

## GUEST EDITORIAL

### Making Childbirth a Normal Process

*Lennart Righard, MD*

It is an exhausting experience for a baby to be born, especially if interventions or complications occur during birth. Do birth attendants consider the possibility that the interventions of modern birth technology could affect the baby in the womb?

Consider some examples. Rupturing the membranes artificially instantly produces much higher pressure on the baby's head than if they are left to rupture spontaneously in a natural birth, when the bag of water protecting the baby's head is usually intact until the cervix is almost fully open. The artificial use of Pitocin in an intravenous drip makes the contractions stronger and more frequent than in a natural birth, in which oxytocin is released in spurts with an interval in between. In a drip Pitocin is given more continuously and at a higher level than in a natural birth, and the frequent contractions often make the pause between them too short for the baby to rest and recover sufficiently.

The strong and frequent contractions make it difficult for a woman to cope. Therefore, she is often given epidural analgesia, an intervention that does not help the baby, because the woman will need still more Pitocin in her drip. The baby in the womb cannot escape the stress of the strong and frequent contractions. Moreover, an epidural increases the likelihood of a forceps or vacuum extraction, which in turn, hurts the baby's head.

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*Lennart Righard was formerly Senior Pediatrician in the Department of Pediatrics, University of Lund, University Hospital, Malmö, Sweden.*

*Address correspondence to Lennart Righard, MD, Department of Pediatrics, Lund University, University Hospital, S-20502 Malmö, Sweden.*

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Cutting the cord at once, as is a routine in many places, adds to the stress on the infant. The baby needs oxygen, and the mother breathes for her baby through the cord as long as it is intact and pulsating.

At birth the baby experiences a huge change of environment and life conditions. Immediately after the birth he or she needs time to recover. It feels good for the baby to be on the mother's abdomen skin-to-skin or in a bath. The experience of being naked on the mother's warm soft skin, safe and secure, and feeling her caressing hands is soothing and comforting for the baby. Being in warm water, listening to the mother's voice, is also very relaxing. Indeed, everything that resembles life in the womb is helpful to the baby's transition to the outside world.

My definition of natural childbirth is a birth without medical intervention. How can health caregivers make this possible? In the first stage of labor, the woman could move about and adopt the positions she finds comfortable. If she is given a peaceful atmosphere with minimal disturbances, she will be able to tune in to herself and find the rhythm of her contractions. The woman in labor should be treated with respect. Other people in the birthing room should avoid unnecessary chatting about trivial matters. Soft voices and dimmed lighting could help her tune in and relax. With good relaxation throughout the first stage and between the pushes in the second stage, drugs are unnecessary for a natural birth.

In the second stage, birth is easier if the woman is allowed to push by herself when she feels an urge to push. In a squatting or some other upright position, the force of gravity will help the woman and make birth easier for her and her baby.

In many countries Pitocin is often given immediately at birth to speed up the delivery of the placenta. In Sweden, it is not given routinely, however, and

consequently there is no stress to expel the placenta. The practitioner may wait for at least 4 to 5 minutes before cutting the cord or until the pulsations have ceased, resulting in about 100 mL of extra blood for the baby. The most natural thing is to leave the cord intact until the placenta has been expelled, which occurs with the instinctual behavior of mammals and some indigenous peoples.

Breastfeeding will be facilitated if the newborn baby is allowed to search and touch, smell and lick, and finally latch on to the breast by his or her own efforts (1,2). In this way the baby's own reflexes come into play. The baby should be allowed to nurse until he or she is satisfied (3). Early breastfeeding behavior can be disturbed by labor analgesia (4–6).

When the mother is relaxed and trustful and everything works smoothly, childbirth seems so easy. Maternity care practitioners complicate this biological process by using many interventions, and as a result, most of the magical happiness is lost. Within minutes, a woman who has experienced natural birth is extremely engaged with her baby, talks to the baby, tries to make eye contact, and feels a happiness that she has not experienced before. Where are the emotional elation and euphoria in medicated births? What makes this difference?

If a woman experiences spontaneous physiological birth without medication or an epidural, the beta-endorphin rises to high levels in her body (7). Endorphin opiates increase tolerance to pain and suppress irritability and anxiety in laboring women (8). Prolactin, beta-endorphin, oxytocin, and other substances influence moods and feelings, caregiving behavior, mother-infant bonding, and breastfeeding. The placenta is full of beta-endorphins and other substances, and the practice of promptly cutting the umbilical cord deprives newborn infants of these substances designed to induce bonding between the mother-infant couple. Beta-endorphin levels fall in response to epidural anesthesia (7).

Swedish investigators have conducted retrospective studies on heroin addicts, and found that they were more often born to women exposed to drugs in labor than to women not so exposed (9,10). Because drugs pass over the placenta and affect the baby, the authors speculated that this exposure may give human infants an increased susceptibility to drugs later in life.

Research has also shown that the presence of a doula, a relative, or a close friend during labor can decrease the intervention and complication rates significantly (11,12). This labor companion should be a calm and experienced person who is there to support the mother-to-be.

Why do most births take place in large hospitals when small hospitals, birth centers, and even homes

are statistically speaking equally safe places to give birth (13–15)? In England expectant couples are given a pamphlet entitled *Informed Choice—Hospital or Home*. This pamphlet is supported by the Royal Colleges of Midwives, General Practitioners, Obstetricians and Gynaecologists and informs prospective parents that home birth is safe in uncomplicated pregnancies. The corresponding pamphlet for professionals about the place of birth lists 58 references. In England home birth is gaining recognition as a viable alternative for interested couples.

It is my belief that the difficulty of changing routines at hospitals will continue as long as doctors attend uncomplicated births, because they want to be in control of what is happening. For example, they want to control labor by having the woman lie down in a bed, they sometimes start labor by induction, and in a cesarean delivery their control is complete. Contractions and the baby's heartbeats are followed by use of electronic monitoring on a screen or a strip. Although this practice is neither safer nor results in a healthier baby than by just observing the woman and listening to the baby's heartbeat at intervals with Doppler ultrasound (16), the monitoring is usually done routinely and gives the practitioner a feeling of better control. Twelve randomized controlled studies compared electronic monitoring with intermittent auscultation of the fetal heart rate and reported an increase in both operative vaginal and cesarean delivery rates (17). The extra cesareans associated with electronic fetal monitoring did not lead to substantive benefits for the baby. A reduction in neonatal seizures was reported to be associated with continuous monitoring of the fetal heart and fetal acid-base estimation in one trial, but no differences in infant health at 1-year follow-up were found (18).

The contractions are often controlled by giving the woman a Pitocin drip, and the woman's pain is controlled by pain-killers and epidurals. In the last stage, when the baby is about to be born, the practitioner tries to control the pushing. If the woman has not received an epidural or a drip, the pushing urge is a very strong force that the woman can just follow. Instead, the doctor, midwife, or nurse often takes command, forcing the woman to push. On the other hand, if they try to avoid telling the woman when to push and just let her push when she feels the urge, the birth will be entirely different—much calmer and more relaxed. It will be a good experience, not only for the woman and the baby but also for the practitioner.

In the third stage practitioners control the delivery of the placenta by giving Pitocin and pulling the cord. Finally, and immediately, they cut the cord to examine the newborn, and thus mother and baby are separated.

If birth is seen from the woman's perspective, how-

ever, everything she has heard or read about birth, the films she has seen, and the hospital setting in which she gives birth will make her either more or less anxious. If she does not trust the signals from her own body and is given little support, she is likely to have problems. If she has low self-esteem and is not assertive, the doctor, midwife, and other hospital staff will take charge. She is more likely to lie down passively on a bed. Once on the bed, the pain will be worse and the woman will need help. The doctor, midwife, and nurse are there to help her. Now she has become a patient. Sooner or later she might be asked, "Do you want a pain-killer?" or "Do you want an epidural?" How often do doctors ask, "Do you want a natural birth?" or even "Do you want a bath?" A pain-killer or an epidural makes the woman even more passive, and it is much easier to have her under control than if she is walking around or kneeling on the floor or relaxing in a bath. Her anxiety or feelings of intimidation will make it easier to accept the suggestion of a pain-killer or an epidural, even though she may not really want it.

Recently, in a large London hospital, I entered a birthing room in which an anesthetist was about to set up an epidural. I could see that the woman was frightened, so I went up to her and asked, "Do you want this epidural?" "No," she said, "I want a normal birth. Could you help me?" "We can try," I said, and asked her husband who was sitting in a corner of the room to come forward. I showed him how to give his wife back massage, and when the next contraction came, I was sitting in front of the woman looking into her eyes and we were together breathing through the contraction. "Ah, this feels good," she said, "I will try it." The anesthetist left the room with all his equipment, and the woman had a spontaneous birth with no drugs. Her acceptance of an epidural had simply been a submission to the doctor's authority, and with just a little help she had a normal birth. From this experience and those in other hospitals, I conclude that maternity care practitioners can help more women have a natural birth when they and the women have a positive attitude.

If the doctor, midwife, or nurse asks every woman, "Do you want a normal birth?" they will learn what she wants. Another question, "Do you want a bath or shower?" is also important. In most cases where an epidural is proposed, a bath or a shower is an alternative. It is very relaxing and the cervix will most often open up; it is also distracting, time passes by, and the moment of birth draws nearer.

Some hospitals around the world have a policy of accommodating the concerns of ordinary people and their interest in natural childbirth (19). They use invasive methods restrictively and are open to alternative birth methods. Until more hospitals change their rou-

tines, women who would like a more natural approach to birth could choose small units or their own homes. At large hospitals women in labor tend to be strictly controlled, and they have few opportunities to decide for themselves. At small hospitals women are still controlled but to a lesser extent. At a birth center or in her own home, however, a woman is most likely to be listened to and respected by her caregivers.

Today, medical interventions are performed in almost all situations in Western hospitals. Perhaps we need an educational and psychological revolution in maternity care! Childbirth should become a normal process as it used to be and still is in all mammals. Let doctors help in cases where something has gone wrong, but let midwives be responsible for normal births. In Lund, the city in Sweden where I live, we have around 3500 births a year and just two obstetricians for complicated cases. Midwives are in charge of all normal births in Sweden, and the country has one of the world's lowest neonatal mortality rates. If every practitioner that a woman meets during pregnancy and in the birthing room looked on birth as a normal physiological process, as part of life, natural birth would be the norm and a birth with medical intervention the exception.

*Note:* Dr. Righard's CD and audiotape "Preparing for Natural Birth" is available in a new edition. It is intended for expectant parents and is based on Swedish experiences. Copies can be ordered from Health Education Associates, 8 Jan Sebastian Way #13, Sandwich, MA 02563, USA. Telephone toll-free in the USA, 1 (888) 888-8077; Special offer for *Birth* readers: \$14.95 for the CD; \$9.95 for the audiotape; 2 free copies with every 5 copies ordered. A 6-minute videotape, "Delivery Self Attachment," by Dr. Lennart Righard, is also available from Health Education Associates for \$19.95.

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