AIMS For a better birth...

The new NICE guideline Inducing labour: what has changed?

AIMS Journal, 2022, Vol 34, No 1

By the AIMS Campaigns Team

A revised version of the NICE guideline 'Inducing Labour'[1] was published on 4 November 2021. As a stakeholder, AIMS submitted sixty-five detailed comments on the draft version. We were pleased to see that the majority of these resulted in positive changes to the final version, although there remain a number of areas of concern to AIMS.

There are many reasons why induction of labour may be offered, and many factors to consider when making a decision about it. For more on this see the AIMS Birth Information page 'Induction of Labour'.[2]

Recognition of the right to decide and enabling informed decision-making

The previous version of this guideline made it clear that induction of labour is a choice to be offered in certain circumstances and that a decision to decline that offer should be respected. We are pleased to see that the new version, following our comments, now includes a greater emphasis throughout on respect for this principle of autonomy, and guidance on how to enable informed decision-making about induction. However, we regret that the authors have not removed the term 'shared decision making' completely. (See the AIMS Position Paper Decision Making in Maternity[3].)

The section on 'Information and decision making' now includes a specific recommendation to *"recognise that women can decide to proceed with, delay, decline or stop an induction. Respect the woman's decision, even if healthcare professionals disagree with it, and do not allow personal views to influence the care they are given"* We hope that all doctors and midwives will take this recommendation to heart, so that the AIMS Helpline no longer has to support large numbers of people who are being pressured into having an induction against their will.

The same section also makes it clear that women should be given information about how agreeing to induction "*will affect their birth options and their experience of the birth process*" as well as details of why the induction is being offered, the alternatives, risks and benefits of induction, and the options if the induction is unsuccessful. It further recommends that women be given time and opportunity to discuss this information with others, to look at other information sources, to ask questions and to think about their options before deciding whether or not to accept the offer of induction. Of course, this should be happening already, but we know it doesn't always, so having the correct procedure spelt out in this way is helpful.

Pregnancy lasting longer than 41 weeks

AIMS is pleased to see this more accurate title replacing the previous "Prevention of prolonged pregnancy" with its implication that a longer pregnancy is automatically pathological. We also welcome that in place of the previous version's specific recommendation that *"Women with uncomplicated pregnancies should usually be offered induction of labour between 41+0 and 42+0 weeks to avoid the risks of prolonged pregnancy*" the new version recommends a less directive and more balanced approach. It says that women should be told that "*some risks associated with a pregnancy continuing beyond 41+0 weeks may increase over time*" and that "*induction of labour from 41+0 weeks **may** reduce these risks* [our emphasis]*, but that they will also need to consider the impact of induction on their birth experience when making their decision* ." This is a helpful clarification that it is for the individual to decide how they feel about the balance of risks and benefits of induction in late pregnancy.

AIMS was concerned that the new wording will increase the pressure put on women by doctors and midwives to accept induction at the earlier point of 41 weeks, which could lead to a further significant increase in the number of labours that are being induced, with most of them being unnecessary. To address this, AIMS suggested that the guideline should include information to be given to women both on the actual risks of waiting beyond 41 or 42 weeks for labour to start and on how likely it is that labour will have started by 40, 41, 42 and 43 weeks of pregnancy. Both these suggestions were accepted. Evidence has now been included on how likely outcomes such as caesarean birth, perinatal death and admission to a neonatal intensive care unit are when induction is carried out at different weeks of pregnancy. However, we feel that the recommendations should be clearer about the limitations of the evidence, and the fact that even in the later weeks of pregnancy the risks remain low. As Appendix A of the guideline[4] states, the information on risks "should not be taken as definitive evidence based on the limitations of the included studies" and that while "the risk of perinatal mortality, NICU admission, and caesarean birth increases over time with a prolonged pregnancy, the absolute risk remains low". (For more on the evidence around this topic see the AIMS Journal article Labour Induction at Term – How great is the risk of refusing it?[5]) We are particularly concerned that in calculating the risks, the guideline authors decided to include the 'SWEPIS' study[6] despite recognising that because the study was stopped early it may have overestimated the apparent benefit of induction at 41 weeks.

The guideline also now includes, as AIMS suggested, information to be given to women about the high proportion of labours (16%) that start between 41 and 42 weeks without the need for induction. We hope that this important information, about the chance of going into spontaneous labour between 41 and 42 weeks, will be shared by midwives and doctors, as well as the information on the risks and benefits of induction during this period.

Timing of induction for 'higher risk' groups

The draft guideline that was put out for consultation contained a highly controversial recommendation to, "*Consider induction of labour from 39+0 weeks in women with otherwise uncomplicated singleton pregnancies who are at a higher risk of complications associated with continued pregnancy (for example, BMI 30 kg/m2 23 or above, age 35 years or above, with a black, Asian or minority ethnic family background, or after*

assisted conception)." Many stakeholders pointed out the racist nature of a recommendation based purely on ethnicity. AIMS also drew attention to the fact that for all the groups mentioned there was no evidence to support the recommendation and it could have led to high numbers of women having unwanted inductions purely because they fell into one of these 'higher risk' categories. We are relieved to see that this recommendation was withdrawn. However, it has been replaced by a rather vague comment that "*women from some minority ethnic backgrounds or who live in deprived areas have an increased risk of stillbirth and may benefit from closer monitoring and additional support*" – without suggesting what form that monitoring and support should take. AIMS feels that this could best be achieved by the rapid roll out of a culturally sensitive Continuity of Carer model of care to women in these groups, as called for in the NHS Long Term Plan[7].

Timing of induction

On the topic of the timing of induction, the authors made two research recommendations. One is to try to identify more precisely, "the optimal timing of induction of labour in the low-risk population of pregnant women" through analysis of when stillbirths actually occurred. The other is to look for evidence about whether earlier induction reduces the risks for women who may be at higher risk of stillbirth or other problems. While we welcome further research we feel it is crucial that research includes the role different factors play in driving the observed higher stillbirth risk for certain groups, including individual health and socioeconomic characteristics, and the role of racial discrimination, bias, stereotyping and culturally insensitive care. As the NHS Long Term Plan observes: "We cannot treat our way out of inequalities."[7]

We note the lack of research around the physiology of spontaneous onset of labour, and on the potential benefits of the physiological process compared with induced labour, for both short and long-term wellbeing of mothers and babies.

If the waters break before labour

After 37 weeks - The Guideline Development Group explained that the management of this situation was "not within the scope of this guideline update" so they did not review the evidence. They did add some wording that makes it clearer that it is up to the woman whether to wait for labour to start, and for how long, after her waters have broken. AIMS is glad to see that the list of factors to discuss now includes, "the woman's individual circumstances and her preferences" as well as possible medical issues.

Before 34 weeks - In the case of 'preterm prelabour rupture of the membranes' there is now a recommendation to offer expectant management until 37+0 weeks if the waters break before 34 weeks as long as there are no other concerns.

Between 34 and 37 weeks - If it happens after 34 but before 37 weeks the recommendation remains to "discuss the options of expectant management until 37+0 weeks or induction of labour." It is confusing that in the former case expectant management till 37 weeks seems to be presented as the preferred

option, but not in the latter, especially since the RCOG guidance[8] is to offer expectant management to anyone whose waters break before 37 weeks.

There are also updates to this section in line with recent guidelines on preventing neonatal infection to say that women who have tested positive for Group B Streptococcus at any time in pregnancy should be offered immediate induction of labour or a caesarean if their waters break beyond 34 weeks but before labour.

Suspected high birthweight in the absence of diabetes

Another useful addition to the guideline is evidence about the risks and benefits of induction or expectant management when a woman without diabetes is thought to be having a big baby. The committee rightly recognised that, "*there was not enough evidence to recommend one method over another*" and therefore said that "*women should be provided with information about different modes of birth so they can make an informed decision.*" This information should include the fact that "*there is uncertainty about the benefits and risks of induction of labour compared to expectant management*", that induction may reduce the risk of shoulder dystocia but increase the risk of a severe tear, and that, "*there is evidence that the risk of perinatal death, brachial plexus injuries in the baby, or the need for emergency caesarean birth is the same between the 2 options.*"

We hope that this will put a stop to cases where people are told that they 'must' be induced because their baby will be big or are scared into agreeing to induction by the threat that "your baby could die" if they refuse.

Conclusion

Overall, AIMS finds much to welcome in the updated guidelines and we are pleased to have been able to influence the text for the better.

It is good to see the clearer emphasis throughout on autonomy and informed decision-making. In practice the effectiveness of this will depend on healthcare professionals really taking to heart the recommendations on providing full information, including the limitations of the evidence and information on the potential impact of induction, and then being prepared to respect and support a mother's decisions even if they disagree with them. The NICE strategy vision[9] commits them to, "drive the implementation of our guidance, forming key strategic partnerships to make sure it's used" and to "make sure it delivers improvements and contributes to reducing inequalities, with measures to routinely track adoption." AIMS therefore calls on NICE to ensure that these measures include research with maternity service users to find out how far their experience matches the NICE recommendations.

A limitation of the guideline remains the broad-brush nature of the recommendations to 'offer' induction in various situations, which is likely to mean that many mothers and babies continue to experience inductions that do not benefit them.

Finally, we note that the NICE vision also includes a commitment to, "provide dynamic, living guideline recommendations that are useful, useable and rapidly updated." AIMS will be sharing our comments with them now, with confidence that these will be carefully reviewed and hopefully addressed to our satisfaction in the next update.

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[1] Nice Guideline 'Inducing Labour', November 2021 www.nice.org.uk/guidance/ng207

[2] AIMS Birth Information page 'Induction of Labour' 2022

[3] AIMS Position Paper Decision Making in Maternity, November 2021 www.aims.org.uk/assets/media/727/aims-position-paper-decision-making-in-maternity.pdf

[4] NICE Guideline 'Inducing Labour' Appendix A: Risks associated with different induction of labour timing strategies, November 2021 www.nice.org.uk/guidance/ng207/resources/appendices-a-b-and-c-10883967373/chapter/Appendix-A-Risks-associated-with-different-induction-of-labour-timing-strategies

[5] Chippington Derrick D. & Higson N. 'Labour Induction at Term – How great is the risk of refusing it?', May 2019 www.aims.org.uk/journal/item/induction-at-term

[6] Wennerholm U-B et al 'Induction of labour at 41 weeks versus expectant management and induction of labour at 42 weeks (SWEdish Post-term Induction Study, SWEPIS) BMJ 2019;367:l6131 www.bmj.com/content/367/bmj.l6131

[7] NHS Long Term Plan Chapter 2, section 2.28 www.longtermplan.nhs.uk/online-version/chapter-2-more-nhs-action-on-prevention-and-health-inequalities/stronger-nhs-action-on-health-inequalities

[8] RCOG 2019 'Care of Women Presenting with Suspected Preterm Prelabour Rupture of Membranes from 24+0 Weeks of Gestation' (Green-top Guideline No. 73) obgyn.onlinelibrary.wiley.com/doi/10.1111/1471-0528.15803

[9] The NICE strategy 2021 to 2026 www.nice.org.uk/about/who-we-are/corporate-publications/the-nice-strategy-2021-to-2026