

The Tree Knows When to Release Ripe Fruit

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Mother Nature has a secret. Modern technology has thus far been unable to unravel Her mystery. Even so, it has become common to tamper with this thing we know next to nothing about...to the detriment of our mothers and babies.

How often do we hear "...and then they had to induce me..."? According to the World Health Organization, we should only hear it rarely. About 10% of births medically require induction. Yet, the overall national rate is double that at 20.5%¹. Worse, in many areas, the rate is nearer to 60 or 70%, despite the fact that we *do not* have a conclusive determination of the complexities of what naturally initiates labor (though we think the baby "knows" when it's ready to emerge). We do, however, have conclusive evidence that inducing labor is NOT a benign action. An action, not in accordance with the baby's system which may govern the process, but on the *mother's* system.

In talking to women, and other childbirth professionals who are also in contact with birthing mothers, it is obvious that the impression women are getting is that induction is, indeed, harmless. They are basing their decisions on this belief. Unfortunately, it is a belief not supported by fact.

There are substantial risks—some due to the act of forcing a baby from the perfectly designed baby-growing environment such as iotrogenic, (doctor caused) preventable prematurity—some due to the drugs not approved for non-medically indicated induction. (Or approved, not because they have been proven safe, but because...even though they are damaging women and their babies...are already in use).²

The quandary here is that most women *are* assured an induction is medically indicated or they probably wouldn't consent in the first place.

¹ Martin Joyce, et al, "Births Final Data for 2001", National Vital Statistics Reports, Vol. 51, No. 5, Dec. 2002, p. 15.

² *FDA APPROVED OBSTETRICS DRUGS: THEIR EFFECTS ON MOTHER AND BABY*, National

Women's Health Alliance, http://www.nwhalliance.org/obstetric_drugs.htm

Alliance for Improving Maternity Services, <http://www.aimsusa.org/>

The Assault on Normal Birth, Henci Goer, <http://www.midwiferytoday.com/articles/disinformation.asp>

Certainly, there are extraordinary circumstances, about 10% of the time, when induction is warranted. In cases of severe maternal malnutrition, for instance, when the placenta has become compromised or toxemia threatens.³ Mothers with pre-existing medical conditions may not be able to provide the optimum gestational environment for a baby to grow well, or a mother who has been injured may need assistance to get her baby out a little earlier for some reason.

However, the top three reasons for inductions seem to be 1.) The ‘too big’ baby 2.) The ‘over due’ baby and 3.) Convenience—of either mother or caregiver.

This is very scary considering the risks include:

- Increased rates of surgical births, with a 5 times greater death rate for mothers
- Decreased breastfeeding rates (leading to problems with baby like painful constipation, increased painful ear infections and assorted other illnesses, increased incidence of SIDS, etc.)
- Increased postpartum depression (work is still being done to determine if this might be due to an alteration in the normal hormonal set up that Nature put in place, or lower breastfeeding rates...which also includes ‘feel good’ hormones, or that women are suffering from Post Traumatic Stress Disorder from current birth management and it is being diagnosed as PPD. Or, possibly all of the above.)
- Drug complications, including: (see earlier links for sources)

Pitocin, Mother

nausea, vomiting, death, hemorrhage in the area surrounding the spinal cord, postpartum uterine hemorrhage, anaphylactic shock (a serious allergic reaction), uterine rupture, high blood pressure (leading to placental abruption, where the placenta detaches from the uterine wall), cardiac arrhythmias (non-normal heart rate), fatal afibrinogenemia (loss of blood clotting fibrin), premature ventricular contraction(non-normal heart function), pelvic hematoma (blood clot in the pelvic region), uterine hypertonicity (excessive uterine muscle tone), uterine spasm (violent, distorted contraction of the uterus), tetanic contractions (spasmodic uterine contractions), convulsions (violent, involuntary muscle contraction(s), coma (unconsciousness that cannot be aroused), fatal oxytocin-induced water intoxication (undue retention of water marked by vomiting, depression of temperature convulsions, and coma and may end in death.

Pitocin, Baby

autism in the exposed offspring, central nervous system or brain damage, bradycardia (slow fetal heart rate), premature ventricular contractions and other arrhythmias (non-normal heart function), low 5 minute Apgar scores (non-physiologic neurologic

³Dr. Tom Brewer has done extensive research into the importance of nutrition in pregnancy.
<http://www.blueribbonbaby.org/>

evaluation), neonatal jaundice (excess bilirubin in the blood of the neonate., neonatal retinal hemorrhage (hemorrhage within the innermost covering of the eyeball), fetal death, fetal brain cell death (due to lack of oxygenation from the longer, harder contractions caused by pitocin). Many of the above problems lead to difficulty in bonding and breastfeeding as well. There have been no adequate and well-controlled studies to determine the delayed, long-term effects of Pitocin on pregnant women, or on the neurologic, as well as general, development of children exposed to Pitocin in utero or during lactation.

Cytotec⁴, Mother

Death, uterine hyperstimulation (leading to reduced blood/oxygen flow to the baby), perforation, or rupture requiring uterine surgical repair, hysterectomy or salpingo-oophorectomy (excision of a uterine tube and ovary); amniotic fluid embolism, severe vaginal bleeding, retained placenta, shock and pelvic pain. There is an increased risk of uterine rupture when Cytotec is used in patients who have had prior Cesarean delivery or major uterine surgery. (interestingly, chemical induction is now often **required** for attempted VBAC)

Cytotec, Baby

death, fetal bradycardia (low heart rate), death, meconium passage (indicating fetal distress). There have been no studies on the long-term effects of this drug on babies, though oxygen deprivation in-utero would likely lead to the same known neurological effects of pitocin.

Very often the use of these two agents, because they interrupt the hormonal feedback loop required for the body to manufacture it's own endorphins (pain/pleasure hormone), and because they produce contractions that are too long, too hard and too close together, mean that narcotics and 'caine derivatives will also be included in the mix. The negative effects of these drugs on mothers and babies is simply so extensive it is impractical to try to list them all here. See the previous links on obstetric drugs to read the extent to which these drugs damage the mother-baby dyad.

It's obvious that the decision to induce is not to be made simply for the sake of a woman tired of being pregnant or a caregiver having an out of town engagement. Sometimes women who come armed with concerns about the rate of complications will be told, "Yes, those things are possible, but they are rare. Aspirin must be labeled, for liability purposes, to warn of increased possibility of hemorrhage too, but are you worried about it"? Well, that is partially true. But think of when the last time you hear of someone hemorrhaging after taking aspirin and how often we hear of some of the affects listed above...problems with breastfeeding are so common we consider it 'normal' to have cracked and bleeding nipples. Problems with PPD are so common, we consider it 'normal' as long as it doesn't erode into postpartum psychosis. Autism has increased by

⁴The actual label for Cytotec from the manufacturer can be found here:
http://www.birthlove.com/free/devil_cytotec.html

400% in recent years⁵, and minor forms of autism, like ADD are commonplace. Normal newborn behavior is being gauged by newborns who have had their brain chemistry altered before birth and who never get a drop of the milk made especially for their specific needs.

What about the 'big baby' and the 'over due' excuses for induction? Are these concerns based on fact or fear?

Do mothers bodies grow babies that are too big to birth? On occasion. All intervention has appropriate uses, and Mother Nature might need a hand if a baby is really 'too big'. But by whose definition, and under what circumstances?

A 4 ft. 9 in. mother growing a baby made by a 6 ft. 4 in. father *might* have a baby too big to fit, but since pelvises move and babies heads mould to fit through a pelvis, that's not at all a given. A mother who has pre-existing diabetes, or who is growing a baby on excessive amounts of sugar, may grow a baby too big to fit through the pelvis. If a mother has been malnourished as a child, leading to a malformed pelvis, or if she's been in an accident that damaged the pelvis significantly, a baby may not fit even if 'normal' sized. However, 'normal' can be up to 10 lbs., though not by obstetrical standards. Midwives frequently assist in safe deliveries of healthy babies that weigh 7 to 10 lb., even with tiny mothers.

Nature has provided a design that has worked wonderfully for millions of years. Contrary to popular belief, we have not improved upon it much in the last 80 years. Yes, fewer mothers and babies die, but it is due to improved sanitation, birth control, antibiotics and better nutrition, not inductions.

Think about it. A woman's wise body knew how to grow a human being from two single cells. It knew how to produce all the organs and systems that human may use for close to 100 years. Every nerve, every cell is precisely placed and functions perfectly...yet the one thing Nature 'forgot' was a way to know when the baby would be too big to get out? Why would this be so only in American women when for every other healthy mammalian mother on the planet the process works just fine?

Likewise, the wise mother-baby knows when the time is right for healthy baby to do well on the outside. Only about 5 % of babies come on their estimated due date. Just as all children reach developmental milestones at their own pace, so too, do babies gestate at their own pace.

How ridiculous would it be to expect all three-year olds to be three feet tall, *exactly* the week they turn three years old? Would it be acceptable to give growth hormones to all children who were not 3 feet tall on their 3rd birthday, and suppressive agents to children who were taller regardless of their genetic heritage? Just because it's 'normal' and 'average' for a child to be about half of their adult height at the age of three (and a lot of people are six feet tall) doesn't mean that they will all be the same height at the same

⁵ See Mother's Intention: How Belief Shapes Birth, <http://www.womanswisdom.info> for more information

time. We don't all get teeth at exactly the same time, we don't all crawl at the same time and we don't all talk at the same time. Why would we all be at *exactly* the same developmental state at 40 weeks gestation? Not to mention the several problems with the '40 week' rule.

- Accuracy of Naegele's rule (the 40 week estimate and origin of the little wheel for calculating gestational age) has been questioned by several sources.⁶ Modern women, generally, are healthier than they were in Dr. Naegele's day. Normal, healthy pregnancy is actually closer to 41 weeks long.
- As already discussed, each baby gestates at their own rate.
- Women with longer menstrual cycles tend to be pregnant longer, too.
- Mother's nutrition is primary in determining how well baby grows and how long mom can sustain both herself and her baby optimally.
- There are slight racial differences in how long babies gestate.

Not only that, but due dates and baby weights are usually calculated via ultrasound. Ultrasound can be off by as much as 2 lb. in either direction (for a total of 4 lb...think about the difference between a 4 lb baby and an 8 lb. baby!) as well as 2 weeks either way. A baby induced as 'overdue' may actually be premature! (I've also heard of two women in the last month who had quick labors, supposedly a month 'premature', only to birth 7 and 8 lb. babies with 9 APGAR scores. These babies were treated as 'premature' despite the logical conclusion that the ultrasound was wrong and these women were actually a month further along than they thought. They were actually given harmful drugs, (again, known to be ineffectual in true premature labor, and not approved for use in pregnancy) to stop their 'premature' labors!

Something I also hear regularly is, "Well, my due date changed again." For some, this was the third or fourth time. Interesting, since the *conception date* is irrefutably stationary. Yet, based on the highly inaccurate basis of several ultrasounds all with different conclusions, women are being induced.

If there is a *confirmed* gestational age, complications can arise after 42 weeks, and the rate of infant mortality jumps again at 43 weeks. Based on this, many women are being advised to allow induction at 40 or 41 weeks...a case of 'if this is good, more is better' run amok. As we've determined, at 40 or 41 weeks, a mother may not even be 'term' yet. The actual guidelines for managing post-dates pregnancy are quite reasonable...closer monitoring of the baby after 41 weeks and induction only after 42 weeks.⁷ Robert Hamilton, assistant clinical professor of pediatrics at UCLA, says that in all his years as a pediatrician, he has seen **actual postdate babies less than 5 percent of the time** [emphasis mine KW] Moreover, the vast majority of post-date babies overcome problems after birth and are ultimately healthy. AGOC estimates that 95 percent of post-term babies are born safely between 42 and 44 weeks. According to "Human Labor and Birth" Oxorn and Foote (a standard medical

⁶ Medline: BJOG. 2000 Nov;107(11):1433-5
Holistic Midwifery, Anne Frye, Labrys Press

⁷ See www.gentlebirth.org for more information on this topic, including sources used here.

text) :

" While prolongation of pregnancy beyond 42 weeks may have an adverse effect on neonatal outcome in some cases, fetal death is rare. Induction of labor does not improve the results. What the latter practice does achieve is an increase in the rate of cesarean section because of failed induction. An uncomplicated postterm pregnancy is not an indication for the induction of labor. Early delivery is necessary only when tests of fetal health show that deterioration is taking place." page 712

So, what's a parent to do if this procedure is so prevalent that a parent, "...has no choice."

You always have a choice.

Some choices are harder to make than others, but they always exist. So, how do you know if this is a probable outcome in your situation and how do you avoid it?

Prenatally, it's important to find out what your caregiver's induction rate is, what his or her partner's rates are and what the overall induction rate is at your intended birth location. (I'm talking actual percentage rate here, not a vague "not high" response.

Once you know this, your options include:

Stay with this caregiver. If his words and actions don't mesh, (i.e. if he says he doesn't believe in routine use of interventions, yet his actions say otherwise...he's showing you who he is) you have accepted the consequences of induction because there is a high probability it will happen. His belief is shaping your birth because if he believed there was any harm in forcing babies from the womb, he wouldn't be doing it. If you are thinking you can change his belief in the next 6 months, that's delusional thinking. If you think a 70% induction rate means he won't induce you just because you don't want him to, that's denial. But, it's still your choice to make.

Choose another caregiver. This might be another OB, but the surgical specialty of obstetrics—meant to save the lives of the sick and injured mothers and babies—generally has the highest rate of inappropriately applied technology with all of the inherent risks. Other choices might be a family practice physician or a midwife.

Then, midwives are essentially in two categories...traditional and certified nurse-midwives. Either might be a good choice as long as they don't operate directly under the OB umbrella, in which case it would likely be obstetrics as usual with nice ladies and pretty rooms.

What if you thought you had a great relationship only to find out that you've been suckered by the old 'bait and switch'? You've got a 40 week emotional investment in

this caregiver you thought was on the same page, and now all of the sudden all the things he said he wouldn't do are being proposed.

You can:

Stay with him and do what he says, no questions asked. If you accept the actions, you accept the consequences.

Stay with him and expend a tremendous amount of energy verifying everything he suggests, refusing what cannot be backed by evidence.

Change caregivers. Yes, even now. I've attended a home birth of a woman who fired her physician two weeks before her VBAC when he changed his tune, telling her he could no longer 'allow' her to give birth vaginally, and I've attended a hospital birth where the young woman fired her doctor while she was in labor. She got up and went to a different hospital!

Ultimately, it is a parents responsibility to base their decisions on what is safe for their baby...not their caregiver's malpractice provider. Ripe fruit falls from the tree at just the right time. So are healthy babies born exactly when they are ready.

Kim Wildner is the author of *Mother's Intention: How Belief Shapes Birth*. Sample chapters and order forms can be found at www.realsideofbirth.com (see past shows), www.hypnobirthing.com (see annual conclave link) and at www.womanswisdom.info.