In 1900, 95 percent of all U.S. women gave birth at home. By 1955, 95 percent of all births occurred in hospitals. This staggering transition was powerfully driven by the systemic reframing, or “pathologization,” of pregnancy and birth by a man named Joseph DeLee. DeLee is known as “the father of modern obstetrics.” His influence on medicine and maternity was so significant he was featured on the cover of Time magazine in 1936. DeLee’s radical views on obstetric interventions were clearly influenced by his experiences as a very young doctor working at a Chicago baby farm. The illegitimate children unlucky enough to be born there suffered a staggeringly high rate of mortality, often from cerebral hemorrhage because of difficult deliveries.

In 1920, DeLee wrote an article for the first edition of the new American Journal of Obstetrics and Gynecology titled “The Prophylactic Forceps Operation.” In it he wrote, “So frequent are these bad effects that I have often wondered whether Nature did not deliberately intend women should be used up in the process of reproduction, in a manner analogous to that of salmon, which dies after spawning.”
DeLee went on to present his unusual perspective on the process of birth: namely, as a pathology. He stated that “Labor is pathogenic because experience has proved ideal results rare.” DeLee aggressively pursued the adoption of massive universal changes in obstetric protocol purely based on his own limited professional experience. No studies were cited, no scientific evidence referenced. More important, DeLee had virtually no experience with how birth looks when it takes place naturally, and is managed with a different (non-medical) set of protocols.

At the time, only 10 percent of women in the Chicago area gave birth in hospitals. It was generally regarded as a last resort for unwed mothers and the poor, hardly a representative sample. Not only were the cases to which DeLee was exposed generally in uncommonly poor health and state of mind, but the mere fact that they were in a hospital environment certainly impacted the birth outcomes.

Professionally, obstetrics at the time occupied a rather innocuous, often belittled place in the medical hierarchy. They were the product of a legacy of physicians whose craft had been perpetually undervalued by both the public and even their own peers.

They confronted, too, the fundamental incongruity of their relationship with normal childbirth. Physicians had no training for “normal.” Theirs was a profession of lifesaving, of heroic intervention upon the ailing and sickly, with the promise of recovery.

But pregnant women aren’t “ailing.” They are not sick at all. What is a surgeon doing managing a person who is not sick? DeLee’s answer was simply to redefine “sick.” Specifically, he argued for childbirth, one of the most self-evidently fundamental human biological processes imaginable, to be called a disease.

It is DeLee’s argument for the “pathologic dignity” of childbirth that he is perhaps best known:
Labor has been called, and still is believed by many, to be a normal function. Yet it is a decidedly pathologic process…if a woman falls on a pitchfork, and drives the handle through her perineum, we call that pathologic-abnormal, but if a large baby is driven through the pelvic floor, we say that is natural, and therefore normal. If a baby were to have its head caught in a door very lightly, but enough to cause cerebral hemorrhage, we would say that it is decidedly pathologic, but when a baby’s head is crushed against a tight pelvic floor, and a hemorrhage in the brain kills it, we call this normal.

This audacious and professionally opportunistic reframing also planted the seeds of the eventual story that our current society holds around medicine and birth, which is that birth was dangerous until doctors saved it. This story is a natural byproduct of the pathologization of birth. If women who are pregnant are “sick,” then naturally they should, like any sick person, rely on a physician’s help. Physicians, from 1920 to the present, have consequently argued for greater and greater medical intervention in birth, greater and greater medical technology, and greater and greater authority and exclusive rights to pre- and postnatal care. Thus, the continuation of the trend from home to hospital birth was driven by powerful social and political factors, some self-serving and some earnestly philanthropic in intent. However, the one factor that did not support the movement of birth into the hospital was science. Hospital births were more dangerous in 1920, and they did not get safer any time soon.

In their book Lying-In: A History of Childbirth in America, Richard and Dorothy Wertz note:

The White House conference on child health and protection issued its report in 1933, entitled “Fetal, Newborn, and Maternal Mortality and Morbidity.” It featured the fact that maternal mortality had not declined between 1915 and 1930 despite the increase in hospital delivery, the introduction of prenatal care, and more use of aseptic techniques. The number of infant deaths from birth injuries had actually increased by 40 percent to 50 percent from 1915 to 1929.

But science did not stop Joseph DeLee or the emerging cartel of the obstetric field. It was in this now-famous treatise that DeLee proposes that all births be managed with sedatives, surgery, and instrumentation.

There were three parts to DeLee’s formula for medical birth management:

1.
Universal sedation of women.

2.

Universal episiotomy.

3.

Universal forceps extraction of fetus.

DeLee’s fatal error is that he manufactured his picture of birth from the minority data, rather than the majority. A sounder scientific approach to the question of how to manage birth would be to create a representative picture of what birth looked like, how it proceeded, and the intrinsic problems or dangers that might exist, before seeking to solve those problems or propose new protocols.

Dismissing the work and results of a massive population of female caregivers was hardly a radical act in 1920, when women had only recently earned the right to vote.

DeLee dismissed the most obvious answer before him: to utilize the system which was producing the best results and improve, replicate, and standardize it. This is indeed what the rest of the civilized world did. But even at the dawn of women’s suffrage, this gesture of acknowledgement to a cultural and sexual minority and professional competitor was beyond the capacity of any typical physician of his era.

It seems hard to believe that DeLee would have had no access to the fact that improvement, standardization, and licensing of midwives had already been accomplished with excellent results in Europe. The Midwife Protection Act in Britain helped to successfully establish the very conditions DeLee and his contemporaries refused to consider: safe home and hospital births managed by trained midwives delivering superior results at reduced cost and with reduced complications.
However, his proposals were a radical suggestion even for the highly medicalized hospital birth environment. They were soundly rejected by DeLee’s colleague, J. Whitridge Williams, author of the authoritative manual on the subject, Williams' Obstetrics. He said, “If I have understood Dr. DeLee correctly, it seems to me that he interferes 19 times too often out of 20.” In his last edition of Obstetrics, Williams stated, regarding the DeLee protocols, “I am confident that the results would be disastrous were [his] suggestions generally adopted.” Ultimately, astonishingly, DeLee’s suggestions would indeed be adopted. The 1936 edition of Obstetrics had the line dropped, and by 1950 the recommendations were accepted without reservation.

The DeLee protocols institutionalized surgical intervention in all births, even perfectly healthy and normal ones. (This category, essentially, was made extinct by DeLee: All births were pathological. Even today, we do not use the term “safe” or “normal” but only speak of birth in terms of relative risk: “high-risk” and “low-risk.”) And while these interventions may have been clinically defendable in rare cases, used universally they institutionalized trauma and complications for women and their babies.

**Consequences, Inertia, and Scientism**

Medicalization of pregnant women in the 20th century engendered the establishment of a culture of institutionalized intervention, which systematically impeded the normal, healthy expression of the biological blueprint for birth.

DeLee’s protocols did not, as he perhaps envisioned, save women’s lives, but in fact perpetuated high maternal mortality rates. He did, however, accomplish one of his goals: that of elevating the status of the obstetrician and the establishment of a virtual monopoly on childbirth for physicians.

Two years before he died, DeLee seemed to sense the Frankenstein’s monster he had unleashed and warned the audience at a Mother’s Day address to avoid doctors who attempted to rush the birth process. “Mother Nature’s methods of bringing babies are still the best,” he stressed belatedly. And while maternal mortality did indeed eventually fall in the U.S., though not until after 1950, many historians aptly note that the dramatic changes in hygiene, nutrition, and sanitation that occurred in the mid to late 20th century were largely responsible for these changes.
In Women and Health in America: Historical Readings, Harvard history professor Laurel Thatcher Ulrich writes:

*The pleasant story of scientific progress has been replaced by a darker tale of medical competitiveness and misplaced confidence in an imperfect science. Medical science did not, on the whole, increase women's chances of surviving childbirth until well into the twentieth century, the new histories argue, and may actually have increased the dangers.*

The question you may be asking again here is how, if the results do not support them, do measures like these get perpetuated? Why aren't they discarded and replaced with more effective measures? Isn't that the way that scientific progress works?

This is one of the most difficult questions to answer. The most cynical will point to greed, corruption, and the conflicts of interest inherent in a system that profits from the protraction and increasing expense of treatments versus cheaper, simpler, longer-term solutions. Apologists will point to tort reform, malpractice insurance regulations, and other sociopolitical constraints to more efficient progress.

It's critical to understand that, over time, the continued perpetuation of any protocol or procedure—even a dangerous or unproven one—generates its own intrinsic momentum. This kind of technical inertia becomes increasingly more difficult to disrupt, developing a kind of immunological resistance to scientific scrutiny.

Much of this failure stemmed from an almost religious faith in the power of science and medicine to solve all of humanity's problems. In the public discourse on medicine and healthcare, this has come to be known as “scientism.”

De-pathologization requires that we accept that technology and science may not be the answer to all our problems, and in fact may be the cause of some. Returning to a respect and recognition of the innate power of nature and the body—of the compelling and uncompromising force of evolution, of which we are a manifestation—is a prerequisite to tapping the potential of our bodies and of nature, and to discriminating between the technology that serves us and the technology that we serve.