Labor Induction Indications and Methods

Episode 73 · June 7, 2018 · with Dr. Allison Hill

IN THIS EPISODE

When is inducing labor truly necessary — and when is it just routine? OB/GYN Dr. Allison Hill walks Dr. Elliot Berlin, DC through the real indications (and non-indications) for induction, the methods available, and the pros and cons of each.

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DR. ELLIOT BERLIN, DC: Welcome to the Informed Pregnancy and Parenting podcast. I'm your host, Dr. Ellie Perland, here with today's co-host, chiropractor, doula, wife and mother, Kristen Polisi. Welcome back.

DR. ALLISON HILL: Thanks for having me.

DR. ELLIOT BERLIN, DC: Of course. Today, we're going to be talking about labor induction. We're going to talk about indications, methods, and outcomes with OB-GYN, author, and now chief of staff, Dr. Alison Hill. Welcome back.

DR. ALLISON HILL: I'm moving up in the world.

DR. ELLIOT BERLIN, DC: What is that like, chief of staff? What does it even mean?

DR. ALLISON HILL: It's like herding cats. Seriously? Yeah, pretty much. I'm trying to make everybody get along, play nice with each other.

DR. ELLIOT BERLIN, DC: That sounds like a tough job.

DR. ALLISON HILL: Between the board of trustees, the administration, medical staff.

DR. ELLIOT BERLIN, DC: I bet if anybody can do it, it's you.

DR. ALLISON HILL: We'll see. I'm 11 days in.

DR. ELLIOT BERLIN, DC: I can't imagine people being mad at you.

DR. ALLISON HILL: I'm trying to. Yeah, that's I'm a peacemaker, apparently.

DR. ELLIOT BERLIN, DC: You're a peacemaker, a good, like, communicator.

DR. ALLISON HILL: Yeah, I hope so. We'll see.

DR. ELLIOT BERLIN, DC: Without being a toe-stepper.

DR. ALLISON HILL: We'll see how it goes.

DR. ELLIOT BERLIN, DC: Good luck with him. Yeah. And congratulations. We want to talk about labor induction and augmentation. It's first of all, I'll say, as we always do, but especially today, that our discussion shouldn't be construed as medical advice. We're just giving information to help better understand your various factors and options and to help you be a part of the decision making together with your health care practitioner. So induction and augmentation are things that come up for my patients all the time and for our listeners all the time because they write in about it. And it's something that people often have to make decisions about without having good information about.

DR. ELLIOT BERLIN, DC: So why don't we just start at the very beginning and talk about the terminology. What is induction and what is augmentation?

DR. ALLISON HILL: Yeah. So labor induction means that we are starting a labor that hasn't started. It is about 30% of pregnancies in the United States are induced. Really? One in three. One in three. So one in three are induced. One in three, you get a C-section. So it's a very few that very, not that many actually go all natural. So labor induction is when we're starting from scratch. Labor augmentation is when somebody is in kind of an early phase of labor, prodromal labor, and they need some help to get things moving along faster.

DR. ELLIOT BERLIN, DC: Okay. And what are some of the reasons why we would induce?

DR. ALLISON HILL: So there are two reasons total, which are actually medically proven, legitimate reasons to be induced. Those two are preeclampsia and the post-date pregnancy meaning greater than 42 weeks.

DR. ELLIOT BERLIN, DC: Okay. Well, let's break those both down a little bit. Preeclampsia, what does that mean?

DR. ALLISON HILL: So preeclampsia is a condition of hypertension that is the result of pregnancy.

DR. ELLIOT BERLIN, DC: Hypertension is high blood pressure.

DR. ALLISON HILL: High blood pressure. So preeclampsia usually starts in pregnancies at some point after 20 weeks. There's mild preeclampsia, there's severe preeclampsia, but for patients with severe preeclampsia, the only way to cure them of this disease is to deliver the baby.

DR. ELLIOT BERLIN, DC: So it gets dangerous after a while.

DR. ALLISON HILL: It is dangerous for the mom. For the mother. Yeah. So as- But we care about her. Yeah. We do care about moms. And for moms with very dangerously high blood pressure, if it's not treated, they can have what is called eeclampsia, which means they have seizures. And it's one of the most common reasons for death during pregnancy.

DR. ELLIOT BERLIN, DC: Oh, wow. So it's serious.

DR. ALLISON HILL: Yeah. It's serious. It affects about 5% of pregnancy. So not particularly common, but there's enough of it to go around. And the only cure for it is labor induction and delivering the baby.

DR. ELLIOT BERLIN, DC: Is this something that somebody would feel? Like, oh, I feel like maybe I'm preeclampsic, or is it just you're doing your weekly visits or whatever, bi-weekly visits, and you see the high blood pressure?

DR. ALLISON HILL: Most of the time, people have no symptoms that they're aware of. And so one of the very important components of prenatal care is checking the blood pressure at every visit. And that's exactly why it's checked. Preeclampsia is more common as you get closer to your due date. So that's why our prenatal visits become more frequent. And at every visit, the blood pressure will be checked. So if your blood pressure is persistently higher than 140 over 90, you're considered to have mild preeclampsia. And if your blood pressure is higher than 160 over 100, you're considered to have severe preeclampsia.

DR. ELLIOT BERLIN, DC: Oh, wow. But what about somebody who normally has 100 over 60? So if they go up to 120 over 80, could that be a sign for them?

DR. ALLISON HILL: There can be some changes. Like if somebody jumps up about 30 points on their blood pressure, that for them could be a sign of preeclampsia. It usually, though, also goes hand in hand with having protein in the urine. So when you're pregnant and you go to the doctor's office and every time they want a urine sample, they're checking for that protein. That's not just for fun? Not just for fun. So, yeah. So the combination helps us to make the diagnosis. And for some people, they not necessarily had high blood pressure before pregnancy, right? It can happen to... It can happen to anybody. It happened to me. Yeah, I was a severe preeclampsic with help syndrome at 29 weeks. What's help syndrome?

DR. ALLISON HILL: Help syndrome is a subset of preeclampsia where people also have liver dysfunction, platelet dysfunction, meaning their blood stops clotting right.

DR. ELLIOT BERLIN, DC: Is that something you feel?

DR. ALLISON HILL: You know, I did feel a little funny when all that happened.

DR. ELLIOT BERLIN, DC: How many weeks were you when it happened to you?

DR. ALLISON HILL: 29. Oh, early. Yeah. Yeah. Wow. So I was induced. So yeah, 29 weeks.

DR. ELLIOT BERLIN, DC: You were induced at 29 weeks?

DR. ALLISON HILL: Yes. Yeah. Whoa. I know. Yeah. So that was my drama, of course.

DR. ELLIOT BERLIN, DC: Were you already practicing?

DR. ALLISON HILL: Yeah. Yeah. Of course, as an OBGYN, all the weird stuff happens to you. So yeah, one day I went to work and I was feeling a little funny, almost kind of foggy in my head. And I went to work, but I was busy and I was running around delivering a baby. And then I was like, maybe I should take my blood pressure. Something feels funny. And sure enough, it was like 180 over 110.

DR. ELLIOT BERLIN, DC: Oh my goodness. So you were like severe.

DR. ALLISON HILL: I was severe right from the get-go.

DR. ELLIOT BERLIN, DC: Yeah. And like 28 is, right? Is that the week of like, this baby's going to make it?

DR. ALLISON HILL: It was a little dicey. It was a little dicey. So I was 29. They gave me steroids for the baby.

DR. ELLIOT BERLIN, DC: So the baby would be?

DR. ALLISON HILL: So they give us a steroid shot so that the baby's lungs develop more quickly. And so they gave me some steroids. We waited 48 hours and then I was induced. Wow. So yeah, how about that? Look at that. Three pounds. Three pounds. I gained three pounds today. Yeah. I'm sure I did. I had a three pound peanut. Had a big lunch. That's huge. Yeah. Wow. So that is a situation.

DR. ELLIOT BERLIN, DC: What were you planning on for your birthing?

DR. ALLISON HILL: You know, I thought I would go up there and pop that baby out and run back to work. I thought it would just be like a walk in the park. Never dawned on me I would get severe preeclampsia. So it can happen to anybody. I didn't have any medical problems.

DR. ELLIOT BERLIN, DC: Is it recurring if it happens once?

DR. ALLISON HILL: When it happens so severely, it's more likely to recur. And mine did recur with my second pregnancy, but not until 36 weeks. That must have felt like forever. Yeah. So I got induced twice. So I know all about the induction. It was definitely one of those situations where had that not been an option, I probably would not be around. In that sense, induction can be a great thing.

DR. ELLIOT BERLIN, DC: Yeah. I always like to point that out, how amazing medicine is and the interventions are when we use them sparingly.

DR. ALLISON HILL: People in third world countries die from preeclampsia all the time. So we're lucky we were able to detect it and we're able to induce when it's necessary.

DR. ELLIOT BERLIN, DC: The other thing you mentioned is going legitimately post-date.

DR. ALLISON HILL: Yeah. So going legitimately post-date, meaning going past 42 weeks with good dates and legitimate dates. So the studies actually do show that after 42 weeks, there is a benefit to the baby in an induction.

DR. ELLIOT BERLIN, DC: A benefit to the baby. Does that mean to say leaving the baby and beyond 42 weeks could be?

DR. ALLISON HILL: Could have a risk involved.

DR. ELLIOT BERLIN, DC: A negative effect on the baby? Could have a negative effect. So to prevent that, we start induction and the benefit of the induction outweighs the downside of induction, whatever that is that we're talking about.

DR. ALLISON HILL: After 42, not after 41. They grow so quickly at that point, right? They just exponentially grow the longer they're in there.

DR. ELLIOT BERLIN, DC: Sometimes it looks like they start to plateau after the due date.

DR. ALLISON HILL: That's true too.

DR. ELLIOT BERLIN, DC: They've reached their growing capacity and they're just late check out.

DR. ALLISON HILL: Is that mostly due to space? What is the reason? That they don't grow as rapidly? No, that after the 42 weeks that it's better. The placenta poops out.

DR. ELLIOT BERLIN, DC: It's only got about a 42 week contract.

DR. ALLISON HILL: Yeah. So the placenta just isn't quite as good as delivering oxygen in general. Obviously there's a lot of variation with that, but those are really the only two situations that have been medically proven to be beneficial.

DR. ELLIOT BERLIN, DC: We see induction for all sorts of things. People are told their fluid is too high or the fluid is too low or the baby's getting too big or the baby's not growing as much and it's too small. What do you do with that kind of information? What is too big, too small, too much fluid, too little fluid?

DR. ALLISON HILL: The studies on this topic show that for those that you just listed, there is no medical benefit. Too inducing. Too induce. Yeah, it is better to let nature take its course, though that rarely happens.

DR. ELLIOT BERLIN, DC: In your mind, someone may electively say that seems like a big baby, I just want to get induced.

DR. ALLISON HILL: Right. I mean, obviously the big issue with the baby size as an indicator for induction is that our ability to measure the baby from the outside is really tough.

DR. ELLIOT BERLIN, DC: So the ultrasound is not a scale?

DR. ALLISON HILL: Yeah, it's just not that accurate. So we overestimate, we underestimate. There's a lot of different factors involved and that's why exactly. If a baby truly was, say, 10 pounds and you thought it was and it actually was, then there might be a benefit. It's just that there's so much variation in our ability to determine that, that it doesn't work out.

DR. ELLIOT BERLIN, DC: Do you remember the biggest baby you delivered?

DR. ALLISON HILL: I delivered once about a 13-pounder. Vaginal? No. Was that hard to get out? It was really hard to get out. She went into labor, she got to about eight or nine centimeters, and then it was like as if the baby headed back the other direction. It was almost like the baby knew, not going vaginally, and started retreating.

DR. ELLIOT BERLIN, DC: I sometimes do that. I'm like, that tunnel's too small. My kids would be like, can I come on this slide with me? I'm like, that's not meant for me.

DR. ALLISON HILL: Yeah, the baby was quite low and then all of a sudden it wasn't anymore. It was gone.

DR. ELLIOT BERLIN, DC: So did you know the baby was going to be really big?

DR. ALLISON HILL: We knew the baby would be quite large because she had had a really big baby before.

DR. ELLIOT BERLIN, DC: Oh, this was the second baby?

DR. ALLISON HILL: Yeah, and both she and her husband were really tall. And so we had a sense it was really big, but it was just, you know, we didn't, I never guessed that big.

DR. ELLIOT BERLIN, DC: Do you remember the biggest vaginal?

DR. ALLISON HILL: Vaginal. I know for sure I've delivered 11. That's still really big. It's still really big.

DR. ELLIOT BERLIN, DC: It's big, but it's doable.

DR. ALLISON HILL: It's doable.

DR. ELLIOT BERLIN, DC: We have an episode called Labor Day Surprises where a woman, her name is Sarah, has an 11 pound baby all naturally, no meds, and not even a tear.

DR. ALLISON HILL: Yeah, I mean, I think the most important thing for women, because gosh, that phrase, your baby's getting big, oh God, I mean, that just kills people because the truth is, we don't know whether it is or not. We might have a general idea, but it scares people. You know, it scares the mom and it scares the doctor. Sure. And so, you know, the moms kind of lose, you know, they get nervous themselves. But really, what kind of what the studies show us is that the best thing you can do if your baby is larger than average is to go into labor spontaneously, you know, because that will allow the baby to hopefully rotate into the correct position, and you have the best chance of a vaginal birth that way.

DR. ALLISON HILL: I think there was a study that showed when women were told that their baby was quote unquote big, the average size was 7 pounds 11 ounces. Really? Whereas the average size in general is 7 pounds 4 ounces, so it's not that much different than average.

DR. ELLIOT BERLIN, DC: I have a theory about this. The ultrasound has a known margin of error of at least a pound in either direction or a pound and a half. So if they said 7 pounds was the measurement, it could be anywhere between 6 and 9 pounds, which you can sort of predict without

an ultrasound. But I think that as, you know, as doctors, we're always looking at where the risk could be. And so I don't think they're looking at like, oh, maybe this baby is too small to come out. You start to think maybe this baby is too big to come out. So within the scale, I think we often more predict on the bigger side than the lower side, and then you have those predictions of 9 pound baby that comes out at 7 very regularly. Exactly.

DR. ELLIOT BERLIN, DC: But once in a while it really is 9, or we were wrong and it was 10. Right. But I can count from my patients on like one hand how often we're off by a lot in the other direction. Absolutely. One of them famously was a V-back where her doctor said if the baby's measuring over 8 and a half, we're not doing a V-back. And the baby never measured over 8 and a half and came out at 10 and a half. That baby knew it was a scratch and a half.

DR. ALLISON HILL: I won't measure.

DR. ELLIOT BERLIN, DC: Make them little shadows on the ultrasound. So funny. What about IUGR? So on the other side of the coin, if your baby's measuring small or we're worried about intrauterine growth restriction, we just can't grow inside it anymore.

DR. ALLISON HILL: The studies on IUGR also show that induction is not beneficial unless there's something that famous term everybody loves, that reverse diastolic flow. So when that- That's one of my favorite terms. Favorite terms. Reverse diastolic flow means that the placenta is so crummy that the blood is actually flowing the wrong direction during a certain phase of the heartbeat cycle. So the resistance in the placenta has gotten so high that the blood flow, normally no matter what, the blood is always flowing toward the baby. But with this, the blood actually flows away from the baby.

DR. ELLIOT BERLIN, DC: Like when people siphon gas out of my tank.

DR. ALLISON HILL: Yeah, exactly. And so it's not supposed to do that. So that's a very severe case.

DR. ELLIOT BERLIN, DC: You can see it on the ultrasound?

DR. ALLISON HILL: They can see that on an ultrasound. Yeah. So like a perinatologist would do an ultrasound and they can actually- So they call that the Doppler flow. So they can actually watch the blood flowing and so they'll see it flowing backwards. Wow. So that is a severe case. But for most cases of IUGR or the small baby, the truth is most of them are just small babies.

DR. ELLIOT BERLIN, DC: Especially if they're proportional. Yeah.

DR. ALLISON HILL: They're just small. Yeah.

DR. ELLIOT BERLIN, DC: Also, we just had a case recently where we had a woman who was exactly five feet tall and her husband's five foot two. And her baby was measuring small and her doctor was freaking out.

DR. ALLISON HILL: I'm like, I'm doing the math.

DR. ELLIOT BERLIN, DC: I'd be nervous if your baby was even half or so.

DR. ALLISON HILL: Unless there's something you know that I don't know. Exactly.

DR. ELLIOT BERLIN, DC: Okay, what is placenta calcification or aging?

DR. ALLISON HILL: So again, our placentas do get older. And as they get older, calcium starts to deposit within the placenta. And you can see that in an ultrasound. And it has a very distinct kind of look to it where on the ultrasound, the placenta has these little white spots all through it. And it's getting calcified. Again though, that is just a normal part of the aging process of the placenta. And unless it is associated with where the blood isn't flowing right, it's not anything that needs to have anything done about it.

DR. ELLIOT BERLIN, DC: Is it measured in degrees? Like first degree, second degree?

DR. ALLISON HILL: No. No, it's just... You just see a lot of calcification, but it's not scary as long as you have blood flow. Right, exactly. But a lot of people get scared by it.

DR. ELLIOT BERLIN, DC: So calcification is not necessarily a predictor that the placenta is going to cramp out early?

DR. ALLISON HILL: No, no. It's just right around the due date time is where we usually start to see it. And as people go post-dates. But again, as long as the blood flow is normal, then...

DR. ELLIOT BERLIN, DC: Some people get gray hair at 20 and then live to 120.

DR. ALLISON HILL: Yeah, exactly. It's just a sign. Fluid levels.

DR. ELLIOT BERLIN, DC: What's a normal fluid level at the end of pregnancy?

DR. ALLISON HILL: Well, so we measure something called the amniotic fluid index, the AFI, which is where we measure the amount of fluid in four different quadrants on the mother's belly. And usually we like it to be 10 or above. As you get closer to the due date, again, because the baby gets bigger, there's not as much space for fluid and the baby's not urinating as much, the fluid starts to go down. So usually by term, we're looking somewhere around eight.

DR. ELLIOT BERLIN, DC: It could be all the way up to over 20.

DR. ALLISON HILL: Yeah, exactly. There's always been this term called oligohydramnios, meaning low fluid, and that is generally in AFI of five or less. But again, isolated oligohydramnios with no other issues is not a reason for induction.

DR. ELLIOT BERLIN, DC: Monitor more closely?

DR. ALLISON HILL: Not even necessarily. If it's the only finding, then no. Go home and have a drink. Yeah, but that's not what usually happens in real life. Most people with low fluid get induced.

DR. ELLIOT BERLIN, DC: Or polyhydramnios on the other side, if you start to measure above the...

DR. ALLISON HILL: Yeah, like 25 or so.

DR. ELLIOT BERLIN, DC: And it's interesting that you said that the fluid is the baby's pee.

DR. ALLISON HILL: Yeah, they're just floating around in a big thing of urine.

DR. ELLIOT BERLIN, DC: Yeah, and it sometimes affects positioning too, because if you have 24 cubic centimeters of fluid, the baby can kind of float around more than other babies and sometimes flip flat back and forth. Yeah. So just an Olympic-sized swimming pool, that's all. Exactly, what they made. Did you have any of these at the end of yours, Kristen?

DR. ALLISON HILL: Um, no, I did not.

DR. ELLIOT BERLIN, DC: Everything measured good?

DR. ALLISON HILL: Everything measured good. I think I was a little on the high side, but that helped later, I think, because I had a posterior baby and they were able to help the baby rotate because I think I had a little bit on the higher side. Yeah, it comes in handy sometimes for sure. Yeah, but aside from that, I didn't have any of that. I also had meconium.

DR. ELLIOT BERLIN, DC: You could see the meconium on the ultrasound?

DR. ALLISON HILL: No, when my water broke.

DR. ELLIOT BERLIN, DC: Oh, when your water broke, you had meconium.

DR. ALLISON HILL: Yeah, so those are my special highlights. Everybody gets something. Yeah, right.

DR. ELLIOT BERLIN, DC: So when you do induction, you're starting labor that didn't start on its own, so it's sort of like an eviction notice.

DR. ALLISON HILL: Yeah, and it's hard on your body. I mean, it's not the norm. Normally, the time leading up to labor takes weeks of preparation, where your cervix is softening, your baby is rotating into the right position. All of these things are going on probably for four to five weeks before you go into labor.

DR. ELLIOT BERLIN, DC: It kind of seems like the initial approach into the Los Angeles area, the final approach into Los Angeles, where all those wing flap maneuvers are happening.

DR. ALLISON HILL: I mean, there's a lot of stuff that's going on in there, especially having to do with cervical softening and ripening.

DR. ELLIOT BERLIN, DC: So let's talk about the cervix a little bit more. Cervix is the opening between the uterus and the birth canal.

DR. ALLISON HILL: Right.

DR. ELLIOT BERLIN, DC: And what's the difference between ripening and softening?

DR. ALLISON HILL: I guess pretty much the same thing. I use those terms interchangeably usually.

DR. ELLIOT BERLIN, DC: The different things that you're looking at towards the end, because there's the Bishop score. Yes.

DR. ALLISON HILL: So we're looking at things like normally, I would say if you felt someone's cervix, which I do all the time, your cervix feels like a nose, like it feels like the firmness of the tip of your nose. And so as you get closer though to the due date and when you're going to go into labor, your cervix starts to get a lot more squishy and thinner, and it kind of rotates a little bit within the pelvis. And there's a lot of things going on in there.

DR. ELLIOT BERLIN, DC: And you're feeling for all those in your pelvic exams.

DR. ALLISON HILL: Yeah, when we do a pelvic exam. So when that cervix starts to ripen, the early stages of that are probably happening at least a month before you actually go into labor. Whereas when we induce labor, a lot of times we're going from that nose and we're trying to force it to do all of the things. Before the changes take place. Yeah, in like a day versus six weeks. Oh, really? It can be super intense. It can be really intense. Yeah, and we're just not as good at it as nature is. The order of things is just not exactly the same.

DR. ELLIOT BERLIN, DC: So sometimes before doing an induction, especially, you know, there's a lot to weigh and measure. We didn't talk about some of the most pressing causes for induction, which are Christmas and New Year's. Oh, yeah.

DR. ALLISON HILL: Yeah, and wanting to deliver during the daytime hours and wanting a certain provider to deliver you who may be going out of town.

DR. ELLIOT BERLIN, DC: And I mean, there's all zodiac signs. Especially in the Chinese New Year, you know, you could be between a pig and a monkey. Yeah, exactly.

DR. ALLISON HILL: It's a big difference.

DR. ELLIOT BERLIN, DC: That's a lifetime. But I don't know if it counts if you cheat.

DR. ALLISON HILL: Yeah, exactly. Exactly. It's like, I was supposed to be a dog. That's right.

DR. ELLIOT BERLIN, DC: You just explain the whole life how it's supposed to be. But you can, in doing the checking and measuring, you can also sort of check the cervix and put that into the equation. I mean, if it's not urgent that you be induced today, you might want to check the cervix and see, am I effacing? Am I dilating? Is the baby coming down? Is the baby in a good rotation before deciding to or not to induce? Yeah. And then, of course, there's lots of different ways to do induction. But before we get to those, let's take a quick commercial break. And we'll come right back and talk about methods of induction with Dr. Allison Ho. Welcome back to the Informed Pregnancy Podcast, we're continuing our discussion of labor induction with Dr. Alison Hill

DR. ELLIOT BERLIN, DC: and our co-host, Kristin Palessi. So we talked about some of the reasons to induce, or maybe some of the reasons not to induce, and what induction and augmentation are. Now let's talk about how we get it done. There are certain things people freak out when they cross the due date.

DR. ALLISON HILL: Yes, it is. That is one of the hardest things for doctors, the patients, and their families. People get that date in their head, and it's like, if I am pregnant for one more second, I'm going to lose myself. And their families, too. But I've got family flying in from so and so. I need to have

the baby out of me by the time my mother lands from Florida.

DR. ELLIOT BERLIN, DC: And also, sometimes the pressure comes from their provider saying, for example, we're here in California, midwives can deliver between 37 and 42 weeks at home. But if you go past 42 weeks, they can't anymore. So then their whole birth plan changes just because they went past 42 weeks. And then also, you're obviously pretty laid back about due dates and how that's just a sort of date. And you mentioned earlier, 42 weeks being a real reason for induction. But other obstetricians don't feel as comfortable going that long, sometimes just till 40 weeks, or 40 weeks in three days, five days, seven days.

DR. ALLISON HILL: No, I have many colleagues that literally on the day after the due date, there is a plan to induce. To induce. Yeah. And they're just people, physicians are really uncomfortable with it. And I think it's a lot of probably medical legal pressures and feeling that if something were to happen to this totally normal, healthy baby, I would be faulted that I let the baby stay in. I'm not exactly sure what it's all about.

DR. ELLIOT BERLIN, DC: I think medical legal is a big part of it because science and courtroom don't always go together. Absolutely. So if something does come up after 40 weeks, that prosecuting attorney can make the case that you could have done something at 40 weeks to get this baby out healthy. And you didn't. And so this is your fault. And jurors don't care that much about science. It doesn't, when you have an injured baby, that speaks a lot louder than the fact that the science doesn't support having induced at that point.

DR. ALLISON HILL: And I will say, regarding the baby itself, there is not... If you have good dates, meaning you started your prenatal care early on and you know exactly how far along you are, the baby isn't more mature at 41 weeks versus 40. Really at 40 weeks, the baby is kind of as good as it's going to get. It's more about the fact that the baby physically may not be ready to come out in terms of its positioning and things like that. So it's not that staying in longer makes the baby like a better breather or a better... Once you're at 40 weeks, you know your baby is going to be able to breathe on the outside and it's going to be able to digest food and do all those kinds of things. But it just may not be in the right spot yet. For birth. For birth.

DR. ALLISON HILL: The birth can be better.

DR. ELLIOT BERLIN, DC: And then the other thing I think is also just, you know, from a human perspective, you never, you know, you as a doctor are caring for your patient. You want the best for them and the best for their baby. And I think psychologically, you start to buy into that. Like if anything goes wrong, this is my fault. This baby is healthy right now. Exactly. I owe it to them to get it out while it's healthy right now.

DR. ALLISON HILL: Yeah. I think that's a big factor.

DR. ELLIOT BERLIN, DC: Yeah. I mean, doctors are our givers for the most part. We're very compassionate. So for that reason, though, sometimes leading up to the 40th week or certainly beyond it, people will do lots of different things to try and get labor going and before even being medically induced. So there's all sorts of natural things. Are there things specifically that you recommend when people ask?

DR. ALLISON HILL: You know, I tell people to do anything that they're up for, whether it's having sex, whether it's going for a long walk. Um, you know, supposedly there's like a salad in the valley that, yeah, exactly. The salad have a little book. Yeah.

DR. ELLIOT BERLIN, DC: All the people who were 41 weeks and ate the salad and went into labor within a week.

DR. ALLISON HILL: Exactly. But, you know, the statistically they were probably going to do that anyway. It's like, what's in this? I know something in the dressing that you can apparently now buy and take home as well. Um, I tried it and I had contractions.

DR. ELLIOT BERLIN, DC: But I'll tell you, actually, acupuncture is kind of amazing because when there's already contractile activity happening, somebody's having irregular contractions, especially if it's been going on for a couple of days that aren't productive and they're not on a schedule. We see over and over again, they stick those needles in these two points by the sacrum and then during the session on the table, it just becomes a more normal labor pattern that turns into active labor and birth. It's pretty good.

DR. ALLISON HILL: Yeah. The other things like sex, walking, um, the data doesn't really support it. I mean, I tell people, go for it if you want to. But, um, bottom line is you're going to go into labor at some point. And a lot of times people will do something like, oh, they'll help sex. And then they went into labor and they think, you know, did A cause B? I mean, we just don't know. But statistically, it doesn't look like it makes a difference. But there's no harm in doing it. Give it a go.

DR. ELLIOT BERLIN, DC: Well, except that some people do it when they're even though they're very uncomfortable. Right.

DR. ALLISON HILL: Yeah. Like if you're not up for it, if you don't feel like going for a hike and it's a hundred degrees outside, then you probably don't. Yeah. Because again, it's going to happen when it's going to happen.

DR. ELLIOT BERLIN, DC: Plus it makes for a very busy day to go hiking and have the salad and have sex. Exactly.

DR. ALLISON HILL: There's a whole agenda going on. It's inevitable. I bet you're so exhausted.

DR. ELLIOT BERLIN, DC: There's also other natural remedies that people talk about, um, like evening primrose oil and, um, homeopathics that you could discuss with your providers to see what they think about them. Yeah. When it comes to medical induction, we have options, right?

DR. ALLISON HILL: There's a few different options and most of the decisions for these options have to do with how, um, soft and ripe your cervix is to begin with. And secondly, the way your provider was trained. So some parts of the country use certain methods more frequently than others. If you're already where your cervix is softening and you're a little bit dilated, and especially if you've had a baby before, probably the most common thing you'll be given is pitocin, oxytocin. But if you are first timer and the cervix isn't quite there, then usually you'll be giving, um, some sort of either a prostaglandin, which is something that makes the cervix soft.

DR. ELLIOT BERLIN, DC: So before we jump into those medical options, what, because oftentimes I'll hear, uh, doctors say, let's just sweep your membranes and see what happens.

DR. ALLISON HILL: So sweeping in the membranes basically means that we do an exam of your cervix and while we're doing the exam, we will put our fingers in the space in between your water bag and the wall of your cervix. And we will actually swing our fingers around in a circle and try to detach that area.

DR. ELLIOT BERLIN, DC: The cervix has to be open.

DR. ALLISON HILL: So the cervix has to be open at least maybe one or a centimeter or so in order to do that.

DR. ELLIOT BERLIN, DC: And you go through it to the other side.

DR. ALLISON HILL: So you go through the cervix.

DR. ELLIOT BERLIN, DC: So now you're in the uterus.

DR. ALLISON HILL: You're in the uterus. Exactly. And you're feeling beyond the nose. Yeah, you're, you're past the nose. The nose is now opening up and you're, uh, yeah. And you put your finger up in there and nostril almost. Yeah.

DR. ELLIOT BERLIN, DC: And I will say, um, and you're circling around and you feel the bag of water

DR. ALLISON HILL: and you feel the bag of water. And does it have a break when you do that? No, it's been a while. Yep. You've got a hangnail or something? No, um, usually not. They wear gloves. No, no, I know they wear gloves. I'm just kidding. I'm kidding. It was a joke. In our country. But usually, um, and I will say many providers, when they're doing, you know, when you go in for your weekly exams toward your due date, um, and especially if you're around 40 weeks, your doctor may very well be stripping your membranes without you even knowing it. Oh, really?

DR. ELLIOT BERLIN, DC: Yeah. Well, and that's a, that's a touchy topic because it's not necessarily its own distinct procedure. It's kind of a pelvic check that goes a little bit further.

DR. ALLISON HILL: It's sort of like a cervical exam plus. And so sometimes that's happening, um, when you, when you don't know it. So there are people that respond. And so the theory is that when the bag of water is separated from the, like the lower part of the uterus, it releases those prostaglandins. And so the prostaglandins are what causes cervix to soften. And they're very, very important for the early stage of labor. So when you do that physically, it releases this, you know, local hormone called prostaglandins. And some people take off. Some people go right into labor with it. Not everybody.

DR. ELLIOT BERLIN, DC: No, we've had a bunch like the next day. Yeah.

DR. ALLISON HILL: So it definitely can work. Um, it's a relatively non-invasive thing to do. I mean, I think compared to having to be with an IV on pitocin and all that kind of stuff, it's, um, but it's not a guarantee that it's going to work. I've had patients where I've stripped their membranes every week

for a month and a half and they still won't go into labor. You know, so.

DR. ELLIOT BERLIN, DC: But it's also good to know that sometimes people don't want to be checked at all. Right. And, um, so they ask not to be checked, but it's also good to know that if you're going to be checked, you can ask not to be have your membranes. Right.

DR. ALLISON HILL: Or, and then again, and some people ask to have it done. On the other side of the coin. Yeah. Like if they're 39 weeks and they're overall this and they want to get the show on the road, sometimes they'll ask, will you do that as well? Help me have a tourist. This did happen to me, actually. Your membrane sweeping? Yes, because I went into labor and I was probably at home for like, I don't know, 15 hours almost. And then I went in to get checked and I was like, I'm only going to be like two centimeters. We got there. I was only two centimeters. Oh, really? Like, oh, let me check you. And I was like, okay. And then she said, let me check you again, just to make sure. Cause I think I looked defeated. I was like, oh man. Okay.

DR. ALLISON HILL: And then my water broke. And that's how they saw.

DR. ELLIOT BERLIN, DC: While she was checking it? The second time.

DR. ALLISON HILL: And then all of a sudden it was like, I was like, whoa. So the same is true of sweeping the membranes. And then another quote unquote method of induction is amniotomy, which is breaking the water bag. So that's something also that can be done. Again, you have to be a little bit dilated at least in order to do that. But breaking the water bag, like stripping the membranes, also causes a release of prostaglandins.

DR. ELLIOT BERLIN, DC: It's just like popping a balloon.

DR. ALLISON HILL: Yeah, exactly.

DR. ELLIOT BERLIN, DC: With a little pin. With a little pin.

DR. ALLISON HILL: A little pin on the hook. Does it hurt? Having the water bag. You know, I wouldn't say the procedure hurts too much. It's just more that for some people, they will then start hitting it pretty hard.

DR. ELLIOT BERLIN, DC: And that's the point of no return.

DR. ALLISON HILL: Like once your water breaks, you're on a clock. Yeah, exactly. Which is different than sweeping the membranes. Because if you have a sweeping of your membranes and it doesn't work, you can just hang out longer. Whereas if you do go with breaking the water bag, you're committed. You're having the baby. Yes.

DR. ELLIOT BERLIN, DC: For you, Kristen, what did that feel like to you, sweeping the membranes, before your water birth?

DR. ALLISON HILL: I mean, it was just really a lot of pressure. It doesn't really hurt, but it's kind of uncomfortable in the middle.

DR. ELLIOT BERLIN, DC: Different than a regular pelvic check?

DR. ALLISON HILL: Like a little bit more like you notice. You're like, well, okay, that's a little bit more than getting a check.

DR. ELLIOT BERLIN, DC: Pass the nose.

DR. ALLISON HILL: Yeah, it didn't ever hurt. It was just then like after. I was like, well, I don't know.

DR. ELLIOT BERLIN, DC: Did it break while she was still in there?

DR. ALLISON HILL: Yep.

DR. ELLIOT BERLIN, DC: Oh, wow.

DR. ALLISON HILL: Everywhere. Yeah, I mean, sometimes it's like ready to blow. Yeah. So, you know, then it happens on its own a little bit.

DR. ELLIOT BERLIN, DC: So if somebody wants or needs to be induced or is going to be induced and the cervix is not ripe, it's still thick.

DR. ALLISON HILL: It's a nose. It's a nose.

DR. ELLIOT BERLIN, DC: You have agents. You were saying you have drugs you can use too. Yeah.

DR. ALLISON HILL: So we usually use prostaglandins, which often come as like vaginal suppositories and things like that. And basically they are prostaglandins and they will help that cervix to not be a nose anymore. What's it called? So the most common one we use around here is called Cervidil. Okay.

DR. ELLIOT BERLIN, DC: Is it a suppository you place yourself or it gets placed for you?

DR. ALLISON HILL: No, the doctor places it and you're in the hospital then with it.

DR. ELLIOT BERLIN, DC: Once you have it, you have to be monitored or you just...

DR. ALLISON HILL: Depends on the provider. Okay. But they want you nearby. But they want you nearby. And basically it's a suppository that goes in. You leave it in for 12 hours.

DR. ELLIOT BERLIN, DC: Which side of the cervix?

DR. ALLISON HILL: It's actually placed right behind the cervix. So in what we call the posterior fornix, the area of the vagina behind the cervix.

DR. ELLIOT BERLIN, DC: On the uterine side? On the...

DR. ALLISON HILL: No, in the vagina. On the vaginal side, so just all the way back against the cervix. All the way back, yeah. It has a string on the end and then you pull it out. Oh, the temper? Yeah, exactly. There's also... How big is it? It's about the size of a quarter. Oh, okay. Yeah, it's like a quarter with a string on it. Okay. There's also a drug called Mesoprostol, also known as Cytotec. Those are tablets, like actual tablets that are put inside the vagina. Downside with those, of course, you can't pull it out, you know, like it's in there.

DR. ELLIOT BERLIN, DC: Oh, and it dissolves.

DR. ALLISON HILL: And it dissolves, but it doesn't have the reversibility of the cervidyl.

DR. ELLIOT BERLIN, DC: And its job is also to thin out the cervix?

DR. ALLISON HILL: Exactly, it's another prostaglandin.

DR. ELLIOT BERLIN, DC: Does Cytotec cause contractions?

DR. ALLISON HILL: As a result, yeah. So basically, prostaglandins, because they soften the cervix, they kind of make the whole system more susceptible to contractions. They allow your natural oxytocin receptors to be more ripe as well. And so sometimes people will get a prostaglandin, and they will just go right into labor, and they never need pitocin or anything like that. But I would say the most common scenario is that somebody gets a prostaglandin, and then once it's done its job and their cervix has softened, then they would get pitocin.

DR. ELLIOT BERLIN, DC: So it's interesting you say that. We had a patient who's on our YouTube series, The Real Midwives of Los Angeles, and her episode at this point hasn't aired yet. But she got the cervidyl and had this major hormonal reaction to it. And labor started really strong just from the cervidyl, and she was not ready for it. Because I said, oh, we're just going to leave this in for 12 hours and pull it out.

DR. ALLISON HILL: I mean, for many, I would say the average experience is that people on cervidyl really don't feel much at all. Usually I would walk into their hospital room, and they're in there watching a movie, they're having dinner, they're just relaxing in there. But every once in a while, we get somebody. And I think those people were probably on the verge of labor anyway, or something. When they had the big reaction. Yeah. And it's like they just needed a whiff, and they were like off to the races. You ever try that here?

DR. ELLIOT BERLIN, DC: Just smell this. Exactly.

DR. ALLISON HILL: I wish we could do things as a whiff.

DR. ELLIOT BERLIN, DC: An uncanny number of people, I don't know if there's a study that proves this or not, but after they get the cervidyl and have to stay there for a bunch of hours, they watch Keeping Up with the Kardashians.

DR. ALLISON HILL: Not sure why that particular show. We should have some studies.

DR. ELLIOT BERLIN, DC: What is the Foley balloon method?

DR. ALLISON HILL: Yeah, so the Foley balloon is a mechanical dilator. And basically what it means is that it is a long rubber tube with an inflatable balloon on the end. And basically it is put, the tube is put into the cervix. So again, the cervix needs to be open about at least a centimeter to thread the tube through. And then once the tube is threaded through, the balloon is inflated. And then the balloon puts pressure on the cervix and releases prostaglandins.

DR. ELLIOT BERLIN, DC: You're going through the one centimeter opening, and you're inflating it behind the other nine centimeters?

DR. ALLISON HILL: The balloon probably inflates to maybe three centimeters in size, but it's the pressure from the balloon on the cervix that causes natural prostaglandin to be released.

DR. ELLIOT BERLIN, DC: Pressure on the cervix, like the baby putting pressure on the cervix would normally cause that.

DR. ALLISON HILL: Same kind of idea as the stripping of the membranes, that you're just kind of irritating that lower part of the cervix.

DR. ELLIOT BERLIN, DC: So it's kind of pushing the bag on one side and the cervix on the other side.

DR. ALLISON HILL: So basically you just inflate the balloon to like three, yeah, with air or with water. And then it's filled up to about three centimeters. And then as the cervix softens, because of the natural prostaglandin release, the cervix will also start to open a little bit. And at some point the balloon falls out. So once you get to three centimeters, the balloon falls out because now the cervix is open bigger. And then you can switch over then to pitocin. And again, sometimes that's all people need.

DR. ELLIOT BERLIN, DC: Those are a lot of different ways to get the cervix soft and starting to dilate. And then the pitocin is to get the contractions going now that there's no brick wall, now that the door is soft and openable.

DR. ALLISON HILL: The uterine contractions are just much more effective if the cervix is soft, because exactly like otherwise they're just kind of pounding on something that's closed. Does the cervix need to be at a certain place before you can use the balloon? Like the other ones, it could be the nose, but does this have to be like a certain? No, just as long as you can thread it through. So the mechanical dilator is actually a pretty interesting concept. Because it's not medicine per se, you know, it's not a drug. So a lot of people do like it. It's just not done in a lot of places. Again, it's sort of a regional thing. There are certain doctors that were trained with it and do it all the time as their first line, whereas other people don't.

DR. ALLISON HILL: So that's something, though, most doctors know how to do it. It's just, it might, it's also an interesting thing. Like if you, as a patient, you could always ask, you know, as a doctor, have you done, you know, what's your experience like with this? Could I try that? You know, I think sometimes if patients bring it up more, it might become more popular.

DR. ELLIOT BERLIN, DC: More of a policy, yeah. Our patients seem to like it as a choice because it's not a medical thing. The cytotech dissolves. They don't like that they can't undo it. And in fact, it does sometimes cause hyper contractions that you can't stop because you can't just pull it out. Yeah, and there's some debate as well about doing,

DR. ALLISON HILL: about using the prostaglandins in people who are trying to be back.

DR. ELLIOT BERLIN, DC: Yeah, induction in general.

DR. ALLISON HILL: In general, yeah.

DR. ELLIOT BERLIN, DC: So, and the prostaglandins because it might just over jumpstart?

DR. ALLISON HILL: That it, that what holds your scar together would also soften too much. And so there's more cases of uterine rupture with the prostaglandin induction.

DR. ELLIOT BERLIN, DC: Yeah. I'm going to back up a hair, which is VBAC is vaginal birth after cesarean. So if you're trying to do that, trial of labor after cesarean, the one major concern that people have, the thing that could go wrong is that the scar that was made during the original cesarean becomes weak and starts to open up. So, which is unfortunately called uterine rupture, which sounds very, very scary, but it sounds like a roadside bomb. So induction sometimes you want to prevent over contracting like too much pressure against it or the prostaglandins you're saying could make that scar softer than it should be. Yeah.

DR. ALLISON HILL: So it's something like then the balloon be an option for them? Right. Because the amount of the artificial prostaglandin that we give is probably a lot more than the way our body would release it naturally. So it could give them more of a chance. Yeah. Yeah, exactly. So I think the balloon dilators are pretty interesting. And again, it's actually not anything I was trained on because that was 25 years ago, but they're becoming a little more popular now.

DR. ELLIOT BERLIN, DC: The pitocin is a synthetic form of the body's oxytocin. Exactly. Oxytocin, the hormone that aside from being the love bonding and orgasm hormone also causes contractions to happen. Yes. And so how is that delivered?

DR. ALLISON HILL: So oxytocin, it can only be delivered IV. So it's a liquid that is run through an IV. It is usually started at a low dose and then increased incrementally over time to higher doses. There's all sorts of different protocols in terms of how quickly it's increased, what's the maximum you can go to. Different hospitals have different plans for that and how long can you be on it, all those kinds of things. Every hospital comes up with their own protocols.

DR. ELLIOT BERLIN, DC: And it sort of has a quick half-life, right? If you needed to... Right. Tone it back a little bit.

DR. ALLISON HILL: Yeah. So oxytocin can be turned off and your body metabolizes it quite quickly.

DR. ELLIOT BERLIN, DC: So if things are moving too fast or the contractions just become too strong or too close together, you can scale back a little bit and then... Exactly.

DR. ALLISON HILL: ...hope that things will go normal. The idea is that in order to get somebody to deliver their baby, their contractions need to be two to three in a 10-minute window. So if somebody gets to where they're contracting every minute, then you go down on it. Or if they're only contracting one in 10 minutes, you would go up on it. So there's protocols that the nurses would follow for that.

DR. ELLIOT BERLIN, DC: A question I get all the time is if somebody's going to be induced, do they have to have an epidural?

DR. ALLISON HILL: Absolutely not. It's just hard.

DR. ELLIOT BERLIN, DC: Because the contractions are different than natural contractions?

DR. ALLISON HILL: Yeah. And also, the other thing that happens when you go into natural labor is that your body prepares by releasing natural endorphins and things like that. And so when you are induced, the endorphin levels aren't as good. And so it's harder to tolerate the pain. The other thing that's tough when you're induced is most of the time, depending again on your provider and your hospital, most of the time, it's required that you have to stay in bed. So you're laying on your back.

DR. ELLIOT BERLIN, DC: Even if you don't have an epidural?

DR. ALLISON HILL: Even if you don't have an epidural, because you have to be continuously monitored. So you've got an IV, you're continuously monitored, you're laying in bed, your endorphins aren't kicking in, and now you just have to lie there and take it. So it's hard not...

DR. ELLIOT BERLIN, DC: Do you have to be catheterized?

DR. ALLISON HILL: Usually only if you get an epidural. So usually, they would let you get up and use the bathroom or a bedpan. But then right back to bed. Right back to bed. So you lose out also on the ability to move around, which I think is really important for getting that baby through the birth canal. So that's another...

DR. ELLIOT BERLIN, DC: Maybe that's why all the other animals do it. Exactly.

DR. ALLISON HILL: They walk around a lot in labor. Yeah, so that's... I mean, I would say a lot of people who get induced end up with an epidural just because of the circumstances of it. Obviously, gauging pain, is this more painful? That's always such a subjective question. But my guess is because you don't have your natural endorphins countering it, it probably does feel like it hurts more.

DR. ELLIOT BERLIN, DC: Yeah, and I think also just by observation, the way the hormones interplay when labor starts and progresses naturally with your body kind of slowing down the contractions, even though you have the oxytocin releasing, you also have the adrenaline. That kind of inhibits the oxytocin until you feel safe. The adrenaline goes away and the contractions take it up to the next step. Whereas this... But pitocin doesn't work that way.

DR. ALLISON HILL: You're just kind of forcing it along at whatever speed is required to get the right number of contractions.

DR. ELLIOT BERLIN, DC: Are there other contraindications to induction besides feedback?

DR. ALLISON HILL: Just anything where you couldn't have a vaginal birth. So obviously like a placenta previa, an active herpes outbreak, anything where you can do a vaginal birth, that would be the only other time that you couldn't do an induction. I would say most people would not induce a breach just because most people don't do vaginal breach.

DR. ELLIOT BERLIN, DC: But even the doctors who I know who deliver vaginal breaches, they usually don't do anything there. The thing is if your body will go into labor naturally, bring the baby down naturally, we'll catch the baby, but we don't push it along. That's a really good point. Other questions? Augmentation. At what point do you decide to augment? Oh, and here's another question.

I'll save it for the last one. Okay.

DR. ALLISON HILL: For augmentation... So again, that is usually used when the labor process is slow. Theoretically, it's that if you're under some sort of pressure to get the baby out because maybe the baby passed meconium and you don't want it inside for a really long time.

DR. ELLIOT BERLIN, DC: Is that something you just see in the fluid coming out?

DR. ALLISON HILL: In the fluid, yeah. Or if the mom has a fever and maybe is getting an infection, you might not want the baby to be in there for too long.

DR. ELLIOT BERLIN, DC: Time is of the essence. Yeah.

DR. ALLISON HILL: So those kind of things are legitimate reasons for kind of helping speed it along. Probably though the most common reason why labor is augmented is because people just get tired of waiting.

DR. ELLIOT BERLIN, DC: Well, I just also see sometimes from the time the water breaks, there's a clock. Yeah.

DR. ALLISON HILL: And the clock has to do with the theory of getting an infection. But the truth is most people don't get an infection unless they're getting all sorts of vaginal exams.

DR. ELLIOT BERLIN, DC: I just also wonder to myself, if infection is the concern, can we just give antibiotics?

DR. ALLISON HILL: You can.

DR. ELLIOT BERLIN, DC: Not that that's the greatest thing ever. Right, right.

DR. ALLISON HILL: You can, but I will say the one thing is that if there is an infection going on, there's not great penetration of the antibiotics to the baby in utero. And again, how much time, how long is too long to wait, that's up for debate. But I think that is a legitimate reason. If somebody is going to have a vaginal birth no matter what, and they're getting close but now they have a fever, you don't want the baby to get sick, obviously.

DR. ELLIOT BERLIN, DC: In weighing the decision whether to be induced or augmented, what are the downsides to consider?

DR. ALLISON HILL: I think the main downside is that induction is just the tip of the iceberg. You're going to probably end up with a bunch of things going on in your body. In terms of you're probably going to be in bed, you're probably not going to be able to eat, you're probably going to be having continuous monitoring, you're going to have an IV, you're most likely going to end up needing an epidural. You know, and a lot of them end up in C-sections. So, you increase your risk for all of those things if you induce. More intervention. Yeah, it's like the cascade of interventions.

DR. ELLIOT BERLIN, DC: Sort of like a gateway drug. Yeah.

DR. ALLISON HILL: Now, if you're, it is a gateway drug, if you've had a baby before, so if it's your second baby, your chance of being successful is like 10 times higher than if it's your first.

DR. ELLIOT BERLIN, DC: With induction. With induction.

DR. ALLISON HILL: And if your bishop score is high, meaning your cervix is already soft, your cervix is already open, the baby's head is low, you also have a very good chance of being successful. So, when people are really not, when their body really isn't ready, there's a very high chance you'll end up with a cesarean. So, those are the downsides to it.

DR. ELLIOT BERLIN, DC: Sounds really informative.

DR. ALLISON HILL: Yeah. Thank you.

DR. ELLIOT BERLIN, DC: I always learn a lot when you're here. I wanted to thank you again for being here. Where can we find you online?

DR. ALLISON HILL: I'm at www.LAOBGYNS.com.

DR. ELLIOT BERLIN, DC: LAOBGYNS.com. And you have a book that people can buy anywhere.

DR. ALLISON HILL: And I have a book, Your Pregnancy, Your Way.

DR. ELLIOT BERLIN, DC: A fascinating book, and of course, it's a refreshing outlook on just the body's way of going to labor and giving birth and how we can assist that and facilitate that, but also kind of get out of the way and let your body do its thing, unless we have to intervene. At home, thanks for listening. If you like our podcast, check out our blog documentaries and YouTube series at informedpregnancy.com.

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