

Questioning induction of labour in older women (part 2)



I noted in the [first part of this article](#) that the past few years have seen a trend towards recommending early induction for older women. The definition of older, however, along with the definitions of other key factors in this debate, seems to change depending on what you read. I did not set out to undertake a systematic review (for this has been done and the main thing we learned was that there is a stunning lack of homogeneity between studies) or to claim to provide the final word in this area, but to reflect from a midwifery perspective on whether the evidence supports the trend.

THE ADMIRABLE GOAL OF STILLBIRTH REDUCTION

It is vital that we consider whether and how we can prevent or reduce stillbirth. But history teaches us that ill thought-out prevention efforts can sometimes backfire and cause knock-on problems without having the intended positive effect. It is because of this that we should always ask whether it is rational to implement a particular policy, and part of our decision should include consideration of whether the proposed change is supported by robust evidence. We have been implementing intervention without robust evidence of benefit for far too long and I would argue that this is one of the underlying causes of the muddle that modern maternity services are in. This muddle includes high intervention rates, a generation of women who have been taught to distrust their bodies and professionals who are tired, de-skilled and frustrated by the gap between what they know and what they're forced to do.

I find it difficult to understand how policymakers can justify the introduction of practices which they claim are designed to reduce stillbirth and yet which are based on expert opinion or on just one perspective rather than on careful consideration of the evidence and the wider issues. Such changes are particularly galling when we look back at the history of evidence-based practice and see that the forefathers of this ideology were trying to move away from the situation where doctors were reliant on guesswork because robust evidence wasn't available. We now also have considerable knowledge from the fields of ethics, social science and human rights law about how people should be treated, and yet practice is still often rooted in a fear-based, adversarial and risk-focused approach.

THE 35/39 TRIAL

Researchers have recently published the first paper from a randomised controlled trial that set out to evaluate the effect of early induction of labour (at 39 weeks) in older women (Walker et al 2016). This study has been termed the 35/39 trial, because it defined older

women as those aged 35 and above. Although many people thought that this study was going to compare stillbirth rates between the two groups, this was actually not the aim. Instead, the authors were trying to determine whether early induction led to an increased chance of caesarean section.

The study experienced really low recruitment levels when 86 per cent of the women who were asked to be in the study declined to participate. This might be because many women aren't enamoured with the notion that they should undergo early induction of labour simply because of their age. Or perhaps they aren't happy with the idea that the mode of onset of their labour should be randomly determined. In the end, only 619 women were randomised into the study. There were no maternal or neonatal deaths in either group and no significant differences in the women's experiences or in the frequency of adverse outcomes. Given that the study included only a small fraction of the women who were invited to participate and that those who took part didn't mind whether their labour was induced or began spontaneously, it may be prudent to take the lack of difference in women's experiences between the two groups with a pinch of salt. The 86 per cent of women who didn't want to be in the trial may have felt very differently from those who were OK with the notions of intervention and randomisation.

NO DIFFERENCES, BUT DOES THAT MEAN ANYTHING?

As with some other induction studies, the data showed no difference in caesarean section rates between the two groups, but even the Royal College of Obstetricians and Gynaecologists (RCOG) (2013) paper acknowledges that professional decision-making features prominently in determining this outcome, as I have discussed elsewhere (Wickham 2014). Research by Wang et al (2011) and Carolan et al (2011) has also confirmed that there is a lower threshold for caesareans in older women. When caregivers become worried that being older is a risk factor, they tend to suggest intervention sooner. The intervention itself can cause more problems, such as increased bleeding, and a self-fulfilling prophecy is created.

WILL THIS CHANGE PRACTICE?

When areas of practice are as complex and uncertain as this one is, it seems prudent to take a wider view on the subject and try to increase our understanding before we wade in with significant policy changes.

This, however, doesn't seem to be happening. I am hearing from colleagues in different areas that older women are being told they are at risk and that early induction is being recommended on the basis of this study and before further research is undertaken. Yet the study showed no benefit to induction, it was underpowered to compare outcomes and its authors state that this wasn't its intention anyway. Few people are looking deeply at the issues or paying attention to the voices of the 86 per cent of women who said no to being in this study, or to others like them.

It's clear that some women who are older experience more problems and that we need to continue to explore this area, ideally with better-quality research than we currently have.

But this is a complicated issue, and there are many other facets to health than age alone. Having looked at some of the evidence on this topic, it's even clearer to me that there is not a straightforward solution to this in the form of a routine recommendation for early induction of labour. If only more people could take a wider view, we might begin to get some better and more woman-centred answers.

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