# Birth as connection rather than separation: the overmedicalisation of labour and birth

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My Dreams crushed, hearing
Baby's heartbeat in distress
Told "stop worrying"
Labelled a "broken mother"
Still feels so fresh, eyes well up

*"She keeps screaming out to stop"*

"Still screaming to stop"
just ignore her—keep going –
We are on the clock
Betrayed, and violated

Frivolously dismissive

*my expectations "too high"*

In a fragile state
Still feel heavy with regrets
*"Why haven't you pushed him out?"*
Yet?

This poem, called 'Screaming out to stop', is part of a poetry collection by poet Pixie Willo, based on women's responses to the largest birth experience survey ever conducted in Australia. The intention of this work was to enable readers to engage emotionally with this qualitative data.[1] Every birth statistic that we come across represents the lived story of a woman and family. Sadly, many depict experiences that are far removed from the true essence of birth and how it ought to be nurtured and supported.

## The essence of birth

The bodily experience of pregnancy is, at its core, a state of connection between a woman and her baby. The baby is physically nourished by, protected and indeed growing within the woman's own body. This intimate relationship has physical but also psychological implications for the woman too. Her connection to her baby manifests physically in her changing shape as she bears the costs of morning sickness, pain and possibly even more difficult experiences if complications occur. She is drawn to consider the needs of her baby at the forefront of her mind, altering her lifestyle, plans and identity in the process. She may form an emotional bond long before birth.

Birth is a continuation of this experience of connection. The moment of birth is not only the climax of pregnancy, but also the portal into motherhood and parenthood beyond. There is a sense in which it is a kind of separation – the physical emergence of a baby from a woman, accompanied by a newfound independence of physiological function. Yet (in all but the most tragic of cases) it is far from an actual or complete separation; the concept of a new mother now freed from the constraints of biological connection would be laughable to her! Birth is more realistically experienced as the beginning and foundation of a new stage of physical and emotional connection and relationship. It provides a powerful entry into the next level of the evolving journey of giving life and love to a baby and being transformed through this process.

While the experience of birth is (relatively) short-lived, it can greatly impact the physical and emotional well-being of woman and child. The effect of these experiences on their unfolding relationship (and other family relationships) can be ongoing in nature. Women and couples may come through birth exhilarated and in awe of the female body or undermined and traumatised. This is why consideration of care and practices surrounding birth and its integral connection between woman and child is so vital.

## The changing face of birth

Birth has always been a central part of human life, yet the way that it is managed has altered drastically in just the last century or so. Throughout history women have given birth to their babies by their own strength with the support of close family and community members. There were sometimes tragic outcomes and so modern healthcare stepped into the important role of offering help when needed. However, it quickly progressed to overstep that role.

Medical intervention continues to be an incredibly important means of improving outcomes for women and babies, when required. Yet we have become so accustomed to its use that it is now drawn upon in the birth experiences of the vast majority of women, often unnecessarily.

Physiological birth is a contemporary term replacing earlier descriptions of ‘natural’ birth. It describes birth which is powered by the innate functioning (physiology) of the bodies of a woman and her baby. This entails the spontaneous onset and undisturbed progression of labour towards birth through the vagina by a woman’s own efforts. While it may sound unremarkable to some, this kind of birth is in fact now an endangered species within our maternity units. Physiology has largely been replaced by medical management.

Exactly why we have come to this point is hard to pin down. Feminist interpretations highlight a historical (and continuing?) suspicion of women’s bodies, which evolved into a mechanistic understanding of birth in the 18th and 19th centuries. Once medical men with a background in pathology and a limited understanding of birth physiology became involved, there was a preference to control the process: Women were restricted to give birth on their backs and adopt a more passive role.[2]

More recent factors such as the privatisation of healthcare, which rewards specialist obstetricians expanding their role from managing medical complexities in pregnancy and birth to include the straightforward experiences of healthy women in the private system, has also played a role in increasing unnecessary medical intervention and even incentivising it.[3] Even in public settings, institutional culture surrounding birth is often characterised by guilt and blame which shapes hospital policy, supporting the practice of medical intervention rather than inaction, sometimes even without a firm basis in evidence.[4]

By exploring the changed face of birth through the lens of its foundational connection between a woman and her baby, insight can be gained into what might be lost in this altered journey. This exercise can also offer guidance regarding how we should shape the structures supporting birth as we pursue the ultimate goals of physical and psychological well-being for both women and babies, which are inherently interconnected.

## The impact of routinised intervention

Birth has always been an unpredictable process. We are still yet to fully understand the intricacies of how labour begins through the hormonal interplay of the bodies of a woman and baby. Unpredictability has a certain undesirability in modern society. Right back from the early 1900s, medical practices originally developed to assist with obstructed labour became widely routinised. This offered control and an expedient streamlining in obtaining the 'outcome' within an acceptable timeframe. In 1906 the use of chloroform and forceps for birth was common among doctors, in preference to awaiting spontaneous birth. Yet even then a GP obstetrician wrote of his experience with first time mothers:

*Through this procedure many lives have been lost, many women permanently maimed. Left to Nature it is surprising how well these patients are immediately after labour, even though the labour may have been protracted. They are cheerful and bright, and, in my opinion, have much more strength and vigour than had they been delivered earlier with chloroform and forceps, and with less risk of atony of the bladder or other complication.*[5]

Not only did unnecessary medical intervention hold serious physical implications for women, but it impacted their emotional well-being as new mothers and the emerging relationship with their babies. They were no longer 'cheerful and bright' and lacked the 'strength and vigour' required for the transition into motherhood. Although chloroform and the routine use of forceps are thankfully no longer utilised, sadly these kinds of observations still hold true today in hospital settings where medical intervention remains ingrained. In many cases, physical and psychological harm result from interventions which may or may not be warranted in the first place.

## The birth experience today

In Australia, we have passed a stark milestone revealed by our most recent birth data. After a long-term decline, our rate of 'normal' vaginal birth, i.e. not surgical birth by caesarean section, nor instrumental birth through the use of vacuum or forceps, has finally dropped just below 50% of all births.[6] 'Normal' isn't normal anymore.

Even these outnumbered 'normal' vaginal births are inclusive of many significant medical interventions such as epidural anaesthesia and labour induction - that is, labour being artificially commenced and controlled (usually via medication as well as artificially breaking the waters). While some experiences of birth via medical intervention can still be quite positive, it remains inconsistent with most women's wishes. Only a minority of women choose caesarean birth[7] and instrumental birth is broadly undesirable due to its increased rates of physical trauma to both women and babies.[8]

While any one woman's experience represented by the above statistics may reflect an entirely necessary medical intervention, at a population level much of it is unnecessary. Today's high rate of medical intervention in birth means that the nature of birth is often changed from a powerful life-giving act to an experience of undergoing a medical procedure. Rather than labour and birth following its physiological trajectory unless something goes wrong, too often the overall structure of the birth experience is reshaped through medical management from the very beginning.

Physiological birth processes are often replaced before anything has even had the chance to go wrong. In New South Wales, almost half (47.4%) of first-time mothers aged 20-34 giving birth to a single head-down baby at full term (between 37 and 41 weeks of pregnancy) are having their labours induced. The induction rate for this select group of young women with relatively straightforward pregnancies has crept up from 41.1% in 2017.[9] Recommendation of this intervention is usually framed in terms of reducing risk to a baby, from various factors, by ending the pregnancy prior to labour's physiological (spontaneous) onset. The most common reasons given for labour induction in Australia are diabetes and pre-labour rupture of membranes,[10] each of which lack substantive evidence as to the significant benefit of induction of labour for this indication.[11]

The ability to monitor the physical condition of a woman's unborn baby alongside her own means that interventions can be recommended for either of their projected good. This gives precedence to a conceptual division of the two, rather than an acknowledgement of their innate connection. The reality too often unappreciated in healthcare settings is that any intervention for the sake of either woman or baby also has an impact on the other, potentially for the worse. While this may well be justified in some instances of risk to one or other, many interventions have been routinised to a point where they are also frequently utilised in the absence of significant risk and without proper appreciation of their genuine harms.

Despite the intention of avoiding physical harm to babies, the rapidly increasing rate of labour induction has not in fact lowered our overall rate of stillbirth or babies dying.[12] Rather, it has had many negative implications, for women: higher rates of instrumental births, episiotomy and post-partum haemorrhage, and for babies: neonatal birth trauma, need for resuscitation, respiratory disorders and admissions to hospital for infections (ear, nose, throat, respiratory and sepsis) up to 16 years of age.[13] These interventions are too often resorted to without adequate justification and appreciation of their negative impacts.

While attempts to replace physiological birth processes with medical means are appropriate when absolutely necessary, there is a far bigger picture of well-being that is being overwritten by their over-use. The extent to which these interventions are occurring unnecessarily in mainstream birth care is causing harm without correspondingly improving outcomes for babies as purported. Labour and birth intervention is often encouraged as being best for a baby, yet the well-being of a woman and her in-dwelling baby are so intimately connected that a bigger picture of their interconnected well-being must be considered.

## A cry for help

Sadly, the physical impacts of unnecessary medical intervention in birth are just one part of the picture. The birth experience can also have a huge impact on women's psychological well-being as well as their relationship with their newborn child. One in three Australian women experience birth as a psychologically traumatic event,[14] and this has ongoing implications for their whole families.

The New South Wales government has recognised the significance of these statistics, each of which represent the personal story of a woman and family, and have consequently initiated a parliamentary inquiry into the matter. It seeks to examine women's experiences of birth trauma (physical and psychological) and consider what legislative or other reforms can be implemented to resolve the issue. The inquiry has received a staggering number of over 4200 submissions, the majority of which contain individual personal stories and provide harrowing reading, such as the following: [15]

Rachel Barry: '*I was induced at 41 weeks … zero to 100 levels of pain and no easing of the pain between contractions. - They dangled an epidural in front of me when I had said I didn't want one.*

*Told me not to be a hero. Told me everyone who is induced gets one. … Epidural failed after an hour and had to be readjusted. - Finally got to 10 cm. Pushed for an hour, but I literally couldn't feel anything so couldn't tell if I was pushing. The epidural was so strong. … Drs came in and said bub was in distress. They then said that there was a serious risk of shoulder dystocia since bub was "so big." They literally told me this, "your baby is likely to get stuck because of shoulder dystocia. If that happens it is the worst kind of obstetric emergency. We will have to cut you from top to tail. We will then have to reach in and break your baby's collar bones. Not only will this be traumatic for you, it will be traumatic for the whole surgical team. You need a c section." (How can they get away with saying these things!!) - Of course I was terrified. Of course I said yes straight away. - Bub was 3.5kg… head circumference was normal range…'*

Michelle Gale: '*I was told I could have three pushes with the vacuum in theatre and that was my last chance. I was told the drapes would be dropped so I could see my child being born, they weren't and I wasn't told why. I was eventually handed a baby so wrapped up that I could only see his eyes, nose and mouth. I felt nothing towards this child that I couldn't see or feel.*'

Name suppressed (submission no. 197): '*I still feel upset about my final birth experience, not because of the outcome but because I was treated so badly by staff, like an inconvenience, and because I was not given options for more time to achieve a vaginal birth given the baby was completely fine and I was also healthy and well. I feel angry at myself for not standing up for my rights and angry that I even feel like this because I should not have to stand up for being treated like a human rather than an inconvenience.*'

While some factors contributing to birth trauma are sadly unavoidable, research has found that one in three instances of psychological trauma are caused by actions of or interactions with caregivers (doctors and midwives) [16] and medical interventions also play a part.[17] Women are traumatised by birth as a result of the system which they had hoped would support them through this experience and this impacts on their entry into motherhood. The reality of birth for many women has become far removed from what it could be. The healthcare system has, in many cases, assumed the active role in pregnancy and birth, standing between the woman and baby as she becomes one who is 'cared for' and disempowered.

The powerful act of women giving birth to their babies is so often unnecessarily undermined in contemporary maternity care settings and this has ongoing implications for them into parenthood. Women and babies are being let down by our systems of care, neglecting to give due attention to their innate connection and what is lost in abandoning physiological birth.

## The beauty and power of physiological birth

Birth today is treated as a medical event situated within the domain of the healthcare system. In limiting this experience we have, as a society, lost sight of the beauty and power of birth. Babies ought not usually be 'delivered', but given birth through women's own internal strength, and this offers a paradigm for ensuing motherhood.

Dr Sarah Buckley is a GP obstetrician who has published a ground-breaking report on the hormonal systems of physiological labour and birth, offering detailed insight into their significance for biologic bonding and interconnected and ongoing well-being of mother and baby. The naturally occurring oxytocin peaks during and after physiological labour and birth have wide-ranging positive impacts on the brains of both mother and baby, unlike artificial oxytocin used in labour induction which appears unable to cross the blood-brain barrier. The hormonal surges of physiological labour and birth not only support the labour process and bodily adaptations, but also promote critical maternal

behaviours, confidence and mood, all of which impact mother-baby bonding. Oxytocin activates reward pathways in a woman's brain to associate interaction with and care of her baby with pleasure. [18] This bonding process provides a firm basis for the ongoing well-being of both mother and baby together.

The experience of birth lays the foundation for motherhood as a woman opens herself up to and for her baby, lovingly giving of herself for their life. This is equally true of every different variety and form of birth, chosen or received. Yet there is such breadth in the range of experiences in this regard.

Many women become mothers feeling disrespected, disempowered or even traumatised, rather than feeling that initial 'strength and vigour' in their capacity to bring their baby life. The prevalence of these kinds of experiences is both avoidable and tragic. Cultures of disrespectful care have no place in birth settings. Physiological birth can and should return to being a possible and indeed normal event, unless serious risk or a woman's own choice leads her in a different direction. Through a woman's very physiology she can be drawn close to her baby as they lay hands on one another for the first time, rather than have this life-giving role moulded into that of a rather more passive participant. Connection is the very essence of birth, too often disregarded and consequently disturbed.

## Where to from here?

The intrinsic physiological and emotional connection between a woman and baby in the act of birth has been overwritten by a system focussed on a very limited picture of their individual well-being. Medical intervention has been and continues to be incredibly important in improving outcomes when it is required. However, utilising it excessively - over and above enabling physiological birth - unnecessarily disrupts the birth process and its significant hormonal interplays, as well as resulting in physical and psychological harm.

Excessive medicalisation of birth underplays the important way in which these experiences transition a woman and baby physiologically and emotionally together into a new stage of connection and relationship. The physical and emotional costs of pregnancy and birth for women reveal the significance of this connection, that a woman can be so thoroughly impacted by another and still carry him through.

In connection to her baby, she nurtures and nourishes him. This is powerfully transforming as she is guided by her body into opening up her very self to give life to her baby. This bodily experience of connection moulds and guides her into motherhood and the lifetime of relationship that lies beyond. She learns that she is able to provide for her baby and give him life. The experience of pregnancy and birth is one of life and growth for women through connection and relationship, as for their babies.

Systemic and structural change is urgently needed in institutions providing birth care. Hopefully this will result, to some extent, from the current parliamentary enquiry. There is already a strong basis of evidence for the benefits of midwifery continuity models of care (where women have access to a known midwife/midwives from pregnancy through birth and beyond). This relatively simple change in support structure has been conclusively shown to increase rates of spontaneous vaginal birth, reduce adverse outcomes, increase women's satisfaction with care and so have a protective effect on birth trauma.[19] Implementation of widespread access to these models of care has been slow but this has the potential to make a huge difference to women's experiences and their physical and psychological well-being, together with their babies, if it can become widely available.

We also need a shift in our cultural paradigm of birth. For millennia, pregnancy has been viewed as a privileged experience of life-giving; "blessings of the breast and womb" are described right back in

Gen 49:25. It is not fundamentally a medical experience, but one of bringing forth new life and relationship. Our medical technology ought to enable us to see and appreciate the intricate and intimately connected nature of a woman and baby in pregnancy and birth and how to support and nurture this relationship, through the portal of birth and into what lies beyond. The scope of medical intervention needs to be reined in. Rather than being a default part of women's stories, it ought to be drawn upon only when necessary, thus reducing the harm currently evident from widespread intervention into the very essence of birth.

In this most extreme experience of intimate human connection, truly supporting women involves acknowledgement and exploration of the connection that exists and is further developing between a woman and her baby, fundamental to the health and growth of each. These are powerful processes at work in mother and baby taking them together on the journey through birth and beyond.

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