

Making Babies

Making Babies

A PROVEN 3-MONTH PROGRAM
FOR MAXIMUM FERTILITY

Sami S. David, MD, AND Jill Blakeway, LAc



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A complete list of references is available at www.makingbabiesprogram.com.

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To my beloved wife, Rena, who awakened and inspired my interest in the integration of Western and Eastern medicine; to my family, who encouraged me to pursue medicine as a profession; and to my mentor, the late Dr. Luigi Mastroianni, who kindled my passion for the practice of making babies.

—S.D.

To my daughter, Emma, who has been such a source of joy that I am inspired to help other women to become mothers.

—J.B.

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Introduction

One in eight couples in the United States has trouble getting or staying pregnant—one in three couples in which the woman is over 35 and one in two in which the woman is over 40. And these figures have been on the rise for decades. Right now, more than nine million American women seek treatment for fertility issues every year, and their partners need treatment, too.

If you are reading this book, you are likely one of them. Or maybe you're just planning to get pregnant and want to be as well prepared as you can be. In any case, you are certainly not alone, and you are facing an amazing frontier. Western medicine is standing by, eager to assist you with every technological tool available, spare no expense. Just about everyone else in the world, from your grandmother and your neighbor to your yoga teacher and the celebrity you read about in *People*, has “helpful” advice for you: Do it every day. Do it every other day. Douche. Don't douche. Drink chaste tree berry tea. Drink Mountain Dew. And, the classic, “Just relax!” (Right, no problem.)

You want to do everything you can, but you want to be smart about it. You don't want to rush into expensive treatments with their inherent risks and side effects. You don't want to waste your time any more than you want to waste your money. You don't want to be guided by unproven old wives' tales, but you don't want to dismiss something that just might work either. Truth be told, you'd try just about anything if it meant having a baby.

This is just the position our patients are in. No matter whether they've sought out a reproductive endocrinologist and microsurgeon (Sami) or a Chinese medicine practitioner and integrative medicine expert (Jill), they need both optimistic messages (there are simple and effective strategies

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you can use) and word-to-the-wise advice (don't get drawn into in vitro fertilization, or IVF, too quickly). And whether a patient is 32 (or under) or 42 (or over), together we *can* help her get pregnant.

Our joint approach is uniquely complementary. We draw on the best of both Eastern and Western medicine, and the lessons learned from forty years of collective experience in guiding our patients (and their approximately four thousand pregnancies). This book brings what we do face-to-face in our offices in New York to women everywhere, who can now benefit from the same careful, individualized attention and personally tailored action plans. Making Babies is a three-month program designed to help any woman get pregnant *as naturally as possible*.

Infertility medicine today is all about aggressive surgical, pharmacological, and technological intervention. It's a high-stakes, high-pressure world. But making babies is still best as a natural process. So we aim to support a woman's ability to bear a child with just enough help to get nature to do its thing. What constitutes "just enough" varies from person to person, from a simple douche, a course of antibiotics, or the shedding of five or six pounds, to a few months of Chinese herbs, precisely *decreased* doses of fertility drugs, or acupuncture in conjunction with IVF. What's always the same is the fact that minimizing harsh intervention is better for the mother, better for the baby, and better for the couple. There are hundreds of thousands of families out there that exist thanks to intensive and aggressive medical intervention—and here's to them!—but for many women, there *is* a better way.

The Making Babies program is valuable for all would-be parents in their 20s, 30s, or 40s. It has all the answers you need (as well as all the questions you need to ask), whether you are only beginning to wonder what is taking so long, are just stepping into the whirlwind that is fertility medicine, or are already battle-scarred veterans—or even if you have been turned away from advanced treatments, having been told that you'll likely never bear children.

If you are trying to get pregnant—or are thinking about trying to get pregnant—you will benefit from the Making Babies program. If you have been having unprotected sex for six months but still aren't pregnant, you *need* it. If you are a woman over 35 trying to get pregnant, or if you are trying to get pregnant with a man over 40, you need it, too. Making Babies provides you with a clear path to getting pregnant with

as little medical intervention as possible. We estimate that as many as half of the women who use IVF could get pregnant without it—if they receive carefully individualized care. We have absolutely nothing against using every trick of technology available to help you get pregnant. We're just against using reproductive technology unnecessarily and unwisely.

THE PROGRAM

So before you make the huge investment (financial and otherwise) in IVF and other assisted reproductive technologies (ARTs), invest three months in the Making Babies program. We know that, like a lot of our patients, you probably feel pressured to make this thing happen. So it is our solemn promise that taking these few months will be well worthwhile.

The Making Babies program is designed to prepare your body for healthy, natural conception. Using strategies that are best for you, you can prime your body to do what comes naturally and identify and overcome common roadblocks that may be getting in the way. Detailed but easy-to-follow instructions show you how to implement lifestyle changes and early-intervention strategies. For many women, this may be all it takes: within ninety days, they'll be pregnant.

Some couples will need to continue with professional help for more intensive intervention. The program will still be a boon, optimally preparing the body for any further fertility treatment, increasing the chances of success as well as the ease with which it is achieved. These couples will enter (or reenter) the technological path to conception with their bodies physically prepared to be most receptive to the appropriate medical intervention(s), their minds open to letting nature and medicine work together without undue stress, and a step-by-step plan to pinpoint precisely—then safely, efficiently, and effectively solve—any problems blocking their way to biological parenthood. The Making Babies program expands to support the various ARTs, ensuring the best chances of success.

The Making Babies program closely follows what we do with our patients in our offices. Both innovative and time-tested, it pulls together the best of both our worlds into one comprehensive program that you can follow on your own or with your doctor or other health care practitioner.

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You will learn from our patients who got pregnant after pursuing one or more of the following strategies:

- Taking antibiotics to clear up a common, asymptomatic infection in the man's sperm
- Gaining a few pounds and using herbs and acupuncture to rebalance hormones
- Thickening the endometrium with herbs and acupuncture
- Thinning cervical mucus with an over-the-counter cold remedy
- Lowering the temperature of the man's daily bath by four degrees
- Taking progesterone to stop extremely early miscarriages
- Restoring regular cycles and ovulation in a case of polycystic ovarian syndrome with a very low-carb diet and the elimination of coffee and alcohol
- Decreasing the intensity of daily workouts to limit endorphin rushes contributing to repeated extremely early miscarriages
- Douching with baking soda
- Improving sperm motility and morphology from poor to perfect by cutting out alcohol and overhauling dietary choices
- Having sex *more* often
- Having sex *less* often
- Taking steroids to block an allergic reaction to sperm
- Dramatically lowering the dose of fertility drugs used for IVF
- Using herbs and acupuncture to prepare for IVF—only to conceive naturally before the day of the IVF appointment even arrived

And of course much more. But you get the idea.

We start by giving you a look at the way fertility medicine is practiced today—and why that can be a big problem. Then we go back to basics to review how the male and female reproductive systems work—and how they work *together*—as well as everything you need to know about how, exactly, to get pregnant. (You might *think* you know everything you need to know, but we bet you'll be surprised at least in part.) The next chapter is devoted to the many lifestyle choices you make every day that have a big impact on

your fertility—the type of exercise you choose, for example, your weight, the environment, and even your cell phone habits. Managing stress is the topic of the next chapter, followed by two chapters on nutrition—both what you eat and what supplements you need (and don't need).

Then comes the heart of the book: a guide to determining your specific fertility type. These types distill the complexities of Chinese medicine to the most salient factors for fertility. Simple checklists help you determine whether you are Tired, Dry, Stuck, Pale, or Waterlogged. Knowing your type lets you focus on just the issues and advice most relevant to you and your situation throughout the rest of the book and the Making Babies program. By identifying and understanding the subtle signs your body is providing, you'll be able to save yourself time, energy, money, and heartache by homing in on what you most need to be concerned about and addressing it as efficiently and effectively as possible.

The chapters that follow explain all the common (and some not-so-common) fertility problems our patients run into, the “who, how, and why” of what tests you should be having to pinpoint your issue(s), and the available (but not always necessary) ARTs you'll want to know about. We cover just about everything, but you'll have to bone up on only a handful of conditions, dictated by your type.

After all that, you'll be more than ready for the Making Babies program. The program provides both specific lifestyle advice geared toward enhancing fertility and guidance on necessary testing in one detailed plan of action, so that you can put everything into play over the course of just three months. You'll follow the version of the program specific to your fertility type. For women, there's a second layer to the program that breaks it down a bit further according to what's going on in the menstrual cycle. Tired types don't need to do the same things as Stuck types, for example. Stuck types may need to do one thing during their periods and something slightly different during ovulation to maximize the benefits of the program.

By the end of this book, you'll know:

- How to tell if you have a fertility problem (and what exactly is behind it)
- Simple yet often overlooked medical treatments that can restore fertility immediately

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- Key lifestyle choices that enhance or impede fertility
- Which problems can be tackled naturally and which need to be addressed with pharmaceuticals, surgery, or advanced laboratory techniques
- When to move to the next level of treatment
- How to combine Eastern and Western approaches in a systematic and beneficial way
- How to find the likeliest path to success for you and why what works will likely be different from what worked for your neighbor, sister, or friend
- How to determine your fertility type and how your type should guide all your choices about conception
- The potential hazards of the infertility industry (which all concerned tend to choose to downplay) and the alternatives that provide a better way
- How to understand, evaluate, and prepare for the complicated problems, processes, techniques, and emotions you face when coping with a fertility issue
- A host of surprisingly simple solutions most doctors will probably never mention
- Why many women using assisted reproduction could conceive much more naturally and how you could be one of them

TRULY COMPLEMENTARY

Within our respective fields of expertise, we have each helped countless women conceive and bear the children they've been dreaming of. But working together, we've witnessed the extraordinary benefits of a middle way. We make a great team! Taking full advantage of both approaches, we cherry-pick the best techniques according to highly individualized diagnostic procedures. Then we press them into service so that each strategy best supports all the others. Benefits begin with (but are certainly not limited to) effectiveness. To put it plainly, *more women get pregnant more easily using our combined approach than they would strictly using one or the other.* This is truly complementary medicine.

When it comes to infertility, Western medicine now routinely creates what once would have seemed like miracles. There's been a huge proliferation of options for women who are having trouble conceiving.

But these don't come without costs — of many kinds. With the wisdom of thousands of years behind it, Chinese medicine can also create what seem like miracles, but it too has its limits. Both fields tend to create more ideologues than practitioners who are open-minded enough to embrace a totally different paradigm. The Making Babies program bridges the gap between the two worlds.

Three-quarters of infertility patients seeking conventional treatments already use “alternative” approaches as well. If you are one of them, you know how hard it is to get these approaches coordinated in any meaningful way. Perhaps you've tried to discuss what else you are doing with your health care practitioner (of any stripe), only to get not much more than a polite nod in response. The Making Babies program pulls together all the best practices for you, so instead of one from column A and one from column B, you can integrate both styles so that they work together, while avoiding any counterproductive conflict.

To harness the power of both Eastern and Western traditions, you need to know how to apply them so they support and enhance each other, rather than hinder progress or even work against each other. As a layperson, you can't really do that on your own, and few and far between are the practitioners who can help you do it. Our patients seek us out for the truly integrative approach we've put down in this book. They want a comprehensive plan that takes the best of alternative medicine and combines it with the best of conventional medicine. They want help in weighing the risks and benefits of all their choices. They want to try the most natural options first. But they also need advice they can trust about when to consider ARTs. We've written *Making Babies* to do all that for everyone who can't come in to our offices.

We are proud of our reputations for helping people find their way through the complicated maze of fertility medicine with compassion and good humor, as well as careful detective work, and we've tried hard to retain all that on the written page. We hope that you, too, will appreciate what's so funny about the detailed analysis of cervical mucus, discussions of choices in scented “personal lubricants,” and the mad dash home from the office for a quickie when your fertility chart tells you IT IS TIME. What we're really all about, though, is taking each and every patient seriously and recognizing him or her as an individual with his or her own particular issues that can never be adequately addressed by cookbook medicine or factory-like clinics. There's no reason for the joyous work of

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helping people have babies to be dreadfully dull. After all, isn't it about bringing more love into the world?

Every day, separately and together, we work through complicated cases with women from all over the country and even from around the world. And always, it is our mission to leave no stone unturned until we figure out exactly what's going on. Once we've shined a light on whatever is standing in the way of a healthy pregnancy, we do whatever it takes to get rid of the barrier, always with a focus on what's closest to how the body does it naturally.

Simply put, we have essentially one job, and one job only: to get women pregnant, often when all other methods have failed. Sometimes we even get first crack at it, as soon as it looks as if there may be a problem. Then not only do we get the deeply satisfying pleasure of helping people become parents, but we also get to save them a lot of time, effort, anxiety, risk, and heartbreak — exactly as we aim to do with *Making Babies*.

PART ONE

Making Babies



Modern Fertility Medicine: The Risks and Overuse of (Sometimes) Terrific Technologies

Pamela had been through ten cycles of in vitro fertilization (IVF) at three different centers but had never been pregnant. Some of the best fertility doctors in New York had told her she was too old (39) and probably had “bad eggs.”

Over the course of ten years of trying to have a baby, Evelyn’s doctors had pumped her up with a total of fifty cycles of fertility drugs, really strong ones. She’d made hundreds of eggs, but still she wasn’t pregnant. Not one of the four doctors she’d seen had ever stopped to ask *why* she wasn’t getting pregnant.

Stephanie took high doses of fertility drugs in preparation for her first IVF cycle at the best clinic in the city. The doctors harvested lots of eggs, made nine embryos, and discovered on testing that every single embryo was genetically abnormal. Although they’d been willing to give IVF a try with her, they now told her there was nothing more they could do because of her age (41).

The good news is that, in the end, all these women got pregnant and had babies. The bad news is that they underwent difficult, unnecessary, and futile treatments before anyone figured out why they weren’t getting pregnant and what to do about it. The worse news is that these women are not exceptions to the rule. The way fertility medicine is practiced today routinely generates stories like these.

Reproductive technologies also create a lot of expanded families, and we never want to discount the blessing that can be. What we long for is a new era in which technological successes will be *unadulterated* blessings, because the technology will be offered and used only when it is necessary. Everyone else will be able to get the appropriate help they need

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to conceive and bear children as naturally as possible—because that’s what’s gentlest, safest, and often most effective, even in the face of some serious fertility issues.

One in 100 babies born in the United States today was conceived with the help of assisted reproductive technologies (ARTs), according to the American Society for Reproductive Medicine (ASRM). Worldwide, more than 3 million babies have been born who were conceived through IVF—more than 400,000 of them in the United States. Each year in this country, 250,000 families consider IVF, and about half of those give it a try. They do so at their pick of 461 clinics nationwide.

The numbers have skyrocketed since IVF technology was introduced three decades ago. The number of ART births more than doubled between 1996 and 2002. A Centers for Disease Control (CDC) report from 2004 counted almost 50,000 babies born after ART interventions in this country that year. Just six years earlier, the figure was 28,000—and that was announced as evidence of the rapid growth in the use of these technologies. Over time, the nature of the industry itself has changed as dramatically as the number of babies born as a result of it, with ART morphing from an option of last resort, available to only a few, to the first choice for every player in the game.

We both celebrate regularly with patients who bring home babies thanks to amazing technological interventions, and we are always glad to do so. And we are both grateful, professionally speaking, to have something to refer patients to when our areas of expertise can’t address their needs. But the sad truth underlying the good news is that ARTs, and in particular IVF, are frequently misused, grossly overprescribed, and too aggressively administered. We’ve arrived at this place because of a culture, both in society at large and in reproductive medicine in particular, that always goes for the quick fix regardless of other options or possible consequences, emphasizes personal gain, and values technology for its own sake. Added to that grim picture are the risks and side effects of the procedures themselves.

Based on our experience with thousands of patients coming to us in various phases of fertility treatment, as well as on what we hear from our colleagues, we estimate that as many as half of all women who receive IVF

could conceive naturally or with minimal medical intervention. This is not just a theoretical best-practices argument. The consequences of fertility treatment for women, couples, and families are immense—even when they succeed. When they don't succeed, that failure adds another layer of heartbreak to an experience that is already extremely stressful physically, emotionally, and financially. Proud parents of babies born thanks to ARTs will say that it was worth everything they went through. But the more important point is not whether it is ultimately worth it, but whether it was *necessary*.

These technologies can be miracle makers, but they must be used wisely to be used well. As a society, we are not yet applying that wisdom. There is a better way, modeled by the Making Babies program. This is it in a nutshell: use all options available *in their proper place and time*, with a preference always for what's closest to the way nature intended and what's best (and most likely to work) for the patient. The truth is, with careful diagnosis, basic fertility education, and simple but detailed diet and lifestyle advice, many women using ARTs could conceive much more naturally. If any drugs or other interventions turn out to be necessary, minimal doses and least invasive procedures can be used, minimizing risks as well as unpleasant side effects—all while increasing success rates.

The stories that opened this chapter ultimately illustrate the possibilities.

Pamela, who'd had ten IVF attempts and a diagnosis of "bad eggs," also had scar tissue from having fibroids removed, which was effectively keeping her eggs from getting into her fallopian tubes. She'd started IVF to get around the scar tissue—a common approach. But clearly something about the IVF wasn't working for her, even if it was circumventing the obvious roadblock. When she came to see me (Sami), I couldn't find any other issues to explain her problem, so I recommended surgery to clear away the scar tissue. (The same laparoscopic procedure can diagnose and correct this problem all at the same time.) Two months after I performed the surgery, Pamela was pregnant, with no drugs and no IVF.

Evelyn, who'd been treated with fertility drugs since before her 30th birthday, finally became pregnant at age 40 after a single course of antibiotics cleared up a mycoplasma infection in her cervical mucus. Two years after her daughter was born, she went on to have a son with no treatment and no delay.

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Stephanie, all of whose embryos had tested genetically abnormal, fit into a pattern we have seen all too often: high doses of injectable fertility drugs predisposing eggs in older women to develop chromosomal irregularities. Stephanie had been given too many fertility drugs for a woman of 41. My (Sami's) approach was to recommend a much lower dose of essentially the same drugs. This time, her eggs and embryos were perfectly normal—and so is her young son.

It is not our intention to set anyone's mind against IVF or any other ART. But we do want anyone who goes that route to do so with eyes wide open—and to know, before he or she heads down that road, that there are many other ways through the forest that are easier, safer, quicker, and cheaper. They all end up in the same place, so the difference between what exists now and the world you envision is understanding that you have a choice, including, but not limited to, ART. So before we get into the details of how to do this right, let's take a bit of time to look at what's wrong with the way it's done now.

PATIENTS WITHOUT PATIENCE

We're about to pin a lot of this on doctors and the infertility industry, but consumers of these services need to take a look at their own behavior as well. Most couples, their hearts set on having a baby and with an acute sense that time is of the essence, want the fastest solution possible. Many feel that technology is their only choice. People struggling with infertility may feel vulnerable and desperate enough to try anything that promises they'll have a child, without doing any of the due diligence and critical thinking they'd apply to making a decision in any other area of their lives. Their doctors bear much of the responsibility, of course, but lots of couples accept IVF without examining other (and usually far better) options.

There are also plenty of people treating IVF more or less as a lifestyle choice, or as just another modern convenience. No room in the schedule for well-timed sex? Let the lab take care of the details! Long-distance relationship? Ship sperm overnight! In certain populations, the culture downplays or ignores the reality of fertility diminishing with age, with an unspoken and maybe even unconscious reliance on technology to bail out those who simply wait until it is too late to conceive naturally. There

are plenty of good reasons to delay childbearing. But doing so is not without risks—the risk of never being able to conceive and/or the risks you expose yourself and your baby to in the use of technology. The plain fact is that many people who do wait (and wait, and wait) before trying to get pregnant don't really do so for hard-and-fast reasons. For too many people, when they are faced with the reality of infertility, in hindsight their reasons for waiting no longer seem compelling.

Although it is true that fertility is not an area where you want to drag your feet in finding a solution, that does not mean that everyone should jump immediately to the most drastic measures. No one should do so without knowing his or her diagnosis and options, with the pros and cons of each. Some people have more time to work with than others, but everyone can confidently take three months to explore the possibility of conceiving as naturally as possible with the Making Babies program. We've devised the program to be as efficient as it is effective. And even if the program itself is not sufficient in your case, it will thoroughly prepare you for the next steps, physically and mentally, giving you the very best odds of success as you move forward.

DOCTORS WITHOUT PATIENCE

Lest anyone think we are blaming the victim, we now want to give the medical profession its due. We've watched from inside the industry as it has experienced explosive growth over the past three decades. And we are sad to report that too often the culture of modern fertility medicine harms more than it helps.

Because infertility patients are so often vulnerable and desperate, they are also easy to persuade—and some doctors take advantage of this dynamic. Driven by patient pressure for a quick fix, financial pressures, overenthusiasm, greed, or just plain thoughtlessness, they are steering women immediately toward drastic medical interventions and unnecessarily exposing patients to the expense, stress, and risks of IVF. Doctors often fail to produce a working diagnosis for their patients and often consider even an established diagnosis as irrelevant in the face of technology. Many fail to identify, explain, explore, and evaluate all options available to couples.

Money has corrupted health care across the board, and nowhere is

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that plainer than in fertility medicine. It's become an industry more than a field of medicine, and a highly commercialized one at that. Highly profitable tests and procedures are performed at ridiculously high rates, at times with no proven benefit to the patient (though the financial benefit to the doctor is high). As one patient who is an advertising executive remarked to us, "Fertility doctors are masters of marketing." That's definitely not the area of expertise you most want from your health care professional.

Some fertility doctors overmedicate patients, fail to tell patients about the downsides of fertility treatments, neglect to offer other (less profitable) treatments that may work just as well and/or be less invasive, turn away candidates they perceive as more difficult cases (because they rely on their success rates as a marketing tool), and, in the rare extreme case, perpetrate outright fraud, such as the swapping of embryos.

There are plenty of talented, well-intentioned practitioners out there, of course. Yet even they reap enormous profits from the aggressive use of technology, and it's the rare one who stands against the current. Furthermore, the irresponsible practitioners among them smear the whole profession. Even if all infertility doctors were good ones, the industry itself is woefully underregulated. Indeed, the way infertility treatment is carried out today is problematic in many ways.

WHAT'S WRONG WITH YOU?

Most of the patients who come to see us have already seen at least one fertility doctor. When we ask new patients, "What's your diagnosis?" eight out of ten of them say they don't know. But what is truly appalling is, *neither do their doctors*. The way fertility medicine runs these days, the diagnosis is seen as almost inconsequential. *Why figure out why she's not getting pregnant, the thinking goes; we're just going to give her drugs anyway. Or, I don't need to know if he's making healthy sperm in normal amounts; we'll get enough to combine with the eggs for IVF.* The general attitude is that doctors are more powerful than nature and can simply force a woman's body to become pregnant.

This is not good medicine, and we find it offensive. Even if we could put those things aside, however, this approach simply makes no sense. If the sperm count is low, why not try one of the easy fixes that may be

possible rather than jumping straight to serious intervention? And if the sperm aren't healthy, do you really want to use them to fertilize hard-won eggs for IVF? The only function of fertility drugs is to make more eggs release. They won't help a bit if the problem is bad sperm, an infection, or something toxic in the environment. You can pump out as many eggs as you like, but if the sperm can't get to them or penetrate them, or the body can't implant them or keep them once they're implanted, it's not going to get you any closer to having a baby. Fertility drugs can get more eggs released, but they can't make a woman more fertile.

The first order of business must always be to find out why someone is not getting pregnant. Roughly 10 percent of all infertile couples will not be able to find out why they cannot conceive. The medical profession is left to shrug its collective shoulders and explain to these people that they are something of a mystery. They are offered ARTs, but without there being a clear idea of what is being fixed, the outcome remains uncertain. It is impossible to determine the best course of treatment without the crucial insight of just what is wrong. What works for someone with blocked fallopian tubes is not going to work for someone with a bacterial infection that's preventing implantation, and what works for that person is not going to help someone who simply doesn't know when she is ovulating or how best to time intercourse.

THE MISUSE AND OVERUSE OF IVF

The culture among both doctors and patients has led fertility medicine in general astray, but the effect is most glaring when it comes to IVF. We'd argue that even in the best practices, IVF is used too often, is insufficiently considered, and is too harshly pursued.

As in all areas of medicine, fertility practices are getting more and more specialized, and so we have plenty of clinics devoted solely to IVF. Psychologist Abraham Maslow famously wrote, "If the only tool you have is a hammer, you tend to see every problem as a nail." These days, IVF doctors are pounding nails just as fast and as hard as they can.

Often women are run through IVF clinics like cattle. Doctors know their treatment strategy before they even meet a particular patient. Doctors make themselves too busy, then don't have enough time to spend with each patient. Many doctors are more concerned with their own

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success rates than they are with their individual patients. Most IVF doctors go all out to convince a woman that they can make her pregnant. Then, if it turns out they can't, they blame it on her, telling her that her eggs are "bad." The big guns are always drawn first; there's almost never an effort to try every basic thing that makes sense for a particular patient before proceeding to more drastic measures. It's the rare woman who walks into one of these practices and isn't told she needs IVF (at thousands of dollars per cycle). That's like everyone who consults a cardiologist being told that he or she needs heart surgery.

On the flip side, many women are turned away from IVF treatment but never presented with any other options, with the possible exception of donor eggs. The system has mostly given up on women with high levels of follicle-stimulating hormone (FSH)—levels that generally increase with age—on the theory that they probably won't respond well to the standard treatments. Imagine oncologists refusing to treat patients who "probably" won't respond to cancer treatments, picking and choosing whom they will treat based on the likelihood of quick success. Yet many fertility practices seem to have no qualms about turning away less likely prospects. They always have one eye on how they'll look on paper, focusing on the stats they have to report each year to the government, for publication. If you've already started the process of ART yourself, you know just what we're talking about. What was the first thing you did when choosing a doctor? Bet you anything it was look up the relevant batting averages.

All this despite the fact that FSH on its own is not a good indicator of fertility prospects (see page 216), although it may predict possible IVF failure. There are many other options for women with high FSH that might allow them to conceive naturally or prepare their bodies so that IVF may indeed work for them. It's become a familiar story: a woman walks into one of our offices frantic over what other doctors have said to her, panicked that she'll never have a child (often because she's been told she'll never have a child), and within months she needs to go back to her ob-gyn—for prenatal care.

PLAYING GOD

In the early 1980s, I (Sami) was the first doctor to successfully perform IVF in New York. I was working as part of a team, but I was the one who actually extracted the eggs and then implanted them once they were fertilized. I placed the cell cluster that was to become the first baby born in the city conceived outside the womb.

And I didn't like it.

I felt like I was playing God, and that just wasn't right for me. I didn't like holding life literally in my hands. It was a kind of surreal experience, still vivid in my memory: the embryologist over my left shoulder, handing me a syringe with three air bubbles in the fluid, telling me that there were four embryos between the bubbles. I just kept thinking, *These are babies inside this little syringe.*

I can't think of anything more satisfying than helping people who want babies to have babies, but I knew that day that this wasn't going to be the way for me to do it. I understood that I was in the middle of a major revolution for medicine—for humanity—but I also understood that I couldn't be part of it any longer. Not that way.

My professional peers by and large saw it differently. Although our training was fundamentally the same, almost all of them made a full conversion into IVF-oriented practices. And for that, I'm often grateful: they're there when I need to refer a patient, and there are a whole lot of children in the world thanks to them.

But the shift in the field of reproductive medicine to focus so intensely on IVF is a decidedly mixed blessing. It has reached an extreme of specialized practices run like fertility factories with one-size-fits-all treatment strategies, where doctors decide on treatments without knowing what they are actually treating. It's like treating a symptom without looking to discover the disease that's causing it. In the process of this upheaval, we've forgotten a lot of what we once knew, and we've been blind to better solutions, old and new.

In my practice today, I focus on medical and surgical treatment of infertility in women of all ages, specializing in recurrent pregnancy losses and women over the age of 39. I consider myself a traditional doctor. Some might say "old-fashioned"—I've made house calls—but I've got a number of cutting-edge techniques in my repertoire as well. I'm a

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surgeon, but I approach infertility first medically, then surgically if necessary. I take only about 10 percent of my patients into the operating room. The way I see it, the less invasive a treatment is, the better (of course, it still has to work). I don't put anybody on fertility drugs unless I have to, which turns out to be less than half the time. And when I do prescribe fertility drugs, I use only one-quarter of the dose most IVF docs do. Some couples I see need drugs, but not fertility drugs—they need antibiotics or steroids. Some benefit from simply taking over-the-counter cough medicine or plain old aspirin. Some of my patients simply need to douche with baking soda before intercourse.

I'll do whatever works best for the patient, even referring for IVF—but only for people who really need it. My preference is always for the gentlest option that will be effective. When the more natural ways don't work, I'm all for making use of more aggressive interventions. Almost always, good medical detective work will uncover the cause of a patient's infertility and so reveal the appropriate solution. And despite what you'd think if you walked into just about any IVF clinic in this country, the solutions don't often involve major invasive interventions.

WHAT'S THE PROBLEM?

IVF is just the most widely used—and the most widely overused—ART. Other techniques are overused as well—and patients are charged even more for them—including genetic screening and intracytoplasmic sperm injection (ICSI), both of which are discussed in chapter 25. ARTs in general have a significant physical, financial, and emotional impact on any couple. The drugs and techniques used pose short- and long-term health risks for the mother and the baby, on top of producing unpleasant (if transient) side effects. Many are not covered by health insurance. Even if they are covered, patients may bear a high proportion of the costs out of pocket. Psychological stress and emotional problems are common—even when the procedures are successful, and even more so when they aren't. That's in addition to the plain old physical stress of going through the procedures. Among other things, treatment disrupts people's personal and professional lives. Appointments (and there are a lot of them) may be made for the convenience of the doctors and staff rather than the patients. In any case, they have to be squeezed into

already very full lives. If you go to a fertility clinic at six in the morning, you're likely to see women lined up there already, waiting to get their blood taken or have a sonogram. All in pursuit of a goal that's anything but a sure thing.

Even if IVF were always carefully considered and judiciously recommended, it would still be a mistake to rely on it as completely as mainstream fertility medicine does, simply because the odds are so great that it won't work. Success rates have greatly improved since the dawn of the IVF era and are inching up each year, but, even so, the chances of having a healthy full-term baby after one cycle of IVF hovers at around 30 to 40 percent (and generally varies between roughly 10 and 50 percent, depending on the age of the mother). One of the best IVF programs in the country, for example, sends about 47 percent of patients under the age of 35 home with a baby in any given IVF cycle. The best program and the most-likely-to-succeed patients—and still patients get what they came for less than half the time.

WHY RISK IT?

The possible health risks of many fertility treatments are often glossed over—and not just by doctors who don't want to emphasize them, but also by patients who don't really want to think about them. The risks are an important part of the big picture, however. *They are small but real.* Negative effects on both mothers and babies are seen more frequently in children of ARTs than in naturally conceived babies. If you've already tried any of these techniques, we want you to keep these risks in perspective. In fact, everyone should keep them in perspective, because there may come a time when these *are* the right strategies for you. These may be risks you are ready to assume. What we wish for all couples trying to conceive is that any risks are *necessary* risks. What breaks our hearts is people opening themselves up to potential problems when safer options are available.

Our aim is not to scare women but rather to underscore why they must view ARTs as options of last resort. The risks are worth it when there is no other way to have a baby, but they are unnecessary if you can get pregnant in a more natural way. Following the Making Babies program will allow you to avoid the potential problems associated with

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fertility drugs, IVF, and other ARTs, including an increased risk of ovarian cancer in the mother; a tubal pregnancy; eggs or embryos with genetic defects; fetal abnormalities; perinatal complications; pregnancy with two or more babies at once (and all the potential health problems that go along with that); premature birth (and all the potential health problems that go along with that); neurological and physical handicaps, developmental delays, learning disabilities, and mental and behavioral disorders later in life; and possible infertility (for the baby) later in life.

There are potential immediate health risks for the mother from ARTs as well, including allergic reactions to fertility drugs, infection, injury during retrieval of eggs, bleeding, blood clots, and damage to organs or blood vessels. Poor lab work, including mix-ups of samples and/or results as well as basic quality issues, introduces another kind of risk in pursuing technological solutions to fertility problems.

The Risks of Fertility Drugs

Most of the risks to the mother come from fertility drugs, and we'll look at the potential problems in more detail in chapter 25. On their own, fertility drugs are the most common approach to infertility issues, and each cycle of IVF begins with fertility drugs. In both cases, the drugs are used to stimulate the ovaries to release more eggs. The usual strategy boils down to using more and more of the drugs, in an attempt to get more and more eggs. But some women receive doses that are too high. Others are given too many courses of the drugs. And some are given drugs when they don't really need them or have a fertility problem the drugs can't solve.

High-dose fertility drugs put women at risk in both the short and long term and increase the risks for babies as well. At the most basic level, many women experience headaches, hot flashes, and mood swings, among other familiar unpleasant signs of hormones at work. These effects may not be dangerous, but they can make a woman quite miserable, and they place even more physical and emotional stress on women and couples already pushed to the edge by fertility issues.

Over the long term, the repercussions are more serious. Some studies show an increase in cancer risk from fertility drugs, which aligns with what we've seen in some patients with a history of extreme fertility drug use. The most common serious side effect of fertility drugs is ovarian

hyperstimulation syndrome (OHSS; see page 323). The most severe cases require hospitalization and sometimes termination of pregnancy. Even with careful monitoring by their doctors, up to 10 percent of women using these drugs for IVF experience OHSS, with up to 2 percent having severe cases. OHSS is widely considered to be an overreaction to the drugs. We might do better to see it as a sign that we are overreacting in our use of such high doses of these extremely powerful drugs.

Once women go to all this trouble to get more eggs, it isn't exactly smooth sailing from there. Many eggs harvested this way are abnormal, increasingly so as a woman gets older, and are more likely to produce embryos with genetic defects than those from a natural cycle. These defects can cause fertility treatment to fail. Experts worry, too, that the drugs may be causing problems that have yet to be pinpointed in children born as a result of fertility drug pregnancies.

The Risks of Multiples

The goal of using large doses of fertility drugs is to get lots of eggs. Not surprisingly, this raises the risk of pregnancy with more than one baby at a time. Only about 2 percent of naturally conceived children are twins. Fertility drugs alone increase the chances of multiples between 6 and 20 percent, depending on the medication. With IVF the number of multiples goes up even further—about a third of IVF pregnancies are twins—thanks to the standard American approach of transferring multiple embryos in each cycle to increase the chances of conception.

Multiples pregnancies are high-risk pregnancies. Essentially, a system designed to grow one new human being is strained to the limit by larger demands. Multiples pregnancies are more likely to end in miscarriage. They are more likely to involve cesarean delivery, premature birth (more than half of twins are born prematurely), and/or low birth weight. (The number of babies born prematurely has increased drastically over the past two decades, right alongside the number of babies conceived with technological assistance.) Babies born early or small have more health problems at birth and over the long term, as well as a higher risk of death in infancy, than full-term infants. Consider, too, the high economic costs of the neonatal intensive care premature babies require.

Even the “solution” to the problem of multiples pregnancies created by IVF is problematic. “Reduction”—the euphemism used for selective

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abortion of one or more fetuses to lower the risks of the pregnancy—is a horrible situation to have to contemplate. And now evidence is showing that single infants born after selective (or spontaneous) reduction have many of the same risks and problems as twins.

The Risks of IVF

Research shows that babies conceived through IVF are at greater risk, even when they are in single pregnancies. If you've used any ART, or if you think you might, it is important to remember that the risks of serious, long-term problems in children born through ARTs are small. For couples with no other viable options for getting pregnant, these are acceptable risks. But for the many couples for whom these are *avoidable* risks, it is unnecessary to run them.

Less than 2 percent of naturally conceived children have birth defects, and although that figure certainly provokes some anxiety in would-be parents, it rightly doesn't dissuade anyone from conceiving that way. In babies born through ARTs, the risks are 50 percent higher: 3 percent. If you could lower the risks for your child even 1 percent, wouldn't you?

IVF babies also are two and a half times more likely than spontaneously conceived babies to have low birth weight, and that brings with it a raft of health risks, just as multiple and premature births do. Scientists do not yet agree on what to blame for the increased risks with ARTs. What is clear is that the more involved or intense the fertility intervention, the more likely it is that some problems will emerge over the long term.

The Risks of Not Knowing

Of all the risks faced by people struggling with fertility issues, the biggest one is not having a child. That's what makes all the other risks acceptable—*when they are necessary*. But the way the infertility industry operates in America today, these very real risks are too easily dismissed, never really considered, or taken for granted. If nothing else, they should give you pause, even if they don't change your decision in the end.

Modern infertility medicine poses subtler risks as well, and these receive even less consideration. There's the risk of receiving a diagnosis and being told there's nothing to be done about it (and so you'll never have a baby). There's also the risk of receiving the vague diagnosis of "unexplained infertility," meaning, really, that Western medicine can't find anything that needs fixing and so, again, there's nothing to be done.

So many patients come to us having failed IVF, or having been turned down as candidates for IVF, and their doctors don't have anything else to offer them, with the possible exception of donor eggs. They've been told that they'll never have a baby, perhaps because they are too old or their FSH is too high. For these women, that's a terrifying position to be in.

These are the risks of not knowing—not knowing what is preventing pregnancy and/or not knowing what to do about it—which the one-size-fits-all approach of fertility medicine today not only deems acceptable but also implicitly encourages. But you don't have to accept them if you follow the Making Babies path.

A BETTER WAY

The program laid out in this book will guide you through the process of conceiving as naturally as you can given your own particular situation. This decreases the risks of ARTs and comes as close as is humanly possible to eliminating the risk of not having a child. It's the paralyzing fear of that worst risk coming true that drives the whole crazy way the infertility industry works today. The latest and greatest technologies are sold as the one true path to salvation, the only things keeping patients away from the abyss. But fear is a terrible place to proceed from.

What a couple being pushed that way really needs is basic information, good advice, judicious use of conventional and adjunctive treatments, and a certain amount of clearheaded patience. What they often *don't* need is IVF. They don't need the physical strain of extreme hormone doses and repeated invasive procedures. They don't need the long-term increased health risks to mother and baby. They don't need the emotional strains the IVF roller coaster puts couples on. (In psychological testing measuring stress levels, infertility patients score higher than cancer patients.) They don't need the tremendous expense—in the New York metropolitan area, we're talking an average of \$12,000 to \$14,000 *per cycle*—and they don't need the additional stress that comes with that expense.

All these patients really need is a baby. When that goal proves difficult to achieve, they need careful detective work to uncover what's really going on and to so reveal how best to address it. Then they need a wise guide to help them navigate through their choices—*all* their choices—until their primary need is fulfilled. Sometimes the solution is indeed IVF, but most times something far less drastic will do the trick.

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High-tech medicine produces all kinds of miracles for all kinds of people, not the least of which are people desperately wanting to be parents. It isn't that we shouldn't use the technology available to us. It's just that we should use it wisely and well. The widespread availability of IVF and all ARTs is undeniably a good thing. The overreliance on them is not. In this book, we aim to help you walk the fine line of what is best for *you*. Let technology work wonders for those who need it. Let nature work *its* wonders for those who don't.

Making Babies Action Plan

- Try to get pregnant as close to the way nature intended as possible by following the Making Babies program.
- Understand the basics of how to get pregnant, including how your body works, how your partner's body works, and how they work together.
- Be patient (within reason).
- Consult with health care practitioners dedicated to treating you as a whole person and to considering all your options with you.
- Know your diagnosis.
- Weigh the negative aspects of IVF and other ARTs against the potential benefits.
- Use ARTs when and as appropriate.