AMERICAN COLLEGE of NURSE-MIDWIVES

POSITION STATEMENT

Implementing Labor Induction with a Commitment to Physiologic Birth

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

- Physiologic birth—defined as spontaneous labor and birth without unnecessary medical intervention—is the gold standard for safe, satisfying, and optimal perinatal outcomes.
- Induction should not be viewed as equivalent to physiologic labor and should not be routinely offered in place of spontaneous labor.
- Midwives should employ evidence-based tools to guide informed choice and shared decision-making related to labor induction.
- Informed consent prior to labor induction should include a discussion of the process of labor and the benefits and potential harms of induction.
- Midwives should support the thoughtful, evidence-based, and person-centered use of labor induction when medically indicated or chosen by an informed individual.
- When appropriate, midwives should prioritize labor induction strategies that preserve physiologic labor.
- When labor induction is medically indicated, midwives affirm their commitment to evidence-based processes and clinical algorithms that support safe and effective care.

Background

The ACNM affirms that physiologic birth, defined as spontaneous labor and birth without unnecessary medical intervention, remains the safest and most satisfying option for most healthy pregnancies. Midwives are trained to support the natural processes of labor, minimize interventions, and promote autonomy, and shared or person-centered, decision-making throughout the childbirth experience.[1] Labor induction often medicalizes birth, alters hormonal cascades, and may lead to additional interventions such as continuous electronic monitoring, epidural analgesia, and cesarean birth.

Despite these values, approximately one-third (32.1%) of pregnant individuals in the United States currently undergo labor induction, a trend influenced by both medical indications and the growing popularity of elective induction at term.[2] The rise in elective induction has been driven, in part, by findings from the 2018 ARRIVE trial (A Randomized Trial of Induction Versus Expectant Management), which suggested benefits in select populations.[3] However, the application of this evidence must be contextualized within midwifery philosophy and the broader evidence base surrounding physiologic labor and person-centered care.

The ARRIVE trial concluded that elective induction at 39 weeks in low-risk nulliparous individuals was associated with a modest reduction in cesarean birth compared to expectant management (18.6% vs. 22.2%) and reduced hypertensive complications.[3] These findings have contributed to growing support for elective induction in obstetric practice.

However, ACNM urges cautious interpretation:

- The ARRIVE trial was conducted in highly controlled hospital settings with strict protocols, continuous monitoring, and high provider availability—conditions not universally available, particularly in midwifery-led or rural settings.
- The study does not address the impact of labor induction on the birth experience, satisfaction, or longer-term maternal-infant outcomes such as breastfeeding, bonding, or perinatal mood disorders.
- In midwifery-led models with low baseline intervention rates, the benefits observed in ARRIVE may not translate similarly. For example, Erickson et al. found no difference in cesarean rates between induced and expectantly managed nulliparous individuals until after 41 weeks in midwifery practices with low labor induction rates.[4]
- Importantly, ARRIVE did not compare elective labor induction to spontaneous labor, but to a combined group of spontaneous and induced labors in the expectant management arm, a distinction that should be communicated to pregnant people.

Thus, while ARRIVE adds nuance to our understanding, it should not redefine the standard of care away from physiologic birth.

Shared Decision-Making Is Essential

All discussions about labor induction whether medically indicated or elective, must be grounded in informed choice and shared decision-making that honors the individual's preferences, values, and reproductive autonomy.[5] Midwives should present absolute risk data (e.g., number needed to treat), explain potential changes to the labor experience, and ensure that clients understand the implications of labor induction on movement, food intake, and methods of fetal monitoring.

Evidence-based tools called decisions aids are essential for guiding choice. An example of a shared decision-making tool to guide discussion on routine induction of labor is described in A decision aid for pregnant people with no medical reason for labor induction.[6]

Special attention must also be paid to disparities in counseling and consent, as research shows that marginalized communities are often less likely to be included in meaningful decision-making conversations.[5] As practitioners who value shared decision-making and patient autonomy, the choice to undergo non-medically indicated induction of labor should fall to the individual and their family without pressure or encouragement from practitioners. If elective labor induction is chosen, interventions that support labor such as position changes, hydration with oral intake, continuous labor support when appropriate and rest, should be utilized.[7]

Labor Induction Strategies Should Align with Midwifery Principles

When induction of labor is medically indicated or chosen by the client, midwives should apply evidence-based clinical algorithms to reduce health disparities and support equitable care, while balancing the need for individualized, person-centered approaches. Within midwifery-led models, care strategies should aim to preserve physiologic aspects of labor whenever possible, including:

- Use of outpatient cervical ripening and mechanical methods (e.g., transcervical balloon) to reduce hospitalization and preserve mobility.[8]
- Support for upright positions, ambulation, hydrotherapy, oral intake, and labor support.[8]
- Delayed or judicious use of oxytocin, as early administration with low Bishop scores has been linked to higher cesarean rates and uterine desensitization.[8]
- Consideration for discontinuation of oxytocin administration when active labor is achieved.[1]

These strategies align with World Health Organization (WHO) recommendations for a positive childbirth experience[9] and ACNM's commitment to minimizing unnecessary interventions.[1]

Conclusion

Midwives have a professional and ethical responsibility to protect the physiologic process of birth, use interventions only when needed, and ensure all individuals are informed and confident decision-makers. While emerging research such as the ARRIVE trial may shape practice, it should not supersede the fundamental principle that birth is a normal physiologic event—not a condition to be managed.

Labor induction, when chosen or needed, can be provided in ways that honor midwifery values: individualization, evidence-based care, and person-centeredness. As midwives, we remain steadfast in our advocacy for informed choice, physiologic labor, and respectful, relationship-based maternity care.

References

1. Carlson NS, Dunn Amore A, Ellis JA, Page K, Schafer R. American College of Nurse-Midwives Clinical Bulletin Number 18: Induction of labor. *J Midwifery Womens Health.* 2022;67(1):140-149. doi:10.1111/jmwh.13337

2. Osterman MJK, Hamilton BE, Martin JA, Driscoll AK, Valenzuela CP. Births: Final Data for 2021. *Natl Vital Stat Rep.* 2023;72(1):1-53.

3. Grobman WA, Rice MM, Reddy UM, et al. Labor Induction versus Expectant Management in Low-Risk Nulliparous Women. *N Engl J Med.* 2018;379(6):513-523. doi:10.1056/NEJMoa1800566

4. Erickson EN, Bailey JM, Colo SD, Carlson NS, Tilden EL. Induction of labor or expectant management? Birth outcomes for nulliparous individuals choosing midwifery care. *Birth.* Published online 2021. doi:10.1111/birt.12560

5. American College of Nurse-Midwives. Shared decision-making in midwifery care. Published 2022. Accessed July 28, 2025. https://midwife.org/wp-content/uploads/2024/10/Shared-Decision-Making-in-Midwifery-Care.pdf

6. Peralta A, Drainoni ML, Declercq ER, et al. Development and testing of a decision aid to achieve shared decision-making for routine labor induction. *Birth.* 2023;50(3):636-645. doi:10.1111/birt.12716

7. ACOG Committee Opinion No. 766: Approaches to limit intervention during labor and birth. *Obstet Gynecol*. 2019;133(2):e164-e173. doi:10.1097/AOG.0000000000003074

8. Carlson N, Ellis J, Page K, Dunn Amore A, Phillippi J. Review of evidence-based methods for successful labor induction. *J Midwifery Womens Health.* 2021;66(4):459-469. doi:10.1111/jmwh.13238

9. World Health Organization. *WHO Recommendations: Intrapartum Care for a Positive Childbirth Experience.* World Health Organization; 2018. Accessed June 16, 2025. https://www.who.int/publications/i/item/9789241550215

Note: Midwifery and midwife as used in this document refer to the education and practice of certified nurse-midwives (CNMs) and certified midwives (CMs) who have been certified by the American Midwifery Certification Board (AMCB).

Source: Division of Standards and Practice
Approved by the Board of Directors, October 2010
Revised: September 2016, August 2025