Saying “No” to Induction

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ABSTRACT

Induction rates have increased dramatically. A childbirth educator wonders how she can help pregnant women say “no” to induction. This column describes the last days and weeks of pregnancy as vitally important for both the mother and her baby, insuring the baby’s maturity and the mother’s readiness for labor. Women are encouraged to appreciate the last days and weeks of pregnancy and to have confidence that when a woman’s body and her baby are ready, labor will begin spontaneously. This information, as well as knowledge of how induction alters the process of normal labor and birth and increases the possibility of having a near-term infant, is the foundation for informed refusal.

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READER’S QUESTION

The number of women in my childbirth education classes who have labor induced has skyrocketed. Some women are tired of being pregnant, and an increasing number are being encouraged by their physicians to have labor induced. Threats of “your baby is getting too big” or “your blood pressure is a bit high” or “going past your due date is dangerous” and seduction with “your baby is ready, let’s get on with it” are almost routine. What can I do in classes to help women resist the threat and the temptation of induction and wait for labor to begin on its own?

COLUMNIST’S REPLY

The *Listening to Mothers* survey reported that almost 50% of the women surveyed had their labors induced (Declercq, Sakala, Corry, Applebaum, & Risher, 2002). Physicians are astonishingly up-front in discussing how much more efficient scheduled inductions (and scheduled cesareans) are. They claim that women will not have to worry about middle-of-the-night births and that hospital staff-

ing and bed turnover can be better managed. Both physicians and women seem to be comfortable with “intervention-intensive” labor and birth.

Women are between a rock and a hard place. It is so easy to be seduced into believing that the baby is ready for birth. It is also frightening to hear the physician talk about a too-large baby or a possible medical problem. In the first instance, potential problems are brushed aside; in the second instance, problems are suggested where none are likely to exist. In both cases, pregnant women do not have the full information required for making a truly informed decision.

To make an informed decision—either informed consent or informed refusal—women need to know the value of waiting for labor to start on its own. The last days and weeks of pregnancy are vitally important for both the mother and her baby. The end of pregnancy is as miraculous as its beginning. It’s a lot easier to say “no” to induction if the mother knows the essential and amazing things that are happening to prepare her body and her baby for birth.

Events during Pregnancy's Final Weeks

In the last weeks of pregnancy, maternal antibodies are passed to the baby—antibodies that will help fight infections in the first days and weeks of life. The baby gains weight and strength, stores iron, and develops more coordinated sucking and swallowing abilities. His lungs mature, and he stores brown fat that will help him maintain body temperature in the first days and weeks following birth. The maturing baby and the aging placenta trigger a prostaglandin increase that softens the cervix in readiness for effacement and dilatation. A rise in estrogen and a decrease in progesterone increase the uterine sensitivity to oxytocin. The baby moves down into the pelvis. Contractions in the last weeks may start the effacement and dilation of the cervix. A burst of energy helps pregnant women make final preparations, and insomnia prepares them for the start of round-the-clock parenting.

The watchful waiting and the intense wanting of the big day to arrive are all part of nature's plan. When the baby, uterus, placenta, and hormones are ready, labor will start. Additionally, all that preparation sets the stage for an easier labor and a fully mature baby who is physiologically stable and able to breastfeed well right from the start.

Waiting for Labor to Start

Thinking of, and clinging to, the “due date” as “the day” makes it difficult for women to trust nature's beautiful plan for the end of pregnancy and the start of labor. What women rarely know, and what people tend to forget, is that some variation exists in how long it takes for an individual baby to mature fully. Acknowledging that babies can safely come 2 weeks before or 2 weeks after the due date does not tell the whole story. Some babies are mature as early as 37 weeks (259 days), and others need 42 completed weeks (294 days) and sometimes a bit more to be fully ready. Size is not an indication of maturity, and the due date is only a guideline.

My colleagues who are midwives talk about due dates in vague terms. “The baby will probably come towards the end of August. If Labor Day comes and goes, we'll watch carefully.” In the days before ultrasound, caregivers encouraged a woman to note carefully the day she first felt her baby move. Moving forward 22 weeks gave a nice approximation of the time she would go into labor. It still does. Waiting for labor to start spontaneously is almost always the best way to know that the baby is ready to be born and that a woman's body is ready for labor.

Risks of Induction

Induction of labor alters the process of labor and birth in significant ways. The cervix often needs to be softened before pitocin (synthetic oxytocin) will be effective. Pitocin causes contractions that both peak and become stronger more quickly than naturally occurring contractions. The result is a labor that is more difficult to manage. In addition, the uterine muscle never totally relaxes between contractions, increasing stress on both the uterus and the baby. Because of the increased potential risks for the uterus and the baby, continuous electronic fetal monitoring is indicated. The fetal monitor and intravenous line make movement more difficult. The hormonal orchestration of labor is disrupted. Pitocin does not cross the blood-brain barrier; therefore, endorphins are not released in response to the increasingly strong and painful uterine contractions. Laboring women do not experience the benefits of endorphins as they try to manage their contractions. Additionally, without the help of endorphins, they are likely to require an epidural. The epidural alters the course of labor, prolonging the length of both first- and second-stage labor and increasing the need for the use of instruments at birth. Without high levels of naturally occurring oxytocin and endorphins, catecholamine levels do not surge at the time of birth, and the mother and her baby are less alert and able to interact in the moments after birth.

Elective induction increases the risk of giving birth to a baby that is near-term (born between 35 and 37 weeks, even when it seems the baby should be 38–40 or even 42 weeks by dates). In spite of their physical appearance, near-term infants are physiologically and developmentally significantly less mature than full-term infants and are at increased risk for mortality and morbidity in the newborn period (Wang, Dorer, Fleming, & Catlin, 2004). The near-term infant is at increased risk for temperature instability, hypoglycemia, respiratory distress, apnea and bradycardia, and clinical jaundice (Wang et al., 2004). The baby's difficulty in coordinating suck/swallow and breathing abilities contributes to problems with feeding; subsequently, poor feeding adds an increased risk of hyperbilirubinemia (Sarici et al., 2004). Near-term infants are 2.4 times more likely than full-term infants to develop significant hyperbilirubinemia (Sarici et al., 2004). Even “well” near-term infants who have a normal hospital stay are at increased risk for hospital readmittance, most frequently due to

inadequate feeding and to jaundice (Bhutani et al., 2004; Escobar et al., 2005; Wang et al., 2004). The AWHONN Near-Term Infant Initiative: A Conceptual Framework for Optimizing Health for Near-Term Infants (Medoff-Cooper, Bakewell-Sachs, Burus-Frank, & Santa-Donato, 2005) is an excellent summary of the problem, the research, and practice implications. Women in your childbirth education classes should know that one way to reduce the number of near-term infants born is to reduce the number of elective inductions.

Promoting Nature's Plan and Normal Birth

Nature is not perfect. However, when it comes to babies and birth, unless there is a clear medical indication that induction of labor will do more good than harm, nature beats science hands down. For both mothers and babies, it is safe and wise to wait patiently until labor begins on its own.

In our childbirth education classes, it would be wonderful if we could help women reframe the last days and weeks of pregnancy and begin to look on this time as important for their babies and for themselves. As each day passes—even if the days are well past the due date—what if pregnant women delighted in the steady maturing of their baby and appreciated the slow preparation of their body for labor? We can help women to think of this time as important psychologically and emotionally, as well as physically, providing an opportunity to rest, to think, and to complete the final preparations for the baby. At a time when we are most likely to meet women, we can also help them approach the end of pregnancy in wonder at the beauty and wisdom of nature's plan.

Lamaze classes may be the only place where women hear the story of normal, natural birth, including the value of letting labor start on its own. Encourage the women in your childbirth education classes to spend time with *The Official Lamaze Guide: Giving Birth with Confidence* (Lothian & De Vries, 2005) and to read the Lamaze International care-practice position paper, *Labor Begins on Its Own* (Amis, 2003), in order to reinforce the importance of the last weeks of pregnancy, the risks of induction, and how to keep labor as normal as possible if induction is medically indicated. When the women in your classes develop their birth plans, make sure they make plans for what they will do to stay confident in the last weeks (even if the due date comes and

goes), as they wait patiently, cherishing each day of pregnancy, for labor to start.

Saying “no” to induction and to other interventions that are becoming routine takes courage and confidence, as well as the knowledge that women have the right to informed refusal. What women learn from you about nature's plan for labor and birth, including the beauty of waiting for labor to start on its own and the risks of interfering without clear medical indication, will insure that the women you teach will have the information they need to confidently say “no” to routine induction.

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Important childbirth education resources, such as The Official Lamaze Guide: Giving Birth with Confidence, are available at the Lamaze Bookstore and Media Center. Call toll-free at 877-952-6293 or visit the bookstore link on the Web site for Lamaze International (www.lamaze.org).

For copies of Lamaze International's six care-practice papers that promote normal birth, call Lamaze International toll-free at 800-368-4404 or download them from the Web site of the Lamaze Institute for Normal Birth (<http://www.lamaze.org/institute/carepractices/intro.asp>). Also, each of the six care-practice papers, along with commentary by leading childbirth educators and health-care providers, is presented in the entire issue of The Journal of Perinatal Education (2004), Volume 13, Number 2, which is available on-line at <http://www.ingentaconnect.com/content/lamaze/jpe> or by calling Lamaze International toll-free at 800-368-4404.