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CLINICAL PERSPECTIVE

Head in the sand: Contemporary Australian attitudes towards induction of labour

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Ambivalence in Australian thought on induction of labour, despite recent evidence, stands out in contrast to ever-increasing rates of this intervention. As consent obligations on information provision have crystallised in maternity care, this article examines whether consumer-led expectations and legal obligations may precipitate change to end the cultural stigma around induction of labour.

KEYWORDS

attitude, induction of labour, legal, practice, stillbirth

INTRODUCTION

A recent Australian observational study[1] on induction of labour (IOL) has led to a debate on the safety of the intervention. Consensus is lacking on when to provide IOL for women and birthing people (*patients*) even though IOL is utilised in more than 45% of selected[1] primiparous patients in Australia. The absence of unambiguous national guidance creates confusion for patients and clinicians. We review current evidence and controversies and provide suggestions to help standardise clinical practice.

EVIDENCE

A systematic review[2] of randomised trials has helped us better understand the risks and benefits associated with IOL. It concludes that the benefits of IOL to low-risk patients include fewer stillbirths, perinatal deaths, caesarean sections, admissions to neonatal intensive care unit and more favourable Apgar scores. The review suggests that an IOL, when compared to expectant management, makes probably little or no difference to the rates of instrumental vaginal births, perineal trauma, postpartum haemorrhage and breastfeeding at discharge.[2]

The observational study,[1] based on population-linked data from New South Wales, appears less encouraging of IOL and carries the potential for confusion. There are no uniform guidelines across New South Wales hospitals for the management of 'soft indicators' associated with stillbirths – such as maternal ethnicity, in vitro fertilisation or maternal body mass index >30. Heterogeneity in perinatal data collection along with changes in clinical practice for 16 years would, arguably, have led to at-risk patients being included in the 'no medical indications' category for IOL. Stillbirth and perinatal death, both critical considerations in IOL counselling, are not evaluated in this study.

The choices patients face in real life lie in between accepting IOL or expectant management. No patient can be guaranteed an outcome of spontaneous labour. The patients who fail to labour eventually require IOL. The results from randomised trials[2] and

a meta-analysis of cohort studies[3] have both found favourable outcomes from IOL when compared to expectant management in low-risk patients. The inherently artificial comparison of IOL to spontaneous labour in the Australian study[1] must not become the basis for counselling patients or decision-making at a public-policy level.

CONTROVERSY

Why are low-risk patients, then, not provided the option to consider an IOL (*elective IOL*) at 39 weeks? The arguments against, yield recurrent themes.

Clinical trials on IOL often focus on morbidity and mortality and do not adequately capture the breadth of positive experiences[4] that pregnant patients desire. Providing an elective IOL, routinely diminishes the rates of spontaneous birth and, importantly, choice if the *offer* is perceived as a *recommendation* at clinical consultations. The increasingly strident focus on risk may barter away maternal satisfaction with the birth process.

A foundational argument against IOL, is the 'ideological and bureaucratic pressure to favour normal birth'.[5] This is inherently problematic. Viewing IOL as an intervention to be discouraged, may render normative, morbidity from childbirth. For example, a patient who suffers long-term incontinence from damage to her pelvic floor at birth may meet the criteria to qualify as a 'normal birth', but patients who opt for an epidural or an elective IOL do not. Any organisational- or professional-led discourse on normality, risks patients being made to feel like failures for choosing interventions. That this is allowed to occur is a failing of health regulatory systems in maternity services.

Concerns abound[6] on long-term maternal and child health outcomes from interventions at birth. The evidence on long-term effects may best be described as evolving.[7] It carries little heft to recommend deferring an elective IOL at or beyond 39 weeks (now considered 'full term') when weighed against the plausible benefits of the intervention.

The systematic review[2] of randomised trials suggests that a large number (544) of IOL procedures would be needed to prevent one perinatal death. While there is 'disagreement about the level of risk that justifies routine IOL',[1] how is one to decide when the threshold is met for disclosure of risks or the *offer* of intervention? There are no easy answers.

Any ethical argument for distributive justice that appears to diminish individual autonomy remains fraught. A deeply embedded 'culture of silence' on stillbirths in maternity care 'means that parents and families who experience it are less likely to be prepared to deal with the personal, social and financial consequences'.[8] Such a 'paternalistic approach'[8] to antenatal care is no longer conscionable. Resource utilisation for elective IOL *choice* must be viewed through this lens.

CHANGE

Offering elective IOL choice may likely become an increasingly popular choice that fits with the lived realities of some patients who wish to do away with the unpredictability of spontaneous labour. This may lead to bottlenecks with scheduling immediate IOLs for higher-risk women. Potential delays to high-risk IOLs from resource constraints may paradoxically pose a risk to the very safety concerns they are meant to address.

Staff will have to work in new ways to facilitate increased IOL rates. Clinicians will need to encourage a decrease in early-term delivery of non-medically indicated IOL, as this carries implications for the fetus.[9] There is evidence that outpatient IOL may be, at least, as safe and effective as inpatient IOL.[10] Hospitals need to invest in additional resources on labour ward design, equipment and staffing, particularly concerning midwifery numbers, and in the multidisciplinary nursery and theatre teams. Just as the perinatal workforce becomes more aware and accepting of elective IOL choice, it becomes imperative for administrators to acknowledge a need for greater resource allocation towards maternity services.

IOL also provides resource-conserving benefits.[11] The health outcome advantages from IOL may be gained without incurring uniformly greater healthcare resource use.[11] The longer time spent by women in labour wards during the IOL process is offset by significantly fewer antenatal visits, tests and treatments and shorter maternal and neonatal hospital durations after delivery.[11] It is encouraging to note evidence that suggests that routine IOL at 39 weeks may be economically viable in an Australian context, as would be the implementation of a continuity-care model.[12]

AMBIVALENCE

The Australian Institute of Health & Welfare publishes national core maternity indicators to improve the quality of maternity services 'by establishing baseline data for monitoring and evaluating practice change'. The web report,[13] despite updates in 2020, continues to provide redundant references from an era before the ARRIVE[14] trial. This trial, published in 2018, has indisputably influenced clinical thought and counselling about IOL. Such lack of attention to current evidence by a federal health agency bodes poorly for its clinical relevance to the clinical workforce or patients.

National guidance on pregnancy care[15] in Australia remains ambivalent on IOL. The guidance broadly aims to reduce 'unnecessary induction'[15] but does not define what 'unnecessary' means. An analysis of cost implications in the document fails to acknowledge recent evidence[12] on the cost-effectiveness of IOL and reiterates the false notion that reducing rates of IOL 'may reduce the rate of caesarean section'. Again, findings from the ARRIVE trial are 'not included' as the document appears to analyse evidence for IOL only after 41 weeks.[15] The exclusion of such a landmark

trial defeats the stated intent of these guidelines to provide 'high-quality evidence-based guidance'[15] in pregnancy care.

Australia risks a post-truth discourse when research that does not align with preferred experiences or opinions faces dismissal.[16] Criticism of the ARRIVE trial is both necessary and legitimate.[16] This said, the validity of what this trial has achieved through a rigorous scientific process must be acknowledged, considering it is now the basis of change in clinical practice,[17] as advised by apex professional bodies.

CONSEQUENCES

Health systems risk grassroots rebellion from clinicians and patients against this ambivalence on IOL. The increases in IOL rates[1] observed over the past decade send a clear message. It is time to end the cultural stigma and institutional ambivalence associated with IOL. This is especially relevant to Australia given its problematic track record on stillbirth rates[18] over the past two decades. A national stillbirth plan,[18] developed through extensive consultation, now hopes to address the stubborn stillbirth rates, through the 'Safer Baby Bundle' program.

Patients seeking elective IOL for soft indicators of stillbirth lack assurance of their requests being met. Health systems may effectively perpetuate discrimination, by not considering requests for intervention from culturally and linguistically diverse patients. If the data are to be believed, that more patients with induced labour are of Australian origin,[1] is this because they are better able to negotiate or exercise their choice *for* intervention than women from a non-Australian background?

Information provision on risk, sans choice, serves no purpose to the patient to whom such risk may be of material significance. The Safer Baby Bundle program[18] advises that 'planned birth to reduce the risk of stillbirth should be targeted according to a woman's individualised risk, taking into consideration the possible adverse consequences of planned birth before 39 weeks' gestation'. The implementation of such advice to allow access to IOL upon request at or beyond 39 weeks is yet to be meaningfully realised in clinical practice.

CONSENT

The *Consent Manual*, published by NSW Health in 2020, has changed obstetric consent processes there and will likely manifest in similar forms across other states.[19] This manual reinforces extant law, as defined by the courts, applicable across common law jurisdictions.[19] Clinicians are obliged to warn patients of material risks of IOL being undertaken or avoided. A risk is considered material 'if, in the circumstances, a reasonable person in the patient's position, if warned of the risk would be likely to attach significance to it'.

The materiality of stillbirth cannot be adequately stressed. Antenatal education that intends to achieve 'decreased rates of non-medically indicated' IOL[15] does not meet the professional standards expected from an informed consent process. A failure to warn[19] patients of stillbirth will likely expose the clinician to tort claims from poor outcomes. Patients, especially those with risk factors for stillbirth, *must* be warned of this risk and counselled regarding management options.

Procedures related to IOL also carry material risks.[19] This includes risks from an emergency caesarean after a failed IOL, uterine hyperstimulation, and cord prolapse and risks from instrumental vaginal births. Patients who decline IOL must be provided alternative fetal surveillance if they accept.

Consent is not a justification to encourage IOL. An unambiguous distinction must be drawn between *offering* a choice and *recommending* an intervention, especially in circumstances where no risk to the patient or fetus has been identified. In clinical practice though, such a distinction can often be difficult to maintain. Vigilance must be maintained against coercion that may result from guidelines supporting an *offer* of IOL.

CONFUSION

How are clinicians meant to bridge the chasms between blurred guidelines, benchmarking pressures and medico-legal obligations? The professional responsibility model[20] of obstetric ethics provides solutions. In this model, directive counselling for fetal benefit must respect maternal autonomy and any decision to the contrary. The best outcomes for *both* are achieved through informed consent, engaged dialogue over any refusal and respectful persuasion that appeals to the patient's values.[20]

We contend that all patients in Australia reserve the right to choose an elective IOL at 39 weeks. Contentious as it will likely be, a consensus position on this issue must be sought by maternity services professionals. Rightly, Australian clinical practice guidelines for pregnancy care ask clinicians to 'always' account for 'the woman's preferences' in the provision of care to meet her 'needs, expectations and aspirations'.[15]

Any consensus position must, first, acknowledge the primacy of maternal choice: the choice for a patient to seek, through a supported decision-making process, an elective IOL at 39 weeks as much as the opportunity to make an informed refusal of intervention. The provision of advice must ultimately seek to inform and not to change minds against deeply held values.

CONCLUSION

The debate on IOL captures perfectly the tensions between the organisational imperative to meet legal obligations of informed consent and the confusion in evidence-based guidance to be able

to ensure this. Systems need to ensure that clinicians in maternity care are ready to transition to increasingly robust obstetric consent processes that are likely to become the norm. Patients must be provided the option to choose an elective IOL at 39 weeks through a supported decision-making process.

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