

Inducing Labour with Acupuncture – Crucial Considerations

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Abstract

Twenty years ago the treatment principle I would use to induce labour was straightforward – establish contractions. I used strong reducing treatment at acupuncture points indicated for delayed labour, with little underlying diagnostic effort required. The results of this approach were often disappointing; whilst women gave positive feedback, often convinced that the treatment had been successful due to the contractions following treatment, clinical follow up was less encouraging. Their resulting labours were not always efficient and frequently involved medical procedures due to failure to progress, foetal distress or "stuck" babies. There was thus little advantage for these women in using acupuncture. They may have avoided a medical induction but the resulting labours were not the "natural" births they were planning. My subsequent experience of working with midwives led to a more satisfying approach, one that used acupuncture to correct possible problems, with a focus on promoting an efficient labour rather than merely hastening the onset of contractions. This article discusses this approach, and includes four aspects that I now consider crucial for achieving an optimal outcome – that of natural physiological labour. The latest research on using acupuncture for induction is also discussed, including the implications this has for clinical practice.

Introduction

Medical induction is the process of initiating labour artificially. Once labour has commenced there is then little choice but to continue with further interventions until delivery, often involving a cascade of interventions that results in a forceps, ventouse or caesarean section birth. Feedback from my early clinical practice placed a typical acupuncture induction (involving points such as Hegu L.I.-4, Sanyinjiao SP-6, Shangliao BL-31, Ciliao BL-32, Jianjing GB-21 and Kunlun BL-60) in a similar category. Once contractions had commenced, women were expected to progress within specific timeframes, and interventions such as rupturing the membranes and administration of intravenous oxytocin were often required to help labour progress, treatments which in themselves frequently led to further interventions.

I realised in hindsight that deciding to try to induce women with acupuncture at 40 or 41 plus weeks gestation - just to avoid a medical induction - was very much an intervention in itself and that attempts to stimulate contractions in women facing a medical induction were of limited value if the underlying reason for delayed labour had not been addressed. Although when compared to a medical induction acupuncture is often perceived as a gentle, natural method, if women do not progress to have an efficient physiological birth, one might question whether the treatment has in fact been beneficial. Midwives

originally became interested in using acupuncture for induction because they were able to observe specific effects following acupuncture treatment such as changes in the cervix, position of the baby and positive emotional shifts that they saw as directly beneficial for the resulting labour. Even if the woman required some medical intervention to initially establish labour they then tended to progress without further medical intervention. Being able to use acupuncture made a significant difference to their clinical practice in terms of reducing the incidence of medical induction as well as other interventions made during labour, including cesarean sections.

A small observational study of the routine practice of 14 midwives over four months indicated that acupuncture treatment before labour appeared to be beneficial in reducing medical intervention, compared to women receiving similar midwifery care without acupuncture.¹ A follow-up statistical analysis showed significant p values (<0.0085) for "an increased rate of spontaneous deliveries for first time and subsequent mothers and for decreasing caesarean section for combined first time and subsequent mothers."²

Acupuncture treatment to prepare a woman for an efficient labour is ideally commenced before an induction is required, although this may not always be possible. When a woman presents for an acupuncture induction, however, whether medical intervention is planned for the next day or the following week, treatment can still be aimed at promoting natural

physiological labour. In order to accomplish this, there are four main aspects to consider:

Crucial aspects

Is the baby in an optimal anterior position?

If the baby is in a posterior position, the woman will face the possibility of a longer and more difficult labour, as the baby has to rotate further to pass through the bony inner pelvis. In such cases, because the baby's head is not pressing effectively on the cervix, the process of cervical dilatation is prolonged, and labour will be delayed. There will also be increased back pain for the woman to cope with (due to the baby's spine facing the mother's spine as it descends). Posterior labour often results in an epidural for pain relief, with interventions such as forceps, ventouse or cesarean section for failure to progress or a "stuck baby". Obviously in such cases, inducing labour without attempting to correct the baby's position is counterproductive.

A woman may have been told that her baby is in a posterior position by her midwife after receiving abdominal palpation. Other key signs and symptoms suggesting a posterior position include: where a baby remains high at term in a woman expecting her first baby, where labour keeps stopping and starting in a woman at term (the baby is in a poor position to establish labour), or where a woman's waters have broken but labour fails to establish (again because the position of the baby is delaying the onset of labour). Acupuncture treatment in such cases can be aimed at repositioning the baby, with follow-up acupuncture or acupressure to stimulate contractions if necessary (contractions will often commence spontaneously, or if they are irregular, become more efficient once the baby has moved into an anterior position). In these circumstances acupuncture at the following points is the most effective induction treatment:

Kunlun BL-60: An empirical induction point. Midwifery feedback suggests that this is a useful point for promoting an optimal position of the baby for birth.³

Sanyinjiao SP-6: An empirical induction point. Midwifery feedback suggests this is a useful point to aid in cervical dilation and it can be used in combination with Kunlun BL-60. Useful for promoting the optimal position of the baby for birth.⁴

Duyin (Extra)⁵: Used for poor or high presentation.⁶

Zhiyin BL-67: An extremely important point if the baby is not in an anterior position.⁷ This point is not usually needled, but rather ear press needles are applied bilaterally at the end of the treatment session, and the woman advised to leave them in place when she goes into labour. An extra set of press needles can be given to the woman in case they become

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dislodged. They can be left in place for several days but should be removed if they become itchy or sore. A moxa stick can also be given to the woman to use at home to provide extra stimulation to the point over the ear press needle. If time allows, this should be applied to each toe for twenty minutes for five to six days. Women can become involved in their own treatment by learning proactive positioning. This involves a woman keeping her knees lower than her hips when sitting, in order to assist gravity to move her baby into the best possible position. Bucket-type seats such as car seats and comfy sofas therefore need to be abandoned in favour of birthing balls, sitting astride chairs (with the arms resting on the back) or even lying (rather than sitting) on the couch to relax. Further information on how to determine the position of babies (belly mapping) and suggestions for optimal foetal positioning prior to and during labour can be found on web sites such as <http://www.birth-angels.com/fetal.html> and www.spinningbabies.com.

Is this woman emotionally prepared for labour?

It is important for a woman to understand that her body has been designed to slow labour down if she does not feel safe. While this can be a useful mechanism, allowing the woman to reach a place of safety to give birth if she is under genuine threat of harm, it is not useful if it is due only as a result of *potential* fear – that is, the fear that commonly arises from the unrealistic and over-dramatised way that birth is portrayed in the media. As one woman recently commented, "I have spent years watching women on TV screaming in agony - I just don't want to do it". An American survey found that more women watched television birthing shows than attended childbirth classes (68 per cent versus 25 per cent). 32 per cent of these first time mothers and 15 per cent of mothers with subsequent pregnancies reported that they felt more worried about birth after viewing these programmes.⁸ Although this was an American survey, these programmes are shown internationally. I have found it increasingly important to check that the content of these shows does not form a woman's primary perception of what a typical birth involves. Women today have access not only to medical shows, but also to other media such as videos of births on YouTube and online chat sites, where some women recount their birthing horror stories.

Fear can also result from a previous birth experience. When asked about how they felt during a previous labour, some women report that they felt as if they were going to die, or that the pain was so great that they wanted to. Once they have given birth, their focus shifts onto how fortunate they are to have a healthy baby. Often their experience is subsequently seen to be irrelevant in comparison to what they have gained. Nevertheless, they sometimes (understandably) dread that they will have to go through a similar experience again.

Fear can also be due to a reluctance to be seen to be out of control, and the perceived loss of dignity that this entails. For this reason many women are concerned about being filmed on video. They may also be reluctant to have their mother (or mother-in-law), best-friend or even partner attend the birth, and yet feel tremendous pressure to do so, as these people often expect to be present. Ina May Gaskin refers to the “sphincter law”, where the cervix and vagina work best in the same situations as anal sphincters.⁹ For some people this involves high levels of privacy, i.e. not being watched over by relatives or friends, and not having the birth treated as a spectator sport. It may be that in order for a woman to really feel safe she may need to reconsider where she plans to give birth and who she really wants to be present to support her. It can also be helpful to have a “Plan B”, so that if similar circumstances arise as during a previous traumatic labour, the woman knows that she will receive immediate pain relief and any other necessary interventions.

Labour can also be affected by strong emotions such as anger and grief, which may originally have arisen due to a variety of factors. If left unresolved these emotions have the potential to delay the onset of labour.

While most women have some level of underlying anxiety or fear about the approaching birth, it is essential to address any significant emotional disharmony. The hormone oxytocin is released several weeks prior to labour, initially stimulating uterine contractions at night, with increasing production then aiding the transition into labour. Stress hormones such as adrenaline and noradrenaline have a direct inhibiting effect on natural oxytocin release, and therefore play a very significant role in inhibiting contractions.¹⁰ While Western medicine views such anxiety as a typical stress response, a traditional Chinese medicine diagnosis can differentiate between specific patterns of imbalance, such as the Kidney and Heart not harmonising, Kidney yin depletion, or Liver qi stagnation, and then provide appropriate treatment to deal with the situation. Dealing with these patterns not only aids oxytocin to stimulate effective contractions, but has important follow-on effects, as oxytocin also has an important role in promoting analgesia during early labour. Treatment for emotional balance is therefore important – a woman propelled into labour who is still actively producing excessive stress hormones runs the risk of a labour with inefficient contractions and without

the pain relief nature has intended to provide. In such circumstances the acupuncture points listed below can be used as the primary focus of treatment, with follow-up treatment to induce contractions where necessary:

Yongquan KID-1: Useful for women who are experiencing fear of induction or childbirth itself.¹¹ This point can be used with needles or acupressure. A practical application is to ask the woman to wear motion sickness bands (usually used to treat nausea in pregnancy through acupressure applied to Neiguan P-6) on their feet.

Taichong LIV-3: Useful for women with Liver qi stagnation. Needled deeply towards Yongquan KID-1.¹²

Lieque LU-7: Useful for emotional problems caused by worry, grief or sadness.¹³

Yintang (M-HN-3): For calming the spirit in emotional problems caused by anxiety.¹⁴

Neiguan P-6: Useful for regulating the Heart and calming the spirit.¹⁵

Shanzhong REN-17: Useful as an induction point to help descend and regulate qi stagnation in the chest.¹⁶

Gaohuangshu BL- 43: For calming the spirit.¹⁷

Is this woman physically prepared for labour?

Some women who present for an induction are physically exhausted, or else have pre-existing physical problems that, once addressed, will help to promote a physiological labour. Women suffering from acute back and pelvic girdle pain will, for instance, suffer from limited movement during labour. Haemorrhoids and vulval varicosities may inhibit a woman’s desire to push effectively during labour, and any condition that interferes with sleep, such as hip pain, heat rashes or heartburn may also need addressing. Being able to reduce pain, resolve problems that interfere with a woman’s ability to labour effectively and help a woman sleep (even if only for one or two nights) can have tremendously beneficial effects, not only on labour, but also on postnatal recovery. Such treatment, even at this late stage of pregnancy, can be surprisingly effective.

Women produce natural endorphins in the final stages of pregnancy, especially in the final week.¹⁸ It is possible that acupuncture enhances this effect, with women reporting not only reduced pain and resolution of physical symptoms after minimal treatment, but also feelings of relaxation, calm and euphoria which in turn promote a sense of calmness about the impending birth.

If women are experiencing tiredness and exhaustion, the acupuncture points listed below can be used as a focus of treatment. If time allows and it is appropriate, moxibustion treatment can be continued at home for several days.

Gaohuangshu BL- 43: A point that tonifies and nourishes the Lung, Heart, Kidneys, Spleen and Stomach.¹⁹

Zusanli ST-36: A useful point to reinforce if the woman is exhausted, due to its qi-tonifying and blood-nourishing properties.²⁰

Women may also present in clinic having received a diagnosis from their midwife or obstetrician that their cervix is unprepared for labour – often described using terms such as “unripe”, “hard” or “rigid”. In such cases Guanyuan REN-4 can be used to aid in cervical ripening, needled subcutaneously (transverse) towards Zhongji REN-3 in order to avoid piecing the uterus. Sanyinjiao SP-6 might also be used to aid cervical ripening by applying acupressure in two hourly intervals.

Is this baby really overdue?

The idea that a baby has a “best-by” date can be very real for some women.

It is important for women to understand, however, that despite advances in Western medicine the exact mechanisms that govern when and why spontaneous labour occurs remain unknown.²¹ They should also be aware that two to three days prior to the initiation of spontaneous labour, fluid production surrounding a baby’s lungs is reduced, and the baby begins to change the way it uses its lungs in utero to prepare for the transition from an environment of amniotic fluid to that of breathing air.²² This is an important stage of preparation for birth, and a clear reminder that induction of labour should remain a last resort - babies should be allowed as much time as they need to prepare for birth. Many women are under the impression that once they reach 40 weeks there is no point in waiting any longer. This is not the case. Also, in light of the fact that even first trimester scans (which are the most accurate) can be plus or minus five days,²³ due dates can be seen to be rather mythical concepts.

Current medical guidelines recommend induction post 41 weeks gestation.²⁴ It is not a case of “the earlier the better”, however – the largest study to date on induction did not induce women until three to four days after reaching 41 weeks, and within this time frame 33 per cent of the women went into spontaneous labour. This study also found no significant statistical difference in mortality outcomes between those women randomised to be induced and those who continued with their pregnancy but were induced only if monitoring indicated concern.²⁵ It should be noted that this research only reflected infant outcomes for mortality. Other risks associated with induction were not examined (for example one woman induced with prostaglandins had a resulting rapid labour involving foetal distress and a forceps delivery; her baby was born quadriplegic, but this outcome was not included).²⁶ Although initially the study reported that women randomised into the induction group had a lower rate of delivery by caesarean section, this was not the case in a later report. When the authors subsequently analysed the women who went into spontaneous labour (regardless of the group into which they were initially randomised), the results indicated that being induced actually increased the potential for a caesarean section birth:

Caesarean sections for first-time mothers who were induced

Originally randomised into the induction group 30%

Originally randomised into the monitored group 40%

Caesarean sections for first-time mothers who went into spontaneous labour

Originally randomised into the induction group 26%

Originally randomised into the monitored group 26%

Caesarean sections for subsequent mothers who were induced

Originally randomised into the induction group 7%

Originally randomised into the monitored group 10%

Caesarean sections for subsequent mothers who went into spontaneous labour

Originally randomised into the induction group 4%

Originally randomised into the monitored group - 6%

To summarise these figures, 30 to 40 per cent of women having their first baby who were induced then went on to have a caesarian section, whereas those who went into spontaneous labour experienced a lower incidence (26 per cent) of caesarian section. Similarly, there was a higher rate of caesarian section for induced subsequent mothers (7 to 10 per cent), compared with those subsequent mothers who went into spontaneous labour (4 to 6 per cent). The authors in the later report stated “We confirm the view that induced labour is associated with a higher rate of caesarean section than spontaneous labour”.²⁷

UK surveys have found that 61 per cent of women did not feel they had any say in whether or not their labour was induced, and 48 per cent of women who had been induced said that they had wanted more information than they were given.²⁸ Women have the right to fully understand the reasons for, and possible risks of, any planned medical induction. This should not be merely wishful thinking, however, as the following stipulation from the guidelines of the Royal College of Obstetricians and Gynaecologists (RCOG) confirms:

*Induction of labour should only follow informed consent by the woman. For consent to be fully informed, it should include the reasons for induction, the choice of method to be used and the potential risks and consequences for accepting or refusing an offer of induction of labour.*²⁹

Induction of labour can be a life-saving intervention, where any potential risks are outweighed by the presenting complications. In view of the fact that post-term pregnancy and social factors are estimated to account for 70 per cent of all inductions,³⁰ however, it is important to ensure that women are not being induced for convenience. While it is outside an acupuncturist’s scope of practice to decide if and when a woman requires a medical induction, it is within our scope of practice to ensure that women have

the information they need to give informed consent. We can encourage them to question both their own understanding of what a due date really means, as well as the reasons given by the obstetrician or midwife for recommending the induction. The articles referenced here can be provided to women in order to facilitate an educated discussion with their obstetrician or midwife about the timing of their induction.

For a woman who has been given a date for their induction, it may be the case that all that is needed for labour to begin spontaneously is to shift the date from 41 weeks to 41 weeks plus four days. For women who have reached 40 weeks and fear the possibility of a medical induction, it is often sufficient to facilitate spontaneous labour if they are reassured that their body and baby will be actively preparing for labour in the following days, and that acupuncture can assist in this process and provide induction treatment if necessary, prior to any medical intervention.

Stimulating contractions

Acupuncture to stimulate uterine contractions is the final stage of any induction treatment. Ideally this can be done one or two days prior to a medical induction, following the appropriate prior treatment considerations as outlined above. In these circumstances Ciliao BL-32 is needled as the main acupuncture point. I have found it important to obtain a strong sensation of qi in the lower back or cervical area with this point, and to achieve this it is necessary to needle deeply, from one and a half inches to two inches in larger women (requiring the use of a three inch needle). If the needling sensation obtained from needling Ciliao BL-32 is not satisfactory, Shangliao BL-31 and Zhongliao BL-33 can also be needled in a similar way. I have tried using methods such as electroacupuncture and moxibustion at Ciliao BL-32, to promote a more efficient response, but have not observed any significant improvement in results. I have therefore returned to simply needling the point with a strong reducing technique (obtaining deqi on insertion and then manipulating the needles every five minutes). Depending on the woman's presentation, additional points can be selected from the following, all needled with a strong reducing technique:

Guanyuan REN-4: To aid in cervical ripening.³¹ Needled subcutaneously (transverse) towards Zhongji REN-3 to avoid piecing the uterus. This is a useful point to combine with Ciliao BL-32 to dilate the cervix and is especially useful if the cervix is known to be unfavourable to labour.

Hegu L.I.-4 and Sanyinjiao SP-6: Empirical points used together to induce labour.³² These points can be needled bilaterally or unilaterally using alternate limbs (left hand and right leg or vice versa).

Jianjing GB-21: An empirical induction point. Useful when the baby has not fully engaged.³³

Kunlun BL-60: An empirical induction point. Useful when the baby has not fully engaged.³⁴

Acupressure can be used subsequent to acupuncture in order to support treatment, applied to points such as Hegu L.I.-4 and Sanyinjiao SP-6. Pressure should be applied for at least one minute at each point. This can be carried out on alternate sides (i.e. using the left hand/right foot and next time the right hand/left foot), with treatment every two hours if a woman has several days before being induced, or else every half an hour if a medical induction is imminent. Acupressure should also be applied at Ciliao BL-32, Zhongliao BL-33 and Xialiao BL-34 at least once a day (twice if possible) by the woman's support person, who should massage the points in firm downward strokes towards the buttocks for five minutes per session. Yongquan KID-1 combined with Taichong LIV-3 is also a useful combination to teach to patients at this time; I have received very positive feedback from women who found massaging these points very effective at calming anxiety. Jianjing GB-21 can also be massaged with strong pressure once or twice daily. A free acupressure booklet on the use of these points can be downloaded from my website at <http://acupressure.rhizome.net.nz>

If time is limited prior to medical induction, I have found that acupuncture treatment to address the underlying causes of delayed labour, followed by regular application of acupressure, is an effective treatment. In this way a woman is provided with treatment to reposition the baby (if necessary), relieve emotional stress, relieve pain and exhaustion, and aid in cervical ripening. They can then commence acupressure the day after their acupuncture treatment, prior to medical induction.

Research

A Cochrane systematic review identified fourteen trials on the use of acupuncture to stimulate the onset of labour. Three were considered for review. The reviewers concluded that the need for medical induction methods was reduced among women receiving acupuncture compared with standard care, but that there were no differences for any other birthing outcomes (epidural analgesia, instrumental delivery, vaginal delivery, oxytocin augmentation, duration of labour and caesarean section). As these trials were of a relatively small size (even when combined), the reviewers recommended that "there is a need for well-designed randomised controlled trials to evaluate the role of acupuncture to induce labour and for trials to assess clinically meaningful outcomes"³⁵

A study following the recommendation of the Cochrane review was published in November 2008,³⁶ in which 364 women were assigned to either an acupuncture treatment group or a control group who received sham acupuncture. Women received two 45 minute sessions over a two day period prior to a planned medical induction (following a hospital policy of inducing labour ten days post term).

Women in the acupuncture group received acupuncture at Hegu L.I.-4 and Sanyinjiao SP-6, Shangliao BL-31, Ciliao BL-32, Zusanli ST-36, and Taichong LIV-3. If appropriate, the acupuncturist used additional points from Fuliu KID-7, Pishu BL-20 or Weishu BL-21. All of the points were stimulated to achieve deqi using Seirin needles of one or two inches in length and a diameter of 32 gauge (0.25mm). Women in the sham acupuncture group were needled with shallow insertion and minimal stimulation at points not considered to be acupuncture points. 28 per cent of the women in the acupuncture group went into spontaneous labour compared to 31 per cent of women in the control group, a difference that was not statistically significant, and which led to the conclusion that acupuncture “did not reduce the need for induction methods”. Regardless of the thoughts of practitioners regarding the use of sham acupuncture in research, the percentage of women achieving spontaneous labour following 41 weeks (but before reaching 41 weeks plus 3 days) is in line with previous research where women were given no treatment except monitoring.³⁷ This suggests that neither acupuncture nor sham acupuncture had any influence on the onset of labour in this study. The authors concluded that the acupuncture points used did not reduce the need for other induction methods (prostaglandin induction, artificial rupture of membranes, oxytocin, artificial rupture of membranes plus oxytocin, or prostaglandins plus artificial rupture of membranes plus oxytocin). There were no statistically significant differences in outcomes for pain relief used in labour, mode of delivery or the duration of labour for these women. The researchers thus concluded that “there is currently insufficient evidence to support the routine use of acupuncture in clinical practice”. Although the main acupuncture points used in this research (Hegu L.I.-4, Sanyinjiao SP-6, Shangliao BL-31, and Ciliao BL-32) are promoted in text books as an effective method of inducing labour, it may be the case that although we see their effects in promoting contractions in our clinics, and receive positive feedback about their use in stimulating labour, used alone in this way as a point formula they are not actually effective in promoting natural physiological labour.

Conclusion

As acupuncturists we have access to a wide variety of treatments that can be used to promote physiological birth. Being able to integrate an acupuncture diagnosis with western medical knowledge - such as the position of the baby, the presentation of the cervix and the physical and emotional effects of hormones on the onset of labour - can facilitate a truly individualised approach that is well suited to the practice of traditional Chinese medicine. The suggestions for acupuncture points given in this article are those I have found effective, but are not intended to form an exclusive list. It is my hope that this article will encourage acupuncturists, whatever their style of practice,

to further explore the use of traditional Chinese medicine in promoting efficient labour for women. The use of acupuncture point formulas to promote contractions forms but a small and final part of this process. ■

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