# The Ideal Cesarean Birth

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**Publication info:** Journal of Prenatal & Perinatal Psychology & Health 14. 3/4 (Spring 2000): 331-343.
ProQuest document link

**Abstract:** None available.

**Full Text:** INTRODUCTION The beauty of gestation and birthing, itself, appears to me a totally foreign experience. I cannot even imagine the feelings, anxieties, anticipations, fears, hopes, and physical experience that a woman has during pregnancy and birthing. Even though I have attended many pregnancies, worked with and assisted many birthings, and intervened in many ways during my career as an obstetrician, I still honor the birth mysteries. What is this experience that so engulfs the totality of a woman? Is it just biological, a process of an annual reproducing its species? Or is it more-a psychic transportation into a world of the spirit-a transformation? What happens within the woman, to the soul, spirit, persona, that this hero's journey is the ultimate magic which completes a cycle? What can make motherhood so deeply vital to a woman that she would seek pregnancy and labor and birth like a shamanistic rite of passage-with all the pain, fear, and loss of control typical of shamanic journeys? I could not find any answers to my questions as a medically-trained technician. I could not even get an answer from the women I served as obstetrician. The responses I did receive were couched in terms like: "It is an empowerment." "What a stupid question!" "Because it's beautiful." "It is a natural thing to do." HOLISTIC CHANGE Yet I continued to talk with women. I listened to their guidance. I worked in the alternative health field. I read the literature which is published outside of the scientific (now called "peer review") literature, which continues to espouse the medical model. As I listened to the pioneers, the midwives, the few brave obstetricians and family practice doctors who stepped out of the standard of care to "participate in birthing" instead of "doing deliveries," I became progressively aware that the medical model I had considered sacrosanct was in fact a victimizing of women and the woman's quest of the "golden fleece"-an affirming experience through birthing. The insights of Stan Grof, Thomas Verny, Dick Grantly Reed, Michel Odent and many others eventually took the place, in my world view, of the ideas of the "great men" of obstetrics, the professors in their ivory towers. Acceptance of these ideas was slow because of absolute fear of orthodox medical practitioners, including myself, of legal actions resulting from potential mal-practice. I realized I had a new paradigm as the criterion upon which I should base my work. Stan Grof pointed out the intensity of the experience of the fetus in the birth canal and the effect of interference on the newborn. Frank Lake (unpublished paper) spoke of remembered pain and the "cold womb" that impressed the first trimester fetus and affected the emotional or psychological being of the child grown into an adult. The implications of the interferences and good medical intentions that I had been practicing crashed in on me. What was I doing in my pressure on a woman to force a good medical result? What was the result? Medically it was the survivability of mother and baby. Quality of life or psychological and emotional peace was not considered. Holistically, by contrast, the most value is placed on the total process with each aspect juxtaposed as a whole. For the first time I looked at my work with pregnant women and realized that although I was getting great medical results I was getting terrible results for the woman with regard to her needs and self-esteem; and, I was unconscious of the baby and of the effects of standard care on this new person. I hated these things. I hated the thought that all my good intentions were wrong. I hated knowing I had not been giving appropriately to what should be vital in the transformative event of birth-the woman transformed into mother and the conceptus into a new human being. I hated knowing all of the shortcuts I took during long labor-operative delivery by forceps and cesarean section just to get on with it; the inductions of labor for my own convenience not for the safety and integrity of the woman; the application of technique and technology to make my job safer from lawsuit and peer criticism and to meet demands of hospital policy. I remember and recognize the anger I felt at women who wanted "natural

childbirth," home delivery, and non-intervention. I am ashamed, and I am also satisfied that whereas I was once stupid but medically sound, I am now awake and profoundly aware that I know nothing about the experience of gestation, birthing, and the transformative experience of becoming a mother. I can only view it, this process a woman passes into, from the outside as a father, a man, and a professional male in obstetrics. I have to thank Spirit for the skills of medicine I have learned, for the many times my ability to diagnose and intervene has resulted in a positive outcome when otherwise there would have been a disaster for mother or baby or both. I am glad I had the skills to really serve when the outcome appeared to be going in directions the mother did not want. As my skills broadened with the new perspectives I was learning, I became aware that to serve truly, skill must include art-creative, imaginative, and insightful art. I needed to become an artist to really support the transformative cycle of womanhood, to celebrate a new life. Michel Odent was the artist and naturalist who taught us through his book, Rebirthing Birth, and the midwife and doula have long promoted the purity and integrity of woman. Every cell in my being tuned itself to my position outside of this passage, and I listened to woman's voice within me and her. Early in my career, I was clear about medical technology and interventions technique. But as the years passed, and as my power of observation improved, my own self-awareness improved, my level of consciousness regarding gestation and birth progressed: as my ability to hear the need that a woman had for her transcendence into motherhood and the "full cycle" completion of her womanhood, I questioned the medical mode and standards of care. In the medical model, gestation and birthing are a managed event where standard care is demanded of the doctor, the hospital, and the labor room. Unfortunately, the woman is forced into the system. The child becomes incidental and is only considered as a result, good or bad, of our delivery. Previous dogma was, "the fetus is only a passenger" with no thought, awareness, or influence over its intrauterine life. Thanks to many astute observers, regressive therapy, and the observations of people in alternative states of consciousness, the unborn child is found to dramatically affect gestation and birthing. David Chamberlain's book, Babies Remember Birth, discusses this new knowledge convincingly. There are new models being practiced by many, some outside the law of the state yet inside the law of humanness. There are new researchers' works on providing alternatives to allopathic care, which not only work but which support the woman and her birth process. These methodologies correctly assist bringing forth the child, and more maturely accept the risks of pregnancy and birthing. CESAREAN BIRTH Cesarean birth, is the one area not addressed in most of the new models except by condemnation. Yet cesarean birth has become the means of delivery for more than one fourth of all newborns. As one labor room nurse said, "It is a vaginal bypass." Who does the operation? The procedure itself is the realm of the obstetrician. No one except those specially trained is allowed in any American hospital to do any cesarean sections. It is a fact that obstetricians have the corner on cesarean birthing. Those of us who have monopoly on cesarean birth, obstetricians, have remained unchallenged except by people like Jane English who through her book, Different Doorway, reminds us that though we were successful in saving a mother or child by the surgical, vaginal bypass, we have given far too little respect to the baby and the baby's well-being. While the procedure undoubtedly rescues many from the brink of disaster, the unfortunate truth is that far too many babies, in fact most, need not have been born by cesarean delivery at all. How can an increased awareness of these issues reach into the procedures surrounding a necessary cesarean birth? What would be an ideal cesarean birth? I suggest that there are three levels on which we can focus: 1) the preconception months; 2) the prenatal months; and, 3) the intrapartum events. There is another area that must be considered in the "ideal cesarean birth" and that is the post partum phase. But that is not the topic of this commentary. PRECONCEPTION We may assume that few have been trained to be parents. It is remarkably clear to me that as a father I did not have any instruction for that role. It has been an on-the-job training program, probably to the detriment of my children. To have an ideal cesarean birth, we must consider the preconception phase vital to the onset of the pregnancy. Our literature in pre- and perinatal psychology is now demonstrating the incredible effects of unwanted birth and unwanted conception in the cellular memory of children and adults who through regression revisit those moments when they discovered

they were not wanted. The cold, unaccepting wombs of women with inordinate fear of pregnancy or fear of motherhood, of women who are forced to carry a pregnancy as punishment for their sexual behavior, and uneducated women who have, with their men, created pregnancies just because it is "natural," all these jeopardize the ideal birth, cesarean or vaginal. Conception requires serious consideration of diet, health, spiritual connection, and value of pregnancy and the new life. A surprise pregnancy is not doomed to lead to a non-ideal birth. However, emotional and psychological work may be required during the gestation so that the unborn recognizes its full acceptance and its anticipated birthing. Principal in our consideration of the preconception phase is the spiritual and emotional maturity of the mother, her assurance and clarity in becoming a parent, and her ability to share her love with her child. She will be greatly benefitted in this by a supportive environment. All families, even for second and later children, should seek preconception counseling. PRENATAL I will assume that the pregnancy is planned, that the parents have deeply and passionately wanted the intensity of their relationship to bring in, through their love, a being for the being's sake, a new life's opportunity. Or if the woman finds herself pregnant as a result of failed contraception, we will assume she has chosen to birth the child, not because she has to, but because she wants to. We assume there is welcome for the child. When the new life is planned for, the uterus can be a home of nurturance and love. The cold womb results when a woman doubts her ability to be a mother or when the woman, consciously or unconsciously, rejects the conceptus. When, however, the conception is mutual, unforced and passionately intentional, the preparation for the ideal birthing will be more successful. When it is known in advance that the birth will be a cesarean, the ideal cesarean birth will include emotional as well as physical preparation of the mother. She must fully explore her feelings about and fears of the operation and recovery. She must identify with the operation and "own" the procedure and see it as the means for her transformation to motherhood, not as a failure of herself or of her womanliness. Since babies are conscious before birth, an ideal cesarean birth would include intensive prenatal preparation of the mother and child. It is vital in considering the ideal cesarean birth that the intelligence of the prenate, its truly astounding state of being, be remembered. We are becoming more aware of the prenate's "control" over the events of gestation and birth. The preparation would include a full acceptance of the baby, a wanted pregnancy, communication within the positive uterus, and a clear forward looking integrity between mother and fetus regarding the impending cesarean delivery. Labor should be allowed to begin, when the cesarean is medically necessary (as with placenta previa or spina bifida), as an indication that the baby is ready and to reduce post operative complications. Emotional preparation for pregnancy and birthing creates the one most important factor toward good outcome: motivation. Removal of fear by combining education with experience of progressive alternative states of consciousness prepares the woman, her intended child and the support family to create an ideal cesarean birth regardless of the medical model or hospital environmental conditions they may encounter (the protocols at most hospitals do not allow much latitude for different birthings or for ideas that contradict "scientific" dogma). INTRAPARTUM Intrapartum means the period from the onset of true labor through delivery of the placenta and includes the recovery room. Labor Cesarean There are two very different situations which might occur for the baby and mother during labor which might end with cesarean section to achieve birth: 1. An emergency situations such as: fetal distress, hypoxia (loss of oxygen and blood supply), extreme prematurity or, for if the mother is hemorrhaging. 2. Non emergency situations such as the mother's medical status during labor (e.g., severe high blood pressure or toxic debilitating illness) and obstetrical conditions (e.g., contraction of the pelvis, or malpresentation). Any of these problems can arise in any woman. The obstetrical approaches to the two situations are different. (It is interesting to me that cesarean birth is rarely needed with the woman who is prepared for pregnancy and birth and well supported by friend, family, and doula (birth assistant); a four per cent cesarean rate seems to be exactly right.) Emergency Cesarean In an emergency cesarean it is essential to get the baby into saving hands or the mother back from severe life-threatening events, whereas with failure to progress in labor or cephalopelvic disproportion, time is not a factor before the operation. In an emergency the surgeon is faced with getting the

baby out of a life-threatening environment rapidly, when there has been a major separation of the placenta from the mother's blood supply (called an abruptio placenta) or when the umbilical cord has preceded the head and the blood supply to the baby is cut off, and the infant must be birthed as rapidly as possible to prevent progressive brain damage and death. We have, most of the time, less than ten minutes from the discovery of the problem to the birth of the child, sometimes far less. Nonetheless, even in these circumstances, the ideal cesarean birth can occur. Rapid, accurate diagnosis of the problem, maximum rescue of the fetal circulation, and clear contact with the mother is vital and definitely required as part of an ideal cesarean birth. The mother must be consciously informed of the situation facing her and her baby, reassured that she can contribute to the birth of the baby by focusing all her healing energy into her unborn and communicating to her baby her readiness for the baby to come to her arms and to be safe. With the prepared mother, this is easy, for the lines of communication are wide open between her, her obstetrical team, and her child. Mother can speak reassuringly to her unborn and guide healing light to this child in jeopardy and to the baby's process, for we must remember at a deep level this emergency is the baby's doing and the baby's way. At the moment of decision the team must be efficient, be respectful of the feelings of all the members of the mother's support team, and act with calm determination for a good result, in spite of knowing there could be medical failure. There could be failure in the sense that the child might be beyond recovery or revival, or might have physical damage due to the prolonged anoxia. These events are rare, but the possibility of need for an emergency birth is the reason most people, medical as well as lay people, want the "safety" of a hospital and condemn home births. Doctors fail to realize that they are penalizing 96 women and 96 babies with the medical approach, hospital-bed birthing, and electronic monitoring, to "save" four babies-really much less than four, as this kind of event actually occurs in fewer than one birth in a thousand. But in a hospital with several thousand deliveries every few years there are a lot of high risk pregnancies. The attending obstetrician, birth attendant, family practitioner, or nurse-midwife must be with the mother as she is prepared to move to the operating suite, giving her his or her healing energy and loving concern. The attendant and the father can 'lay on hands" carrying their affection and encouragement to the unborn, desperate fetus as an anaesthesia is started and before surgical drapes are applied. As a surgeon, I enter the womb rapidly and gently, my touch affirming this different doorway, elevating the fetal head gently and reassuringly applying oxygen, and allowing the child to come out into the light. I make sure rapidly that there is life. At the same time, as best I can, I duplicate the passage through the birth canal as the baby continues to deliver through the surgical wound. I insist that the cord be allowed to stop pulsating before clamping, thereby continuing the supply of placental blood and oxygen to the baby. Also, I assist in stimulating breathing only if needed. I cover the infant's body with a warmed towel if the condition which necessitated the emergency birthing is corrected by the birth. The infant is handed to the waiting neonatologist if resuscitation is required. The neonatologist must, ideally, be in the same calm and accepting frame of mind to reach the barely alive consciousness of the child, talking quietly and reassuringly to this fresh-born, and avoiding excessive traumatic stimulation. Once in a while it is necessary to place a tube to the lungs of a severely stressed infant. At all times the child should be spoken to and informed. Vigorous stimulation of the skin should be avoided-a child who has never felt the roughness of a towel would want to avoid this horrid event. If the child is beyond rescue and is stillborn, we must remember that the mother and father have a right to the dignity of their grief for the loss. We can, and ideally will, support contact with the spirit abiding in the baby and the parents by allowing the goodbyes necessary for all. The operating room team will also have their grief and self-criticism for the loss and the inability to rescue the baby, so they can join in the grief relieving contact with the new spirit by joining, each in his or her own way, with the child. Respect, mutual and shared, is the valued action now. Non-emergency Labor Cesarean In the non-emergency labor cesarean, through no fault of the woman because her preparation has been complete, mechanical events have led to the need for cesarean birth. In this case there is time for emotional preparation of the mother, time for connection with the unborn and time for unhurried operative preparation. Often the woman has gone through hours of labor

and is tired. The baby may appear to be in good shape but it has also undergone stress and fear in loss of its oceanic, cosmic ecology during labor. The family, through their own anxiety, may be overwrought with fear for their loved ones, mother and unborn child. The father is feeling helpless in the face of his inability to help his loved partner and his child. The staff may be frustrated and anxious for the mother and child. The labor room is tense, thus not reassuring to the mother. In the ideal situation we would already have the mother, her unborn and her personal support people in tune with the melody of this birth. We would then only have to quiet the medical staff and have them focus on the dynamic duo, the mother and her unborn. Ideally, and I have not seen staff this enlightened, we could gather around the informed mother, join her in a meditation, surrounding her with healing, loving light and energy, and respectfully do our jobs, which would lead to achieving the goal of childbirth-a child alive with this mother and father, ready for a full life. At and during the operative procedure, we can, by means of regional nerve block anaesthesia, allow the woman to be awake with her partner by her side. She can continue singing to her child, reassuring it that the invading hands are safe and that she, the team and the father are all there only for her or him, the child. Those on the operative team can focus their energies on the child by directing their energy to their hands, and on receiving the baby, not delivering it. The presenting part can be lovingly handled to make the move out of the uterus into the air emotionally, gently and assuredly. Resuscitation can be accomplished with concern for the infant's own desire to clear fluid and achieve breath. Gentleness and unhurriedness is vital at this point. The team should be concerned for the infant's somatosensory apparatus. The infant can be gently compressed by the hands of the obstetrician to simulate vaginal passage, and the infant can be covered with more warm, wet hands or a warm towel while waiting for fetal circulation to stop and the mature infant circulation system to take over. I have a big, gentle hand, and I speak softly to the child while I cover its whole body with my hand, which is gloved, wet, and smooth-like the uterine wall. I allow the child to breathe on its own, reasonably, instead of forcing it to breathe, and when all is ready, part the child from its mother by clamping the cord and presenting the child to the mother and father. Only if the infant is struggling and needs help from the pediatric team for resuscitation would I give it to them (pediatric teams tend to believe the child belongs to them to do with what they please instead of allowing bonding by contact and joining of the now enlarged family). Where possible, the operating room can be less cold and the light less bright. The eyes of the newborn can be shaded and glare and sounds that are harsh and urgent can be avoided. A bath, Leboyer style, can be ready, and the infant cradled in the father's arms in the bath. The child can then wait in the father's arms beside the mother while her wounds are being repaired. Breast feeding can occur almost immediately. The only restrictions are the surgical drapes and the flat position of the mother on the operating table. The mother may have to wait until she reaches the recovery room to breast feed. With new anaesthesia techniques the first hours are pain-free, so the child can remain with the mother instead of going to the brightly lit, noisy nursery where there is only aloneness and plastic boxes. In both of the above situations the baby and mother are at risk, and it is our intention to maintain the mother's control of the events. She must at all times feel she is important to and guiding the birthing, regardless of the emergency and the operative procedure. This also goes for the baby in a spiritual and metaphysical sense. Ideally the obstetrician and labor room personnel will honor these two people most strongly. Non-labor Cesarean Birth There are few reasons for non-labor cesarean birth: 1) placenta previa; 2) previous classical cesarean scar; 3) previous invasive uterine scars; 4) repaired cervical incompetence; and, 5) invasive cancer of the cervix. Additionally, in the past and perhaps still today, active cervical herpes may also be an indication for non-labor cesarean birth. In the ideal non-labor cesarean birth, the mother's prenatal course has been free of complications, and she is looking forward to the birth. Her pediatrician and anesthesiologist have agreed to cooperate in a consciously attended birthing and are very aware of spiritually welcoming the baby and facilitating bonding and breast feeding. The labor room staff is excited about the new approach, the opportunity to participate with the mother and father in the birthing of their new baby and to be integral to the experience. The obstetrician and his team have spent their prenatal time responding to the mother and the child and the

family. The baby has been a welcomed passenger in the uterine environment which has become a lot less roomy over the last month of pregnancy. The infant is contributing its readiness to birth. The baby's position is set, the lungs are mature, and the mother is ready emotionally and physically. Ideally we wait for labor where it is safe to do so, though certainly not with previous classical (vertical) scar, for rupture occurs most often in labor. Nor do we wait for labor when the placenta is placenta previa, covering the cervical canal, for hemorrhage is a severe, life-threatening event. Otherwise it is safe to allow labor to start. In fact, when labor is allowed to begin, there are fewer complications for the mother and the maturity of the baby is assured. After the appropriate laboratory work, which is done for the unlikely occurrence of serious complications during surgery, the mother is admitted to the labor suite-she has visited this unit and spent time with the staff responsible for her. On admission, time will be set aside for completion with her and her significant others, including her children if she has them, all recognizing that she will be different in a transpersonal sense after the birth of her unborn. The group will meditate together and give affirmations to each other. Then they will all "hold the baby", letting the baby know everyone is ready to share their lives together and reassuring this child it is wanted and they will be there for her or him. The process has been ongoing and now only lets the child know it is time. The obstetrician is there not as leader of the meditation but as an agent who will be responsible for the birthing of the infant. It is imperative that the obstetrician be part of the meditation, as well as be involved during the pregnancy. Once completed, we-those of us on the surgical team, the waiting pediatrician and his staff, the scrub nurse, the circulating nurse, anaesthesia and their staff-all gather around the mother on the operating table. Conduct in the operating room will be affirmative, positive, even lightly humorous. We will be careful not to project our anxiety, though we know that in every case the unexpected can appear. , we will have confidence in our skill and affirm the outcome. The parents will feel safety and peace only to the degree that the team has a sense of safety and peace. We will tune ourselves together by a mantra, a prayer of welcome, a song, or some music, and begin. Anaesthesia will be spinal or epidural, so that there will be no drugs in the mother or the baby, and the uterus will be opened transversely. The transverse incision of the lower uterine segment is imperative, so that the mother has the opportunity in the future for a vaginal birth rather than "once a cesarean, always a cesarean." The bag of water will not be ruptured. The baby's presenting part, hopefully the head, will be elevated gently into the surgical entrance to the uterus. With gentle pressure on the uterus, the baby's head will be delivered slowly inside the bag of water (delivered in the caul). This is not the same as a vaginal birth-it is quicker, and there are no titanic contractions over time-but the move through the vagina can be simulated this way, though it is a very poor substitute. The face is exposed only after the intense light has been deflected, and the bag of waters is opened over the face. We will maintain quiet at this point. The bag of waters is further opened, and, if needed, the nose and throat are gently aspirated before the baby aspirates excess amniotic fluid. (Amniotic fluid aspiration syndrome, with its attendant collapse of the lungs and bronchi, is still a danger, rare but life-threatening.) Gently, with pressure on the dome of the uterus, the anterior shoulder is delivered not by pulling on the head as though it were a handle, but rather lifting and depressing the head, guiding the shoulders out of the womb and through the wound. The newborn is now born and is covered by all operating hands, briefly simulating a vaginal passage, our voices quietly welcoming him or her and reassuringly stating all is well and safe-it is safe to breathe and to be here. As the cord stops pulsating and the infant-maternal circulation system has separated, the cord is clamped and cut, and the infant is given to the mother and father. Thus, the newborn's first sensations will not be of masked noisy giants, but of dim shapes speaking lovingly with rapt attention to the neonate's emotions. Bonding, as the infant's vision clears, will be with mother's voice, face, and eyes, and the infant will be lying on her chest recognizing the sounds it has grown used to, her heartbeat and breathing-the music of the womb. Loud noises are avoided, for the infant's hearing is acute. Pediatricians will judge the condition of the infant now, and if needed will assist the first moments of breathing with gentle stimulation. Meanwhile, the surgeon completes the delivery of the placenta, awaiting its delivery instead of jerking it out, and closes the uterus and abdomen. The operation is complete, and the music playing on the tape

recorder is a soft happy melody. The operating staff will gather around the mother, significant other, and baby and whisper, each in his own way, a greeting and appreciation for having been a participant in the baby's birth. Mother, baby, and significant other are taken to the recovery room, where together they recover from the event. Mother is encouraged to allow her feelings of joy or sadness. (Many mothers report the first hour or so after birth is so overwhelming they need time to gather their wits.) Allowing time and supporting any kind of reaction by the mother or father is important for the recovery room team. No feeling is to be discounted, and an emotional space is provided for the transformed woman and her newborn child within which to play. Ideally, the nursery staff will never touch the baby. They come to the mother and child for cleaning, pictures, and medication if needed, rather than moving the infant. It would be wonderful to avoid eye medication, but it is the law. Ideally, mother and child will be together skin to skin sharing the recovery, and will be rooming-in. Medication for surgical pain will often be little needed, but will be available during the post-operative stages. This will allow conscious contact between mother and baby, will allow deep bonding with the significant other who can stay in attendance until discharge. The child will be treated with loving touch and respect for its intelligence. So, ideally, we will have completed a cycle, a cycle of intention, conception, gestation and birth, all the while conscious of the transpersonal experiences of all involved which will dominate the cycle. Is this ideal possible? Yes. But there will have to be a tremendous awakening of the medical community to the need for this ideal cesarean birth. Perhaps this article will be the alarm clock. AuthorAffiliation 1 Robert J. Oliver, M.D. AuthorAffiliation 1 Dr. Oliver, is a holistic practitioner of obstetrics and a member of the APPPAH Board. He may be contacted at 81 Medical Park Loop, Suite 202, Sylva, NC 28779 Phone: (828) 586-5865 email: docroliver@aol.com

**Publication title:** Journal of Prenatal&Perinatal Psychology&Health

**Volume:** 14

**Issue:** 3/4

**Pages:** 331-343

**Number of pages:** 13

**Publication year:** 2000

**Publication date:** Spring 2000

**Year:** 2000

**Publisher:** Association for Pre&Perinatal Psychology and Health

**Place of publication:** Forestville

**Country of publication:** United States

**Journal subject:** Medical Sciences--Obstetrics And Gynecology, Psychology, Birth Control

**ISSN:** 10978003

**Source type:** Scholarly Journals

**Language of publication:** English

**Document type:** General Information

**ProQuest document ID:** 198686129

**Document URL:** http://search.proquest.com/docview/198686129?accountid=36557

**Last updated:** 2010-06-06

**Database:** ProQuest Public Health

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