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Case Series

# The process of labour induction should be streamlined

Wedisinghe L[1]*, Edirisinghe O[2], Somaratne A[2], Basnayake C[3], Lane E[4]

[1]West Morton Health, Ipswich Hospital, Ipswich QLD 4305, Australia and University of Queensland, Brisbane QLD 4067, Australia
[2]Bond University, Gold Coast, QLD 4226, Australia
[3]University of Adelaide, Adelaide, SA 5005, Australia
[4]West Morton Health, Ipswich Hospital, QLD 4305, Australia

***Correspondence to:*** Wedisinghe L, West Morton Health, Ipswich Hospital, Ipswich QLD 4305, Australia and University of Queensland, Brisbane QLD 4067, Australia, Email: Lilantha.Wedisinghe@health.qld.gov.au

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## Abstract

Up to 40% pregnancies are being induced in England. Although the induction of labour (IOL) is a common obstetric intervention, there is no established system to prioritise the urgency of IOL. While lack of a standard system to prioritise may be associated with adverse outcomes, a streamlined process might improve the quality of obstetric care and outcomes. A system of categorisation was developed based on the classification of urgency for caesarean birth, which consists of 4 categories. The most urgent, category-1 inductions to be commenced within half a day, category-2 inductions should be commenced within a day. The caesarean counterparts for these are naturally much faster: about half an hour and hour respectively, for categories 1 and 2. This categorisation system can also be used as a triaging tool when pre-booked induction appointments are postponed. While predicted benefits are numerous, potential disadvantages of adopting a categorisation system for induced labour appear to be minimal. Therefore, a carefully monitored roll-out can be considered.

Induction of labour is becoming increasingly common in current obstetric practice due to various reasons. Rate of induction of labour was reported to be high as 40% in some hospitals in England [1]. This requires some regulation as the process is associated with significant risks to the mother and baby [2]. While caesarean delivery has a well-established system of categorization of its urgency, labour induction does not have a similar counterpart.

A cohort study involving 472,520 low-risk pregnant women in Queensland by Crawford et al., [3]. concluded that planned birth at 39 weeks could lower the risk of perinatal mortality and other adverse outcomes. Compared to expectant management, planned induction of labour at 39 weeks was associated with lower odds of severe perinatal trauma, shoulder dystocia and caesarean birth. However, the urgency of the delivery changes based on many factors, thus some pregnancies should be induced sooner than anticipated and sometimes sooner than others. This often challenges the service delivery as postponing IOL is associated with adverse maternal and perinatal outcomes3. Basically, any pregnancy complication that occurs in the third trimester could happen during this period of waiting and hence is liable for litigation unless it is managed appropriately. Although the induction of labour is common, there is no established system to prioritise the urgency of IOL. The following categorisation system of the urgency of IOL (Figure 1) might mitigate this issue [4,5].

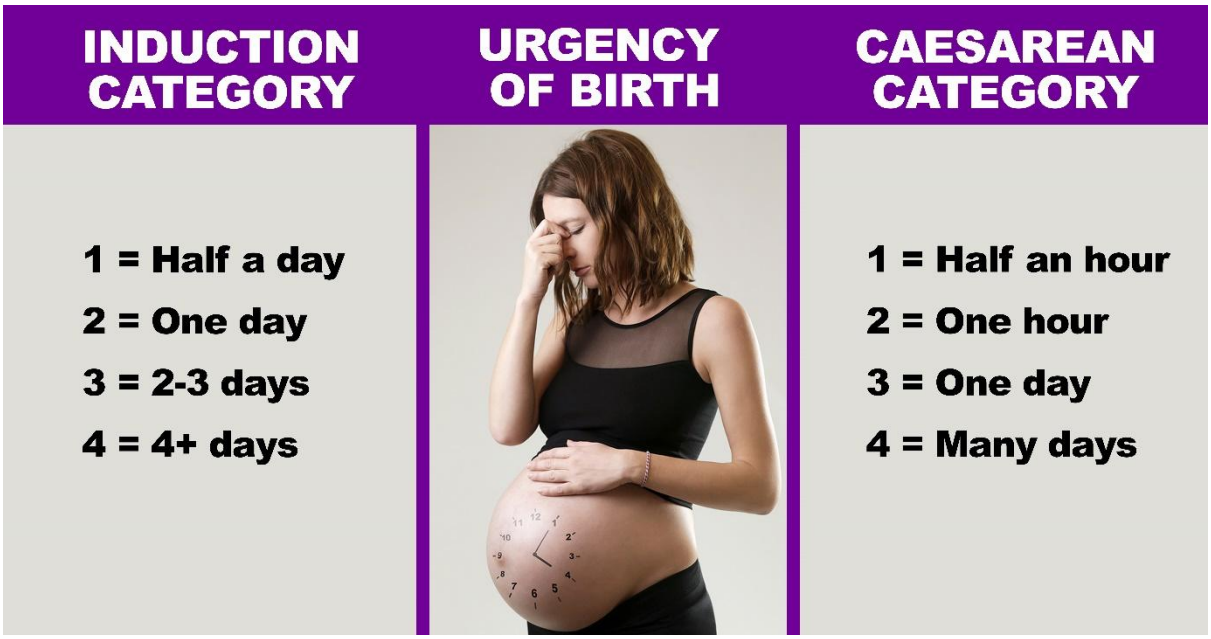


**Figure 1:** Urgency of birth

We suggest commencing IOL within the following time frame (Table1) from the decision time: by 41+3 gestation at the latest. Obviously, category can change with time and it should be re-visited as necessary. At times, urgency of birth (delivery) can change significantly. For example, a category-4 IOL can be upgraded to category-1 IOL and even a category 1-3 caesarean birth.

| **Table 1:** Proposed description of urgency of induced labour categories | | |
|---|---|---|
| Category | Within (days) | Within (hours) |
| 1 | Half a day | 12 |
| 2 | One day | 13-24 |
| 3 | 2-3 days | 25-72 |
| 4 | 4+ days | 73+ |

**Note:** Induction should commence by 41+3 gestation at the latest

We adapted the principles of classification of urgency for caesarean birth (Table 2) [2] in developing this induction counterpart as the objectives would be similar.

| **Table 2:** Classification of urgency for caesarean birth | | |
|---|---|---|
| Category | Description | Within (hours) |
| 1 | Immediate threat to the life of the mother or fetus | 0.5 |
| 2 | Maternal or fetal compromise which is not immediately life-threatening | 0.6 - 1.25 |
| 3 | No maternal or fetal compromise but needs an early birth. | 1.26 – 24.0 |
| 4 | Birth is timed to suit mother and/or healthcare provider. | 25.0+ |

Only pregnancies that are competent to withstand the induction process will go through the lengthier process of induction, and hence, the time frame is in days rather than hours in cases of caesarean deliveries. The principles of categorisation would be similar between caesarean and induced deliveries (Table 3).

| **Table 3:** Classification of urgency for induced birth | | | |
|---|---|---|---|
| Category | Description | Indication | Within (days) |

| | | | |
|---|---|---|---|
| 1 | Significant maternal or fetal compromise but not immediately life-threatening | Severe pre-eclampsia, severe hypertension, significant antepartum haemorrhage, signs of fetal distress | Half a day |
| 2 | Maternal or fetal compromise which needs early birth | Pre-labour rupture of membranes, Complicated reduced fetal moments | One day |
| 3 | No maternal or fetal compromise but needs early birth. | Uncomplicated reduced fetal movements, complicated fetal growth restriction | 2-3 days |
| 4 | Birth is timed to improve pregnancy outcomes. | Post term, diabetes, Uncomplicated fetal growth restriction, large for gestational age, maternal request | 4+ days |

Streamlining the IOL process through appropriately categorising its urgency can bring many benefits. Adhering to a systematic approach could potentially:

1. Lower the prevalence of exaggerated symptoms of pregnancy such as discomfort, musculoskeletal pain, respiratory symptoms, etc.
2. Lower the prevalence of maternal complications of advanced gestation such as pre-eclampsia and mental health issues in pregnancy.
3. Lower the prevalence of perinatal mobility and mortality caused by abruption, cord accidents (and consequences of hypoxia), bacterial sepsis, meconium aspiration and unexplained stillbirth.
4. Reduce the risk of a caesarean birth and its potential complications.
5. Reduce the length of hospital stays and their consequences (for the patient, family, and healthcare providers).
6. Social issues such as domestic and family violence, lack of access to carers and financial issues
7. Reduced rates of being born before arrival and its complications
8. Reduced chance of rushed emergency admissions and consequences (transfusions of un-cross matched blood, category-1 caesarean deliveries etc).
9. Reduced risk of complaints and hence, litigation.
10. Improved openness, transparency and hence, patient satisfaction.
11. Less stress on healthcare workers and its consequences.

The decision (date and time) is agreed upon between the clinician and patient based on many factors. This may be decided a long time in advance. This categorisation can also be used to define how long the pre-agreed date can be deferred, for triaging purposes. For example, IOL for a woman with type 1 diabetes may be booked as a category 2 or 3 IOL at 37+3 gestation. If so, the healthcare team can move the date by 1-3 days. The same pregnancy could be booked as category 2 at 37+5 in advance, so that the non-clinician administrators could manage the IOL appointments safely and effectively.

Potential disadvantages are minimal. This is not about the timing of induction, rather the streamlined method of making it happen. Therefore, adverse outcomes are negligible if clinicians 'decision time' is correct. This approach should share similar advantages and disadvantages of classification of urgency for caesarean birth if categories are appropriately used.

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