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# The History of Cesarean Birth From 1900 to 2016

Melissa McIntire Sherrod

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**Correspondence**
Melissa McIntire Sherrod, PhD, RN, NE-BC, Texas Christian University, Harris College of Nursing and Health Sciences, TCU PO Box 298620, Fort Worth, TX 76129.
m.sherrod@tcu.edu

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**ABSTRACT**

Nurses struggle with conflicting priorities regarding the care of women during childbirth and the expectations of physicians and employers. Nurses are expected to perform technologically sophisticated interventions that were once performed by physicians, which can affect the perception of comfort that nurses traditionally offered. In this historical overview, I suggest that scientific childbirth advances have contributed to soaring cesarean rates and identify the role of the nurse as a contributor to this trend.

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Melissa McIntire Sherrod, PhD, RN, NE-BC, is an associate professor in the Harris College of Nursing and Heath Sciences, Texas Christian University, Fort Worth, TX.

> Many women are ready to undergo the slightly increased risk of cesarean section in order to avoid the perils and pain of even ordinary labor. I am confident that if women are given only a little encouragement in this direction, demand for cesarean section will be overwhelming. (Holmes, 1921, p. 299)

The birth experience for most American women changed during the early 1900s from an event that occurred at home attended by a midwife, close family member, or friends to a brief inpatient hospital stay, medically managed in a sterile environment and attended by strangers (Leavitt, 1987). Within such a medical model, an approach to care depicted by the diagnosis and treatment practiced by physicians, the focuses during the birth process shifted to risk instead of health and to technological intervention instead of natural processes. More neonates were born by cesarean, and the role of the nurse became entrenched in the management of interventions. Consequently, a woman's expectations and emotional needs are often secondary, and the birth experience is overly standardized, task oriented, needlessly aggressive, and physician and hospital controlled (Anderson, 1977; Davies & Hodnett, 2002; Declercq, Sakala, Corry, Applebaum, & Herrlich, 2014).

## Nurse-Managed Labor

Nurses are still the primary caregivers for women in labor. In fact, without exception, all women who give birth in hospitals in the United States are cared for by registered nurses (Edmonds, Hacker, Golen, & Shah, 2016). Nurses primarily work in nurse-managed labor models that are characterized by relatively autonomous nurses who are in intermittent contact with physicians, who are often offsite. Of the approximately 2,606 U.S. hospitals that provide intrapartum nursing care, 90% use this model of care (Edmonds & Jones, 2013).

The expectations for labor and delivery nurses in the United States are remarkably similar across the country. Nurses are responsible for triage and admission, maternal–fetal assessment, management of oxytocin, management of pain, and care throughout labor (Edmonds & Jones, 2013). Their responsibilities are also associated with practices known to increase the likelihood of cesarean birth, such as early hospital admission, epidural analgesia, and induction of labor. Radin, Harmon, and Hanson (1993) found that the rate of cesarean births attended by individual nurses ranged from 4.9% to 19%; this difference was not explained by variables such as maternal demographics or physician practice patterns.

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**Armed with knowledge of science and skills, the first obstetric nurses transformed the birth environment and the mother into an aseptic field to reduce infection.**

Instead, certain labor and delivery nurses consistently had low cesarean and intervention rates and positive neonatal outcomes, irrespective of physician preference or risk level (Radin et al., 1993). This finding suggests an independent association between nursing practice and rates of cesarean; however, this association is poorly understood (Edmonds et al., 2016; Sleutel, Shultz, & Wyble, 2007).

Cesarean birth is now the most common surgical procedure experienced by women in the United States, and the current rate of 33% exceeds the upper target of 15% suggested by the World Health Organization (2015) and the Healthy People 2020 target of 23.9% among low-risk women with no previous cesareans (U.S. Department of Health and Human Services, 2016). In an effort to understand the escalating cesarean rate, researchers have focused on physician practices, hospital protocols and staffing patterns, and the health status of the pregnant women. Few investigators have focused on nursing practice and how nursing interventions and the experience of a nurse might affect cesarean rates (Edmonds & Jones, 2013; Radin et al., 1993).

## Historical Indications for Cesarean Birth

Cesarean has been practiced for centuries and was initially a postmortem procedure, the objective of which was the possible rescue of the fetus (Boley, 1991). Referred to in myths and folklore in ancient societies, cesarean was performed when the mother was dead or dying. The procedure may have evolved because of a requirement to save the fetus to add to the population or possibly to adhere to a societal dictum that the mother should be buried separately from her deceased newborn (Lurie, 2005; U.S. National Library of Medicine, 2013). The first documented evidence of a cesarean birth is in a legal text that dates from 1795 to 1750 B.C. Sage Susruta, who was considered one of the founders of Hindu medicine, noted in 600 B.C. that the operation should be done quickly after the mother dies or the fetus will die as well. Because the operation was done on a dying or deceased mother, it was considered a cultural or religious event rather than a medical necessity (Lurie, 2005).

A factor that limited the widespread practice of cesarean was lack of knowledge of female anatomy. In 1543, *De Corporis Humani* was published and included the first accurate description of female anatomy and abdominal structures (Vesalius, 1543). This work provided the foundation for operative obstetrics, which emerged in the 18th and early 19th centuries. However, from the Renaissance until the 18th century, the mortality rate from cesareans performed on living women was 100%. This fact caused enormous opposition to the operation and prompted a noted 17th century French obstetrician, Francois Mauriceau, to condemn the practice to prevent martyring and killing the mother to save the child (Todman, 2007).

In 1870, surgical techniques remained largely unchanged from ancient times. The uterus was not sutured but permitted to contract; it was thought the uterus would reduce to 1 to 2 inches if it was healthy (Churchill, 1872). The mortality rate was high (75%), mainly as a result of hemorrhage, sepsis, exhaustion, peritonitis, and eclampsia (Lurie, 2005). In 1882, Dr. Charles Sanger insisted that suturing the uterus was essential and used wire to close the wound. Prior procedures after cesarean involved partial hysterectomies, which increased the risk of hemorrhage and infection (Munro Kerr, 1954). According to the Centers for Disease Control and Prevention (1999), by the early 1900s, the mortality rate due to pregnancy-related complications dropped to between 6% and 9% per 1,000 births as a result of the combination of suturing, asepsis, anesthesia, and noninterference in early labor (Munro Kerr, 1954).

Before the 1930s, physicians were invited guests into the homes of women in labor. Increasingly, physicians were called to provide anesthesia and perform technical procedures such as the use of forceps and internal version. In emergency situations, they were called to extricate nonviable fetuses or, in dire circumstances, to perform craniotomies to save the life of the birthing woman (Leavitt, 1987). According to noted obstetrician Joseph DeLee (1920), physicians at the bedside felt pressure to follow the decisions of others in the home, such as the clergy, father, mother, family, or friends. Many physicians cautioned that tradition limited their ability to function independently, which caused them to feel restrained, because frequently women and their friends resisted new techniques, such as managing labor hygienically with sterile cleansing and shaving pubic hair (Leavitt, 1987). DeLee (1901) described a





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