



THE SIX CARE PRACTICES THAT SUPPORT NORMAL BIRTH

Care Practice #1: Labor Begins on Its Own

A pregnant woman in a Lamaze class tells the class, “My doctor says my baby is pretty big. My neighbor had her labor induced because her baby was thought to be ‘too big.’ Do you think I should ask to be induced?”

All over the United States and in many other countries, expectant women hear similar statements in childbirth education classes. Induction of labor—starting labor artificially—is one of the most controversial issues in maternity care today. In many hospitals, labor is induced only for medical reasons, and care providers follow strict guidelines. Yet in other hospitals, women have elective inductions—those done for convenience rather than for medical reasons. Many women are confused about when induction is truly necessary. Are there problems with induction? What are the benefits of allowing labor to begin on its own? When does it make sense to induce and when is it better to wait?

Nature’s Plan for Birth

During the last weeks of pregnancy, your body and your baby prepare for birth. For a first-time mother, the baby often “drops down” into the pelvis in the weeks before birth. The cervix tilts forward and gradually begins to soften. Over a period lasting from a few days to a few weeks, you may (or may not) feel irregular contractions that help your cervix gradually thin and perhaps even dilate a few centimeters. During the last part of your pregnancy, your baby’s lungs mature and he or she puts on a protective layer of fat, taking on the characteristic chubbiness of a newborn. Researchers now believe that when a baby is ready for life outside his mother’s uterus, his body releases a tiny amount of a substance that signals the mother’s hormones to begin labor.⁵ In most cases, your labor will begin only when both your body and your baby are ready.

Medical Reasons for Induction

There are good medical reasons for inducing labor. Labor may be induced if it is more risky for your baby to remain inside your body than to be born. According to the American College of

Key Points

- Labor normally begins when both your body and your baby are ready.
- Induction of labor doubles your chance of having a cesarean section.
- Carrying a big baby is not a medical reason to induce labor.
- Letting labor begin on its own means you are more likely to experience the other care practices that support normal birth.

Obstetricians and Gynecologists, labor may be induced if:

- your water has broken and labor has not begun.
- your pregnancy is postterm (more than 42 weeks).
- you have high blood pressure caused by your pregnancy.
- you have health problems such as diabetes that could affect your baby.
- you have an infection in the uterus.
- your baby is growing too slowly.¹

It is important to know that “postterm” means you are 2 weeks past your due date. All obstetric associations define a normal pregnancy as lasting anywhere from 38 to 42 weeks. The expert physicians who write the leading obstetric textbook, *Williams Obstetrics*, have a policy of following closely women whose pregnancies have reached 41 weeks.⁶ But they do not induce until the pregnancy reaches 42 completed weeks unless there is another medical reason to do so. They say that inducing at 41 (rather than 42) weeks would mean that about 500,000 more women each year would use interventions that have not been conclusively proved necessary or harmless.

It is also important to know that suspecting a large or very large baby is not a medical reason for induction. Studies have shown that inducing labor for macrosomia (large baby) almost doubles the risk of having cesarean surgery without improving the outcome for the baby.^{10,13,17} Furthermore, it is very difficult to know how big your baby is until it is born. Ultrasound is not good at predicting which babies are macrosomic (very large). As many as 70% of women who are told they are carrying a macrosomic baby are actually carrying a normal-weight baby.³

Induction for Convenience

Induction is sometimes considered convenient for the people involved. Hospitals can staff extra nurses during shifts when inductions are scheduled, physicians can schedule births for the days and hours that are the most convenient for them, and expectant parents can make work and family arrangements according to the scheduled date of induction.

However, elective induction is not convenient when routine delays at the hospital postpone the starting time of the induction. It is not convenient when an induction does not work and the pregnant woman is sent home to try another day. And it certainly is not convenient when it leads to a cesarean birth and a new mother has to recover from major abdominal surgery rather than from a vaginal birth or if the baby has breathing problems and is separated from its mother in a neonatal intensive care unit (NICU). Before deciding to induce labor for nonmedical reasons, consider the risks of induction for both the baby and the mother.

How Labor Is Induced

Most often, labor is induced in the hospital setting by giving the drug Pitocin through an intravenous line (IV). Sometimes, medicines called “ripening agents” are used before the induction to soften the cervix and prepare it for labor. These drugs have been tested and approved by the U.S. Food and Drug Administration (FDA).

Occasionally, a drug called “misoprostol” (or “Cytotec”) is used to induce labor. This drug is approved by the FDA to treat stomach ulcers, but it has not been approved to induce labor. The FDA warns that when medical providers use misoprostol to induce labor, there can be rare but serious side effects, including a torn uterus. A tear in the uterus may result in severe bleeding and, consequently, having the uterus removed (hysterectomy), or it may cause the death of the mother or baby. These risks are more likely in women who have had previous uterine surgery, a previous cesarean section, or many previous births.¹⁹

What Research Tells Us

There is growing evidence that induction of labor is not risk-free. In 2007, Goer, Leslie, and Romano reviewed the entire body of literature on the risks of induction in healthy women with normal pregnancies and found that when labor was induced, the following problems may be more common:

- vacuum or forceps-assisted vaginal birth;
- cesarean surgery;
- problems during labor such as fever, fetal heart rate changes, and shoulder dystocia;

- babies born with low birth weight;
- admission to the NICU;
- jaundice (yellow skin caused by the breaking down of red blood cells) that required treatment; and
- increased length of hospital stay.

Additionally, women whose medical providers induced labor were more likely to use an epidural or other drugs for pain relief.

Prematurity

One of the reasons that babies born after elective induction can have poor outcomes such as low birth weight and jaundice is that some babies are accidentally induced before they reach full term (at least 37 completed weeks). This is because due dates are not exact. An ultrasound used to determine due dates during the first 20 weeks of pregnancy is accurate only within 7 days. Ultrasounds done from 20 to 30 weeks are only accurate within 14 days, and ultrasounds done in the last 10 weeks of pregnancy are only accurate within 21 days.² If there is a 2-week error in calculating a due date, a woman scheduled to be induced at 38 weeks might be only 36 weeks pregnant.

In a study published in *The Journal of the American Medical Association* that examined 4.5 million births in the United States and Canada, researchers concluded that babies born only a few weeks early—at 34 weeks through 36 weeks—were nearly 3 times more likely to die in their first year of life than full-term infants.¹¹ The causes of death included infections, breathing problems, various birth defects, and sudden infant death syndrome. The researchers stated that “obstetricians should be aware of these risks when contemplating preterm induction or cesarean delivery, and pediatricians may wish to consider closer monitoring of mildly and moderately preterm infants after hospital discharge” (pp. 847–848).¹¹ In a later interview, Dr. Michael Kramer, lead researcher of the study, said, “Obstetricians may perceive induction as risk-free and therefore not adequately balance the risks and benefits” (Tanner & Associated Press, 2000)¹⁸.

Another study published in 2004 in *Pediatrics* found that “near-term” infants born at 35 to 36 weeks gestation were at higher risk for breathing problems, jaundice, feeding problems, and problems maintaining their temperature.²² The March of Dimes has launched a campaign to increase public awareness of the increased risks for babies born between 34 and 36 weeks gestation.¹⁶ They encourage pregnant women not to ask for or agree to labor induction unless there are medical reasons for it.¹⁵

Complications and Cesarean Surgeries

Studies consistently show that inducing labor almost doubles a woman’s chance of having cesarean surgery.^{7,8} Also, in hospitals where many women are induced, a low-risk woman having her first baby is more likely to end up giving birth by cesarean section.¹⁴ The risk is not decreased by using cervical ripening agents. In fact, when medicines are used to ripen the cervix before Pitocin is given, the risk of cesarean section is even higher.^{4,9,20,21} Additionally, the risk of a rare, but life-threatening complication called “amniotic-fluid embolism” is twice as high in women whose labor is induced.¹²

Other Considerations

Increased Need for Interventions

In addition to increased risk for mild prematurity and cesarean surgery, induced labor often creates the need for more medical interventions. In most cases, if you are induced, you will need an IV and continuous electronic fetal heart rate monitoring. In many settings, you must stay in bed or very close to the bed. As a result, you may be unable to walk freely or change positions in response to your labor contractions, possibly slowing the progress of your labor. You may be unable to take advantage of a soothing tub bath or a warm shower to ease the pain of your labor contractions. Artificially induced contractions often peak sooner and remain intense longer than natural contractions, increasing your need for pain medications. Labor induction leads to a cascade of interventions, which often result in cesarean surgery.

Psychological Disadvantage

Induced labor, especially when it is not medically necessary, can send a powerful message that your body is not working correctly—that you need help to begin your labor. Allowing labor to begin on its own may increase your confidence in your ability to give birth and take care of your baby once it arrives.

Recommendations from Lamaze International

Lamaze International recommends that you neither choose induction nor agree to be induced unless there is a true medical reason. A “large” or even “very large” baby is not a medical reason for induction. Allowing your body to go into labor on its own almost always is the best way for you to know that your baby is ready to be born. Spontaneous labor also increases the likelihood that you can experience the other care practices identified by Lamaze International that support normal birth—especially freedom of movement and no routine interventions.

Experiencing natural contractions produced by your own body’s oxytocin increases your freedom to respond to your contractions by moving around, changing positions, and trying the tub or shower. Interfering with or replacing the natural hormones that orchestrate labor, birth, breastfeeding, and maternal attachment may have consequences that we do not yet understand. Laboring and giving birth without unnecessary medical intervention decrease the possibility of complications for both you and your baby and increase the likelihood that you will have positive, lifelong memories of your birth experience.

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