

Description

Are some maternity care choices more equal than others?

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On the 3rd October 2019 the British Journal of Obstetrics and Gynaecology published two sides of a debate about r **outinely offering all women a choice in induction of labour.** Both author teams presented high quality arguments, based on evidence, and with respect for the wellbeing and autonomy of women and babies. Unfortunately, however, only the paper supporting such a choice (titled Induction of labour should be offered to all women at term) was made open access. A week later, when the authors of the other side of the debate raised this issue, the journal acknowledged the oversight, and made the second piece free to download. In the gap between the publication of the 'for' and the 'against' papers, significant debate took place on social media platforms, with emotive opinions expressed on both sides of the argument.

The right to choice?

Based on some of the related discussion on social media, we want to consider both the 'right to choice' debate, and the actual provision of choice in maternity care. Broadly, our position is that if it is an ethical imperative for maternity services and staff to offer induction to all women in the name of choice, then we must also offer **all** women **genuine** choice in other options that we know are beneficial. This includes genuine choice for continuity of midwife carer, place of birth (e.g. homebirth or birth centres), sufficient time to have their needs attended to properly every time they encounter a health professional, mobilisation in labour, and support and techniques from respectful, skilled caregivers to maximise the opportunity for a physiological birth for those who want this option.

There is a more subtle point here, about the context in which 'choice' is offered, and the extent to which the intervention being 'offered' ends up becoming the (morally acceptable) 'norm'. Widespread debate about the need to offer choice for induction at or before term was triggered by the publication of the ARRIVE trial. The trial did not show a difference in the primary outcome of mortality/morbidity for the neonate, though it did show a reduction in one of the secondary outcomes, caesarean section rates.

Duty to offer women routine induction of labour

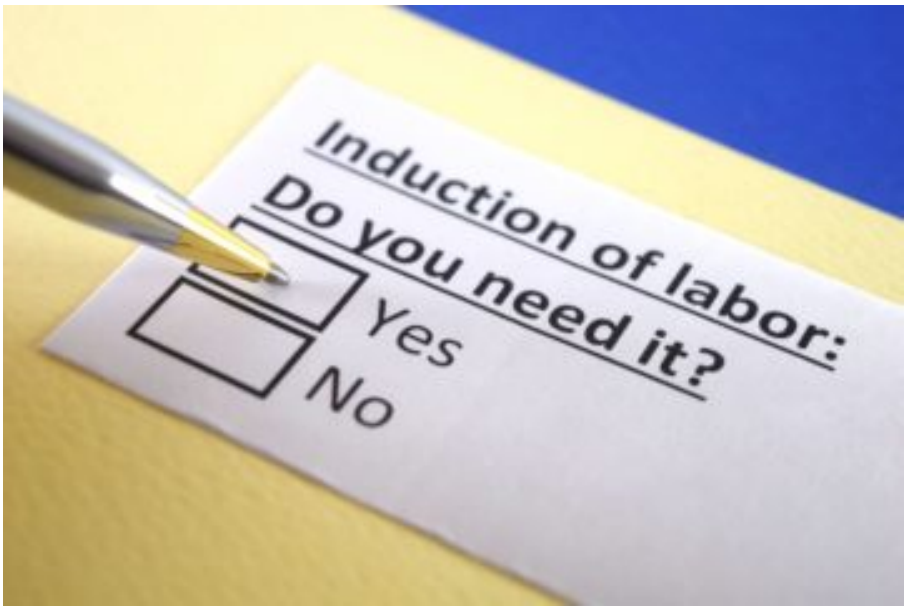
Despite this, some of the conversations in this area seem to be turning towards the duty to offer women choice in routine induction of labour, as a baby safety issue



here is that this rationale becomes converted from women's choice to women's moral duty. There are increasing accounts from around the country of women who go over 40 weeks gestation (or even over 39 weeks gestation) being told that their induction date is booked for them (with no room for discussion or agreement), or that if they don't agree to be induced their baby will die, or that if they 'refuse' induction (rather than decline the choice to be induced) they will be referred to social services, and their baby might be taken away from them. Paradoxically, the notion of women having a choice in terms of being induced for postmaturity has ended up creating an distinctly anti-choice environment, for some, at least, and not one in which women can make a genuine, informed, unbiased choice for, or to decline, an induction offer. Responding sympathetically to a **request** for induction is, of course, important. However, in our view, before we consider **routinely** offering induction at (or even before) term, we must ensure that women have a genuine choice NOT to be induced, at any gestation, if we are to preserve the human rights of **all** childbearing women.

There is a more fundamental issue here. This is the responsibility of the maternity services to ensure health-enhancing care as a fundamental principle. As noted above, the primary benefit of routine induction in healthy women before 41 weeks gestation, based on RCT evidence, seems to be a reduction in caesarean section rates. However, it is very clear from a range of evidence that companionship in labour has a bigger effect on CS rates. It is also clear that the high and rising rates of caesarean section, and the large disparity between hospitals on this measure, are at least partly to do with local unit philosophies. It seems, however, that there is very little will to tackle this issue of context. It is hard not to conclude that the simple solution of induction (in the laudable name of women's choice and autonomy) could become translated by some maternity care systems as a quick fix to address rising surgical birth rates.

> This is a substitute for the hard, challenging, self-reflexive thinking that we should all be undertaking to try to solve the underlying problem of maternity services that seem to supervalue risk aversion and intervention over the enactment of good quality evidence about the value of relationship-based solutions.



Montgomery v Lanarkshire

Some of the arguments in favour of offering routine choice for induction rely on the Montgomery and Lanarkshire ruling about informed consent. However, we would argue that some of those using this argument are misreading the implications of the judgement. The essence of the Montgomery and Lanarkshire ruling was not that all women should have all information about all risks (and benefits) of all options they could conceivably have. The ruling was that those risks and benefits that are **material** to each individual woman should be discussed. How often in the induction conversation (if there even is such a conversation) are women asked what their values and beliefs are on this topic: what matters most to them about how their labour starts? And even if that happens, and a woman says they would prefer not to be induced, how often is that treated as an equally valuable and acceptable decision as that of a woman who decides to accept the offer of induction? It seems that, in some or even many settings, the working assumption is that agreement to induction is good, and anything else is refusal to accept advice (bad). This is contrary to the current legal situation on consent, as far as we can see.

We have gone down this road many times in the past. Use of twilight sleep for pain relief in the name of women's' choice, routine use of DES to prevent miscarriage (with adverse effects now down to the third generation), routine use of episiotomy for primigravid women, lying babes' supine routinely, DeLees call for routine use of forceps; all of these interventions, and more have come and gone leaving long term (and in the case of DES at least, transgenerational) consequences in their wake.

Choices have consequences

It is unlikely that we (or, at least, most of us!) would consider that it is ethical to offer all women routine episiotomy because it might benefit some, and some might request it. Or routine ventouse at 8 centimetres because it might prevent either a bad tear or a surgical birth in a few. Or routine caesarean section at 39 weeks, because, why not? And there is also the issue of the opportunity cost. In 2010, Conrad estimated that around $18 billion was being spent each year on unnecessary interventions in maternity care in the US. This was based on 2005 data, so this colossal spend is now likely to be much higher. NHS funding is finite. If, as in other similar cases, the offer of routine induction turns into a normative practice that women find hard to decline, then those funds cannot be spent on, for example, sick babies, or the elderly. Moreover, some women are now reporting significant delays in the induction they were told was urgent for the safety of their baby. These delays are caused partly by staffing shortages, and large backlogs of women awaiting induction, sometimes for days as antenatal in-patients. This in itself is of significant concern should induction rates increase further.

Choices have consequences, and the offer of choice entails responsibility for the effect on the NHS more widely. It is curious that the assumption appears to be being made that choice for intervention (caesarean section on demand,

routine induction for example) is seen to be affordable, while women are being told that they can't have a home birth or continuity of care as it is too expensive/there are no resources to support it.



Offering induction of labour, with clear and completely balanced information on the risks and benefits of **both options** (induce or not) should always be part of good quality care, both for women who are at high risk of adverse outcomes for them and/or their babies, and for those who proactively ask for this option. This offer should include good human support in labour, good quality pain management, whatever option for this is chosen, and respectful acceptance of whatever decision the woman makes. This is a very long way away from offering an intervention to all, that is not needed by most, especially when other offers of effective and desirable care are not being made to all, or when requests for such options are sometimes being actively refused.

We thank the authors of both BJOG papers for stimulating public debate in this area. Maybe the time has come for some serious discussion about what the 'routine offer of induction' debate tells us about the differences between UK policy and what is happening in reality. We think that future discussion should consider why it is seen to be reasonable, or even morally imperative, to offer 'choice' to all for resource-intensive technical interventions that are only requested by some, while simultaneously, at the individual hospital level, refusing to support the infrastructure for other policy-mandated choices, including continuity of midwifery care or out of hospital birth, on resource grounds. Is this really (in line with Montgomery and Lanarkshire) serving what is material for the needs and values of all women and babies? Based on our arguments above, we can't help feeling ***that, in maternity care, all choices are, in theory, equal, but, in practice, some are more equal than others.***

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