Common myths about placenta delivery

Myth: The placenta is delivered at the same time as the baby

The placenta is not usually born simultaneously with the baby. It remains attached to the uterine wall while the baby is delivered, then separates as the uterus contracts and becomes smaller. The separated placenta and membranes pass through the vagina during the third stage of labour.

This stage may be managed physiologically, allowing separation and delivery to occur without routine medication, or actively, commonly with a uterotonic medication intended to support uterine contraction. The exact approach varies according to local protocols, clinical circumstances, and the patient's preferences. A person who has had significant bleeding, has risk factors for haemorrhage, or develops complications may be advised to have active management because the potential benefits may outweigh the disadvantages.

After delivery, clinicians generally inspect the placenta and membranes for completeness. This matters because retained placental tissue can interfere with effective uterine contraction and may contribute to ongoing bleeding or infection. Inspection is a routine safety step, not evidence that something has gone wrong.

Myth: A placenta that takes time to deliver is always dangerous

The duration of the third stage varies. A placenta may separate quickly, or it may take longer without necessarily indicating a serious complication. Time is only one part of the assessment. The maternity team also considers the amount of bleeding, uterine tone, vital signs, pain, the appearance of the placenta, and whether there are signs that the placenta has separated.

Concern increases when the placenta remains undelivered beyond the time threshold used by the local maternity service, particularly if bleeding is heavy or the patient becomes unwell. This may be described as a retained placenta. Possible explanations include failure of the placenta to separate, abnormal adherence to the uterine wall, or trapping of the separated placenta behind a contracted cervix. These conditions cannot be distinguished reliably from symptoms alone.

Management depends on the clinical picture. It may involve medication, examination, removal by a trained clinician, additional monitoring, or escalation to theatre. The aim is to control bleeding, identify the cause, and protect the patient’s health. A longer third stage should therefore prompt assessment rather than automatic panic, but it should never be ignored when accompanied by substantial bleeding, dizziness, faintness, worsening pain, or abnormal vital signs.

Myth: Delivering the placenta should be painless

Some people feel little during placental delivery, particularly after receiving analgesia or regional anaesthesia. Others notice uterine cramping, pelvic pressure, or discomfort as the uterus contracts. After birth, the uterus continues contracting to compress the blood vessels at the placental site; these contractions can feel like menstrual cramps or stronger afterpains.

Discomfort does not necessarily mean that the placenta is abnormally attached, and minimal discomfort does not prove that the process is complete. The clinical team uses observation, examination, bleeding assessment, and inspection of the delivered placenta rather than pain intensity alone to judge whether the third stage is progressing safely.

People should be able to ask what they are likely to feel and what pain-relief options are available. They can also ask before birth how consent will be handled if the placenta does not deliver normally. Including these preferences in a clinically realistic birth plan may support communication, while recognising that urgent treatment can become necessary if haemorrhage or another complication develops.

Myth: Eating the placenta reliably improves recovery

Placentophagy, or consumption of the placenta, is promoted in some communities as a way to replace iron, increase energy, improve mood, stimulate uterine contraction, enhance milk production, or prevent postpartum depression. These claims are biologically plausible to some readers because the placenta contains hormones and nutrients, but plausibility is not evidence of clinical benefit.

A review of the available research found that evidence for proposed benefits was inconclusive and that further research was needed regarding both benefits and risks. The Mayo Clinic similarly reports no established health benefit from eating the placenta and notes potential harm to the parent and baby. Preparation methods such as steaming, cooking, dehydration, or encapsulation do not guarantee that infectious organisms or other contaminants have been eliminated.

There is particular concern when contaminated placental material is consumed and then contributes to exposure of a breastfeeding infant. The risk cannot be assessed safely from appearance or smell. People considering placentophagy should discuss the decision with their obstetrician, midwife, or other qualified healthcare professional, especially if they or their newborn have symptoms of infection. Placenta consumption should not be presented as a substitute for evidence-based assessment or treatment of postpartum depression, anaemia, pain, or low milk supply.

Myth: Lotus birth is the same as delayed cord clamping

Delayed umbilical cord clamping means waiting for a period after birth before clamping and cutting the cord. The timing is defined by clinical guidance and the circumstances of the newborn and parent. Lotus birth, by contrast, generally means leaving the umbilical cord attached to the newborn until it

separates naturally, while the placenta is kept nearby for the intervening days.

These are different practices with different practical and medical considerations. Once the placenta is no longer perfused, it is biological tissue that can become contaminated. The placenta may be difficult to keep clean, and the attached tissue can complicate handling, transport, newborn examinations, skin-to-skin contact, and movement. Reports and reviews discussing traditional or spiritual practices have highlighted infection concerns and the lack of evidence for claimed medical benefits of lotus birth.

A person’s cultural or spiritual reasons deserve respectful discussion. Respect, however, does not remove the need for infection-control planning or newborn assessment. Anyone considering lotus birth should raise it antenatally with the maternity service and ask how the local team would manage cord care, emergency treatment, routine examinations, and signs of neonatal infection. A decision about delayed clamping should be discussed separately from a decision about prolonged attachment.

Myth: Placenta-related traditions are either medically beneficial or irrational

Placenta-related customs can carry meanings involving continuity, protection, family identity, spirituality, or connection to land and ancestry. Treating every tradition as a medical intervention can create confusion, but dismissing a tradition can damage trust and make it less likely that a patient will disclose what they plan to do. The most useful clinical conversation separates symbolic meaning from claims about physiological outcomes.

For example, a family may wish to see the placenta, take photographs, bury it, or conduct a ceremony. These requests may be compatible with care when they do not delay necessary treatment, compromise infection control, or prevent examination of the placenta when clinically indicated. Other practices may require modification because the patient or newborn is unwell, the placenta is needed for pathology, or urgent management of bleeding takes priority.

Shared decision-making should include a clear explanation of benefits, uncertainties, and possible harms. A patient can ask who will examine the placenta, whether it can be released to the family, how it will be stored, and what would change the plan. This approach acknowledges autonomy while keeping

safety central.

Myth: Once the placenta is delivered, postpartum risks are over

Placental delivery is an important milestone, but it does not mark the end of postpartum monitoring. The uterus must remain well contracted, bleeding should be assessed over time, and the placenta and membranes should be checked for completeness. Postpartum haemorrhage can occur soon after birth and may require rapid treatment even when the placenta appeared to deliver normally.

Urgent evaluation is warranted for heavy or rapidly increasing bleeding, large clots, faintness, severe weakness, shortness of breath, chest pain, confusion, severe or escalating abdominal or pelvic pain, fever, or a foul-smelling vaginal discharge. The appropriate threshold depends on the maternity service's instructions and the person's health history, so people should obtain specific discharge guidance before leaving the birth setting.

Postpartum emotional symptoms also deserve medical attention. Eating the placenta has not been shown to prevent postpartum depression, and neither cultural practices nor personal expectations should delay help for persistent low mood, severe anxiety, intrusive thoughts, inability to sleep despite opportunity, or thoughts of self-harm or harming the baby. A healthcare professional can assess the situation and discuss appropriate support.