Ten Things ...

I wish every woman knew about induction of labour by *Sara Wickham*

In modern western culture, most women know about induction of labour before they even become pregnant.

They know that it is suggested when it is felt that it would be safer for the baby to be born than to stay inside its mother, and I suspect many women know that one of the main reasons for recommending induction of labour is because pregnancy has lasted for a certain number of weeks and the baby is perceived to be 'overdue'. Many women will know a good few other women who will have had their births medically induced, and so they are likely to know that other reasons are sometimes given for this. These reasons include that the woman is older than average, that her waters have broken early and/or that she has a health problem or condition which is felt to necessitate the bringing on of her labour.

But this is not the whole story, and there are many, many other aspects to the decision that some women need to consider about whether or not to have their labour medically induced. I have spent the past few months writing about this topic, and the result is the recently published and completely updated AIMS book, ***Inducing Labour: making informed decisions***.[1] For the book's launch event in Bristol at the beginning of May, I prepared a presentation entitled **'Ten things I wish every woman knew about induction of labour'**. I didn't want to focus on the things (as above) that are commonly understood, but instead on some of the evidence, issues and implications that I think women are less aware of and might want to take into account when making their decision. There are, of course, way more than ten things to know, but my list was intended to serve as a starting point for discussion rather than to be exhaustive.

1. It's not like normal labour

This might be obvious to some people, but I know from experience that it isn't to others. Induced labour is very different from labour that starts spontaneously. Individual women's experiences vary, of course, but there are a number of key and interwoven areas of difference that are fairly universal. Firstly, a woman having her labour induced is given artificial hormones, which can create more pain more quickly than would occur in spontaneous labour. Synthetic hormones don't trigger the release of a woman's own natural pain-relieving substances as her own hormones would if she were in spontaneous labour, and they come with a range of possible side effects, which means a woman whose labour is being induced needs to be monitored more closely. The increased monitoring can lead to the woman being less able to move around, which can increase her pain and stress, and this can quickly lead to a woman feeling that things have spiralled out of her control.

2. It's painful

I started to cover this already in point 1, but there are even more and varied sources of pain that I think women deserve to know about before making a decision. For example, the contractions caused by prostaglandin gels or pessaries, which are often given as the first stage of medical induction, can become really sharp really quickly, but without having any measurable effect. This can have a negative effect on women's experiences, and it is easy to become tired and/or disillusioned more quickly than if they were in spontaneous early labour. Oxytocin-induced contractions can also be very strong, and there is often less time to get used to these than when labour starts spontaneously. In addition, the increased number of vaginal examinations and other interventions (such as the insertion of cannulas) can create additional pain or discomfort.

3. It's a package deal

I have written about this quite a bit on my website (www.sarawickham.com) so I won't repeat myself too much here, but the fact that I get asked so frequently whether women can have a physiological placental birth or decline monitoring and/or vaginal examinations if their labour is induced makes me think that this is not a commonly understood fact. It is not that anyone wants to prevent a woman from making the decisions that are right for her. It is that the drugs used to induce labour are powerful substances that block a woman's own hormones and that can cause problems for the woman and baby. It is the effect of these drugs that needs to be measured, monitored and compensated for in induced labour. If a woman is concerned that aspects of induction are not what she wants, then it might be better for her to consider whether induction is really necessary in the first place.

4. Stretching and sweeping isn't benign

Nowadays, many areas have introduced a policy of offering women a 'stretch and sweep' at a certain point in pregnancy in the hope that this will reduce the number of women who go on to have medical induction. Even if we ignore the assumption that all of the women who are offered induction will consent to having it, a stretch and sweep can cause discomfort, bleeding and irregular contractions, and in some of the studies the stretch and sweep intervention only brings labour forward by about 24 hours. The authors of the Cochrane review on this concluded that: *'Routine use of sweeping of membranes from 38 weeks of pregnancy onwards does not seem to produce clinically important benefits. When used as a means for induction of labour, the reduction in the use of more formal methods of induction needs to be balanced against women's discomfort and other adverse effects.'*[2]

5. 'Natural induction' is an oxymoron

This is another one that I have written about elsewhere, in an article that is freely available on my website,[3] but the gist is easy to summarise. Either we are awaiting spontaneous labour as nature intended, or we are trying to interfere and bring it on earlier than it would otherwise have occurred. Sometimes there is good reason to try to bring labour on, but if a woman takes castor oil or asks her midwife to do a daily stretch and sweep or picks any one of the range of things that are purported to bring on labour, then she is aiming to induce her labour with non-medical means. I am not saying there is anything wrong with that, but I think that, particularly because we exist in a culture that continually devalues women's bodily processes, it is important to be clear about what our intention is.

6. It is NOT the law

I was absolutely appalled to discover, part way through writing the book, that AIMS had received a call to its helpline from a woman whose midwife had said: *'We have to induce you twenty four hours after rupture of membranes. It's the law.'* The woman had agreed to induction and went on to have what she felt was a very traumatic birth. I wish all women knew that there are no laws that state what a pregnant woman must or must not do, and both AIMS and I are very concerned about this. Any practitioner saying such a thing should be reported to their professional body. Any woman who is threatened in any way or told something of this nature is welcome to contact AIMS for information and support.

7. It's not 'just a trickle'

I am always really concerned when I hear midwives and doctors using language that downplays the interventions that they are recommending, and I particularly dislike the terms 'trickle' and 'whiff' when used in relation to intravenous oxytocin (syntocinon). This is a powerful drug and needs to be respected as such. It can cause fetal distress, and in fact in some areas the practice is to keep increasing the amount of syntocinon that women receive until the baby reacts, and only then turn it down as it is considered that the appropriate level has been found. But even where this is not done and the syntocinon is only increased until contractions are effective, it is a drug that needs to be given respect and its potential effects should not be minimised by professionals, whether intentionally or otherwise.

8. Women don't fail. Inductions and systems do

This one pretty much speaks for itself. Induction doesn't always work, and this is not the fault of the woman. I wish I could reassure all women who have had an induction that was unsuccessful that there was nothing wrong with them or their bodies. This is another case where some of the language used in the maternity services really needs to be reconsidered.

9. The post-term risk is later, lower and less preventable than people think.

Figure 1 shows a table that I used in the presentation as well as the book, and it summarises the results from a study that looked at the risk of unexplained stillbirth in each week of pregnancy. If you look at the figures – and I would particularly like to invite you to compare the risks at 37 and 42 weeks of pregnancy – you will see that the increase in risk doesn't happen as early as some people believe, and that the increase is lower than is often implied. In fact, the outcomes experienced by women who awaited spontaneous labour and by women whose labour was induced were so similar that none of the individual studies that compared induction with non-induction were able to show a benefit to induction in their findings. It is only when all of the results for all of the studies are added together that it is possible to see a small difference. However, the quality of one of the

Figure 1

Cotzias et al (1999) looked at unexplained stillbirth in each week in relation to the number of ongoing pregnancies.

The risk of an unexplained stillbirth at 35 weeks was 1 in 500
The risk of an unexplained stillbirth at 36 weeks was 1 in 556
The risk of an unexplained stillbirth at 37 weeks was 1 in 645
The risk of an unexplained stillbirth at 38 weeks was 1 in 730
The risk of an unexplained stillbirth at 39 weeks was 1 in 840
The risk of an unexplained stillbirth at 40 weeks was 1 in 926
The risk of an unexplained stillbirth at 41 weeks was 1 in 826
The risk of an unexplained stillbirth at 42 weeks was 1 in 769
The risk of an unexplained stillbirth at 43 weeks was 1 in 633

Cotzias CS, Paterson-Brown S, Fisk NM (1999) Prospective risk of unexplained stillbirth in singleton pregnancies at term: population based analysis. BMJ 1999;319:287. doi: dx.doi.org/10.1136/bmj.319.7205.287

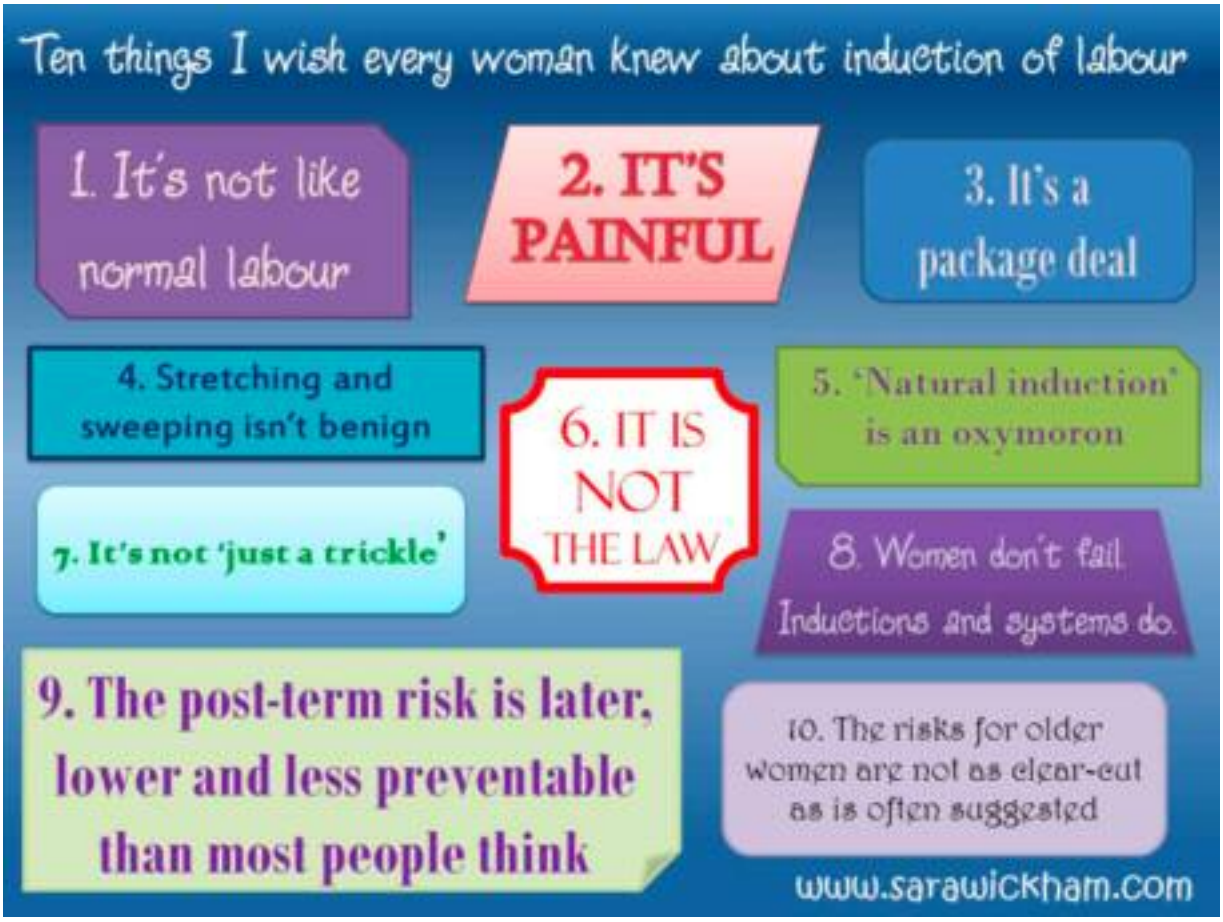

Figure 2

studies – which just happens to be the one that tips the scales – is really poor. For all of these reasons, it is really questionable as to whether current policies of suggesting induction for post-term pregnancy before 42 completed weeks confer any real benefit. There is lots more on this in the book, including a full analysis of the literature.

10. The risks for older women are not as clear-cut as is often suggested

My final point relates to the idea that women who are older are at greater risk of having a baby with a problem, and that they should be induced because of this. It is true that some studies suggest that there may be a correlation between increased maternal age and an increase in certain types of complications, but there are a number of reasons to be cautious about this. Women who are older are often offered monitoring and intervention in abundance, and this can cause complications. Older women are also more likely to have other health challenges (sometimes called co-morbidity) and it is hard to tell whether these problems and/or their age are the cause of any problems. The studies that have looked at this have not always separated these issues out, and the only papers that have done so looked at women who gave birth some years ago and who may not be comparable to women today. So there is a real lack of good data in this area, and unfortunately the studies that are being carried out to look further at this are tending to induce even younger women even earlier in pregnancy, so their results may not be of much use to women either.

A day or two after the talk, I asked some colleagues what would be on their list and, perhaps inevitably, they came up with all sorts of other things. In fact, there are not ten but literally tens of things that we wish women knew, but at least this is a start. You can find out more on most of these areas (and many more) in the AIMS book, ***Inducing Labour: making informed decisions***. Our focus now is on getting this information out to more women before they make their decision.

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References

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