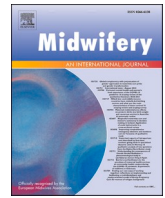




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Comment on ‘Outcome of induction of labour at 41 weeks with foley catheter in midwifery-led care’ of Velthuijs et al.^{☆,☆☆}

Velthuijs et al. provided valuable insights into the outcomes of labour induction from 41 weeks using a Foley catheter in the context of midwife-led care (Velthuijs et al., 2024). This study is important as it contributes to the debate on effective methods for caring for women with post-dates pregnancies within midwife-led care models, promoting greater continuity of care and reducing capacity issues in hospitals. However, there are several aspects in this paper that could benefit from further clarification.

The authors reported protocol violation in six women from the midwife-led care group, which included delaying the removal of the balloon catheter, failing to remove the Foley catheter after the direct rupture of membranes, and not transferring to obstetrician-led care at the agreed time. All these situations increase the risk of intrauterine infections, which were reported to be higher in the midwife-led care group. Given the relatively small sample size, the inclusion of these violations will have influenced the findings. We therefore believe it is a premature conclusion to advise not to offer nulliparous women induction of labour with a Foley catheter in midwife-led care. Instead, advice should be given to adhere to the protocol and information should be provided on risks when deviating from the protocol.

Moreover, the clinical relevance of the composite outcome, including probable infections, is questionable. There was no statistical significant difference in definite sepsis. Care providers may be influenced by their suspicion that the risk of infection is higher after the use of a Foley catheter in midwife-led care, which may lead them to a more rapid assumption of infection. A similar study, which was also described by Velthuijs et al., confirmed that the rate of infection was similar in both groups (Zonneveld and Leijnse, 2019). The protocol in that region allowed caregivers to wait longer for spontaneous contractions after rupture of membranes, which, along with a higher percentage of multiparous women, likely may explain the higher rate of births in midwife-led care. In that region, no differences were found in probable sepsis (3 % in both groups) and no cases of definite sepsis were reported. Therefore, the conclusion that the rate of neonatal infection in midwife-led care is higher, is premature. A larger sample size, which also allows for stratification by parity, is required to draw valid conclusions.

Furthermore, the authors argued that “emergency referrals during labour are more difficult to accommodate in already overstretched labour wards than planned inductions”, but this statement is questionable. Planned inductions are associated with longer hospital stays (Glantz,

2005; Ostborg et al., 2017), potentially exacerbating capacity issues. Emergency referrals are inherently unpredictable, but women typically stay on the labour ward for a much shorter time. Besides, the study of Velthuijs et al. highlights a significant reduction in pain relief in the midwife-led care cohort. This reduction leads to a decreased need for medical staff, lower healthcare costs, shorter hospital stays and neonatal admissions, and less iatrogenic harm associated with the use of pain medication (Anim-Somuah et al., 2018). Induction of labour should therefore not be promoted because of the constrained care facilities, but should only be used when it is certain that the benefits for both mother and child outweigh the risks, while ensuring that access to care for other women—both urgent and non-urgent—is maintained.

As the authors acknowledge, women’s experiences and preferences are central in patient-centred care. Without understanding how the women felt about their Foley catheter induction in midwife-led versus obstetrician-led care, it is difficult to draw definitive conclusions about the acceptability of the intervention. The absence of data on patient satisfaction undermines the ability to make meaningful recommendations for clinical practice.

Concluding, while this study provides valuable data on Foley catheter induction from 41 weeks in midwife-led care, all of the aspects mentioned above limit the validity of the findings. Notably, the absence of a power calculation raises questions about whether the study was adequately powered to test its hypothesis or investigate adverse outcomes, particularly when stratified for parity. Future research should ensure sufficient power to assess these outcomes and provide more definitive conclusions. Until then, this single study should not serve as the basis for shaping regional policies. More research in different populations, as well as attention for women’s experiences and preferences, is needed to ensure that decisions regarding induction of labour with a Foley catheter in midwife-led care aligns with the need of women. Besides, when making policy decisions, it is essential to consider additional factors such as capacity problems and resource allocation. When limited resources and available capacity in hospitals are allocated to routine inductions for healthy women, less space and care may be available for those who need it most.

CRediT authorship contribution statement

Renate Simmelink: Writing – original draft, Writing – review & editing. **Anna Seijmonsbergen-Schermer:** Writing – review & editing.

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Declaration of competing interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

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