The timing of birth has major consequences for a baby. Too early or too late can mean the difference between life and death—or so we have come to believe—and it’s undoubtedly true at the extreme ends of preterm and post term birth dates.

Although few babies are born at these extremes of the normal length of pregnancy, much of our prenatal care is based on bringing babies to birth “in a timely fashion”—neither too early nor too late. But our understanding of “timely” is clouded, and some of our methods are self-defeating. By intervening in the natural timing of birth, we sometimes exacerbate the problems or create entirely new ones.
Normal human pregnancy is approximately 280 days, with a variation of about three weeks. There may be reason for concern if labor has not begun weeks after the due date, since placental function begins to slow after some point in gestation. Placental insufficiency can lead to poor fetal growth and, eventually, damage to the baby’s organ systems or even stillbirth. This is rare, but it is not necessarily connected to the calendar. The placenta can begin to fail at any point in pregnancy, and part of good prenatal care is monitoring growth and fluid levels so we can act before the baby’s reserves are drained. We induce labor—even advise a cesarean without labor—if the baby is in trouble, regardless of due dates. It is obvious that a baby is “better off out than in” if the placenta can no longer nourish him/her or if the uterus has become a dangerous place.

**Induction Risks**

Induction of labor causes so many problems that it should be a rarity, performed only when the benefits can be proven to outweigh the risks. Induction multiplies the risk of cesarean section, forceps-assisted delivery, shoulder dystocia, hemorrhage, fetal distress and meconium aspiration. It is a major contributor to birth-related expenses and complication in the US yet it is so common that we almost think of it as normal. More than a third of American women were induced in 1999, and another third had labors augmented with Pitocin. (The FDA says that this is the lowest estimate and that the true incidence of induction is “widely under-reported.”)

Even with early pregnancy tests and ultrasounds, induction of labor remains one of the largest causes of prematurity. Ultrasonic estimation of gestational age is still an inexact science; the range of error increases as pregnancy advances. Artifact and technician inexperience can multiply the inaccuracy. Many practitioners seem unaware of this error range or, alternatively, are unwilling to second guess a due date “confirmed” by ultrasound, even when the woman’s history and clinical assessment indicate a later due date. Hence, the woman may be induced, even though the baby is clearly several weeks early. Some people discount the danger of early induction as long as the baby is within the last month of gestation. But even minor degrees of prematurity can cause harm. Babies born before full maturity can suffer from breathing difficulties or transient tachypnea, requiring separation in the hospital. They may be more prone to meconium aspiration. They are at risk for hypoglycemia and may have trouble maintaining body temperature. They are at increased risk for nursing difficulties and feeding disorders. They suffer from colic and digestive disturbances. These “minor problems” can affect the early bonding experience and make family adjustments more difficult. The incidence of child abuse is higher with “difficult” babies. As midwives we should aim for our families to experience the best
emotional as well as physical health possible. A timely birth is a good step in this direction!

Preterm birth is rising in the United States. Some of this rise results from misjudged due dates and the fear of postdates pregnancy. Some reason that the risk of inducing an early baby is lower than the risk of allowing a pregnancy to continue past due, even when the due date is uncertain. This might be true if the perceived risk of postdates matched the actual risk. But it doesn’t!

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A Timely Birth: Part 1

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Tuesday, 01 March 2005 00:00 - Last Updated Friday, 04 April 2014 10:42

This article appeared in *Pathways to Family Wellness* magazine, Issue #05.

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