Induction of labour for post-term pregnancy

Abstract

There has been a shift in healthcare philosophy in recent decades beyond simple requirement of client consent to treatment towards a more intricate notion of informed choice. Debate continues as to whether advocacy of shared decision-making in maternity care is more rhetoric or reality. In the context of management of so-called 'prolonged' pregnancy, the scope and authenticity of informed choice withers under scrutiny. It is considered that induction of labour at this juncture in pregnancy has become routinised, affecting an illusion of safety and depressing maternal stimulus to exercise choice. The offer of induction for advanced gestation has thus acquired normative power. Observation during clinical practice has revealed that there may be ethical failings in risk communication, manifested in data manipulation and scaremongering. However, a culture of powerlessness constrains midwives and compels them to seize the risk agenda and adopt the 'medical standard' for this common intervention.

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Recent decades have seen a theoretical power shift from clinician authority to user autonomy alongside a public and political movement emphasising personal choice and control in relation to maternity care (Department of Health (DH), 1993; NHS Executive, 1996). A new language and philosophy continues to resonate in current UK reports and policy documents, which advocate a humanistic, woman-focused service and promote childbearing women as active consumers and decision-makers (DH, 2004; DH, 2007; DH, 2010). The contemporary approach to care appears to revoke the traditional paternalistic biomedical model, which prioritised the physical aspects of pregnancy and assigned 'patient' status to the childbearing woman.

Research on childbirth indicates that women's participation in healthcare decisions is strongly associated with feelings of trust (Levy, 1998a), lower levels of fear (Melender, 2002; Green and Baston, 2003), increased responsibility for health of self and baby (Harrison et al, 2003), improved self-esteem and lower incidence of postnatal depressive symptoms (Chalmers, 1982; Jomeen and Martin, 2008), shorter recovery periods (Green et al, 1988) and more favourable maternal feelings towards the newborn, as well as improvements in the child's long-term health and wellbeing (Bowlby, 1988; Schore, 2003; Verny, 2002).

The midwifery model acknowledges this link between choice and perceived sense of control, enriched quality of experience and improved psychological outcomes (Spurgeon et al, 2001; Walsh and Newburn, 2002). It holds that by offering and supporting choice, the midwife can empower the woman and help her to sustain autonomous and self-determining behaviour (Mander and Melender, 2009). Whether this translates to practice depends on the quality of the midwife-mother relationship, the cultural and organisational environment and the midwife's ability to practice autonomously (Leap, 2000).

Informed choice can be defined as the integration of evidence-based knowledge with individual healthcare needs, beliefs, values and preferences (Marteau et al, 2001). Choice, however, is dependent on more than just maternal preference for information and participation; it requires the availability and accessibility of options and alternatives (Guadagnoli and Ward, 1988). The prevailing dominance of the medical system in a climate of risk magnification, growing emphasis on surveillance, the development of increasingly sophisticated antenatal screening services and professional fear of litigation all serve to divert attention away from maternal choice in a direction that favours technology and professional expertise (Beck, 1992; Kotaska, 2008; Dahlen, 2009). Choice therefore generates tension for women as they are simultaneously attributed active and passive roles in their childbearing experience (Edwards, 2004). In a risk-averse society, perhaps, informed choice is but an illusion.

As a student midwife I frequently observed the conspicuous absence or lack of discussion between women and maternity care providers etc. This was especially so in respect of induction of labour, in which a fully informed discussion is a prerequisite to any decision made (Royal College of Obstetricians and Gynaecologists (RCOG), 2001). It is widely recognised that women continue to be under-informed about one of the most commonly performed childbirth interventions (Out et al, 1985; Jacoby and Cartwright, 1990; Fleissig, 1991; Salmon and Drew, 1992; Declerq et al, 2006; Shetty et al, 2005; Murtagh and Folan, 2014). Therefore, this article aims to understand why midwives feel compelled to abandon the discourse of normality in adhering to the 'medical standard' of induction of labour for post-term pregnancy (Annadale, 1988;

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Anderson, 2004). It is considered that a culture of powerlessness constrains midwives and draws them into practising a more interventionist type of care, such that they are ill-equipped to empower their clients and instead may collude with the medical model in its maintenance of control over women (Kirkham, 1999; Wagner, 2001).

Routine intervention and socially sanctioned 'choice'

Induction of labour is a common childbirth intervention with multiple obstetric, medical and sometimes social indications (RCOG, 2001). The World Health Organization counsels that induction should not be undertaken for convenience but rather reserved for specific instances, and has proposed a target 10% cap for all geographic regions (WHO, 1985). In Wales, however, the proportion of induced deliveries was most recently reported to be 23% (Welsh Government, 2012).

Induction is indicated in circumstances where it is deemed that the outcome of the pregnancy will be more favourable if it is artificially interrupted rather than permitted to follow its natural course. Such circumstances include the presence of various pre-existing medical disorders: diabetes mellitus, thromboembolic disease, hypertensive, renal or liver disorders, antenatal investigation of abnormality, poor obstetric history and suspected fetal abnormality or compromise (National Institute for Health and Care Excellence (NICE), 2008). Intervention is also recommended for cases of post-term pregnancy, where medical concern hinges on heightened risk of perinatal complications in association with advanced gestation (Smith, 2001). In the past, danger was attributed to 'wasting' of the unborn child due to placental degradation (Vorherr, 1975), a condition now known to affect babies whether or not they are post-term (Mannino, 1988; Shy, 1991). Although fetal, maternal and neonatal risks increase beyond 41 weeks there remains no conclusive evidence that prolonged pregnancy is the major causative factor (Bernischke and Kaufman, 2000). Some have argued that the elevated risk, which ritual induction at 41 weeks seeks to diminish is dubious, if it exists at all (Menticoglou and Hall, 2002).

Accurate diagnosis of post-term pregnancy depends on establishment of a predicted date of birth. Even with the best available technology, however, the estimated due date is just that—an estimate (Hart, 2004). According to Naegele's rule, the human gestation period is 266 days, but this fails to account for wider variations affected by ethnicity, parity, nutritional status, maternal body mass index, smoking or familial patterns, among other feasible factors (Bergsjø et al, 1990). There are known to be variables in intrauterine development just as there are variables in development after birth (Ahn and Phelan, 1989). Jukic et al (2013) found that among natural conceptions where the ovulation date is known, the variation in pregnancy length spanned 37 days. Indeed, gestational length has been debated for over a century, and need remains to refine our understanding of myriad influences on the duration of natural term for any given woman (Baskett and Nagele, 2000). Given such uncertainty, post-term pregnancy may just as often as not be misdiagnosed (Henriksen et al, 1995). When approximately 1 in 4 pregnant women will not have laboured spontaneously at this gestation, it reasonably follows that routine induction at 41 weeks is an affront to biological norms (Menticoglou and Hall, 2002).

Preoccupation with a specious 'due date' can hinder women's trust in nature's plan for the end of pregnancy and start of labour, leading those who fail to heed the ultrasound prophesy to feel deviant (Davis-Floyd, 1994; Kukla, 2005). Studies suggest that women whose pregnancies continue beyond term might be in need of additional social support, since a newly imposed 'high-risk' classification can invite a sense of isolation, alienation and inadequacy (Oakley, 1984; Conrad, 1992; Handwerker, 1994; Stahl and Hundley, 2003). Women with prolonged pregnancy might hesitate to embrace the concept of informed choice in relation to induction of labour because they consider it a routine aspect of maternity care (O'Cathain et al, 2002; Baston and Green, 2007; Heimstad et al, 2007). In the context of a culture where technological intervention is equated with safety, where doctors have social and cognitive authority and the dominant model is action-oriented, the offer of induction is far from neutral (Kukla and Wayne, 2011).

Are we honest about induction of labour?

The continuation of pregnancy requires that a woman's cervix remains firm and closed and her uterus non-contracting. If labour is to begin, these conditions must be upturned. Most methods of induction involve the manipulation of prostaglandins, inflammatory mediators and other agents in order to achieve this. There is, however, marked associated potential to turn a low-risk pregnancy into a high-risk labour, and thus to significantly alter women's experience of childbirth (Duff and Sinclair, 2000). Induced labours are generally less efficient, more complicated and more painful than those which begin spontaneously, and a higher operative delivery might be expected (NICE, 2008). The disruption to labour's hormonal

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orchestration extends to the crucial moments immediately after birth when the mother-infant dyad might be less alert and able to interact (Thomas, 2012). Some reason that when a woman relinquishes autonomy of her body to the control of the medical system, she suffers varying degrees of assault on her self-worth, self-trust and confidence (Szurek, 1997). Honest communication of the psychosocial repercussions of induction might be impeded by the widely held fallacy that all that matters is a live mother and baby (Bryers and Teijlingen, 2010).

The decision to undertake induction of labour should be clear, clinically justified and preceded by careful, case-specific appraisal of the evidence and sensitive discussion with the woman (NICE, 2008). It is the midwife's role to critically review both historical and contemporary developments within the field (Wickham, 2006). Integral to provision of appropriate care, the midwife must be able to confer accurate and current advice relating to pregnancy and birth (Nursing and Midwifery Council (NMC), 2008). On best-estimate diagnosis of post-term pregnancy choice should be made available to the woman by means of a detailed, balanced explanation of both induction of labour and the expectant management recourse. Before seeking consent for the intervention, the woman needs to be informed about the nature of the condition, the likely risks and consequences of not receiving treatment, and about the range of reasonable alternative approaches, expanding to discussion around any uncertainties (RCOG, 2008). Adequate impart of information is especially important in light of mounting evidence regarding risks associated with intervention itself (Goldberg, 2009). It is essential that what are presented as 'facts' are aligned with evidence, not with beliefs (Oakley, 2000). It seems that 'information-steering' occurs more often than ethical promotion of informed choice. Rather than initiating an earnest discussion, midwives have been observed engaging in an act of crude instruction: 'I'm just going to book your induction.'

The law

Before undertaking any medical intervention, informed consent is obtained in order to serve a twofold purpose: to respect patient autonomy and to protect the person initiating the action (Spaeth, 2010). Due to the inability to determine with any great certainty when a situation or an intervention will be harmful to the baby or the pregnant woman, considerable care must be exercised to present a fair evaluation of predicted outcomes for both parties (American College of Obstetricians and Gynaecologists, 2005). If a woman believes that a clinician has abused her right to informed choice she can pursue remedy in the courts for negligence, (Silverman, 1989). Harm is here judged not to be intentional but to have arisen from carelessness. In respect of negligence, the quantity and quality of information about risk required is that conceived to be 'reasonable' by the court in light of the choices that patients face (Griffith et al, 2010; NHS Litigation Authority, 2012).

The civil courts have analysed consent to medical treatment for 250 years and continue to uphold the importance of autonomy. Reinforced by the Human Rights Act (1998), there appears to be a consistent, coherent approach to informed choice from the UK government, institutional bodies, health professionals, and the law, where each set forth that women be provided with accurate, impartial information and enabled to reach their own decisions about any proposed treatments, free from intimidation (DH, 2009; NHS, 2012; RCM, 2008; RCOG, 2008; Welsh Government, 2008). These decisions must be respected, even if they contravene the recommendations of the campaigning clinician (Strasser and Gallagher, 1994).

Medical care may well be of practical benefit regardless of whether a patient chooses it. Nevertheless, as soon as choice is withdrawn from a competent adult, care becomes intrinsically harmful. The nature of this harm is not physical but moral, and is often concurrent with psychological distress (Klein, 2002; Leap, 1997; Melender, 2002). As an expression of respect for the woman as a person with moral right to bodily integrity, informed choice is therefore not just a legal, but an ethical necessity (Foster and Lasser, 2011). Documented ethical codes in midwifery give sanction to values that are arguably inherent to the profession, such as respect for women's dignity and autonomy, their right to privacy and participation, the need to uphold equity and justice, a duty to protect self-worth and informed choice, and the importance of fostering trust (International Confederation of Midwives, 2003; NMC, 2008). Reported experiences of childbirth nevertheless suggest that women are being coerced into passive acceptance of whatever care is prescribed, that routine interventions are regularly forced on them, and that they continue to have limited control over their bodies and their decisions (Kitzinger, 2006).

Ethical communication of risk

Methods of predicting complications in an individual pregnancy are currently lacking, so induction of labour cannot be confined to those at known risk. Intervention is therefore recommended in all cases of prolonged pregnancy, however inappropriate for the majority of that group (NICE,

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2008). Informed choice in official British policy would seem to imply a non-utilitarian bearing, yet clinical practice guidelines on induction of labour suggest otherwise. In fact, consistently high induction rates reflect a technocratic and classical utilitarian approach to maternity care in which choice is largely subjugated (Davis-Floyd, 1993). Guidelines, of course, can swiftly mutate into 'standard practice' and in turn to midwifery knowledge and 'consensus', ultimately governing how far a woman can veer off the 'medical highway' (Menticoglou and Hall, 2002; Davis, 2003).

There is differing opinion among doctors, obstetricians and midwives regarding just how dangerous prolonged pregnancy is, whether it warrants medical intervention, and the appropriate stage at which to take action (Westfall and Benoit, 2004). The figure of 42 weeks is known to incite professional anxiety, leading to defensive practice and possible tendency to overreact (Hart, 2004; RCM, 2005). Incidence of fetal compromise and stillbirth does increase steeply from around 41 weeks, but this rise is from a low baseline and needs to be communicated as such.

Communication of clinical risk can be profoundly challenging, especially given the brevity of average consultation times and a dearth of well-designed consumer literature (Lupton, 1999; Lyerly, 2007). The midwife must adapt information to accommodate the woman's capacity to understand it, without overburdening her with detail (Levy, 1998b). She must also caution against stereotyping women in terms of their learning needs (Cody, 2003). Striking this balance is all the more difficult in the context of post-dates pregnancy, when neither the benefits nor the risks of induction of labour are clearly defined. Still, there remains a fundamental obligation: information must be presented to facilitate choice, not to ensure compliance.

Within the hospital setting, however, the medical model is particularly seductive. The bedrock for coercion is maternal responsibility and the promise of a healthy baby if women abide by the rules, or insufferable disapproval if they do not (Murphy-Lawless, 1991). If women are told, whether implicitly or explicitly, that they must agree to a certain protocol 'for the sake of the baby' then consent has been improperly obtained by means of emotional blackmail (Hayes, 1992; Kitzinger, 2006). This tactic is well enough entrenched in medical culture to have earned a name, and is chillingly termed 'playing the dead baby card' (Hall et al, 2011). It functions to silence the woman, promptly ensuring that all decision-making privileges are surrendered to the medical team. The technique is often played out during care planning for prolonged pregnancy,

'Preoccupation with a specious 'due date' can hinder women's trust in nature's plan for the end of pregnancy and start of labour'

when data relating to stillbirth risk can be tortured as women are subjected to 'management by shroud waving' (Lupton, 1999; Dagustun, 2012). Kotaska (2008) describes the obstetrician's subconscious proclivity to place emphasis on the one remote adverse event, thus adhering to 'the 0.1% maternity care doctrine'. Dwelling on the 1:1000 inevitably results in more interventions; the increased risk of stillbirth between 41 and 42 weeks of gestation leading to induction is a typical example.

This emphasis on risk factors serves to link childbearing with what can go wrong, thereby stalling the ideological shift from the biomedical to the midwifery model of care (Kukla, 2005). Pregnancy is culturally portrayed as fraught with hazards, and even very marginal risks to the baby are treated as unacceptable (Lyerly, 2007). Feelings of anxiety are innate to pregnancy, as they are to any significant life transition, but both the woman and the health professional exercise choice in a climate of manufactured fear (Dahlen, 2009). The risk agenda therefore functions as a means by which the medical profession can retain control over maternity services (Walsh, 2004). Are midwives better able to put risk in perspective, or are they complicit in the restriction of women's choice?

Midwives, women and the metaphorical tightrope

Women of childbearing age in the UK report wanting more information and involvement in decision-making than any other patient group (Singh et al, 2002). Furthermore, Baston and Green (2007) found that women have become increasingly more amenable to childbirth interventions over the past two decades. It is unclear whether this is due more to women's restricted understanding of the risks

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that interventions entail, or that the interventions themselves have become routine, effecting an illusion of safety. Although no method of inducing labour is free of hazards, the more something is done, the more innocuous it appears. Induction of labour has thus evolved to be regarded by women and health professionals alike as a normal part of pregnancy, depressing the stimulus to exercise choice (Nautila et al, 1999; Heimstad et al, 2007).

Women's attitudes to prolonged pregnancy have been explored in various research, which document increasing maternal reluctance to accept conservative management in line with pregnancy progression. Among other rationales for consent to induction, women report pressure from family, friends and health professionals, awareness of 'rules' in their various guises, escalating physical discomfort, restlessness, concern regarding fetal size, no perceived benefit in waiting and no perceived risk in induction, dwindling availability of family support, and desire for birth to fit a social schedule (Stewart, 1977; Roberts and Young, 1991; Bramadat, 1994; Westfall and Benoit, 2004; Shetty et al, 2005; Heimstad et al, 2007; Murtagh and Folan, 2014). What these studies suggest, perhaps, is that information and communication are but minor component parts of the decision-making process, having less bearing on choice than social and cultural influences (Bekker et al, 1999).

Women are generally best placed to make choices in the context of their own values and circumstances (Grimes and Sniveley, 1999). However, research has demonstrated that there may be cognitive and emotional barriers to risk comprehension arising from socioeconomic status, environment and the characteristics of individual women themselves (Lloyd, 2001). A study of 1386 women to explore maternity care users' perceived uptake of informed choice found women of lower educational status, those in manual occupations and the unemployed to be most convinced of their autonomy (O'Cathain et al, 2002). It might be interpreted that these groups of women had lower baseline expectations and less inclination to challenge obstetric authority (Handwerker, 1994). Conversely well-educated, well-informed and self-assured women (who in any other context would be held in high regard) are often described as 'difficult'.

Most patients are reluctant to take the initiative when the doctor is hesitant, or exhibits resistance to 'alternative' practices. Authoritative knowledge is vested with obstetricians, whose power is the underlying factor guiding and curtailing what information midwives can give (Jordan, 1997). Thus the midwife's obligation to observe hierarchical norms hinders communication, damages trust, stifles choice and makes it difficult to support women in making decisions which oppose consultant preference or local policy (Beech, 2005). A midwife might feel she is caught on a tightrope, balancing the conflicting needs of her colleagues, the woman, and institutional dictates (Stewart, 2001). Although some may devise strategies to stymie medical dominance, the majority are considerably constrained by the structure within which they work (Savage, 1986; Hutchinson, 1990). The midwife and the woman are therefore in a very similar situation: both struggle to function freely and optimally in an environment which threatens their respective autonomy (Sandall, 1998).

Conclusions

Despite a theoretical drive to improve patient autonomy, the absolute perspicuity of legal and ethical standards of informed consent, and convincing evidence of substantial benefits in association with active decision-making, the practical application of informed choice is neither clear nor consistent (Oberman, 2000).

An official policy of deference to women's autonomy struggles to overcome the medicalising praxis of the maternity care system. The rhetoric of choice fails to grapple with the pressing issue of who is in control, and thus ignores the pressure exerted upon women to choose a socially endorsed plan of care (Anderson 2004; Kirkham and Stapleton, 2004).

To routinely induce labour at 41 weeks is to interfere with a normal physiologic situation, and evidence to justify it is lacking. Furthermore, if the psychosocial ramifications of induction are given rightful attention then it could reasonably be argued that the marginal benefits of intervention

Key points

- Information-steering is ethically distinct from promotion of informed choice
- Induction of labour is not an innocuous procedure, and neither is it a 'normal' part of pregnancy. 'Choice', however, is culturally constructed, and women may be drawn toward the socially sanctioned option. Midwives need to engage in honest discussion with women about the potential for this intervention to significantly alter their experience of childbirth. Practicable alternatives to induction of labour need to be made accessible to healthy women of advanced gestation
- From early on in the antenatal period, midwives have a role to play in encouraging women to embrace nature's plan for the end of pregnancy and the start of labour. This entails quelling the emphasis on an uncertain 'due date' and then providing enhanced emotional and social support to women whose pregnancies progress beyond 40 weeks gestation
- Health professionals are equally obliged to support informed refusal, even when it contravenes the recommendations of the campaigning clinician

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are outweighed by the marginal risks. In the context of management of post-term pregnancy, choice is simply a misnomer for compliance with medical hegemony (Edwards, 2004). The technocratic model here holds sway in two clear respects: a dualistic philosophy is applied to the mother-baby unit, and childbearing bodies are viewed as inherently dysfunctional (Davis-Floyd, 2003).

Choice ought to reflect maternal desires. In reality, however, it is an empty exercise contingent on evaluation of risks, benefits and consequences as filtered through the biased lens of experts. The oppressive nature of the modern-day medical, legal and cultural framework does not so much facilitate maternal choice as undermine it (Beauchamp and Childress, 2001). To persist in updating the jargon of informed choice is thus to obscure an unethical situation in which both women and midwives are under coercion and denied autonomy (Clarke, 1995).

Twenty years on, *Changing Childbirth* (DH, 1993) still represents unfinished business, and the paternalistic model continues to thrive (Wittmann-Price, 2004). How can midwives make a difference? Issues at a deeper level need to be addressed, such as lack of resources, imbalances of power, fear of litigation and professionals' perception of meagre support (Kirkham and Stapleton, 2004). The most powerful thing that midwives can do is to empower the mothers of babies at whose births they assist (Cronk, 2000). But it cannot happen when midwives themselves are disempowered (Jamieson, 1994). Midwives need the skills to provide women with material alternatives to the dominant model of birth, else there is no choice. Saying 'no' depends on us opening up to honest discussion with women and fearlessly offering a practicable alternative. BJM

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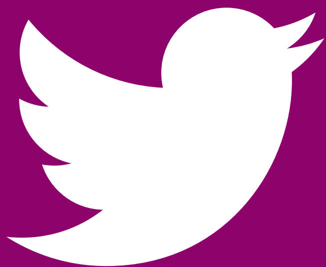

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