This is an attempt to briefly address the issue of using pitocin during labor. This is just a sketch based on my research compiled from numerous journals, articles and books, in addition to discussions with childbirth educators, practitioners and many moms.

Inducing labor with pitocin or any other drug is not the same as the body going into labor naturally, and the results of induced labor are not the same as those of natural labor. A woman's body was designed to give birth. It is a natural, normal function. When you interfere with the natural birth processes, you often get unfavorable results. The body reacts quite differently to its own natural timing of labor and the forced induction of labor. When the woman's body and the baby are ready, labor begins. In fact, the baby releases hormones that precipitate labor. When the baby is ready to be born, he sends endocrine signals, consisting of catecholamines, to the placenta, which stimulates estrogen production. Then, the woman's body secretes bursts of the hormone oxytocin, which signals the uterus to contract. It is vital for the baby's complete development to allow this process to happen naturally. Forcing labor before it is truly time subjects the baby to an early arrival for which he is not prepared, and causes the uterus to work ineffectively, complicating the birth process. The now-common practice of labor induction was not introduced for the safety and best interests of mother and baby.

The drug pitocin is a synthetic form of oxytocin made from mammalian pituitary extracts in combination with acetic acid and chloretone. Unlike the body's pattern of natural oxytocin bursts, pitocin is administered in a steady IV flow. Dosing of pitocin is not an "exact science;" it can be hard to determine how much to use. The most common problem with pitocin is hyperstimulation of the uterus, leading to fetal distress. Pitocin inductions are the leading cause of C-sections. Let us not forget that first and foremost, OBs are trained surgeons. The overwhelming majority of OBs have never witnessed a normal labor; they are indoctrinated with the presupposition that labor is dangerous and the need for surgical intervention looms around every turn. They are not taught that a woman's body knows how to birth. Their technocratic ideology promotes the belief that a woman's body is a faulty machine that needs intervention during the labor process.

Pitocin is most often used to induce labor before it has begun naturally (its other use is to augment a labor that has already begun). When the body is not yet ready for the birthing process that it is being forced into, the result is often excessive maternal discomfort and fetal stress. Unlike natural contractions, pitocin-induced contractions lack a slow build-up and are much stronger/harder, faster, and more frequent than normal. When uterine contractions are too hard and/or too long, uterine blood flow is reduced and the baby is deprived of oxygen. It's important to remember that the baby experiences every contraction just as the mother does. Unnaturally strong and long contractions, produced by pitocin, are quite difficult for the baby, not just painful for the mother. And while a mother opts for pain medication to numb her experience of the monster contractions, the baby does not experience pain relief. When the baby experiences the increased pain and decreases of optimal oxygen supply from these unnatural contractions, his heart rate is compromised, which prompts the diagnosis of "fetal distress," and leads to the conclusion that a C-section is "necessary" to "save" the baby. Of course, the OB is merely

"saving" the baby from the unnecessary and dangerous complications that were caused by the administration of the induction drugs.

Timing is very important in labor. When the body is ready for birth, the cervix ripens. If a woman is induced before this ripening occurs, higher amounts of pitocin are required, which cause even more painful contractions, longer labor and stress to the baby. As one MD has said, "Inducing labor is not like turning on a faucet. If the body isn't ready, an induction may fail and, after hours or days of trying, a woman may end up having a cesarean delivery. This appears to be more likely if the cervix is not yet ripe."

The CDC-reported US cesarean rate for 2004 was 29.1%. That rate was an increase of 40% since just 1996. In 2010, the U.S. cesarean rate was 32.8%.[1] The World Health Organization states that a cesarean rate greater than 10-15% cannot be justified.[2] Journal-published OBs/ practitioners, scientists and educators from around the world are saying "high caesarean birth rates are an issue of international public health concern" and are studying the causes of this trend. The United States has the highest C-section rate in the world and many concerned experts in the birthing community are asking why. Among other causes is the link between induced labor, epidurals and C-sections. The issue may be contentious, but is compelling. Even the American Journal of Obstetrics and Gynecology has revealed this "unintended effect" of epidurals during labor. The basic understanding is that the combination of induction and epidural often causes fetal distress, and increases the risk of an operative delivery (C-section). [The epidural/pitocin cycle usually takes one of two courses. In the first scenario, the woman wants an epidural during labor. Epidurals slow contractions by lowering the mother's release of oxytocin, slowing natural labor and often leading to mom being labeled with "failure to progress." The result is most likely the administration of pitocin. In the second scenario, the labor is induced, producing monstrous contractions, at which point the epidural is administered.]

Pitocin was synthesized in 1953 and was available by 1955 for use in labor induction. By 1974, pitocin was found to have a 40-50% failure rate. Pitocin was investigated by the US Senate and hearings were held between 1978 and 1981. During the hearings, OBs testified on the dangers to mothers and babies of the use of pitocin for routine elective labor induction.

In 1978, the FDA advisory committee removed approval of pitocin for elective induction of labor. I repeat, this drug is NOT approved by the FDA for elective induction of labor.[3] The World Health Organization advises against the routine use of pitocin. The Physician's Desk Reference states that "pitocin is not indicated for elective induction of labor." The PDR

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[1] http://www.cdc.gov/nchs/data/nvsr/nvsr60/nvsr60_02.pdf

[2] World Health Organization. Appropriate technology for birth. Lancet 1985; 2: 436-7.

[3] http://www.drugs.com/pro/pitocin.html

recommends the use of pitocin only when medically necessary…dosage is difficult to determine and you cannot predict how the woman's body will respond. It also instructs that once given pitocin, the woman should be given oxygen, continuous fetal monitoring and constant medical supervision. Pitocin overdose causes fetal distress, which is treated as an emergency condition. [This is what I call the cascade effect: one birth intervention leads to another and so on, until the birth is no longer a natural process, but a stressful medical event. These other interventions, such as constant electronic fetal monitoring, have their own negative impacts, but I shouldn't run down too many rabbit trails.] A recent study in the American Journal of Obstetrics and Gynecology suggests that medically induced labor should be reserved for situations in which continuing the pregnancy means a health risk for mother or baby. (And I'm no fan of the ACOG, but even that organization has doctors raising eyebrows over the rise in inductions and the rise in C-Sections.)

Side effects of pitocin include (info from package insert)[4]:
For the mother:
- Anaphylactic reaction
- Premature ventricular contractions
- Postpartum hemorrhage
- Pelvic hematoma
- Cardiac arrhythmia
- Subarachnoid hemorrhage
- Fatal afibrinogenemia
- Hypertensive episodes
- Nausea
- Rupture of the uterus
- Vomiting

Excessive dosage or hypersensitivity to the drug may result in uterine hypertonicity, spasm, tetanic contraction, or rupture of the uterus. The possibility of increased blood loss and afibrinogenemia should be kept in mind when administering the drug. Severe water intoxication with convulsions and coma has occurred, associated with a slow oxytocin infusion over a 24-hour period. Maternal death due to oxytocin-induced water intoxication has been reported.

For the baby:
- Bradycardia
- Low Apgar scores at five minutes
- Premature ventricular contractions and other arrhythmias
- Neonatal jaundice
- Permanent CNS or brain damage
- Neonatal retinal hemorrhage
- Fetal death

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[4] http://www.accessdata.fda.gov/drugsatfda_docs/label/2007/018261s028lbl.pdf

- Neonatal seizures

The induction rate in the US was 9.5% in 1990. In 2006, it was 22%.[5] The rise in inductions is attributed to elective inductions, not medically necessary ones. The legitimate medical reason for inducing labor is recognized as extreme risk to mother or baby. This includes uterine infection, high maternal blood pressure, severe pre-eclampsia or toxemia, and other complicating illnesses. It is difficult to pin down a statistical percentage of how many women truly need to be induced. According to researcher and former president of the International Federation of OB/GYNs, Roberto Caldryo-Barcia, that number is about 3% of women. [A related statistic: The number of women classified with "high risk pregnancies" is commonly considered between only 5% and 10%. So 90% of all pregnant women are considered "normal" and can expect "normal" births.]

The fact is that most babies are not born on their "due dates." Previous generations were not given specific dates, but were told, for example, "your baby is due sometime in late October or early November." Normal gestation is from 38 to 42 weeks. About 10% of babies gestate beyond 40 weeks, completely healthily.

It has long been recognized that pharmacological agents used to stimulate uterine contractions may overstimulate the uterus in labor, which, among other complications, can shear off the placenta, rupture the uterus, or cause abnormal contractions that distress the baby.

The following illustrates one of my personal "peeves" with the medicalization of birth.

A relatively new drug being used to induce labor (a "cervix-ripening" drug), is Cytotec (misoprostol). Cytotec is a peptic ulcer drug and is not approved by the FDA for labor induction. Even the package insert says, "Cytotec may cause the uterus to rupture" if the drug is used to induce labor.

By 1997, Cytotec became the "predominant agent of choice for labor induction," according to Charles Lockwood, chair of obstetrical practices for the ACOG. One reason for this? The drug is very cheap: a 25 mcg dose costs less than 50 cents. A round of pitocin costs several hundred dollars.

As with pitocin, dosing Cytotec is problematic. It comes in tablet form and is administered as such. At first, whole 100 mcg tablets were administered. After reports of uterine ruptures, docs started cutting the tablets in half or quarters to give "smaller doses." There is no established medical agreement about what constitutes the right dosage or even the right way to administer the drug. Some docs give it orally, some place it inside the cervix, some behind the cervix, some rectally.

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[5] http://www.time.com/time/health/article/0,8599,2007754,00.html

Like pitocin, Cytotec often causes unnaturally hard, long uterine contractions. The documented dangers of Cytotec are available, but not easy to compile from one comprehensive source. The FDA has reports that in three years (1998-2000), Cytotec caused 30 uterine ruptures (in 8 cases the baby died in utero) and 2 maternal deaths. Additionally, in 30 Cytotec induction studies (involving 3,415 births), results showed 14 baby deaths, 25 uterine ruptures, 2 maternal deaths, and 2 life-threatening hemorrhages. These "complications" occurred in women given the smallest dose possible, 25 mcg. A 1999 study revealed that Cytotec inductions in women with a previous C-section carry a 28-fold increase in risk of uterine rupture.

The Cochrane Collaboration, an international body of doctors and researchers, says "Cytotec cannot be recommended for routine use." In August 2000, the Searle Corp. (manufacturer of Cytotec) sent letters to 200,000 practitioners, warning that off-label use of Cytotec has caused maternal and infant death, uterine rupture, hysterectomy, retained placenta, severe vaginal bleeding and shock. After this, about 1/3 of the hospitals routinely using the drug for inductions stopped the practice. But in November 2000, the ACOG submitted a "citizen petition" to the FDA requesting it require Searle Corp. to withdraw its warning letter. The docs didn't want to lose their favorite induction drug.

I'm also no great fan of the FDA, but here is its Cytotec warning:

> This Patient Information Sheet is for pregnant women who may receive misoprostol to soften their cervix or induce contractions to begin labor. Misoprostol is sometimes used to decrease blood loss after delivery of a baby. These uses are not approved by the FDA. No company has sent the FDA scientific proof that misoprostol is safe and effective for these uses.
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> There can be serious side effects, including a torn uterus (womb), when misoprostol is used for labor and delivery. A torn uterus may result in severe bleeding, having the uterus removed (hysterectomy), and death of the mother or baby. These side effects are more likely in women who have had previous uterine surgery, a previous Cesarean delivery (C-section), or several previous births.

There's a slew of information available on the issues surrounding birth interventions, such as inductions, epidurals, continuous electronic fetal monitoring, labor/delivery positions, and more.

My research long ago put me in the noninterventionist camp. Clearly, I don't believe in the medicalization of normal birth. I have to be honest and admit that I wish nonintervention were the norm. But until it is, my hope is that expectant parents become well-educated and well-prepared "informed consumers." I believe that means studying beyond the typical OB/hospital point-of-view.

I'll close with an illustrative recollection:

When we were interviewing our local hospital birth places for Caleb's delivery, I was telling the "touring" OB nurse that I would be giving birth naturally with a CNM, would not want any drugs, monitoring or confinement to bed, that we wanted access to a tub and as relaxing an

environment as possible. Her annoyed response was, “Then why are you having your baby in a hospital?!” I chuckle now, but I remember being offended by her attitude toward us (I truly desired a homebirth and certain factors—not health-related—prevented it at that time, which I have always regretted). But later, after having the natural birth we’d planned (and dealing with more flak from other nurses along the way) I realized that we were just an anomaly in their “system” and shouldn’t take it personally. The experience was educational on various levels. My other children have been birthed at home with a traditional professional midwife...beautiful, peaceful, empowering experiences. I would never choose to do it any other way.