



POSITION STATEMENT

INDUCTION OF LABOR

The American College of Nurse Midwives (ACNM) affirms the following:

- Spontaneous labor offers substantial benefit to the mother and her newborn. Disruption of this process without an evidence-based medical indication represents a risk for potential harm.
- Induction of labor should be offered to women only for medical indications that are supported by scientific evidence which indicate the benefit outweighs the risk of induction of labor, including the potential risks of prematurity or postmaturity.
- Informed consent prior to labor induction should include discussion of the normal processes of labor and the benefits and potential harms of induction, including the optimal method to use during the induction process.
- Development of the state of the science regarding the use of obstetric interventions for healthy childbearing women should continue, focusing on both the health outcomes associated with induction of labor and the context in which the decision for induction of labor occurs between healthcare providers and childbearing women.
- Through a process of education and discussion, midwives can assist childbearing women to make informed decisions regarding induction of labor.

Background

In the United States, 23% of women with singleton pregnancies experience an induction of labor for medically and non-medically indicated reasons.¹ Evidence-based medically indicated inductions of labor offer an opportunity to improve maternal and infant health outcomes when selected complications of pregnancy are present.^{2,3} Such inductions of labor are generally considered within a risk-benefit decision making process in which the risks of the medical condition worsening or causing harm are balanced against the risks of an induction of labor, including consideration of the gestational age of the fetus.

In contrast, induction of labor without an evidence-based medical indication – often termed elective induction – is not an evidence-based practice and represents a misapplication of obstetric interventions.²⁻⁴ Elective inductions have been cited as contributing to late pre-term births prompting policy statements^{5,6} and quality indicators⁷ which have decreased the practice of inductions of labor prior to 39 weeks gestation.¹

Until recently, induction of labor has been thought to be directly related to higher risk of cesarean birth. However, recent studies⁸ suggest that this relationship is related to multiple factors: maternal - nulliparity and high maternal body mass index; clinician related - lack of cervical preparation, failure to allow adequate time to achieve active labor, and then for labor progress⁹⁻¹² and lack of provider advice and counseling regarding induction of labor.^{13,14}

Midwives are uniquely positioned to empower women to have physiologic labor which is “characterized by spontaneous onset and progression of labor.”¹⁵ Induction of labor interferes with the normative physiological processes of spontaneous labor; the full extent of which is not yet known nor well understood.^{16,17} Research related to the longer term effects is emerging but is still insufficient to determine the full impact of induction of labor on outcomes such as fetal brain development near term or increased risk for Autism Spectrum Disorders.¹⁸⁻²⁰ Evidence also suggests that some critical processes, such as lactogenesis, attachment, and parenting, are interrupted by induction of labor, though the extent is uncertain.²¹⁻²⁵

The context in which elective inductions of labor are performed raises ethical concerns and merits further scrutiny. In some instances, maternity care providers have reported that elective inductions of labor are primarily performed based on maternal request, for convenience or other non-medically indicated reasons. In other instances, women report that maternity care providers are encouraging or pressuring them to induce their labor in the absence of medical indications.^{4,26}

The decision to induce labor requires consideration of the potential for harm compared to possible benefits, including short- and long-term implications for the woman and her baby. Therefore, midwives should use models of decision-making that acknowledge the woman’s role in making the decision.²⁷ When induction of labor is medically necessary, careful evaluation of the need for cervical ripening, and discussion of the expected time frame should be considered to improve the opportunity for success and limit the risk of cesarean birth as a consequence of a failed induction.

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