Induction of labour should be offered to all women at term AGAINST

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BJOG DEBATE

BJOG PERSPECTIVES

Induction of labour should be offered to all women at term

AGAINST: Induction of labour should not be offered to all women at term: first, do no harm

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Induction of labour can improve maternal and neonatal outcomes. However, more and more women without medical risks or complications are being induced. Although induction at term could prevent rare cases of fetal death, all induced women will be exposed to potential disadvantages. Women whose labours are induced have a higher risk of postpartum haemorrhage, uterine rupture, hyperstimulation resulting in fetal distress, and perineal injuries (Miller et al. *Lancet* 2016;388:2176–92). Furthermore, more women need pain medication and have limited freedom of movement, a longer labour, and a negative birth experience. There is increasing evidence that suggests negative consequences of synthetic oxytocin administration. This may influence maternal–fetal bonding, the maternal psyche, and neonatal preparation on being born. A large cohort study found higher rates of jaundice, feeding problems, infections, metabolic disorders, and eczema up to 5 years of age among children born after induced labour (Peters et al. *Birth* 2018;45:347–57).

Induction of labour has been associated with reduced caesarean section (CS) rates in some randomised controlled trials (RCTs) but not in cohort studies (Rydahl et al. *JBI Database System Rev Implement Rep* 2019;17:170–208). The study population in these RCTs is often rather different than the general population. Additionally, before a major intervention (induction) is offered to reduce another intervention (CS), effective non-medical physiological approaches should be implemented first.

An example of this very effective strategy is providing continuous support during labour (Bohren et al. *Cochrane Database Syst Rev* 2017;[7]:CD003766). This has been shown to reduce CS rates by 25%. Further, women who receive continuous support are 10% less likely to have an instrumental birth, 31% less likely to report a negative childbirth experience, and 10% less likely to need intrapartum pain medication, and labours are on average 0.69 hours shorter. Moreover, babies are 38% less likely to have a 5-minute Apgar score of ≤7. In spite of these very good outcomes, most women do not receive continuous support during labour.

Another big problem of inducing more women is the increased pressure on maternity healthcare resources, which are already constrained in many countries. Women who are induced occupy hospital beds, sometimes for several days, before labour starts. This means not only an enormous increase of workload for the healthcare workers but also reduces access for women with acute risks or complications. As a consequence, the availability of staff to provide non-medical approaches such as continuous support and to focus on prevention will become even more restricted than it is already.

Most women prefer giving birth without interventions and value having a positive childbirth experience in addition to healthy outcomes (Downe et al. *PLoS One* 2018;13:e0194906). Induction of labour often results in a cascade of interventions that are neither pleasant nor empowering for women. Minimising obstetric interventions and giving support to childbearing women improves maternal experiences of childbirth and enhances empowerment. Offering induction to all women at term ignores the principles of the Hippocratic oath, 'first, do no harm' and should therefore only be reserved for women with a clear medical indication.

Disclosure of interest

None declared. A completed disclosure of interests form is available to view online as supporting information. ■