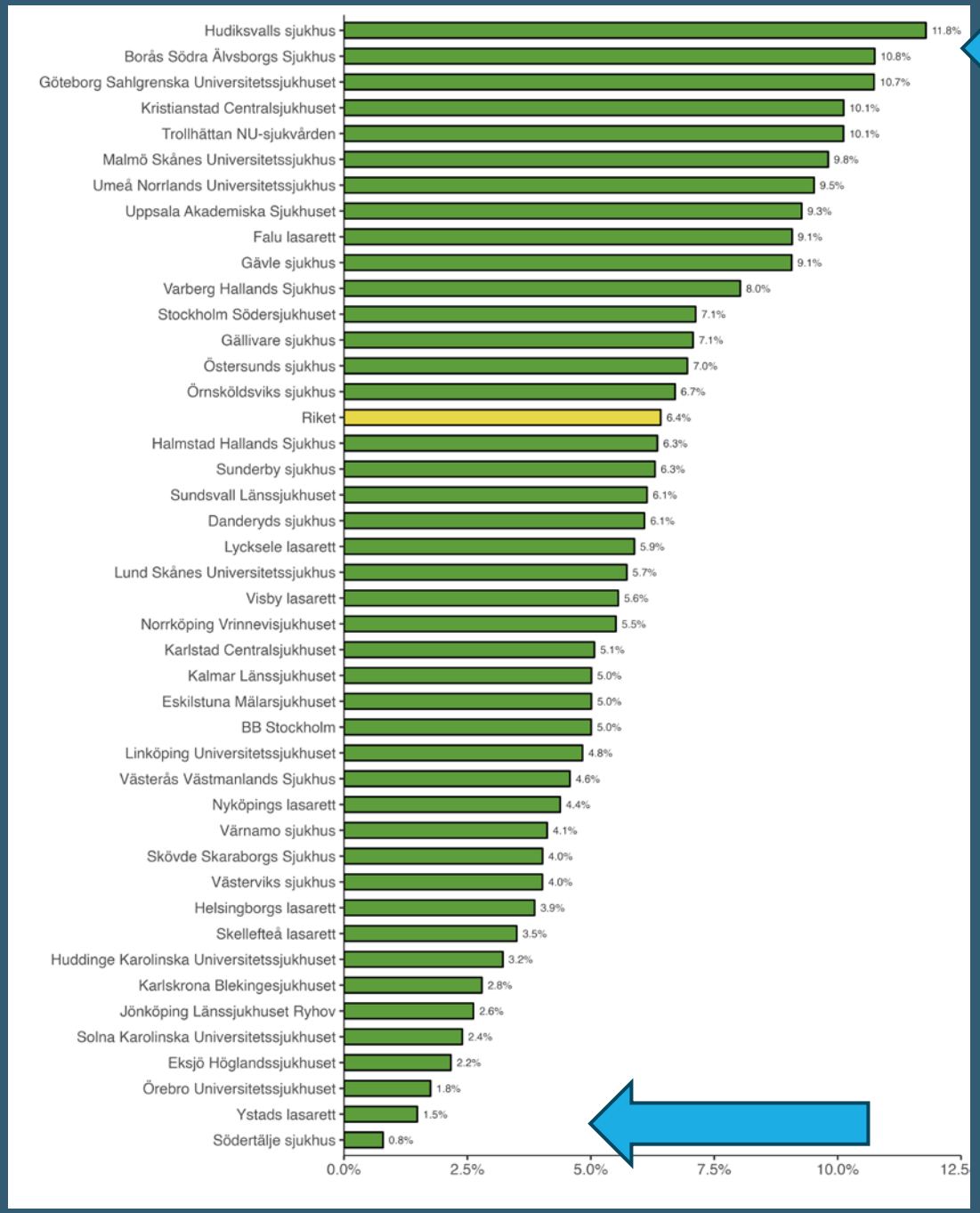
YES

Variations among relatively similar populations



Inter-regional variation

Seijmonbergen-Schemers et al, 2020



Episiotomies:

Variation between laborwards, Sweden 2022

Elvander, 2022

Is medicalisation a cultural matter?

- Increases substantially over time

  (populations change slowly

YES

- Huge interregional variation

YES

State of contemporary maternity ca

Current labour practices have seen a rapid escalation in the application of interventions to initiate, accelerate, monitor, or terminate the physiological process of labour, all with the aim of improving birth outcomes

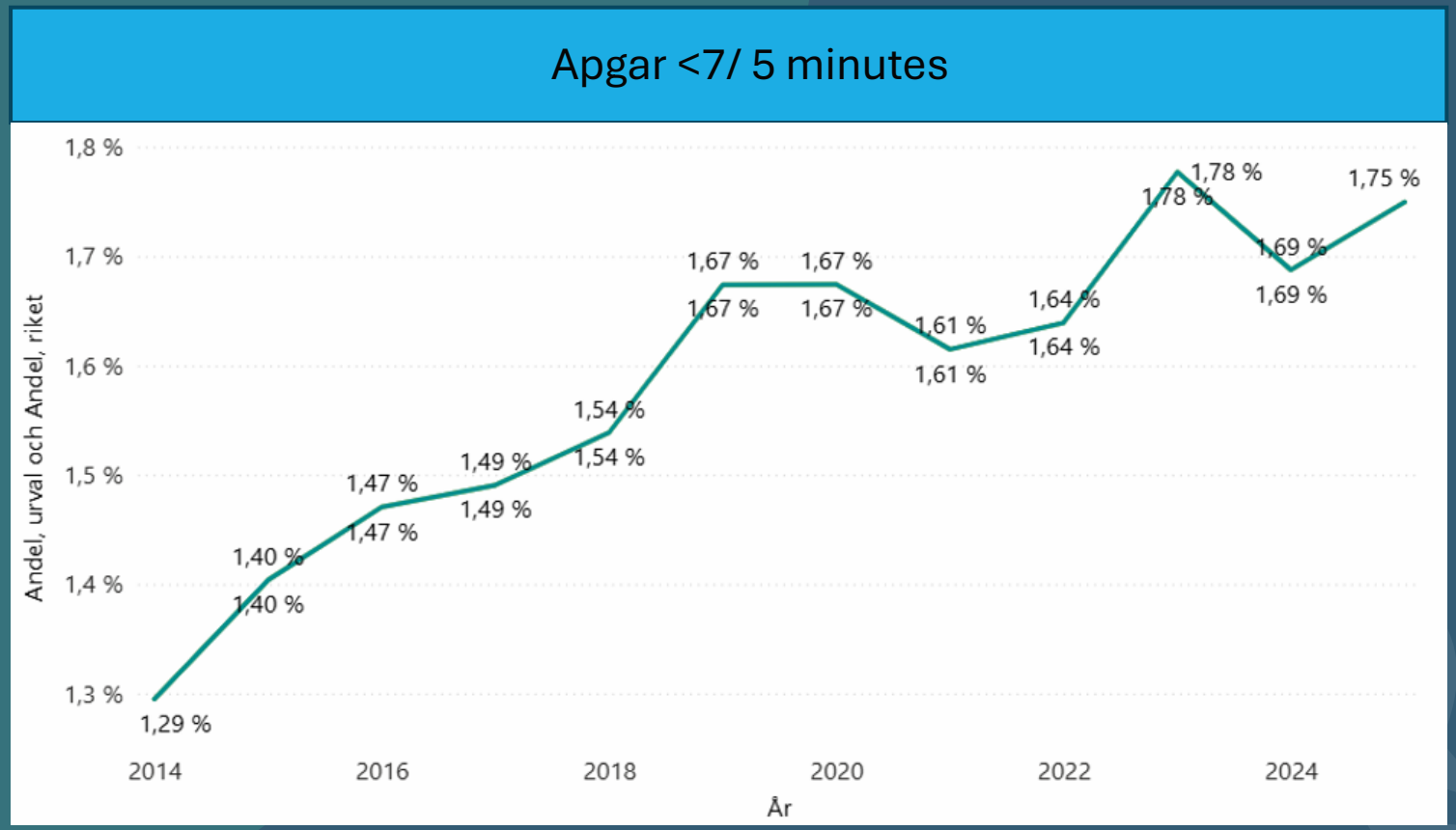
The increasing medicalisation of childbirth tends to undermine the labouring woman's own ability to give birth as well as impact negatively on her labour experience

(WHO, Intrapartum care, 2018)

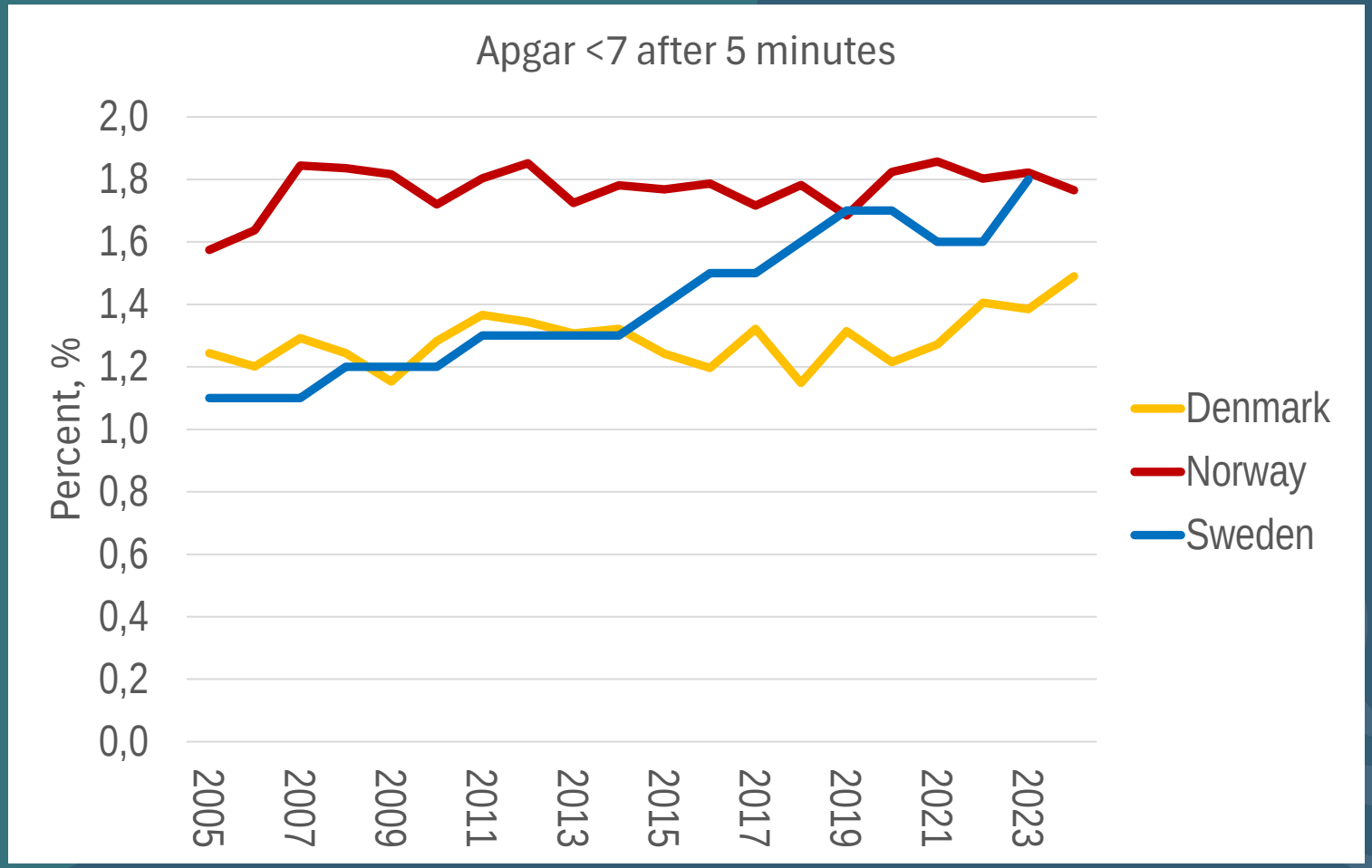
2: Improving birth outcomes?

Maternal and newborn health

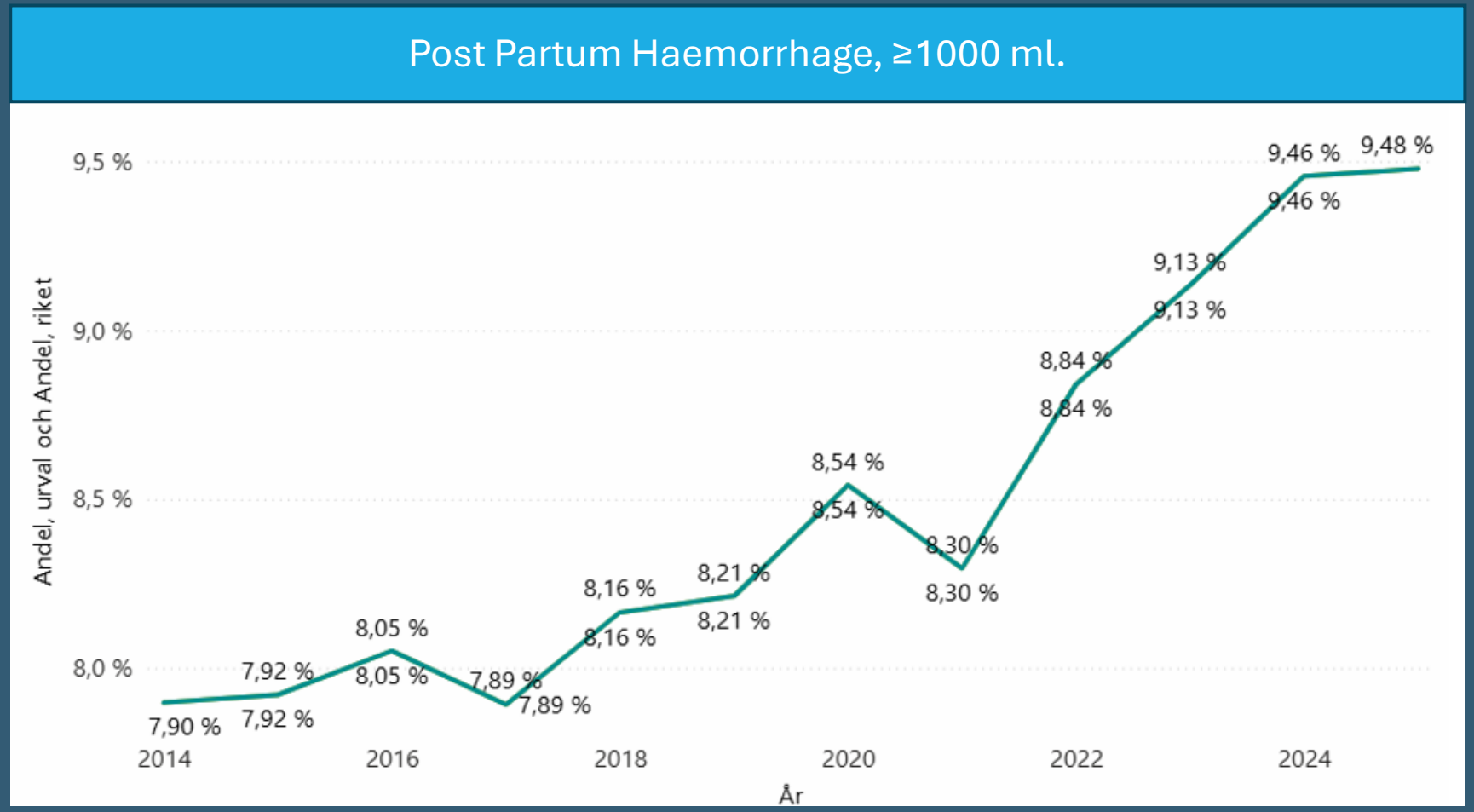
The newborn ´s wellbeing, Sweden



The newborn ´s wellbeing



Severe post partum haemorrhage (PPH), Sweden



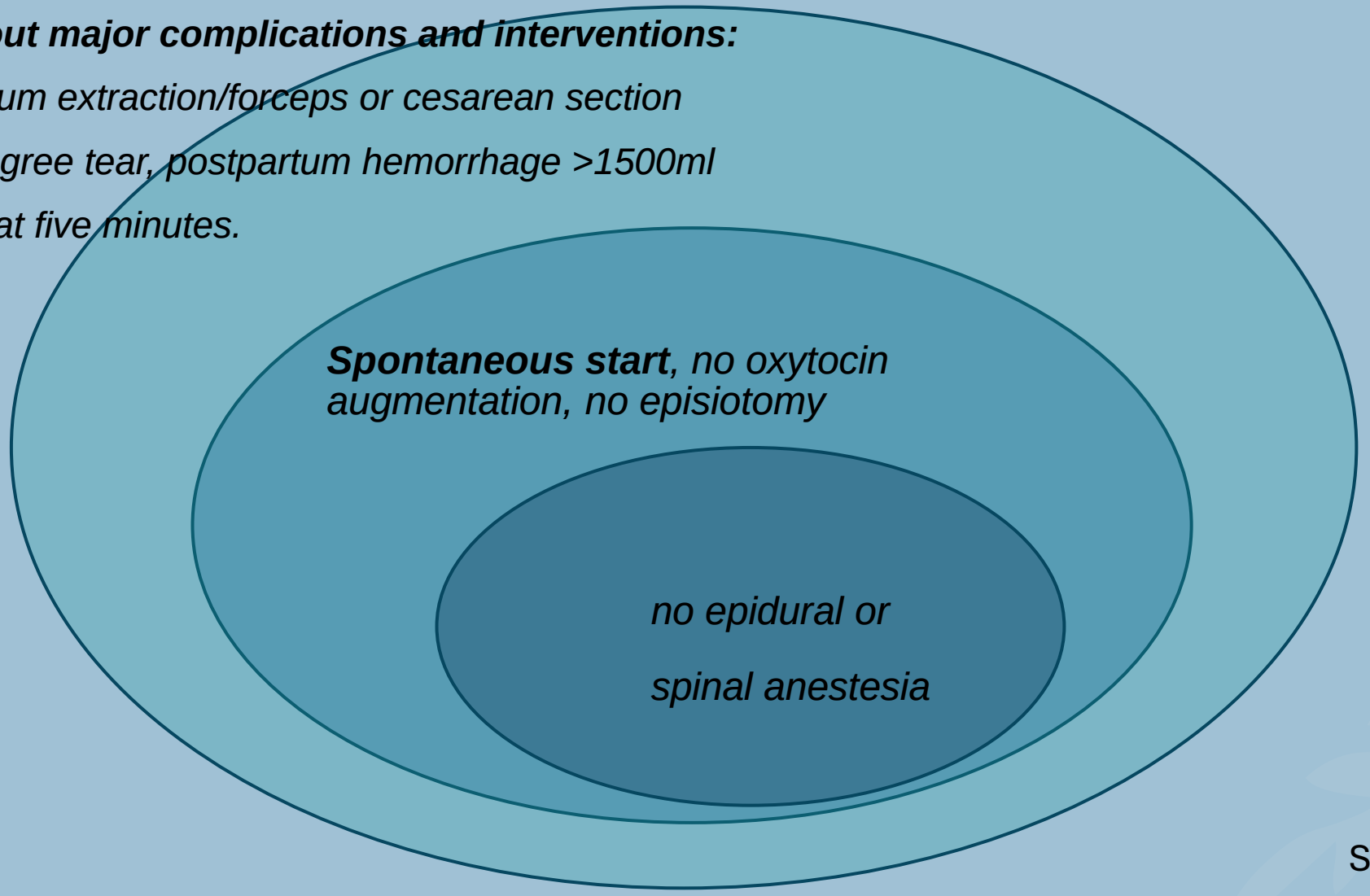
Physiological birth among first time mothers, 4 Nordic countries

Births without major complications and interventions:

without vacuum extraction/forceps or cesarean section

3rd or 4th degree tear, postpartum hemorrhage >1500ml

or Apgar <7 at five minutes.



Swift et al, 2026

Outcomes among Nordic first time mothers

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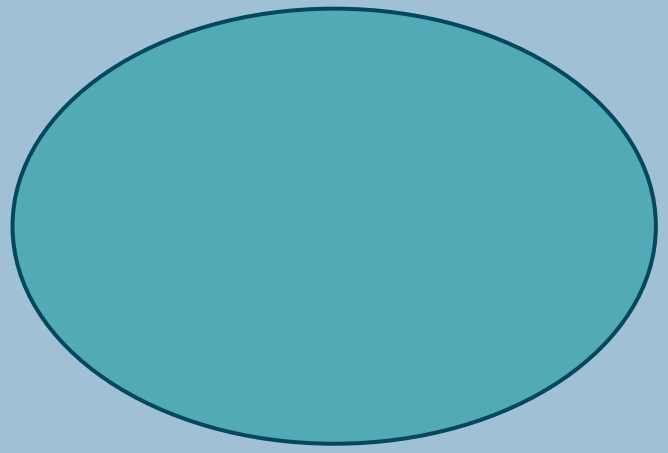

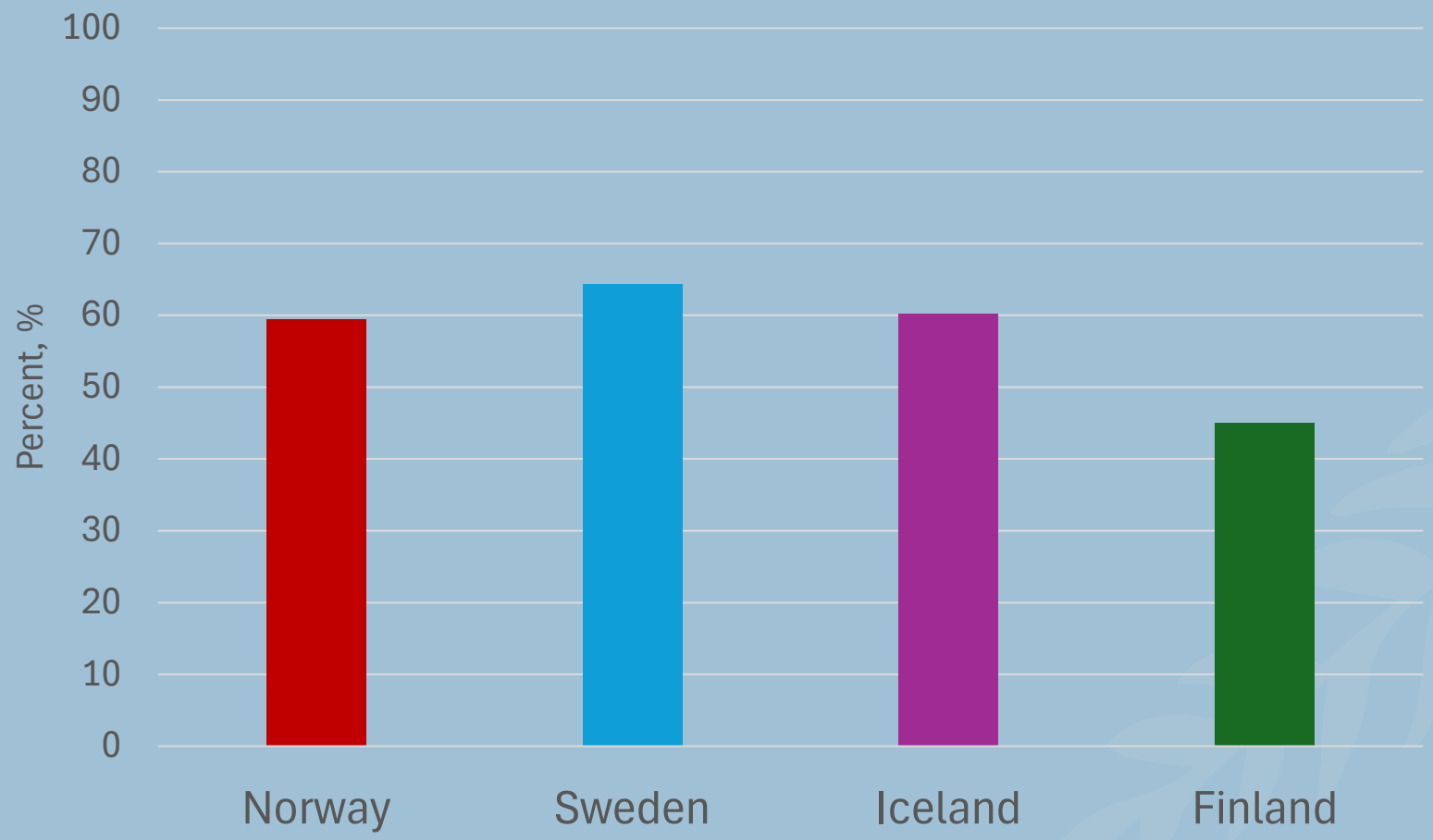

Outcomes among Nordic first time mothers

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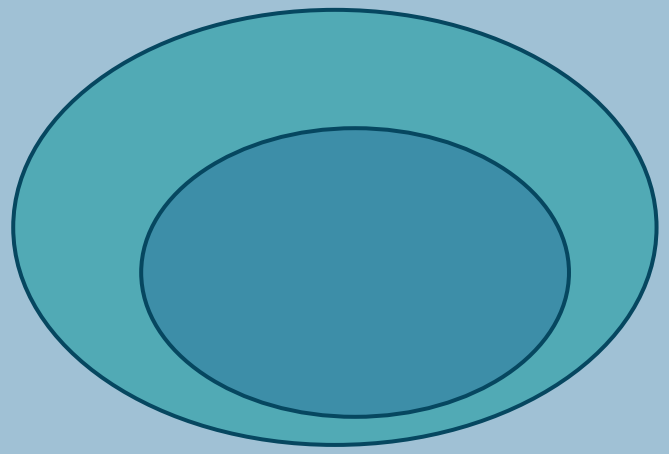
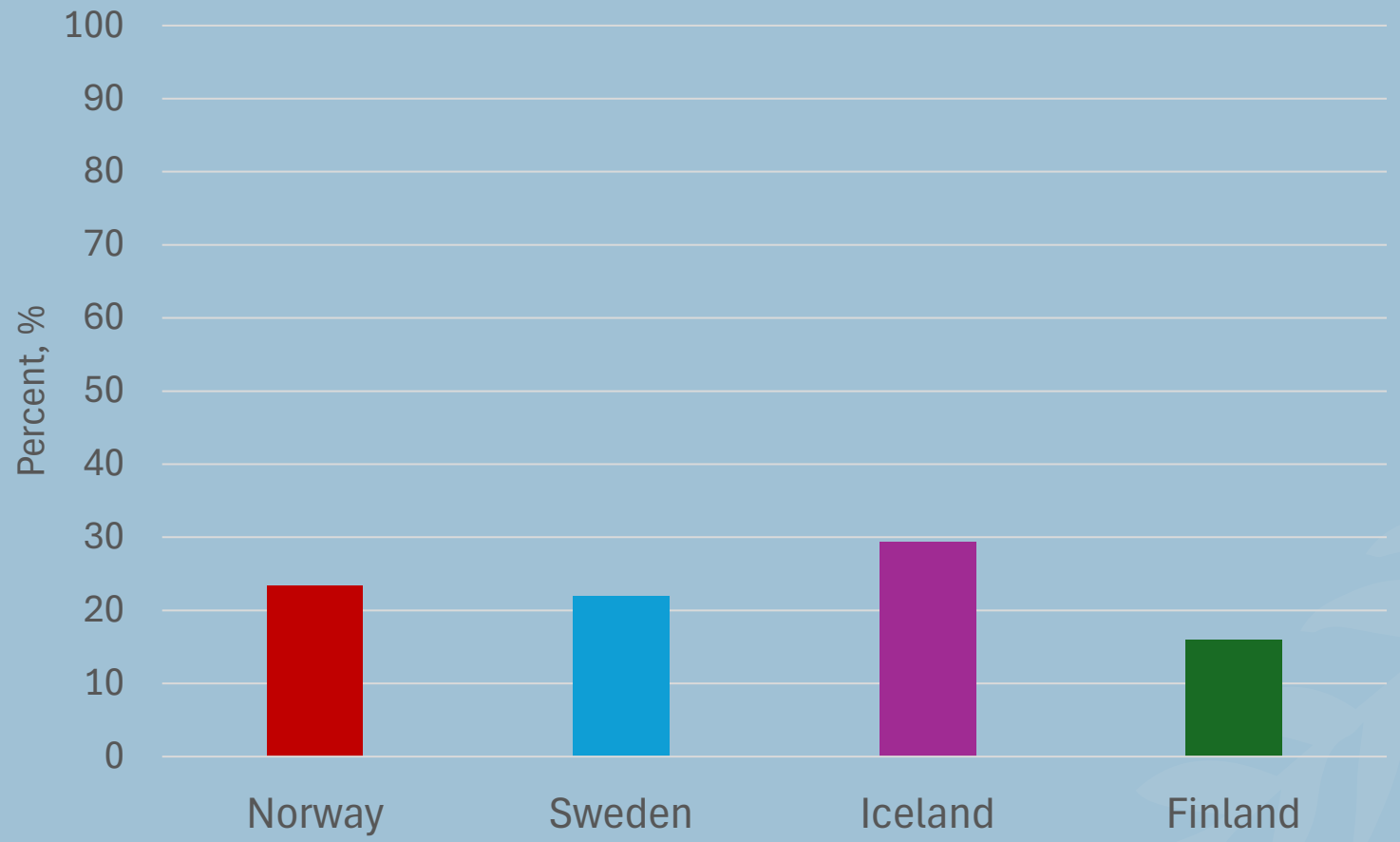
AND :

Spontaneous onset of labor

No oxytocin augmentation

No episiotomy





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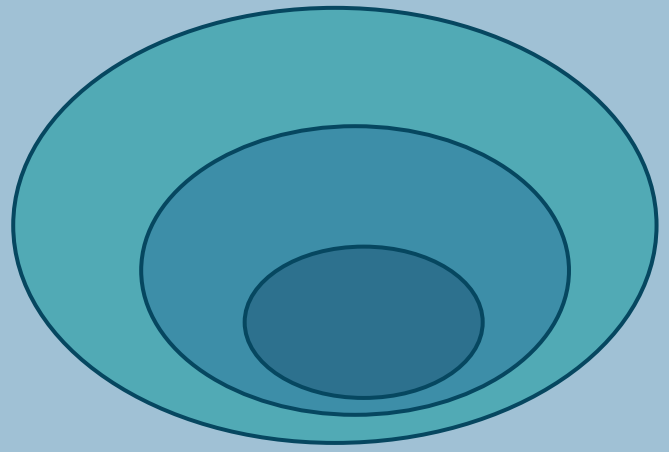
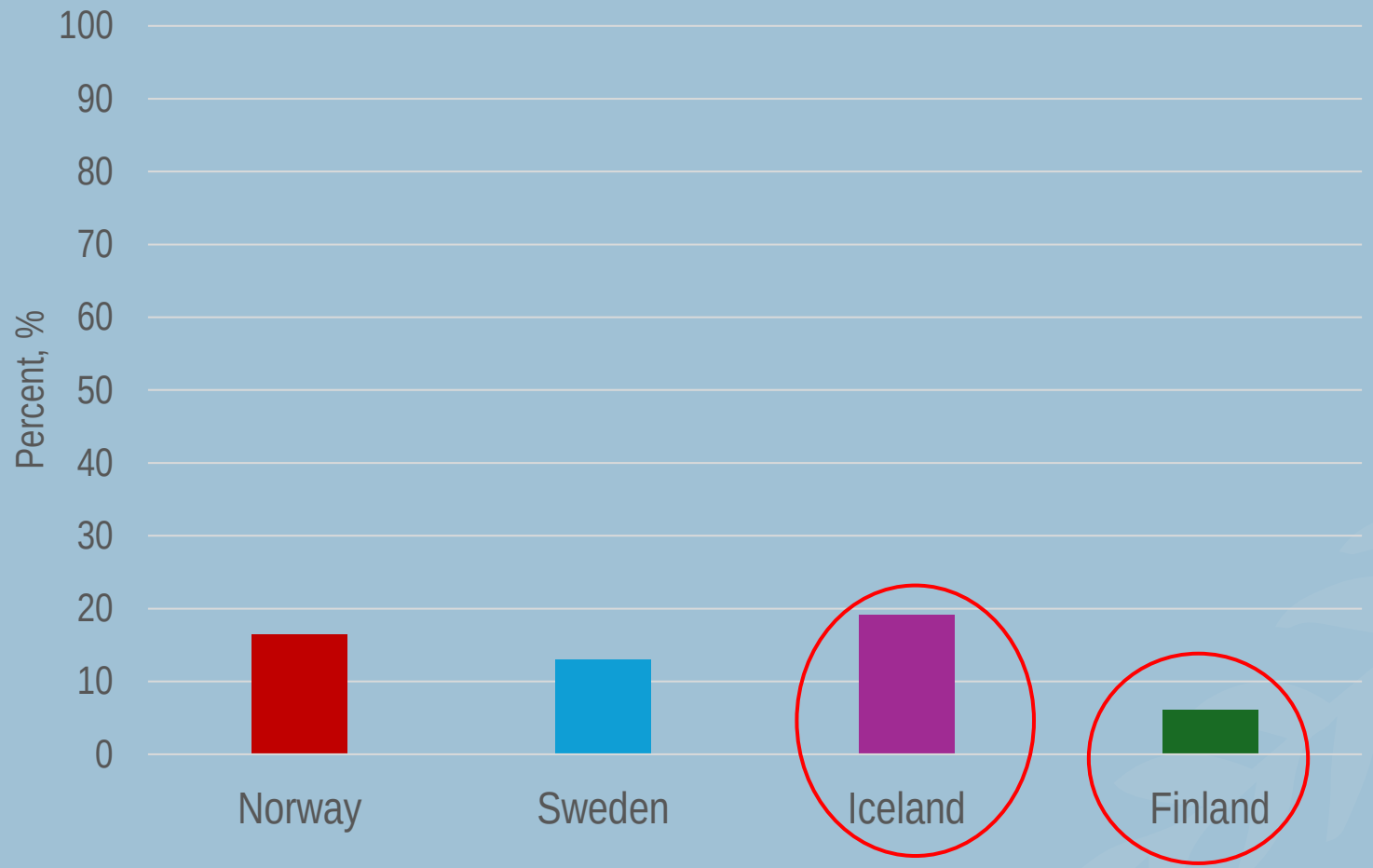
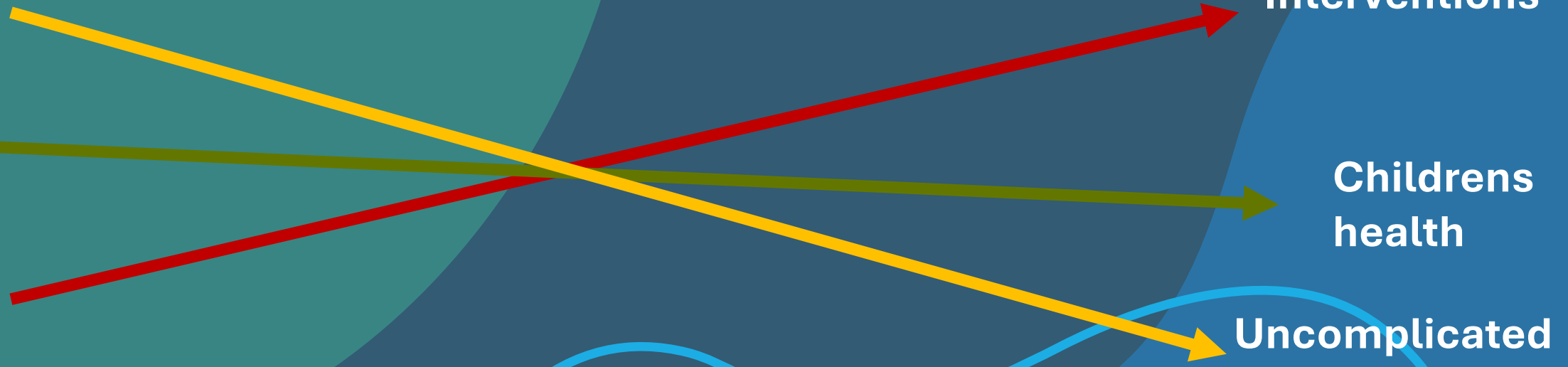
AND:

No epidural





To summarize



Labor experience

Buckley 2015;Olza 2020; Jukic 2013

Women´s experience:

- 9 - 44% of women experience giving birth as traumatic event (3% develop PTSD)
- Qualifying events are:
  - instrumental, emergency cesarean, severe perineal tears, PPH
  - Lack of support from caregivers
  - Lack of relationships with caregivers
  - Lack of involvement in decision-making

De Graff 2018, Miller 2021, NICE 2020

3: Medicalisation, a theory

MEDICALISATION

“Is the process by which human conditions and problems come to be defined as medical problems and treated as such”

Peter Conrad, 2007+2010

Characteristics of the medicalised society

- Medical expansion
- Social control
- Faith in science/ technology
- A matter of personal salvation

Medical expansion

Diagnosis:

- Deviance = illness
- Homosexuality
- Alcoholism
- ADHD

Normal processes:

- Menopause
- Pregnancy
- Childbirth

Professional expansion on behalf of others

- The “death of the midwife”

Illich, Zola, Foucault and Conrad

Consequence: social control

Relief- your odd behavior is an illness

- ADHD

Social problems transform

- Individual problem

Expectation to act

- Treatments
- Healthy lifestyle

- Social obligation/ stigma

Maternity care

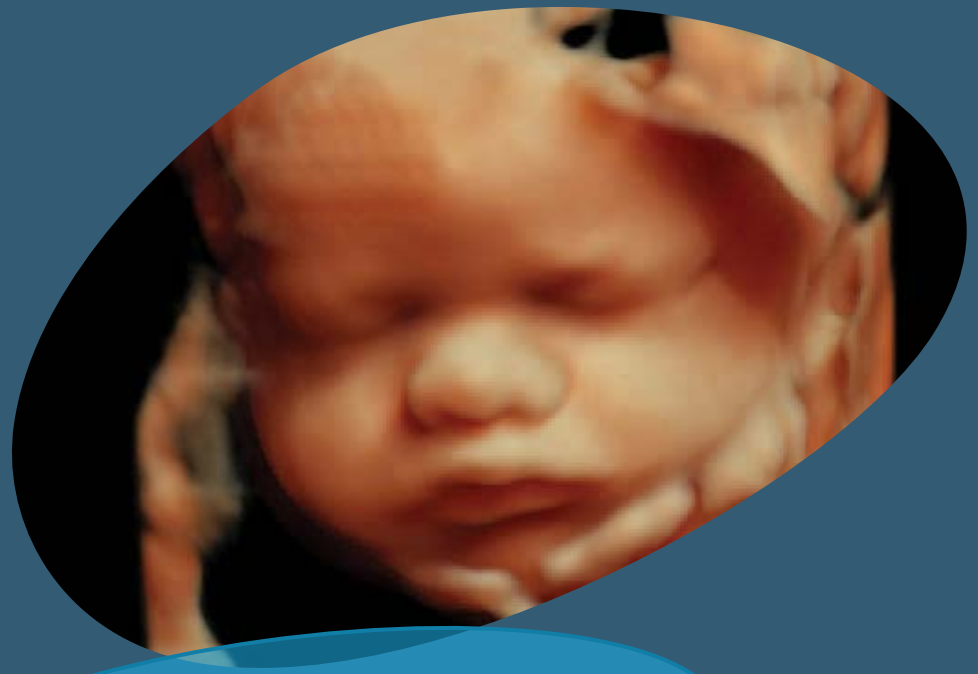
Smeenk & Have, 2005. Conrad, 2007

Faith in science and technology

-Technology as a facilitator
  -CTG-monitor
  -STAN

-Pharmaceutical industry create markets
  -Menopause
  -androgenetic alopecia (baldness)

-Enhancement
  -Anti anxiety pill before exam
  -Viagra for better sexual performance



Maternity care

The individual religion:

- Healthism (and its counterfactual)
- The body as the personal salvation
- Bodily enhancements

(Helped by the industry)

  - Breast enlargement
  - Lip fillers

Maternity care

Being pregnant in medicalized society

- Normal processes perceived as medical problems
- High focus on health by risk aversion
- Great faith in medicine
- A social obligation to adhere to
  - medical advises
  - suggested interventions

Frontpage, National Board of Health, 2021

Signs of medicalisation in the labor ward

Signs: Medical dominance

- Reductionist
  - Dystocia- target the uterus
- Mechanistic
  - Treat the uterine muscle

Newnham 2021

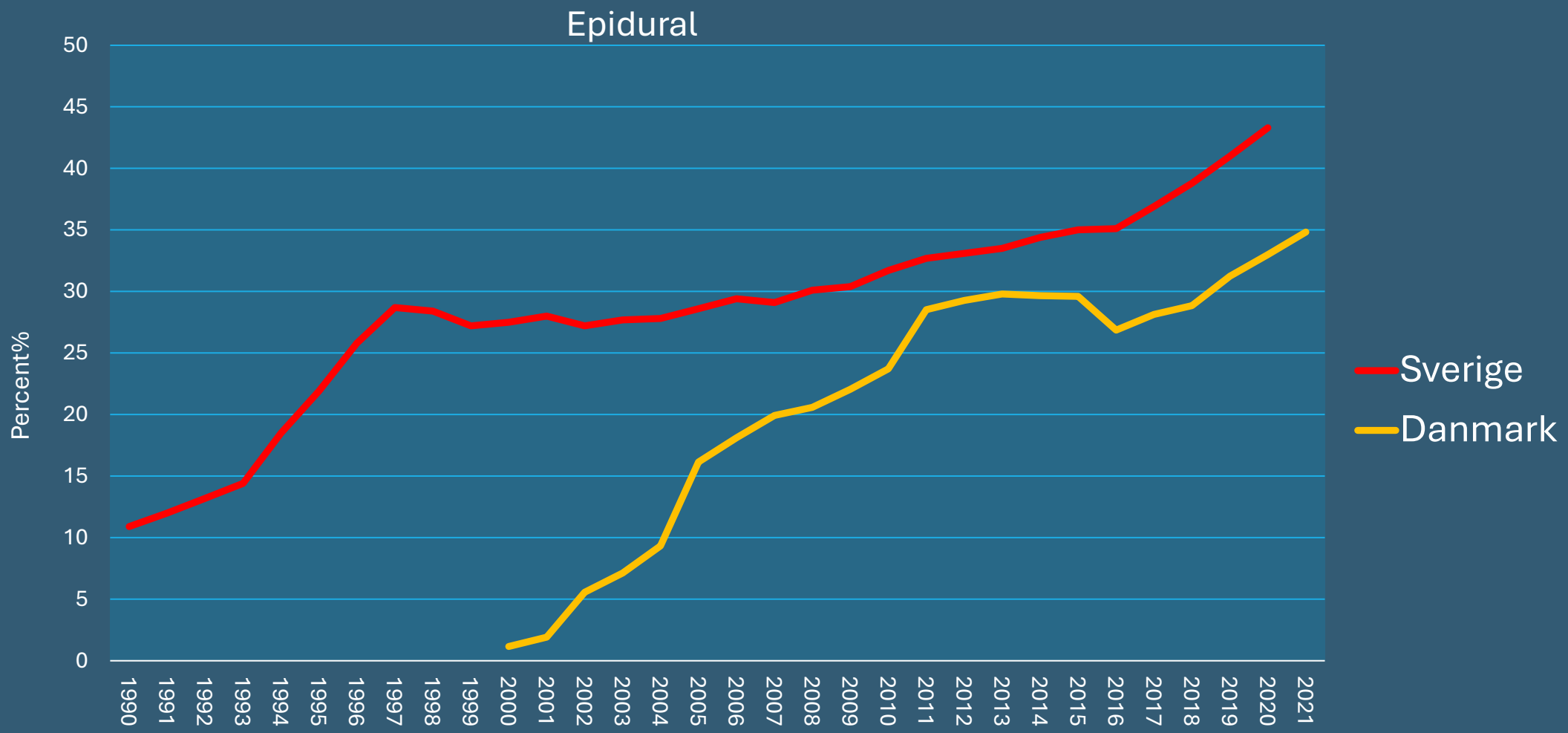
Signs: Techno-rationalism

- Equates scientific advances with progress and moral good

- Technological imperative

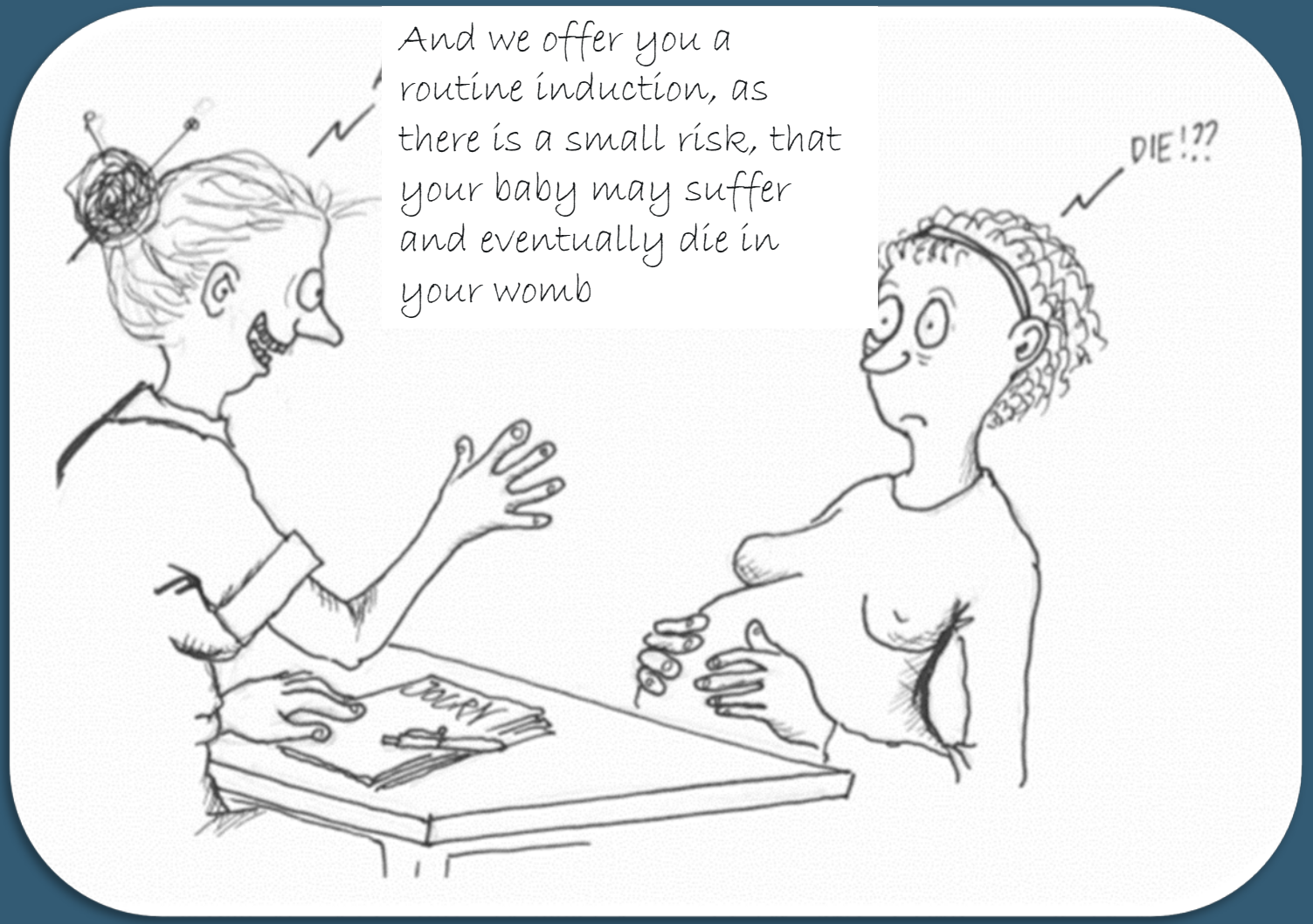
Newnham 2021

Signs: Pain avoidance



Socilastyrelsen.se & Esundhed.dk

Signs: Prevention of abstact risks



Newnham 2021

Signs:

Value the complex over the mundane

Newnham 2021

Signs and consequence:

Relationship is taken out of the equation

” Birth has become a life event that has been completely medicalized” (Conrad)

..

- Does the labor start timely
- Labour progress timely
  - Cervix dilatation (cm/hour)
  - Uterine contractions
- Pain can be removed
- Pushing techniques
- Perineum as a concept
- Active management, placenta

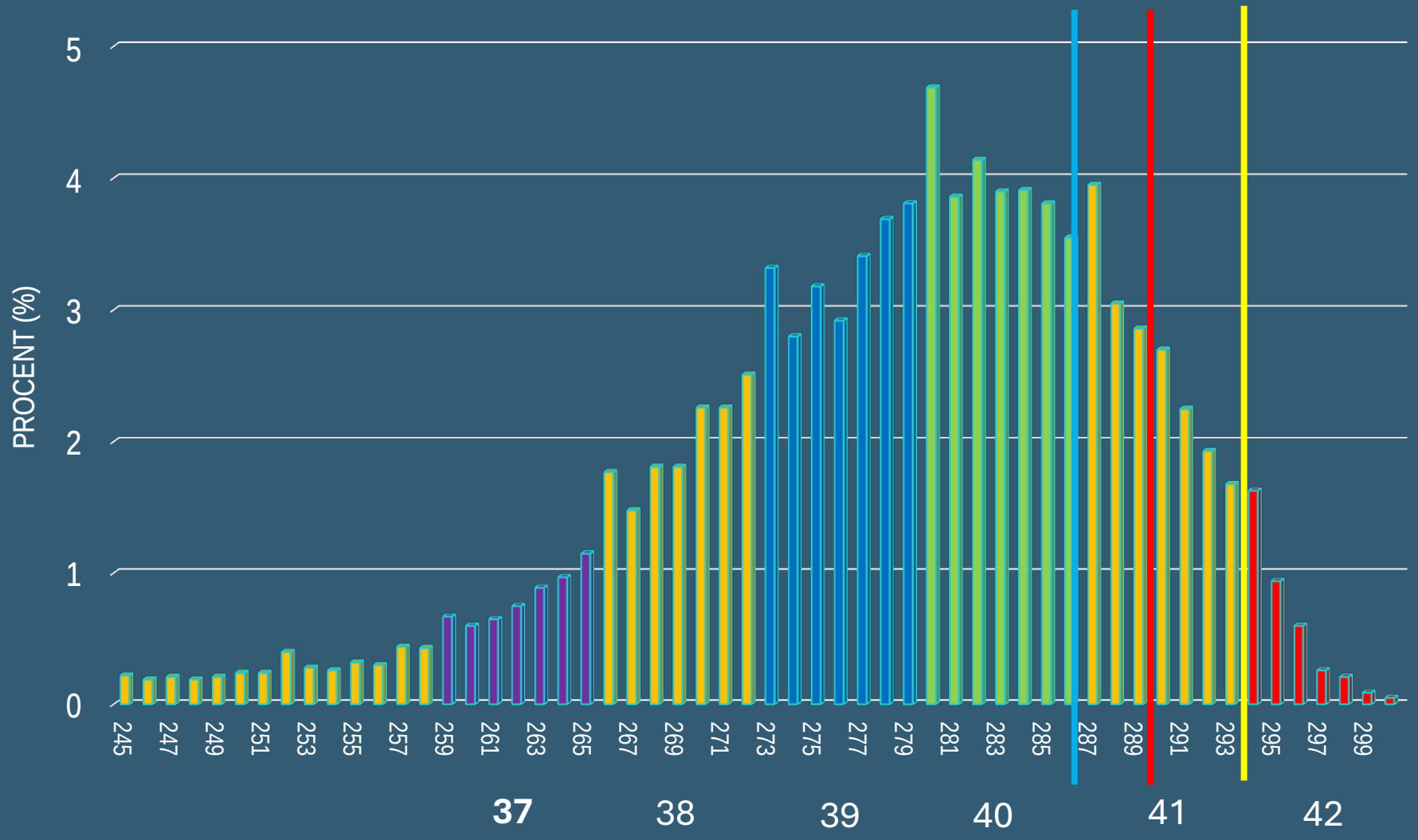
- And then……..

4: Promotors of medicalisation

Lowering the treshold
Treating on risk factors

Lowering the threshold for normal gestational age

Lowering the treshold for ”normal” gestation

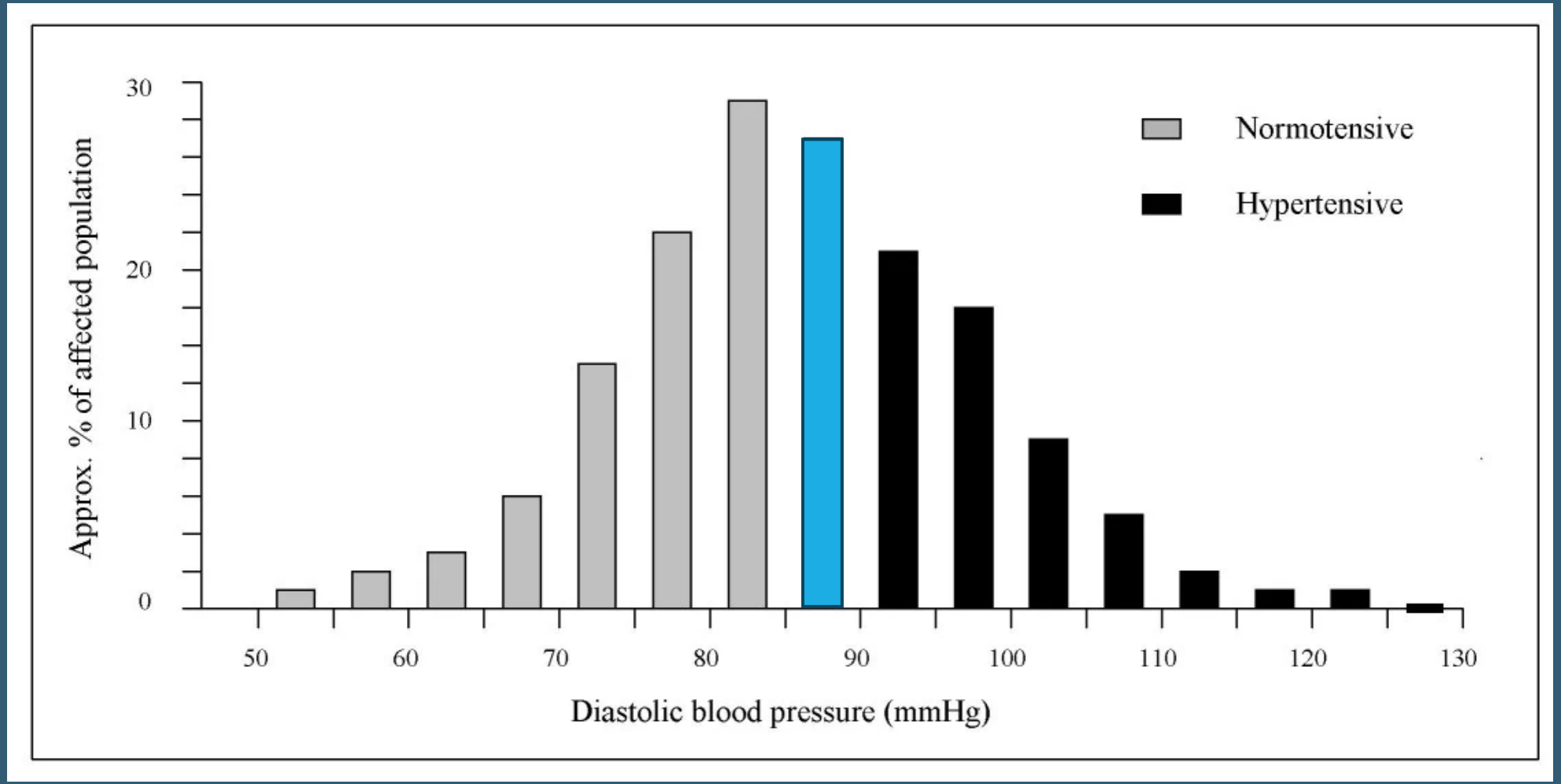


42+0: 4-6% still pregnant

41+3: 15% still pregnant

41+0: 24% still pregnant

Lowering the threshold, diastolic blood pressure



Implications of lowering the threshold

- Substantial increase in number of treated individuals
- Treating the healthy
- The numbers needed to treat for one person to have a positive effect increase substantially too (high NNT)

Brodersen & Jönsson, 2022

Example- Denmark

Lowering the threshold from 41+3 to 41+0

At the time for routine intervention:

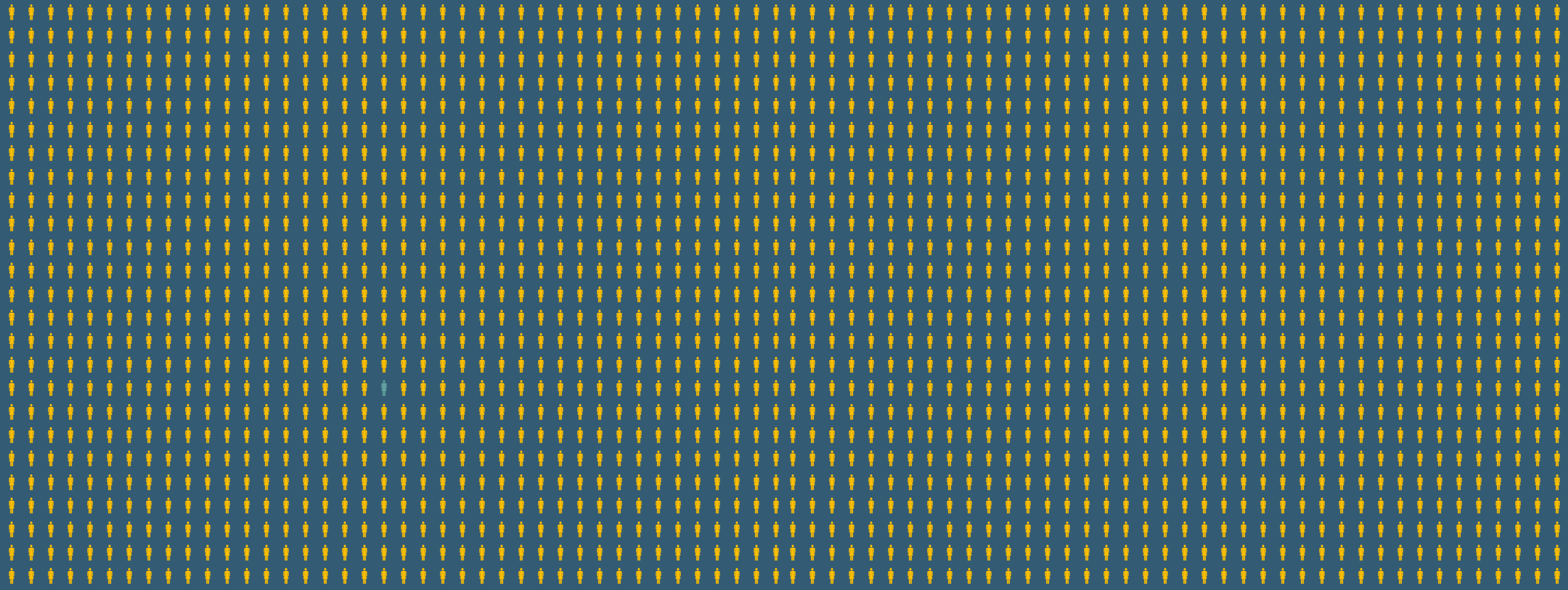
- Mother and child are healthy
- Induciton on a statistic risk that something will become pathological in the future

How many deaths are preventable ?

- 0,62 per 1000 suffer intrauterine death or death within the first week after birth in the low risk group (those prone for routine…)
- If we could save 100%, then NNT= 1000/0.62= 1612
- This is however not realistic. Danish Health Authorities suppose 80% can be saved if all accept being inducced: (80% out of 0,62= 0,50). NNT=2016
- More realistic: if 50% reddes. NNT= 3225

Sundhedsstyrelsen, 2022

NNT 2016



If 80% are saved

Saved Die anyway Induced without benefits + possible harms

NNT 1000/ (0,62*0,80)

Popularity paradox

- If you get diagnosed with something you never will be bothered of anyway
- The treatments saved you (off course)
- You will be gratefull

Brodersen & Jönsson, 2022

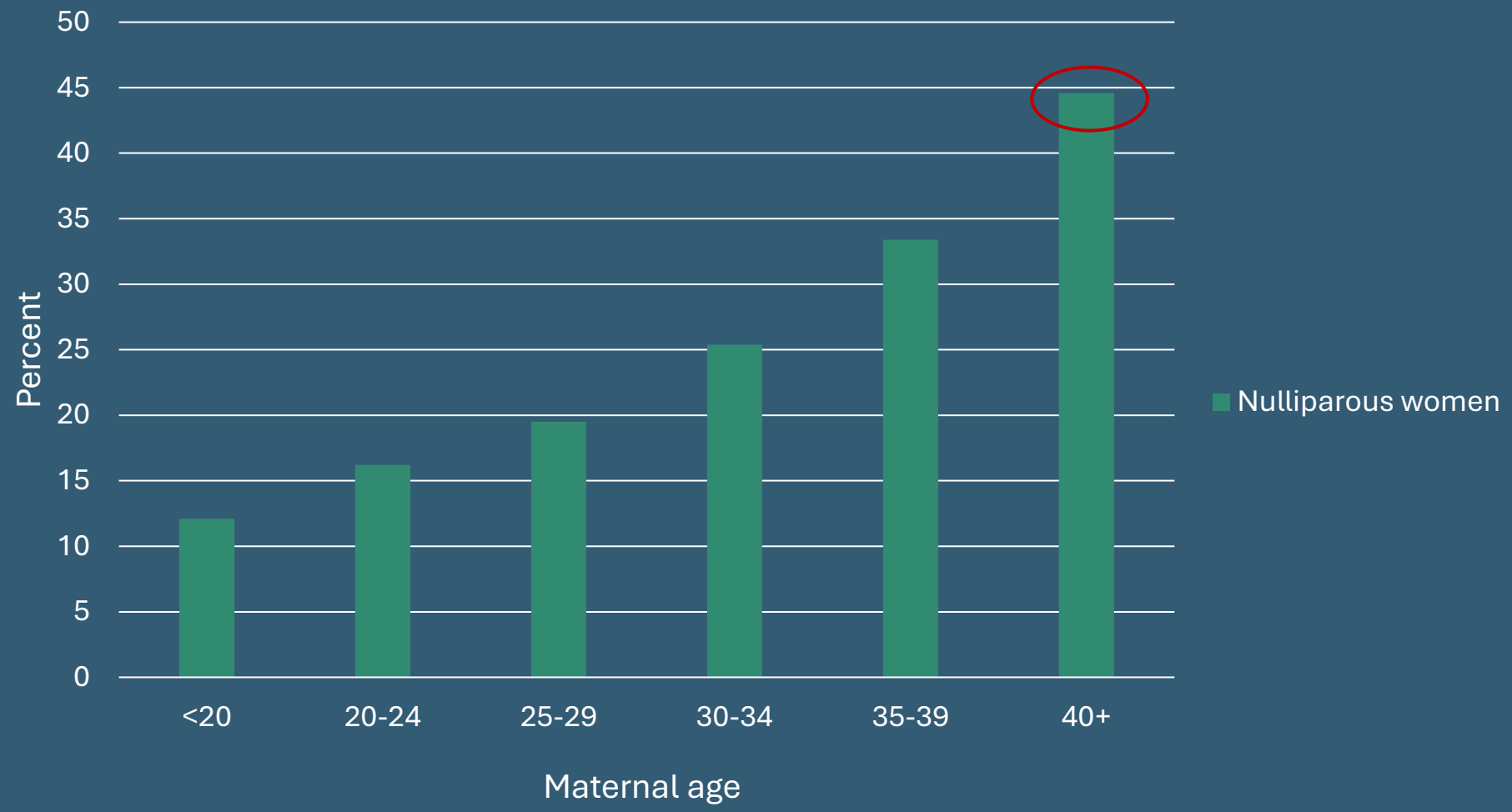

Intervening on risk factors

Advanced maternal age & cesarean section

- Population-based cohort
- All Danish births 1998-2015
- N = 1,122 964

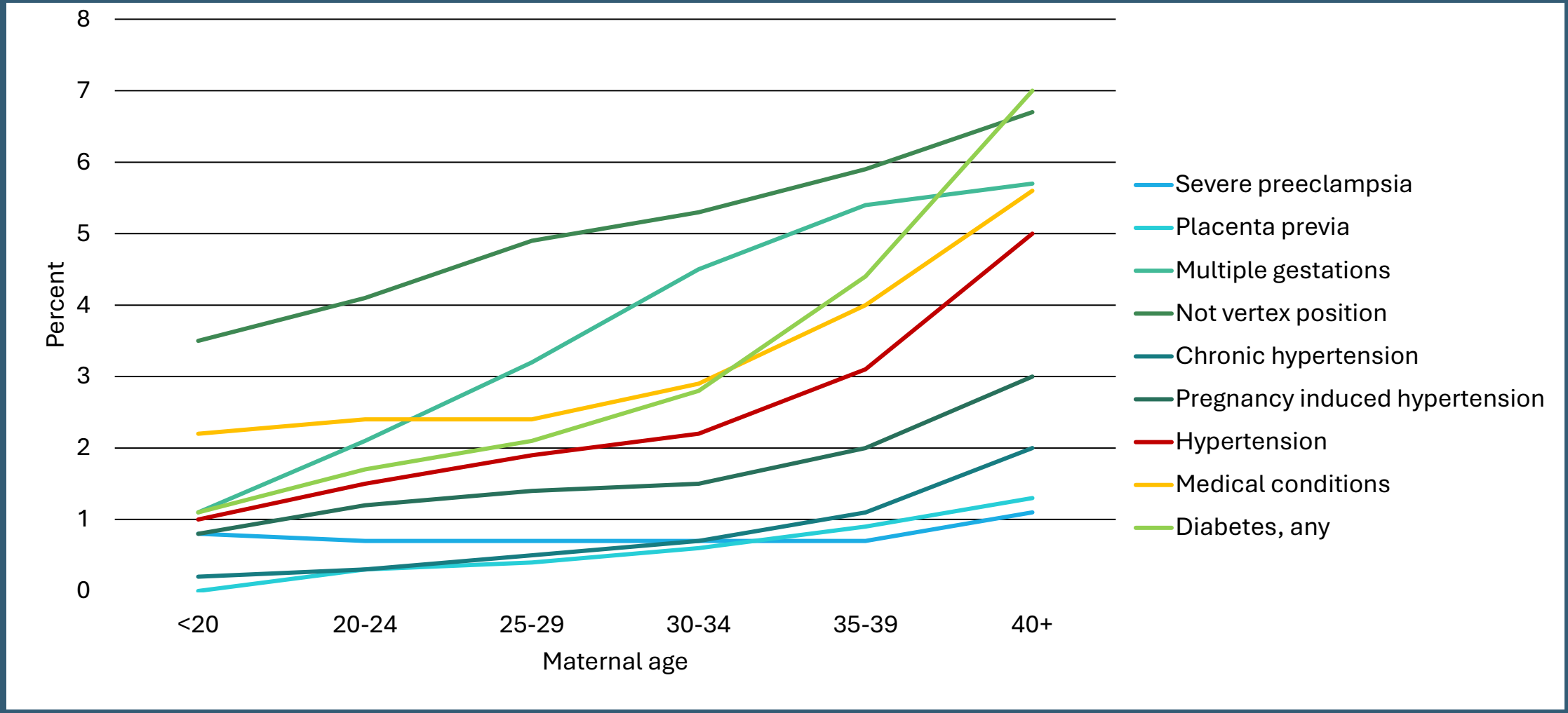
Rydahl, Declercq, Juhl & Maimburg, 2019

Association between age and cesarean section (1998-2015)



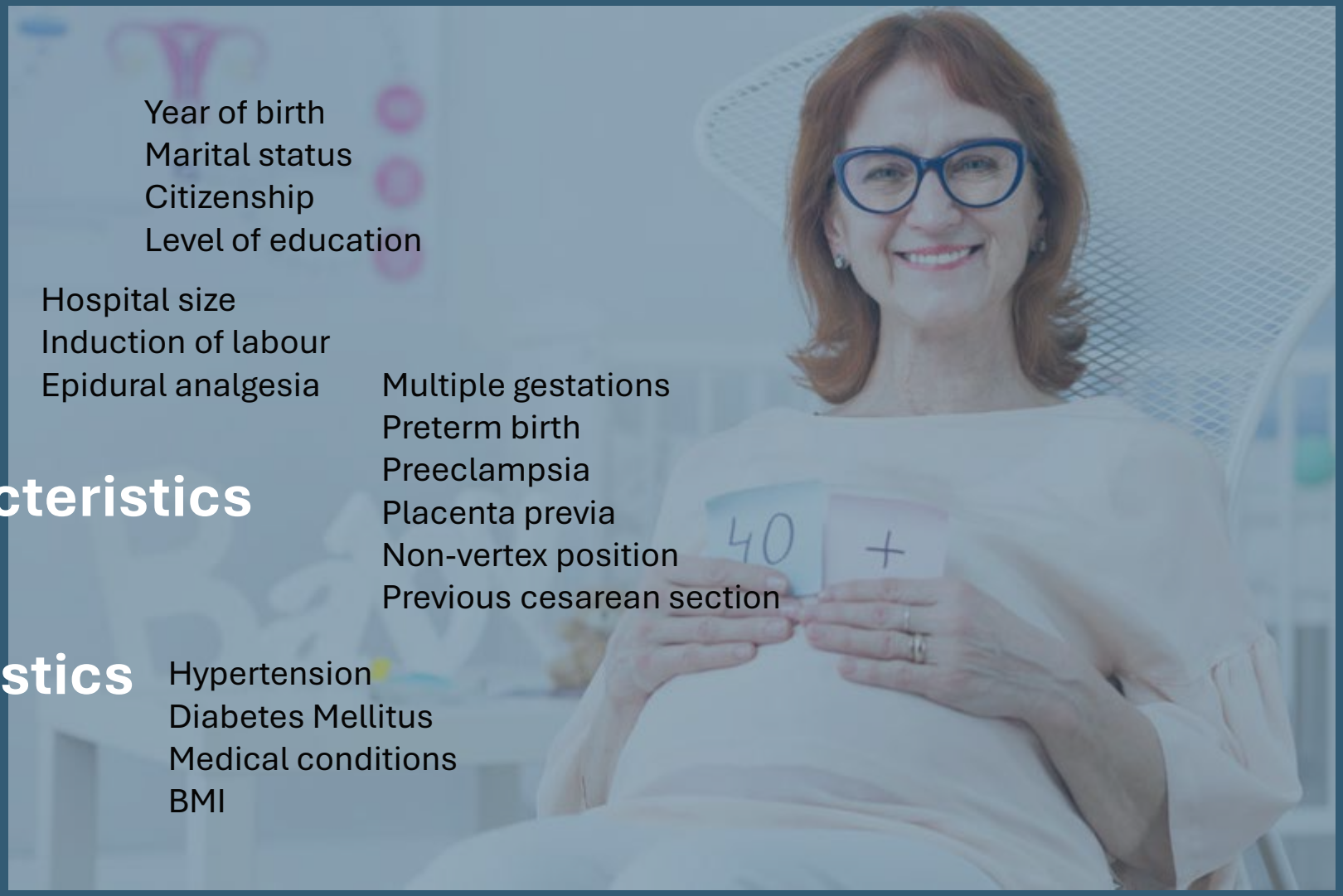
IS THIS BECAUSE OF INCREASING MATERNAL MORBIDITY?

Age and childbirth related morbidity

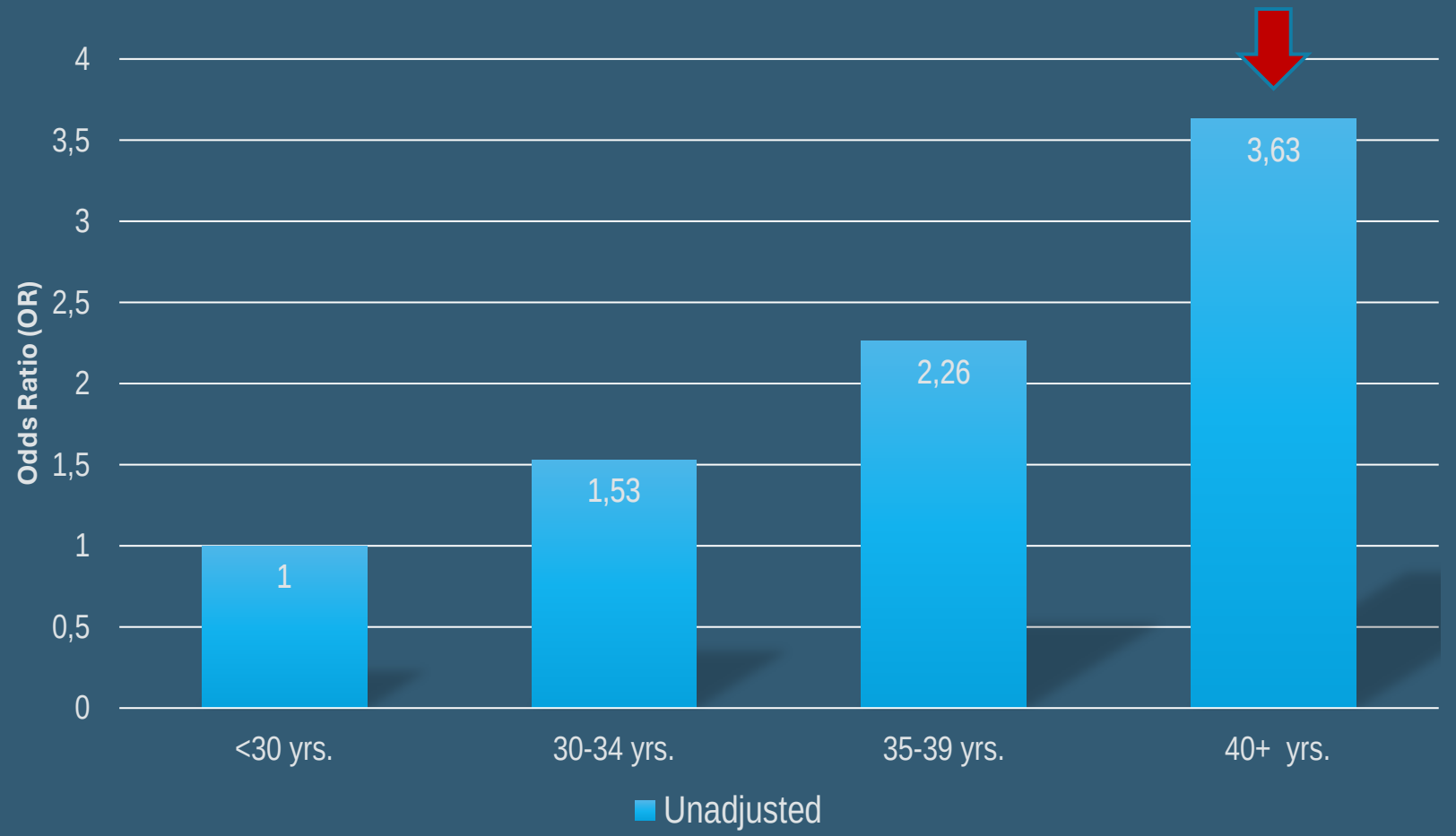


What if: adjusting for diffences? Reference age <30

- **Demographic**
  - Year of birth
  - Marital status
  - Citizenship
  - Level of education
- **Obstetric**
  - Hospital size
  - Induction of labour
  - Epidural analgesia
- **Pregnancy characteristics**
  - Multiple gestations
  - Preterm birth
  - Preeclampsia
  - Placenta previa
  - Non-vertex position
  - Previous cesarean section
- **Health characteristics**
  - Hypertension
  - Diabetes Mellitus
  - Medical conditions
  - BMI



Before adjustment, nulliparous women



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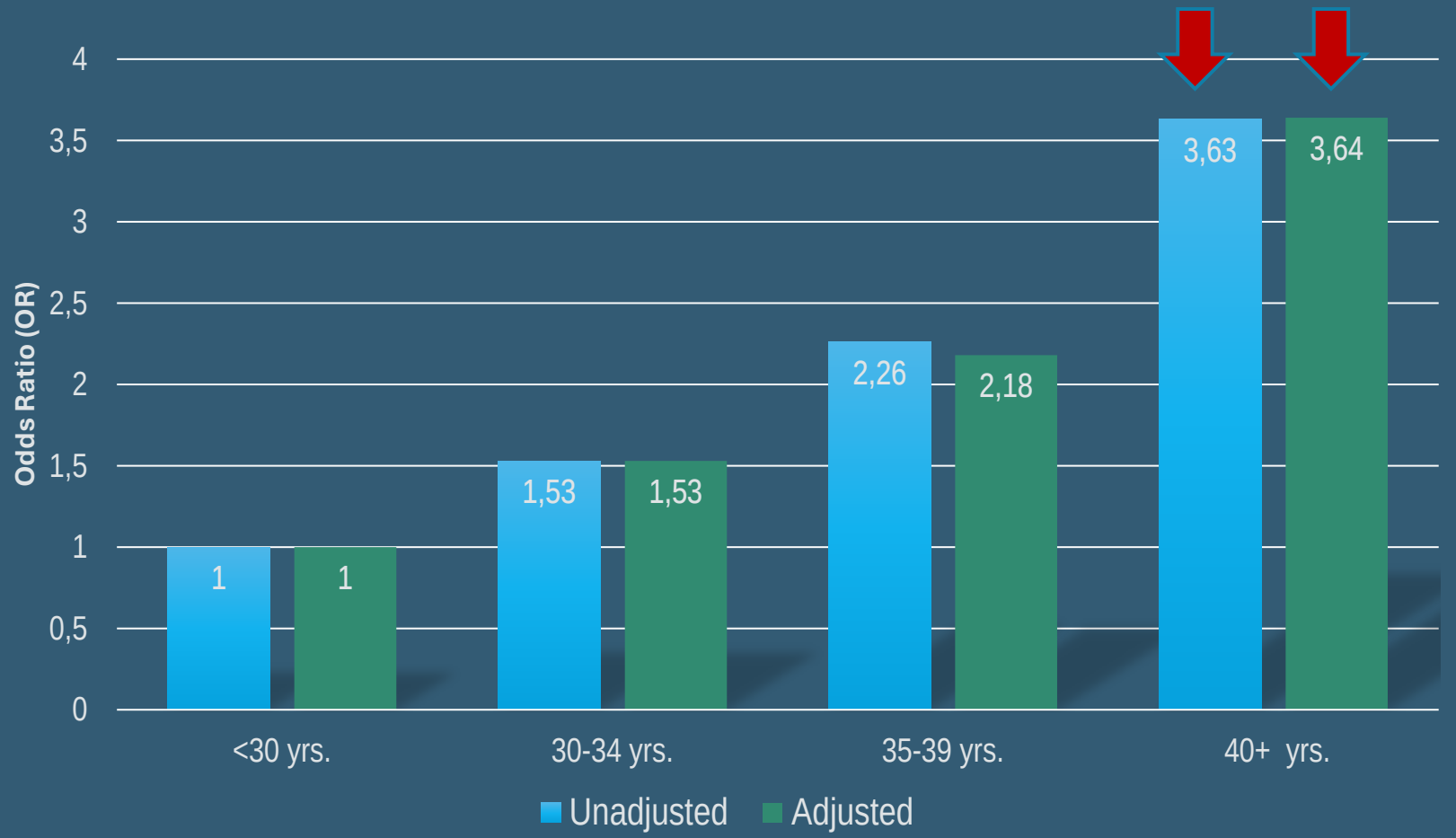
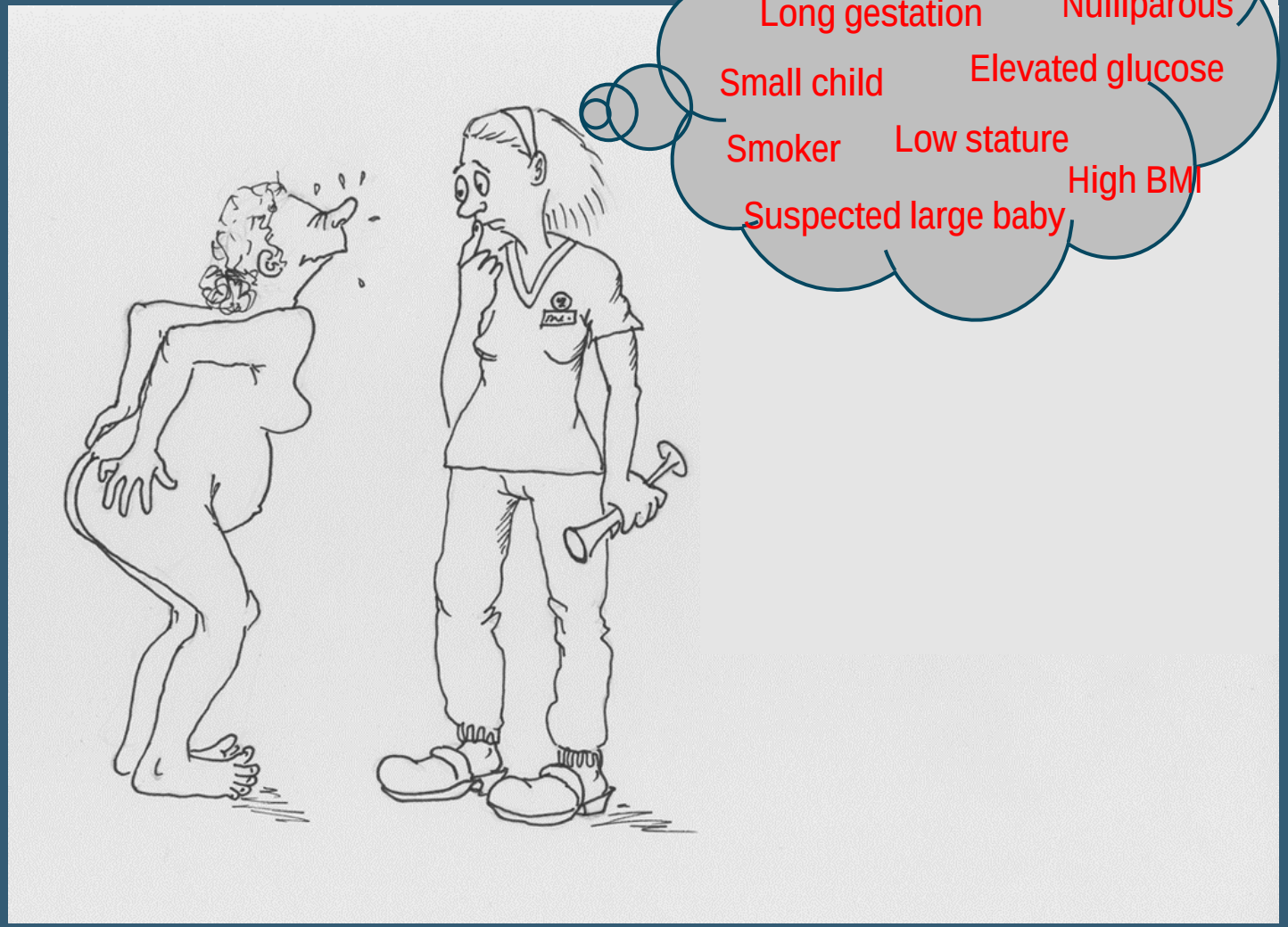


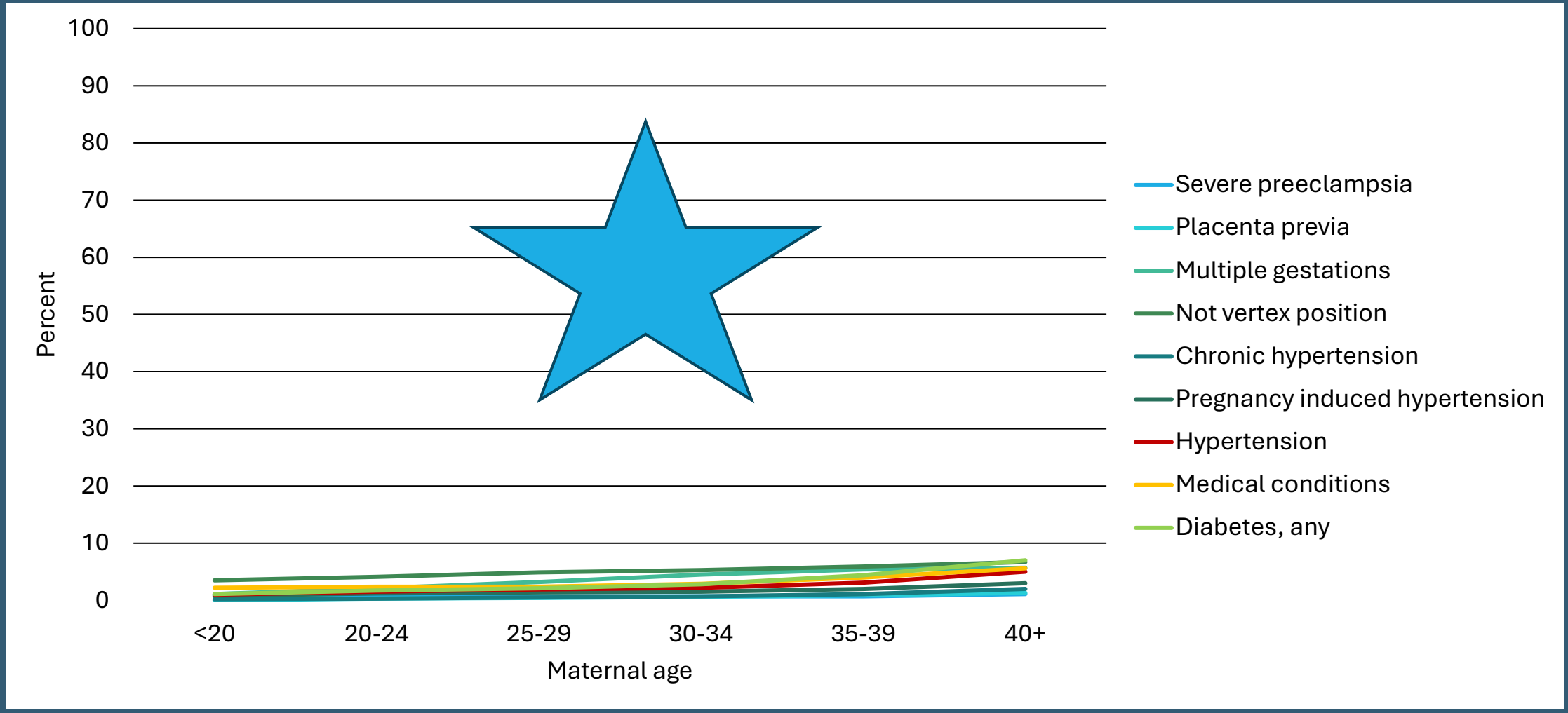
Risk factor or actual pathology?

"In many instances, the distinction between risk factors and actual pathology has been lost, and women with "high-risk factors" are treated as though they have actual complications"



Rooks, 1999

Age and childbirth related morbidity

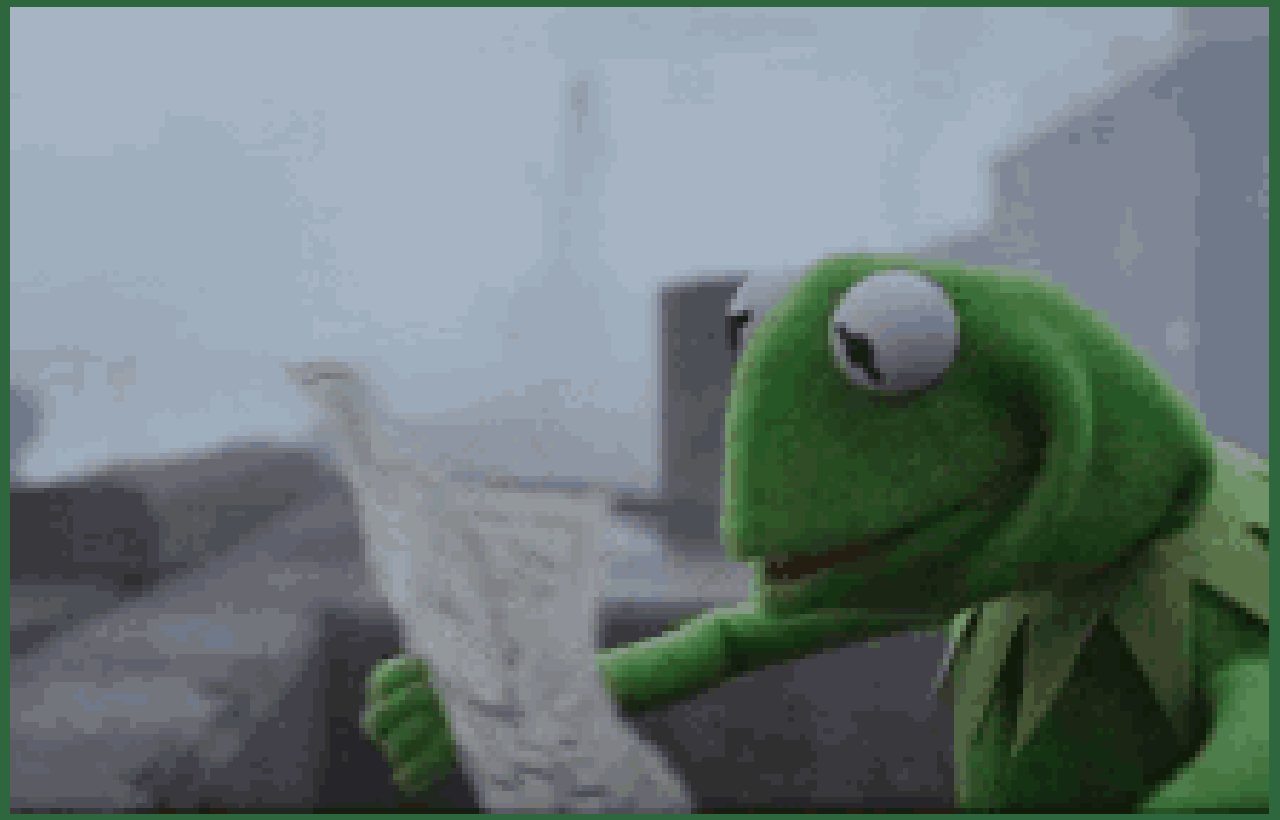


Promotors of medicalisation

Lowering the threshold
-create more interventions

Treating on risk factors
-create more interventions

5: Are we heading in the right direction?



1. Signs of an increase in medicalisation and cascade of interventions
2. Not evident, that health improves
3. Women´s satisfaction and mental health needs focus
4. Medicalisation will continue unless you choose to stop it

Choosing Wisely®

1. Is this intervention truly necessary for this mother and child?
2. Could this intervention be unnecessary?
3. What are the potential harms to the woman, the baby, or the birth process?
4. Is there a clear net benefit?
5. Could watchful waiting or monitoring be a safe alternative?
6. Does the patient actually want this intervention after informed discussion?

Thank you for listening

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