Using Essential Oils for the Ultimate Birth Experience
Guest: Dr. Penny Lane

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Dr. Zielinski: Hello, everyone! This is Dr. Eric Zielinski from DrEricZ.com. I'm a chiropractor and public health researcher who specializes in natural therapies. My passion and life's work is to help people live the abundant life, which is why I'm honored to cohost this Essential Oils Summit with my dear friends Jill Winger and Dr. Josh Axe.

In my opinion and according to a decade's worth of research, there's nothing on the planet that is more versatile for everyday use and that promotes healing in the body than essential oils, which is why I'm very excited about this particular session of The Essential Oil Revolution because I'm interviewing founder of Believe Midwifery Services, Dr. Penny Lane.

Dr. Penny, welcome!

Dr. Penny: Thank you so much for the honor to be asked to join the summit. And I appreciate it!

Dr. Zielinski: Well, we are honored and blessed! You're the sole representative of the Midwifery community. And that is something that is just so dear to my heart. And we're going to talk a lot about this, I'm sure today. My wife and I have delivered 3 natural babies or three natural homebirths, I should say. My wife did all the work. But I was there. And I will say men need to get a little more credit for helping our wives go through that. We do!

Dr. Penny: Yes! Definitely!

Dr. Zielinski: I was veritably the birth stool during all of them. And it was

great. I've got to tell ya! We have a lot to talk about. And included with the whole midwifery package was the focus on natural healing through essential oils. And that's your specialty.

And, Dr. Penny, you actually come with a pretty impressive background because you hold a doctorate degree in nursing practice. You're a certified nurse midwife and an international board-certified lactation consultant. I mean, that in and of itself, should put all of your patients and clients to rest. So tell us your story. How did you get started on this journey?

Dr. Penny: Well, it's interesting. When I started nursing way back in 1997, I honestly don't know that I knew about midwifery outside of the Old Testament. So, yeah, I ended up with an OB position in an intensive care unit at the IU Med Center. So it was a really neat position. We had 80 percent—very, very high-risk women from all over the Midwest.

And it was a unit that was really evidence-based and a teaching model. We really didn't fall into that convenience-based, fear-based medicine—well, not until the Hannah 2000 Breech Study, of course. And then we started doing breech births. But outside of that, I really loved the job. I think that what I struggled with in the hospital was just being an advocate.

So I can't say becoming a midwife for me was about natural childbirth entirely. But it was more about being a voice for women and just helping them with make their decisions. Whatever that is? Just be informed and be an advocate for them. So I worked there for about 6 years. And then started…Actually, the physicians encouraged me towards midwifery and thought I would be a good fit for that. So…

Dr. Zielinski: Really?

Dr. Penny: Yeah, I do have a really neat background. And I think I was definitely molded to be where I am today. I can see more now. But yeah, so I started working in a birth center—an independent birth center. And then I

also worked in an in-house birth center. And then I did a little bit of work with some direct-entry midwives and home births. So I really did get experience in all those different setting. And I'm trying to create within my own practice now a blend of all of that. Pick the best of all those environments.

Dr. Zielinski: That's wonderful! I love the phrase, basically a patient advocate—an advocate for moms. That really was my first impression of what a doula was. My wife had a doula. Actually, all of our births, 3 of them, she had doulas. But that's one thing that the doula told us. That's what she was. She's like, "I'm your advocate. So you tell me your birth plan. And if we need to go to the hospital, I'm the one who's going to talk to the doctor for you because you need to focus on focusing on the baby."

And that's exactly what our doula did for a friend of ours who needed to be transported. And she just worked with the doctor and the nurses and said, "Hey, here am I. I'm going to talk to you." And so that's fantastic because we don't recognize that women need advocates—

Dr. Penny: Absolutely.

Dr. Zielinski: —in the system. And unfortunately, the system isn't here to support them fully. But I think it's changing. And hopefully, we have a minute or two to talk about that.

But before we do, Dr. Penny, you've been attending births for roughly, what? Twenty years now. And it seems to me, from what I could tell, home birth is becoming almost en vogue now. So let us know your thoughts a little bit on how the tides have been changing the last decade or two since you've been in the business?

Dr. Penny: Yeah. And back in '06 when I had intentions of opening a homebirth practice, I was a nurse midwife. It would have been…It's completely legal to do so in the state I live in. But I still had that fear of prosecution because there were no legally practicing nurse midwives at the time in Central

Indiana. So we did. I did take that leap and opened a practice. And I always was on guard.

And it was interesting because within 2 years of opening the practice, the Indiana State Board of Nursing did honor myself and the practice with a nurse of the year award. So I received [inaudible] advancing the nursing profession. And it was really amazing to me because I really didn't think they understood who I was and what I did for a living.

And so when I was able to speak to the group, it was an amazing experience. And it really made me see how far home birth had come and how really accepting the community is. And really even our medical community, how much they really wanted home births to be done well.

It's growing incredibly. We were point half of a person in 2004. We're nearly at one person at this point. But that's all out of hospital births, including birth center births. Home birth is definitely growing quicker than birthing nurse. But we're no longer, I would say for our practice, at the point of…We're forgetting that we're unusual. The community really has accepted us. And I think the hospitals are really supportive. So yeah, it's come a long way.

Dr. Zielinski: Now, what can you say about some of your colleagues around the country? Because I know for certain that's not the case everywhere. And, for example, my wife was actually kicked out of her OB/GYN practice because they found out we gave birth at home. And we live in Georgia.

And as far as I know the statutes, it's illegal for a midwife to do what they do. And so they have to "attend the births." So there's ways around it. But can you speak to any of that for some of the folks who don't live in your community?

Dr. Penny: Yeah. We have a large Amish clientele in Indiana. So I think that really helps pave for the way for home births in the Midwest. Yeah. A good friend of mine has a birth center—a home-birth practice in Knightsville,

Florida. So she does care for a lot of the Georgia women. And it is unfortunate. I'm also on the home birth section for the ACNM, which is our professional organization. And it is very surprising to me. I sort of forget that I have maybe found this utopia for home birthing.

But, yeah, there are three states in the country where home birth is not legal for nurse midwives to attend. And it's rather unfortunate. I do think having that high-risk background in the hospital really helped me because I feel that those medical professionals knew me as a safe clinician before I stepped into the home birth.

But, yeah, it's a tricky environment. And I think that building bridges is so important early in your career to help to move that action for home birth.

Dr. Zielinski: Now, according to our midwife who has had 40 years in the industry, she's the mother to many of the midwives now in Georgia, because we've had two. We've delivered babies in Michigan and now Georgia. I want to encourage people listening because if you're an advocate of home birth, get involved with your state politics because as far as I understand, the Georgia law was veritably put in place to hold back…

It was basically used as a racial profiler because a lot of the African Americans were giving birth at home. And at the time—what it was, 60, 70 years ago—they enacted this law to control that population. And that is just irreproachable. However, it's a law that's been place for 60, 70 years. It's just a racist law. And so we are trying to fight that. And it's unbelievable. It almost takes an act of God to do something. But, however, we need to stick together because again a lot of these laws are just antiquated.

And thank you, Dr. Penny, for spearheading what you've done in Indiana because it's really inspiring because we need to open up those doors all across the country.

I have to tell you, doc, I love your website. And that's one thing that really

caught my attention about you and your work because you're evidence-based. And so I know that's a hot topic now. People throw that out. But yet, what does that mean? And so I'm curious, what does evidence-based medicine look like for you midwives and women looking into home birth?

Dr. Penny: Yeah, it is the hot term right now. I think for me, it really encompasses midwifery and the way that I approach it in that midwifery has a very long history. We're very traditional-based. We can gather a great deal of information from our ancestry. And then we also have more modern medicine that unfortunately has become very convenience-based and also very fear-based because we have a lot of litigation in our country.

So I think that for me, evidence-based care means that I get to balance both of those. I get to pick what is current in the literature. And sometimes that's practiced in modern medicine and sometimes it's not because of litigation. Breached birth is a perfect example of that. And then there's a lot of in maternal-child health that just hasn't been studied. So that's where we can pull our intuition and our traditional history in.

But I think for me what's important is to know the difference. When I'm informing my clients of any sort of procedure, I want them to know what the literature says, what the community standard is. What my midwifery sister shares is an anecdotal traditional medicine. And then let them find their conviction because ultimately whatever they choose, they're going to pay the consequence of, good or bad. So I really want them to own that decision.

Dr. Zielinski: That's awesome! That's awesome! Have you found yourself gravitating geographically regarding the research meaning this—the U.S. research might be a little biased versus overseas? Or what is your opinion of the global perspective because I've seen that in the essential oil research it seems like if you go to India, if you go to Iran, you're going to get a very interesting twist on essential oils than what you might get in the states?

Dr. Penny: Yeah, in many cultures, European cultures, for example, midwives are very common. You just see that as your first step into the maternity care. And so obstetrics is a new profession in the country. But I think our generation feels they've been around forever. So it is the science of maternal-child health is very new. So it is something you do often see—deeper studies or more significant studies overseas.

However, I feel like the literature really does support midwifery in most everything. It's simply that, of course, that…For example, inductions, many women just want inductions. So it does come down to trying to please the client. And it really drives then…For example, monitoring babies in labor, wearing that monitor continuously, people have come to assume that's absolutely necessary. So then physicians serve that need for them. But it isn't evidence-based. And we forget that.

Dr. Zielinski: So when you look at the history of birth—just stating the obvious—up until what 100-plus years ago, everyone veritably gave home birth, right. There was little option other than that. Now, with all of these options that we have, I want to talk a little bit about home birth. Is it for everyone? Why and why not today in America's society?

Dr. Penny: Well, I think the most important…Well, I'll say first, I do think midwives have a place in maternity care for everyone even the real high-risk mommas because you can have a high-risk lady who has a maternal fetal medicine obstetrician, for example, that's helping and managing their care. But a midwife can again be an advocate, can really help her understand the information she's being given, and counsel her well. So I think that relationship is important for every woman.

Not all women in the U.S. understand midwifery and feel safe with midwifery though. So I think that's probably the biggest factor is women need to seek care with who they feel the safest with for the best outcome.

But, yeah, it is interesting when you look at the history of home birth. When it

first moved into the hospital, death rates increased significantly. But 10 years later, we have antibiotics. And so birth everywhere improved. But you lose sight of that timeline and feel like birth improved moving into the hospital.

Dr. Zielinski: I've read so many different articles rather peer-review or for the lay person, doctors stating midwives are much more qualified to give just regular vaginal deliveries or to help administer and attend regular vaginal deliveries than any OB/GYN because they're trained to be surgeons.

And that's something that I hope that we could use the summit for and other tools to just make that awareness known. The research out there is unbelievable. If you want to share some cool statistics, when you talk everything from birth defects to injury to mom, to baby, it's almost every case. Is there ever a situation clinically, the data has shown that people should go into a hospital versus working with a midwife at home?

Dr. Penny: Well, I will say I think sometimes midwives can be a little harsh towards our physician colleagues in that asking them to attend a normal birth for a normal healthy momma is probably pulling them out of their expertise. They are the experts for disease-oriented pregnancy conditions and surgery.

And so in countries that have the best birth outcomes, they do use midwives for their primary care and then refer to physicians who actually have really high cesarean rates, even higher than in the U.S. because that's where they're working predominantly. And that's really I think the best model.

But, yeah, as far as women that really shouldn't attend birth at home, again it comes down to them feeling safe. But also women that aren't good candidates for vaginal birth at all are important to have that medical care. I will say medically that's not always the determining factor in our practice because we do have MFMs—Maternal-Fetal Medicine—that collaborate really well. So if I can keep them managed well through their pregnancy, they're generally a good home birth candidate.

In our practice though, we have women that maybe don't commit well. They don't attend the Childbirth Ed classes. We wouldn't accept a smoking mother, for example. If you have gestational diabetes, we really do want you to eat well and monitor your blood sugar. So sometimes it's just a…I don't like using the word "compliance." But sometimes it's a lack of commitment to just healthy living and optimizing the pregnancy. And so for those women, we do encourage them to seek care in the hospital.

Dr. Zielinski: That makes a lot of sense. Our midwife in Georgia, she has used my wife countless times to help counsel some of her other clients and say, "Listen, Sabrina, you've got to talk to this mom. If she doesn't lose some weight, she's not going to do it."

And it's almost like you need to have that discussion because moms want to do it. And they don't realize this is a marathon. And I've seen 3 of them. And I know you've seen tons more. But it is a marathon that you need to be prepared…

Dr. Penny: Triathlon.

Dr. Zielinski: Yeah. Exactly. This is an Iron Man. One of those 100 mile deals, right. You're running to the moon and back. It's a rite of passage. And I hope we can talk about that, too. The rite of passage is so important in my opinion.

But let's address first-time parents listening. The moms and the dads to be are people that are newlyweds or they're looking into having children. What would you say to these people who are considering a home birth and they might be a little concerned because of, I would have to say the propaganda because to me, it is propaganda. What would you say to these folks?

Dr. Penny: Yeah, I think home birth is a mindset. I don't defend home birth though, in general. So what I typically do when I'm being asked about the safety and that sort of thing is to ask clients to consider what they think they're receiving in the hospital.

So when I worked at the IU Med Center, it was a tertiary center. And we had physicians in-house 24/7. And to get an emergency cesarean accomplished in 30 minutes was a great feat. And we thought we were doing a great job. And there were those centennial events: abruption, terminal d-cells, those sorts of things that, to be quite frank those sucked no matter where you're at. It's just horrible.

And so to be in the home or, for example, remote facilities, that's the primary site for most births in the countries. We don't have as many tertiary centers. So in a remote facility, a Level I, a Level II hospital, there're not physicians in-house all the time. Those nurses lean a lot on the ER physicians for speedy births and those sorts of things. So as a nurse in that environment, I realized, especially on the night shift, I would have 3 clients, most all of them on epidural drips having epidurals. Many of them were smokers. And I would observe all 3 of them simultaneously.

And so when they were in active labor and moving towards birth, that's when I would notify the physician. Or if I had a concern, that's when we would notify the physician: obstetrician, anesthesia, pediatrician. We would bring in the surgery team, the blood bank, the ultrasound tech. They were all at home on-call.

And so it was up to me to find, to assess continuously, find early warning signs, and to bring them in from home. And so for me, in a home-birth setting, you have one mother that's low-risk, has no interventions. And there's a team of 3 of us at her home continually assessing her. And so the likeliness of her having an event is very rare.

But if that event happens, in our practice we do have 3 trained people, at least 1 nurse/midwife and then 2 assistants. And so we're traveling with her to the hospital as we stabilize her. And many times, we beat the physicians to the hospital that are awaiting us. So I think choosing to birth at home is very much about avoiding the risks associated with interventions. But you also

want to choose a really strong clinical team that can manage the "what if" scenarios. And that's discernment on the client's part, which can be challenging in home births.

Dr. Zielinski: You bring up a very interesting point to me because I've actually have used this argument without knowing the data. But it was common sense to me. I've always told people that said, "Well, what if something happens?" Like actually my mother-in-law, I love her. She is very close to me. And she had some concerns about her first baby being delivered.

And then she says when she was speaking to our midwife, she helped interview her, and she goes, "Well, what if this? What if that?" And she had all these questions because she's delivered 3 babies. And one of the questions was, "What if there's an emergency and we got to get to the hospital?"

So a question I have for you, Dr. Penny, is—I don't know if you know the data—but what average response time would there be for a woman in a hospital with a "emergency situation?" When you said you would oftentimes beat the doctor to the hospital because they're at home, so what response time do they have in case someone has an abrupt acute situation?

Dr. Penny: Yeah. I mean once you determine that a C-section is necessary, the goal is to have that baby delivered in 30 minutes. However, that's a nurse making the assessment. Then the physician has to travel in often to make that diagnosis of an emergency cesarean. And in our area that means the physicians need to live within 30 minutes of hospital. So that means traveling in. And that's not just the obstetrician, but anesthesia, pediatrician, and so forth.

And then the surgery proceeds from there. And then now hopefully your nursing team is already working ahead of time and the mom's literally in the OR waiting for you. But that's what we're doing, as well. We're also preparing our client with IVs and foley caths and those sorts of things.

The big question is it is less likely in a home birth setting to have high-risk emergencies. If you do a good risk assessment, you really shouldn't see those sort of events that often come with epidurals and Pitocin. And funny enough, women sign those consents when they agree to those interventions. You just sort of, I think, forget.

And women have become fearful of childbirth in our country because we have such poor outcomes. You have a better outcome in Cuba these days than you do in the United States when it comes to maternal-child health. But again our culture, it has come to really feel those interventions are necessary for safety. So it's a big misconception.

Dr. Zielinski: So just to package what…Because this is so important, to me at least. So to package this in summary for everyone listening, if a woman's at a hospital and she has an emergency situation where she needs to deliver a C-section, it would take roughly where Dr. Penny lives, roughly a half an hour for the medical team to get in. And so my argument would be if you live within a half an hour of a hospital, you may as well just do it home.

Again, you have to have trained professionals at home with you to determine whether or not there's an emergency. But the reality is—here's the point. You're not safer there than at home. And that's the argument I've gotten so many times from people is like, "Well, what if I bleed out?" And I'm like, "What do you mean bleed out?" People just have the fear that people are just going to have whatever. So thanks for clarifying that, Dr. Penny, because that's so key. And we are just avid midwifery advocates ourselves, as you are advocates for moms.

All 3 of our home births, we've worked with midwives. And it was important for us to have hospital privileges just in case. Just so everyone knows, my wife and I just aren't delivering in our backyard. We're not jumping over a stick. We have nurse midwives my wife was going to, in conjunction, prenatal care. And if we needed to, every step of the way they knew what was going on. But if

we ever needed to, we could always go to the hospital, which for us is a roughly 8 to 10 minutes away.

So, Dr. Penny, in your opinion, in addition to being a doctor and nurse practice, you're a nurse midwife with household privileges. So I want to talk a little bit about the importance of having back-up care when women are planning on delivering their baby at home. Can you make it practical for them because it might be confusing for people to even to think about this?

Dr. Penny: Yeah. So I do have hospital privileges. However, it is on a non-admitting basis. So it depends on which network in Indiana you're working with. Some of them call that non-admitting privileges. And then the other corporation, they just are very familiar with me. And we have a very easy relationship. I don't remember. I think they call us a preferred provider or something of the sort. But I don't admit clients to the hospital and care for them in the hospital. We are exclusively a home-birth practice.

And when I think of back-up physicians, I don't know that that's a term we use really in our practice because I think for a lot of people, they see that as a supervising role. We work within the healthcare infrastructure just like an obstetrician does. An OB may have a client that's having heart palpitations and lightheadedness. He may refer to a cardiologist for that. Or he may have a client that's having blood coagulation issues. And so he may refer out for that.

We do the same thing. We are experts in home birth and we are experts in normal childbirth. And so if we feel like a client needs help outside of our expertise or outside of our resources, then we refer. And honestly, we expect to be treated with respect. And we generally are.

So in a home-birth setting, Methodist Hospital, for example, in Indianapolis has 27 nurse midwives on the unit. So they're very familiar with our practice. And we can call them and say, "This is the client we have. And this is the situation. And we're traveling into you." We have electronic health records. So we can get that over to them before our

client arrives assuming their fax machine is working. But we can get those right over.

And then there is assumed care. And most facilities in our area are just very…I think they appreciate when you have your ducks in a row. They appreciate that you have a line of safety. But at the same time, we have really pushed that standard of care. And once they take that deep breath and see that our documentation is good and mom and baby are safe, then they'll continue to support those decisions by our clients. But we remain with them as support in the hospital.

I would say more of our consults…We probably only transfer 2 or 3 a year. But more of our consults happen prenatally. And we don't refer to one physician, specifically. So there are a lot of states that want home-birth midwives to have one specific collaborator. But that really doesn't work anywhere in medicine because nobody knows everything that a consult's going to need.

So we refer to whoever has the expertise and the client's need, whoever is in their insurance network, whoever is close to their territory. I would never transfer somebody an hour north of us to somebody that is maybe my collaborator an hour south. So you really want to know your resources in your community and know who to refer to.

Dr. Zielinski: And, folks, that's a great question to ask a midwife when you're interviewing one. As far as I know, when we were interviewing some midwives in Atlanta, our nurse midwife told us in the medical practice that my wife was going to, she would not work with us if we were working with a specific midwife because that women's practices weren't supported. And that raised a red flag to me.

But the woman we ended up choosing, the grandmother of midwifery in the Atlanta area, she has a great relationship with all the nurse midwives, a great

relationship with the doctors and all that. So that's really key when you're talking to people like Dr. Penny, ask them. That's a great question.

Dr. Penny, we're going to transition a little bit into the topic at hand. I've really appreciate you helping people. Just give more of an idea of what evidence-based midwifery practices look like in America. And I personally love midwives for several reasons. One, I'm a chiropractor, which makes it…I'm a little jaded to that. Not jaded, but I'm a little biased because every midwife I've ever met always recommends 2 things. Well 3, I guess—healthy diet and all that.

But every midwife I met has always recommend chiropractic care and essential oils. Everyone! At least, that I've met. They just seem to go in tune with what you all offer. I couldn't imagine having our 3 children at home without chiropractic care and essential oils and using them so extensively.

In your opinion, what are your favorite adjunct therapies that you recommend to your clients?

Dr. Penny: Yeah. And not because you're a chiropractor is not why I'm telling you this.

Dr. Zielinski: Yeah. Yeah.

Dr. Penny: [*Laughs*] But yeah, we actually have a chiropractor in our office because it is so essential to our practice. And I remember 7 years ago when I first started our practice, I think I was more gentle in my approach with clients because I just really wanted to give them information and let them make their decisions.

But it would be really discouraging to me to then end up 9 months later in a home birth for 3 days with an OP baby and a mom that's not progressing. And she really didn't see the chiropractor. So, especially with VBAC clients, women who have had cesareans before, I honestly don't even want to approach a home birth with them if they're not willing to see a chiropractor because I

don't know what caused their cesarean in the first place. But even after the event of surgery, they're certainly going to need a chiropractor.

And so we really don't have much argument in our practice. It just makes sense. And babies have to work through a pretty tight little—not tight—but they're navigating through there so to really optimize that structure, makes perfect sense.

But, yeah, outside of chiropractic and nutrition is huge. We do have a nutritionist in our office. And we work with her a great deal, especially with women are becoming older now that are choosing home birth and more educated. But they're also more obese. And so that does increase the risk for healthcare and maternal-child outcomes, no matter where you're choosing to birth.

So we have a functional medicine-focused nutritionist that really compassionately and empathetically works with these mommas to improve their outcomes. And we have never had a gestational diabetic in our practice need insulin so far. So I think that's huge!

Dr. Zielinski: Yes! Unbelievable!

Dr. Penny: Yeah. And I will have to say you don't always think of hydrotherapy as maybe an adjunct therapy, but I do think our spoils are part of our success. They're real deep. And I think a first-time momma planning to birth at home that won't use a chiropractor is a tough one. That's one that makes me nervous about transferring in for pain. So those 3 things I think are pretty huge.

But, yeah, herbs and essential oils are a big part of that. And moms are often pretty educated in those when they join our practice. They're very eager to use those sorts of modalities.

Dr. Zielinski: Well, let's talk a little bit about essential oils. What are your go-

to oils? How do you personally use oils in your midwifery practice?

Dr. Penny: Well, I will say this is a question I get almost every single day from clients. And I do honestly say that pregnancy and childbirth are normal events. So we can again be harsh on our obstetrician colleagues for being a little extra interventive, more than we feel maybe is necessary as a midwife. I think midwives can be a little interventive, as well, with herbs and homeopathy and essential oils.

So I will be quite honest. As much as I love essential oils, I rarely use them in childbirth because most of the time things are going beautifully. And women have a rhythm in labor, maybe even a cadence of sorts. And so I feel there are times that if you pull essential oil out that she's not already started for herself, you may throw her rhythm off a little bit. So I see them as an intervention. And I use them accordingly.

So my most popular—and I'm known to be the peppermint midwife—is that is when you get to that really tough time, that transition. Or for a woman that have had multiple babies sometimes it's that transition from early labor into active labor when you're just getting real discouraged and tired. And you want to wake mommas up and sometimes wake the birth team up a little bit and wake you up a little bit and just really let's get the ball rolling, we like to use peppermint.

Primarily, the way we use it is we get a bucket of ice water and just drop some essential oil in there and then put [inaudible] in it and fan it on women. You wouldn't want to drop in their spa, for example, or in the bath water or wipe it on their face, those sorts of things because women can…You don't want it in their face certainly. But they may not like it. And so you want to be able to get it back as quickly as possible if it doesn't work for them.

I will say lavender is a pretty common essential oil in midwifery. When I first started working in home births, I think every home birth I ever attended had lavender diffusing. And it is lovely. It certainly calms women and makes them

feel very relaxed and safe. But I think there are many home births with lavender diffusing that maybe last way longer than necessary. And I think that serenity of home birth is an amazing thing. But I think for our practice, we really allow our clients to create that environment, whatever they feel that's best for them.

So for me, I think often I'm pulling the lavender away and using the peppermint because we really just want to get a baby born.

Dr. Zielinski: That's a good point. That's a good point. My midwives or both midwives and my wife seem to have…They hit a wall. And I was the intermediary. And they're like, "Sabrina, you've really got to do this." She didn't want to get in the squatting position. She was over the ball. And she wanted to do her thing.

I'm like, "Sabrina, let's get this done with." And I appreciate that because your job is to deliver a healthy baby. Your job isn't to make this fun and roses. That's not the goal. The goal is—yeah it's a pleasant experience—but we want to deliver a healthy child in proper timing. So that's a good piece of advice. Yeah.

So in addition to peppermint, what other oils have you seen effective?

Dr. Penny: Yeah. Well, I think of clary sage oil to labor and birth as I think of red raspberry tea to pregnancy. Clary sage is that herb that's going to help mom do whatever her uterus needs to do in labor. And I think those two things, clary sage and red raspberry both have a little bit of misconception. They're adaptogens.

So they actually help the uterus do its job better. It's not really going to start labor for you, just as red raspberry's not going to start labor either. It's just going to help…If the uterus is irritable and not effective, it's going to help calm that down. If it really needs to be more effective, in good active labor, it's going to help with that, as well.

I'm not too often do I use clary sage. I'm more of a philosophy that if labor isn't progressing very well on its own, I like to stop labor. So that's when I would use the lavender. I'm not really one to pull to drag it along because I think you're going to get a really exhausted mom in second-phase labor, dehydrated mom and exhausted baby. So I would rather put them to sleep, just at that point relax them and give some therapeutic rest, which is where your lavenders and your more calming essential oils come.

And that's really what I love about essential oils is I actually was introduced to it through herbs really growing my knowledge-base in that way. And essential oils are just easy. You can travel with them really well. Everyone is sort of drawn to them. Like eucalyptus, you don't need to learn that eucalyptus is great for your airway. You smell it and you know exactly what it's doing.

It was hard for me I think because I always wanted to understand the evidence and really how many studies have been done on eucalyptus and respiratory issues and those sorts of things. But really intuitively, essential oils speak to you, I guess. And you do know in your heart that some of them are calming.

And citrus oils, pregnant women love citrus oils. They just really refresh them. And for the peppermint, for example, we have had so many births that are just so long. And it's good for your staff to even use to keep awake and keep a clear mind about you. So wintergreen is popular for back pain. Again, we use a lot of chiropractic. So we don't really see very many OP babies. But when we do, wintergreen is one that we're often using.

Dr. Zielinski: Now, there was a study in 2000 in the *Complementary Therapy Nursing Midwifery Journal*. And it discussed aromatherapy specifically clary sage and chamomile in reducing anxiety, stress, and pain. I was just curious. Have you seen that through your practice of actually using clary sage or chamomile for pain, specifically?

Dr. Penny: It's hard to tell. I guess it's hard for me anecdotally to ask women

what was beneficial for them for pain. For example, the TENS machine, which I know is not essential oil-based, but when you look at the studies using TENS machines in labor, every women says that yes they'd probably use it again. But they don't know if it was the pain relief or the distraction.

And I think that's important, too. I don't know that for me that I always care if it's pain relief. Pain in childbirth is not a negative thing. And so it's more work really. But I think chamomile, traditionally people have been using chamomile forever. And they know that's calming. And so yeah, I think those are great options.

Dr. Zielinski: Well, I appreciate it. Now, besides the birth experience itself, which the 3 that I've experienced, they were very unique. My wife had a specific keen smell to things, a different desire of food and drink. It's like you're not the same person. I know 4 people: my wife and my wife during 3 different births. And they're completely different people. Music. Everything. It was just whatever's in the moment.

So if you're a woman out there—correct if I'm wrong, Dr. Penny—but you can't predict what's going to happen on game day. You could train. But things are going to change. So outside of using essential oils on game day, what do you think about the pre-game workout, pre and post-natal intervention and how essential oils can help pregnant women and also with post-partum?

Dr. Penny: Oh, that is vital! Absolutely vital! And that's why actually I called it a triathlon as opposed to a marathon is…

Dr. Zielinski: Oh!

Dr. Penny: Yeah. You switch from the bike into swimming into running. And you've got different issues in each of those sets of the race. And so I'm nervous for those mommas that come to us with a really extensive birth plan or a very specific vision for their birth. What I prefer is to work the entire pregnancy to show them what their options are and have them play with essential oils. And

some women are drawn towards more rose and geranium, jasmine, those sorts of things. In labor, they all have their benefits. But other women are much more citrus. And so I like to see what…I typically go to their essential oils more than I pull from my own bag.

Dr. Zielinski: Oh, nice!

Dr. Penny: Yeah. And some women like them diffused, which would be myself. And some women like them massaged on them. So touch can be too much stimulation for some women. So that is a lot of what we're really discerning in labor.

And having men practice with their wives…I always ask mommas during their pregnancy what their husbands do for them when they're sick and what irritates them and what makes them feel better? Because sometimes that's what you'll see in labor. But every birth is so different. And I think that's part of what catches women by surprise.

So, yeah, knowing what's always in your labor bag and your options is very important.

Dr. Zielinski: So let's talk to the pregnant mom briefly. What sort of oils specifically, or homeopathic approaches would you recommend for just for some of the common things—nausea, headache, pain, that sort of thing?

Dr. Penny: Yeah. Nausea, of course, ginger and peppermint, those sorts of things are very popular. But nutrition, of course, is a large part of the nausea—eating frequently and eating small bits glazing like a bird, good balanced meals. And chromium, I do that supplement there. So there are essential oils that have some more blends, I would say, that are specific to helping women. Cinnamon balances their blood sugars.

Pain…Wintergreen's a popular one. I think though for me, pain I don't necessarily I guess like to treat pain because I always want to understand

what's going on there. That's a symptom of something more specific that we need to address. In our office, we have a saying, "That's Vickie's issue," which is our chiropractor. So a lot of those sorts of things, we just send across the hall to Vickie.

Dr. Zielinski: I love that! And that's awesome! If we don't address the symptom, we have to approach the root cause.

Dr. Penny: Right. I will say citrus oils are something we…I was trying to think of what we use most frequently in office. We use a lot of citrus oils for varicosities, which is probably a pain that is just a general discomfort in pregnancy. And I wonder if it's that it enhances the blood flow and decreases some swelling a little bit. But that is something that we definitely use frequently.

And we've actually very experimentally use those for women who have lost their babies early in pregnancy, but they haven't passed their baby yet. And I think again it just helps elevate their mood, too, but might encourage some blood flow. But again that's very anecdotal. But while you're expectantly managing those losses, I think that's something that can just really support her.

Dr. Zielinski: Wow! There's actually a study published last year on not the fusion, but the inhalation of lemon vapor from a lemon essential oil. And it showed to decrease dramatically the likelihood and the sensation of nausea and vomiting for women that were battling different kinds of morning sicknesses and nausea during their early stages of pregnancy. So lemon, ladies, just try it out. It can't hurt to bust open a bottle of a good therapeutic grade lemon and just smell it, right?

Dr. Penny: Of course.

Dr. Zielinski: Unless you think that's contraindicated, which brings me to this because we're running out of time. We just got started. And, man, I've got

100 more questions left. What contraindications or safety concerns would you like to share overall? You made a good point. You don't want to mix oils and water if you're going to be doing home birth because it's obvious the baby can be affected by that if the baby's going to be birthed in the water and that kind of stuff. You don't like things in the face. But are there any serious contraindications that you would advise against?

Dr. Penny: I don't want to be too soft. But it's really just common sense and just really trusting your intuition because essential oils have a long history of safety. When you look at the data on who's been harmed in their pregnancies with essential oils, they were using two and three hundred times the dose.

We did have somebody in our practice this year call our office. She spoke to my partner midwife and said that she had been using cinnamon and she thought that it was putting her in pre-term labor. And she was having quite a lot of contractions. And so I told my partner, I'm like, "No, I really don't think cinnamon's associated with pre-term labor." Biut we wanted her to come in to be checked out. And she declined.

And so we called her later to check on her. And a couple hours later, they had started to die down a little bit. And so when I saw her in her prenatal, we talked a little bit about it. And she said, "I really do think it was the cinnamon." And I said, "Really? I just haven't had that understanding about cinnamon." And she said she used 30 drops of cinnamon in her toothpaste. And I thought, "Well, okay." Not only was that probably the most expensive cinnamon or toothpaste you've ever used, but far more than was necessary.

And so we see that in a lot of natural remedies is…And that is the part…The FDA I think sometimes get to direct. But there is that place for helping people find their common sense. And it is important to just use it wisely and just to really consider essential oils are so…That's the beauty of them is that you can have one jar of essential oils for ten years because you just need so little of it. So that would be my, I think my recommendation is to just to be smart about your use.

Dr. Zielinski: I appreciate it. I've searched. I've literally have combed the resources over and over again about peppermint in milk supply. And I can't find it. And I know if you go online, you're going to hear countless women say, or in my opinion probably only one woman said it, but you've got a thousand bloggers pretending it's real, but it's not clinically proven. So there's a lot on that. I'm actually writing an article on that to be published in the *Journal of Childbirth Education* just to share what the evidence-based approach is.

Well, thanks, doc, so much. Any last words of advice you'd love to give to the future moms and dads or current moms and dads, of course, too?

Dr. Penny: Yeah. You asked me that previously. And I was thinking one thing that I learned—this is more clinician-based—but one thing I've learned in my doctorate was…You know I'm a very passionate woman. I love midwifery and home birth and all those sorts of things.

And so sometimes in my argument, I've learned that my argument is passionate-based and not fact-based. And so I've really come to ask myself, "Do I really know what I'm saying is true?" And I think just understanding that from a clinician's perspective is so important. And then if there isn't certain facts in the literature to support what I'm saying, trusting yourself intuitively.

And the history of essential oils is very appropriate. Certainly, there are times when pharmaceuticals don't have literature to support them. And so it would make sense then to lean maybe more on an essential oil.

But I think that's the big piece of advice that I share with my staff and with clients in my practice.

Dr. Zielinski: Thank you so much!

Folks, if you have found this information helpful…I don't know how you couldn't. This was just awesome information from Dr. Penny. You could take it

home with you by clicking on the banner beside or below for more details. And for those of you who want to follow Dr. Penny—she has a fantastic blog—you could go to BelieveMidwiferyServices.com. Follow her. Follow her team, see what they're up to.

And I just want to thank you all for attending the Essential Oils Revolution. This is Dr. Eric Z. And we'll talk to you soon. Bye-bye!