

# Questioning induction of labour in older women (part 1)



As a student midwife, I looked after a few women who were having their first baby near or around the age of 40. As far as I can recall, my mentor midwives had two main concerns. The first was the slight increase in the chance of congenital problems that occurred with each additional year of maternal age, a subject which they raised in a kindly manner before explaining the range of available screening tests, noting the risks of testing, and reassuring women that it was also OK to decide not to have testing. (This was in the days when we had time to talk women through such things and help them make the decisions that were right for them.)

The second thing of concern to some of my mentors was whether those older-than-average women would have a good labour, given that these midwives had a theory – based purely on their own observations, I should add – that women who

were older tended to have read more and to take longer to get ‘out of their heads and into their bodies’ when they were in labour. I’m not sharing that because I think it’s true, but as a reflection on how times have changed.

## HOW TIMES CHANGE

Nowadays, midwives have another topic to discuss with older women: the question of early induction. Some midwives are feeling they need to raise this topic early on, even if just to warn older women to be aware that their 39th week of pregnancy may be interrupted by someone wanting to schedule an induction date out of the blue. Older women may also be told they need more monitoring or intervention, whether or not their labour is induced. But, as the early induction recommendation seems to be taking hold around the country, I keep wondering whether the negative bias towards older mothers is justified and whether the evidence really supports the recommendation to induce labour early?

I can’t possibly do justice to such an enormous question in a couple of pages, but I would like to share a few thoughts and look at some of the issues that aren’t getting quite as much press. One of these is the excellent point made by Rosemary Mander about the way we view pregnancy, birth and motherhood in older woman:

‘Research reports and recommendations ‘tend to ignore the positive aspects of advancing maternal age. These include the likelihood that psychological and social strengths, such as increased confidence, may more than compensate for any biological problems with which advanced age may be associated’ (Mander 2013: 49).

## WILL WE JUST INCREASE INTERVENTION?

Rosemary was responding to a discussion paper published by the Royal College of Obstetricians and Gynaecologists (RCOG) (2013) which suggested that induction should be routinely offered to women aged 40 years or more at 39-40 weeks gestation, in the hope of reducing the rate of stillborn babies. (In practice, induction is now being offered to even younger women, but I’ll come back to that in part two of this article.)

One problem is that the data that we have in this area are equivocal and often lacking, and there is more than one way of responding to such uncertainty. While bodies such as the RCOG (2013) err on the side of recommending intervention, it is also possible that a policy of advising older women to have their labour induced will increase the problems and intervention experienced by this group of women and babies without making a significant difference to the stillbirth rate. When we have areas in which differences between different courses of action are marginal and the size of any potential benefit or loss is unknown, shouldn’t women be told about both sides of the debate and supported in making the decision that is right for them and their family?

## THAT LUMPING PROBLEM AGAIN

While research has suggested that there may be an association between increased maternal age and a higher chance of certain types of complication, this finding is not straightforward. For instance, Huang et al (2008) carried out a meta-analysis which showed that older women may be more likely to have a stillbirth than younger women, and yet the researchers themselves noted that the magnitude and mechanisms of this increased risk weren't clear and that further research was needed.

This doesn't stop people quoting the Huang et al finding in support of routine induction, and yet Huang et al's point about the magnitude of any increased risk being unknown is vitally important. It is possible that the size of this increased risk varies so much between the included studies because the included studies themselves were really varied. Some studies were recent and some were 20 years old. Some included healthy women and some included women with illnesses or problems. There was no consensus as to what the cut-off point for 'advanced maternal age' was, and the studies also defined stillbirth itself differently, in that they used different cut-off gestational points.

## HOW CAN WE INDIVIDUALISE?

As has been the case with other research into induction (Wickham 2014), this lumping together of such a variety of studies can be really problematic. It also raises an important question for women: if the data influencing practice are generated from studies which pool large numbers of very different women, then how can individual women hope to be able to get information specific to their situation? If you are a healthy woman, then surely you want to know what a healthy woman's chances are and not what the data are for the whole population, which includes women with problems or medical conditions that might in themselves increase their chance of problems?

The RCOG are aware of this issue and sought out studies which controlled for some of these factors, but the only studies left then include data from women who gave birth 30 or more years ago, when midwifery and obstetric practice was (as I mentioned above) rather different. Women's lives may be very different too, in all manner of ways.

It's just so hard to find good data and, no matter which studies I look at, I haven't found evidence that convinces me that routine induction of labour in older women is justified. But a recent randomised controlled trial set out to look at this area and its results have further ignited discussion. Next time, I'll look in more depth at that study and consider how its results might affect women and babies. [You can find part two of this article here.](#)

## REFERENCES

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