Is There Still a Place for Normal Birth?
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Summary

The cesarean birth rate in the United States has reached an all-time high of more than 30%. It is projected that by the end of 2007, 1 in 3 babies will be born by cesarean section. In other words, one-third of women will undergo major surgery for a process that is supposed to be normal, not pathological. Could Mother Nature be so inept that she intended 1 in 3 births to require this kind of intervention? Is there any good reason to worry about this climbing surgical birth rate? What about the continued use of episiotomy and forceps in vaginal births? Or would it be more appropriate to celebrate what modern medicine can do to prevent maternal and neonatal harm? This article explores these questions.

Let me share with you a story about a normal birth, in a hospital, attended by an obstetrician. I want to share this story because this kind of birth is becoming a rare event.

The mother in this story (let’s call her Cathy) came to my practice because she wanted a normal birth. Her first child had been born by forceps delivery because she was unable to deliver spontaneously after an epidural—a noted problem in epidural administration. She said she’d had the epidural “because my husband was scared,” a capitulation common to many laboring mothers. In more than 30 years of practice, I have seen many women undergo anesthesia so they could be available to take care of their anxious husbands or so that their husbands would be comfortable enough to stay with them through the birth. When undertaken together, birth is a collaborative event between the mother and father, and the father can be either a positive or a negative influence. In particular, an obstetrician who does not properly prepare the father for his appropriate role may find him a difficult partner in the process.

Let me take a moment to say a word here about the role of the father, which is to love his partner and keep the energy focused on her. His part is to do everything he can to visualize sending his energy to her. However, the birth process is a difficult one for most men because they are not in control. They often see their role as protector and sometimes as coach, but they don’t know how to protect their partner from the risk, the pain, the doctor, and the hospital and its intrusive procedures. And they find themselves coaching a team that won’t play by their rules. Helplessness is not a comfortable place for most men. Their responses to this untenable situation vary. Some men withdraw completely. Some try to control the doctor and nurses, succeeding only in getting often-unnecessary interventions for their partners. And I’ve seen everything in between, some strategies being more successful than others.

Cathy understood at some level that in her first birth, her attention had been on her husband. The result had been an epidural, a forceps delivery, and a fourth-degree episiotomy, which had continued to cause her some problems. “So this time the birth is going to be for me, and he will just have to get over it,” she declared.

Along with my own unique combination of “high-risk” care and midwifery, I also recommended that Cathy hire a doula based on my own experiences as well as an Acta Paediatrica Japonica study that showed how they can help. Doula is a term coined by the researchers Kennell and Klaus based on a series of their own studies—one of which was done in the hospital at which I trained. It comes from the Greek doule meaning female helper or maidservant. So fortunately, long before there was a training program and a national organization for doulas, the experts were in my community providing services as private labor support. Nadia Stein was one of the best, and Cathy proceeded to hire her.

On the day of the birth, Cathy; her husband, Jeffrey; and Nadia arrived at the hospital. Cathy was in advanced labor. My prior evaluation of the mother and baby was that they were perfectly normal, so Cathy was taken to one of the hospital’s labor, delivery, and recovery rooms until I could join them. When I arrived, I was surprised to find her lying in the bed, which is not my preference; it was apparently hers, and she was doing extremely well. She and Nadia were the perfect team. Nadia held Cathy in a kind of bubble of calm that nothing—not even the intrusive routines of the hospital—could penetrate. Occasionally, Cathy would falter, become tense, and cry out. At those times Nadia, in her soothing Argentine accent, would bring her back to focused calm, “Ah, you are doing perfectly. Yes, breathe. All is well; your baby will soon be here in your arms. That’s it; just let go!”

Cathy’s husband was a bundle of nerves. I can’t remember whether I recommended that they go through childbirth classes, but I suspect they felt it unnecessary since it was their second birth. In any event, whatever childbirth education the father had taken was not helpful. Pacing the room to the farthest extent the 4 walls would allow, he clearly felt trapped. He was,

Note: The patient’s name has been changed and, although this story is true, the interpretations of the motivations and actions of the patient and her husband are my own. I apologize to them if I got some of it wrong.


iii Nadia Stein has continued to provide doula services and is the founder of the Community Doula Program (www.communitydoula.org), a nonprofit organization that, in a private correspondence in June 2007, Stein told me has helped more than 10,000 disadvantaged women to birth with a cesarean rate that is some 20% below national average.
nevertheless, present (much to her relief) and keeping out of the way (much to my relief).

Finally, the telltale signs of an urge to push appeared. I checked Cathy and found her complete and plus 1 (an obstetric term for the baby being below the ischial spine, usually designating that the head is moving down through the mother’s pelvis). “Your cervix is completely open,” I said, “so whenever you feel like it, just let your body tell you what to do, and do what feels good to you. There is no rush, the baby sounds fine. You can push whenever you want.” My approach to second-stage labor (the pushing phase of labor, from complete dilation to delivery of the baby) is, whenever possible, to be as non-directive as I could. This approach is backed by research. I believe that actively coaching women to push increases both maternal and fetal hypoxia and maternal pelvic trauma (more on this below).

Then, the most amazing thing happened. Jeffrey, the husband, came over to the bedside, clearly relieved that the labor might be almost over and that he had survived it. In his excitement and relief, he leaned over his wife and kissed her—the sweet kiss of a lover for his beloved. And Cathy opened her eyes, gazed into his, and said, “Oh, Jeffrey, kiss me again . . . It feels so GOOD when you KISS me.”

And with those words Jeffrey was transformed. His fear and anxiety disappeared. Now he had a job he understood and was completely competent to do. And Jeffrey reached down and took Cathy in his arms and planted (as Kevin Costner said in the movie Bull Durham) the “long, slow, deep, wet kiss that lasts 3 days . . .”

Now Nadia and I suddenly realized we were intruders, voyeurs really, to the final event in a sexual act of love that had started 9 months earlier. We looked at each other in embarrassment and wished we could disappear. The trouble was we needed to stay, because, as we watched, Cathy’s legs fell open and the baby’s head began to appear! No, Cathy was not pushing—Cathy was kissing! Now the baby’s forehead was out, then the nose, then the chin, all over an intact perineum! Cathy? Still kissing! Still kissing! As much as I didn’t want to disturb this amazing event, it occurred to me that my job was to get the anterior shoulder out, so I panhandled to Nadia, “What should I do? Look, I think I need to deliver the baby or something . . .” And Nadia panhandled back, “Well, you’re the doctor! Do what you think you need to do!”

So, ever so carefully, I grasped the tiny head and eased the anterior shoulder under her mother’s pubis, and the baby slid out. I placed her up on to her mother’s belly, where she lay with her eyes opening in surprise. Cathy and Jeffrey? Still kissing! As Nadia and I watched, the baby looked around with the expression of someone puzzled to find herself in a totally new world but not at all anxious or worried about it. Just puzzled. As we watched, she took her first breaths, turned completely pink, and lay quietly waiting to see what would happen next. No suctioning was needed, no stimulation to breathe, no drying with a rough baby blanket, no crying, and no help transitioning from a world surrounded by maternal love into this world filled with parental loving.

Finally, the kiss broke and Cathy looked down in utter surprise! “Oh, my goodness!” she cried, as though she couldn’t figure out how this pink, puzzled infant had appeared on her belly. And Nadia and I burst out laughing.

Later, Cathy confided to me, “I forgot I was in a hospital.”

“I know,” I replied. I had almost forgotten myself.

This was the first birth I witnessed that allowed me to see the process as a profoundly sexual event, but it was not the last. Sadly, there are too few women who look forward to birth as pleasurable, and, not surprisingly, too few women who are able, like Cathy, to forget they are in a hospital. I understand this is not true of home births, for obvious reasons. To me it is one of the greatest arguments in favor of home birth. There is currently a movement to collect and document the stories of women who have had this kind of pleasurable birth (see www.orgasmicbirth.com). I hope they succeed in helping women to birth the way Cathy did.

The importance of this birth story, which I have told many times, is that it encourages women to attempt non-mediated, non-medical birth. Why is this important? As more and more women chose epidural anesthesia during labor (now used in well over half of all births) and more and more women undergo cesarean birth (approaching one-third of all births), an increasing number of complications are occurring. In both physician’s and patient’s ongoing attempts to justify these interventions, I suspect these complications are not being discussed in advance with birthing women—and during labor is certainly not the time to get truly informed consent. Indeed, many of these complications are hidden beneath the interconnections of various interventions, making it impossible to connect a complication directly with any one intervention.

This is such an important topic that I’d like to give some examples of complications obscured by an intervention. If, in an effort to speed or induce labor, the physician ruptures membranes, s/he is introducing an increased risk of infection that may lead to a host of seemingly unrelated future problems—if an infection ensues, the baby may need to be separated from the mother to get antibiotics, which may change the baby’s bacterial flora and lead to later gastrointestinal problems. No one has put together a study to connect these, as there are too many variables. In addition, when the membranes are ruptured, the hard fetal head begins pressing against the cervix and the mother’s vagina, which increases the pain and causes the mother to request more pain medicine and/or an epidural. This leads to an increased need of forceps delivery and possibly a baby who doesn’t bond or nurse as easily.

Another example: If the mother is encouraged to push actively, she may tear the fragile supporting fibers of the vagina that support the bladder rather than letting them stretch. When she later develops stress incontinence it is blamed carte blanche on vaginal delivery and not the fact that the second stage was hurried.

The Reality Behind C-Sections

The total cesarean rate in the United States rose to 30.2% in 2005. If it continues to increase at its current rate of 4% per year, this figure should reach 32.7% by the end of 2007. Some of the increase is due to a 13% drop in rates of vaginal birth after cesarean (VBAC), which now takes place in less than 10% of women who have had a previous cesarean. This is true in spite of the increase is due to a 13% drop in rates of vaginal birth after cesarean (VBAC), which now takes place in less than 10% of women who have had a previous cesarean.
of the fact that in even in the worst situations, more than 60% of these VBAC women should be able to birth vaginally. In addition, the risks during a vaginal birth of a catastrophic rupture leading to fetal death or brain damage are small at less than 1% (although likely greater than with repeat cesarean in the usual setting).

The most common reasons given for choosing cesarean birth are to protect the baby or to protect the mother’s pelvic floor from trauma. The Women’s Health Initiative, a major 15-year research program to address the most common causes of death, disability, and poor quality of life in postmenopausal women, reported 5% to 15% of women had urinary incontinence, 1% to 5% reported fecal incontinence, and half reported pelvic organ prolapse. In another study, 1 in 9 women with incontinence have surgery, and one-third of those have repeat surgery for urinary incontinence or pelvic organ prolapse.

But does cesarean section prevent these complications? In 1 study that compared nulliparous women and their parous sisters, vaginal birth had no effect on risk of incontinence or its severity, suggesting that cesarean section would not prevent incontinence. In another study, cesarean delivery improved the incidence of urinary incontinence over vaginal delivery but increased the risk compared with nulliparous women. It is much less clear, however, whether such trauma is clinically relevant, and how important it is in the etiology of pelvic floor morbidity later in life [italics mine].

Another issue with damage to the pelvic floor is the problem of sexual dysfunction related to pelvic floor trauma and/or incontinence. Interestingly, in another study, neither the type of delivery nor the presence of stress incontinence or fecal incontinence affected self-reported sexual functioning. Only urge incontinence (not thought to be related to childbirth) and having a child in the home, regardless of the mode of delivery, affected sexual function. So the concept of performing a cesarean section to prevent pelvic trauma in order to improve quality of later life is in question.

Additionally, many of these risk factors are interrelated. For instance, the single-most important risk for fecal incontinence is an anal sphincter tear. One study showed that women who birthed vaginally have a 4.4% risk of anal sphincter tears, but women having forceps delivery were 10 times more likely to have a tear. Half of those who had a tear had undergone forceps delivery. When considering reasons to have a forceps delivery, the most common are epidural anesthesia, occiput posterior presentation (which is more common in women who have epidural anesthesia), and large infant size. In addition to these figures, women who undergo episiotomy are more likely to have anal sphincter tears (OR 4.9, CI 2.5-9.6). If forceps are used, the risk is much higher yet. Sphincter tears occur in about 0.1% of all deliveries.

In my experience, a woman who is able to feel her pelvic floor as the baby descends (ie, without epidural) is less likely to injure herself because she knows when to stop pushing if she is about to tear something. This is especially true if she is allowed to control her expulsive efforts. Encouraging a woman to wait until she has the urge to push allows the physiologic elongation of the vagina as the uterus pulls up on the lower segment and upper vagina to elevate the bladder out of the way of the descending head. This prevents trauma to the supporting structures of the bladder and incidentally decreases the need for operative delivery.

Needless to say, the mother must find a way to accept the intense sensations that the descent of the fetal head produces, and many women are unable to do this without anesthesia. Women’s birth experiences, however, suggest that many factors are at play in determining whether the pain is acceptable. For example, a systematic review showed that a woman’s relationship with her caregiver and her involvement in decision-making are more important than pain in determining how she views her birth experience in retrospect. Although pain from episiotomy (now thought to be unnecessary in most vaginal births) is often cited as a negative aspect of vaginal birth, rarely is it mentioned that there is a significant increase in the amount of postoperative pain with cesarean delivery.

What About Baby?

And what risks do the different delivery methods pose to the baby? It is very difficult to compare the risks of vaginal delivery and cesarean section because the circumstances in which they occur are so different. It is also virtually impossible to do any kind of randomized study, as women would be unlikely to allow themselves to be randomized. In a study of 33,709 infants born in Canada between 1992 and 2002, there were increased risks of admission to the neonatal intensive care unit for respiratory distress in the infants born by cesarean section, but about half of these could have been prevented by following the American College of Obstetrics and Gynecology guidelines for timing of elective cesarean. The risk of intrapartum or neonatal death was increased with vaginal delivery (1 in 3,406 deliveries), increasing (to 1 in 882) in women who had a previous cesarean section and attempted VBAC. The authors concluded that the risks to the infant of vaginal delivery versus cesarean section in low-risk women was about equal in those who had not had a previous cesarean. In other words, the group of women who attempted VBAC were in a unique risk group.

It also is important to ask what the experience of the baby might be, especially one whose mother is physiologically in a state of bliss or sexual ecstasy rather than fear during birth. Fear raises adrenaline, which causes vasoconstriction and uterine relaxation, neither of which is conducive to the timely birth of a healthy baby. The hormones of sexual ecstasy, on the other hand, are oxytocin and endorphins. Their effects on the mother at the end of labor serve to assist in the expulsion of the baby by
increasing frequency and intensity of contractions and providing pain relief, respectively. Oxytocin may also be the hormonal initiator of the orgasmic or ecstatic experience during birth, just as it is in sexual intercourse. These hormones’ effects on the baby may also be important and profound. Beyond the benefits of having a mother who connects her feelings about her baby with a wonderful birthing experience, the hormones of labor appear to be important in helping the baby with physiologic adaptation to life outside the womb.

For instance, in one experiment, babies delivered by cesarean section were exposed to a novel smell right after birth. If they had undergone labor before the cesarean, they showed a preference for the smell, turning their heads more often to the direction of that smell when presented with multiple options.\(^{28}\) This could be important to the success of breastfeeding, as it has been shown that smell is an important initiator of normal breastfeeding.\(^{29}\) Add to this the fact that breastfeeding is more likely to fail if need intensive support to succeed after cesarean delivery.\(^{30}\) Since it is clear that successful breastfeeding offers many advantages for the infant—including lowered risk of infection, improved maternal-infant bonding, and resilience against later stress—then it seems that efforts to have fewer cesarean sections should be made.\(^ {31}\) In fact, the greater stress resilience may explain less risk of later obesity,\(^ {32}\) an issue of growing importance.

Babies born by cesarean section have lower levels of adrenaline and are more susceptible to symptomatic hypoglycemia after birth,\(^ {33}\) which is often treated by intravenous therapy and in some hospitals requires separation from the mother. They are also shown to have decreased activity and reduced “optimal neurological responses” for several days after birth, a scenario thought to be important in post-birth neurological adaptation.\(^ {34}\)

In considering epidurals, babies whose mothers have epidural anesthesia show a parallel drop in levels of beta-endorphin, along with their mothers.\(^ {35}\) Since beta-endorphin is a pain-relieving chemical, and epidural anesthesia decreases the mother’s but not the baby’s pain, perhaps we need to ask if there are implications for the baby’s experience of pain and ability to respond to a difficult birth, such as one involving forces.

**Conclusion**

More than 10 years ago I wrote the following bit of prescient pondering:

If Rupert Sheldrake’s theory of morphic resonance is true—ie, if the universe does not have absolute “eternal laws” but rather has “habits,” and because of morphic resonance, that which is learned by one organism will be more easily learned by others—we are “learning” to give birth to our children by cesarean. This would predict that labors will get longer and more painful, that epidural anesthesia and cesarean delivery will increase in number, especially exponentially. If we want to turn this trend around, increasing the number of VBACs will not succeed as a strategy.

Instead, we need to be honest that the “war on cerebral palsy” has failed, so performing added cesareans to decrease brain damage is not working. Thus, we will need to work hard on learning to labor and give birth normally.

Perhaps the solution is easier yet. We may simply need to tell stories of normal, joyous births every chance we get to help rebuild a belief that birth can be a wonderful and ecstatic experience.

**References**


