

Women's experiences of induction of labour: a qualitative study

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Abstract

This qualitative study examines women's experiences of induction of labour from the perspective of informed choice and decision-making. Induction currently affects 23.3% of all births in England (BirthChoiceUK Professional, 2014). Although much research has been conducted into clinical aspects of induction in recent years, very few studies have considered it from the woman's point of view. The current discourse on woman centred care is conceptualized as empowering women to make informed choices and to have control over their reproductive health. From this perspective, this study sets out to explore the circumstances in which women gain information and make decisions about induction and how induction affects their overall birthing experience.

Data was collected through semi-structured interviews with 21 first-time mothers approximately 3-6 weeks after giving birth and was analyzed thematically.

The findings indicated that information from health professionals was sparse and often difficult for women to relate to their own circumstances, indicating a need for information to be individualized to women's specific needs. There was a notable disparity between women's expectations of induction and their actual experiences. Time on the antenatal ward was likened to a state of prolonged liminality, where women were separated from everyday life and subjected to restrictive policies and regulations. Following induction, there was a notable shift in women's attitudes towards medicalised childbirth, with one third favouring the idea of a caesarean section in future.

Despite the current discourse on informed choice, this study supports Mavis Kirkham's theory that it exists more in rhetoric than in reality and is hampered by the prevailing structure of maternity care. In order to improve the induction experience, a more woman-centred model of care is called for.

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Abbreviations

41+ weeks	41 completed weeks plus number of days of gestation
ARM	Artificial rupture of the membranes
CAM	Complementary and Alternative Medicines
CS	Caesarean section
FHR	Fetal heart rate
IV	Intravenous
NICE	National Institute for Health and Clinical Excellence
OP	Occipito posterior
PGE₂	Prostaglandin E ₂
PROM	Pre-labour rupture of membranes
SCBU	Special Care Baby Unit
SVD	Spontaneous Vaginal Delivery
VE	Vaginal examination
NCT	National Childbirth Trust
F	Forceps
V	Ventouse

Glossary

Amnihook™	A device used for manually rupturing the amniotic membranes surrounding the fetus.
Amniotomy	Artificial rupture of the membranes surrounding the fetus.
Antenatal	Before birth.
Birth Plan	A written plan of a woman's preferences for care in labour.
Bishop's score	A set of measurements made during vaginal examination, to assess the condition of the cervix prior to induction of labour.
Cardiotocography (CTG)	A method of electronically monitoring the fetal heart rate (FHR) and uterine contractions to assess fetal wellbeing.
Cervical ripening	The process by which the cervix changes; becoming softer and shorter, in readiness for labour. It is assessed using the Bishop's score .
Cervix	The neck of the uterus where it opens into the vagina.
Clarysage	A herb used in non-pharmaceutical preparations believed to stimulate the onset of labour or to augment contractions.
Dilatation	The process by which the cervix gradually opens during the first stage of labour.
Effacement	The softening and shortening of the cervix. One of the factors measured using the Bishop's score .
Elective	A clinical procedure that is planned as opposed to being an emergency.
Electronic fetal monitoring	See cardiotocography .

Entonox™	A gas formed of Nitrous Oxide and Oxygen used as a form of analgesia or relaxation aid in labour.
Epidural	A form of analgesia administered via a catheter into the epidural space around the lower spinal cord.
Exogenous	Originating outside of the body.
Expectant management	The process of allowing pregnancy to progress with monitoring, but without medical intervention.
Expected (or estimated) date of delivery (EDD)	The end of the 40 th week of pregnancy.
Favourable cervix	The cervix is said to be favourable when its characteristics suggest that spontaneous labour is imminent, indicating the likelihood of a positive response to methods used to induce labour. It is assessed using the Bishop's score .
Fetal monitoring	Assessing fetal wellbeing by intermittent or continuous auscultation of the heart.
Gestational diabetes	A form of diabetes which occurs only during pregnancy and normally resolves shortly after the birth.
Hypertension	Abnormally raised blood pressure.
Induction of labour	The initiation of labour using artificial means.
Intrapartum	During labour.
Intrauterine growth restriction (IUGR)	The result of any condition which restricts normal fetal growth.
Intravenous	Administered via a vein, usually in the hand or arm in an adult.
Ischial spines	Bony prominences on the lower part of the pelvic girdle which may be felt via vaginal examination and are used as landmarks to track the descent of the presenting part
Latent phase	The early period of labour during which the cervix is effacing and beginning to dilate. This phase may be

symptomless or characterized by irregular cramping pains, restlessness and discomfort.

Lower uterine segment	The lower third of the body of the uterus.
Membrane sweeping	An intervention in which a finger is inserted through the cervix and rotated to separate the membranes surrounding the fetus from the lower uterine segment. The aim is to release prostaglandins which may stimulate the onset of labour.
Multiparous	A woman who has given birth to one or more babies.
Myometrial muscle	Contractile muscle of which the uterus is comprised.
Neonate	A baby in the first 28 days of life.
Nulliparous	A woman who has not previously given birth.
Occipito posterior	A fetal presentation in which the back of the head (occiput) is aligned with the mother's sacrum
Oxytocin	A hormone that stimulates the contraction of the uterus. Synthetic oxytocin, usually referred to by the manufacturer's brand name Syntocinon™, may be used to induce or augment labour.
Parity	The definition of a woman's childbearing history, often expressed as a symbol: P0 = a woman who has never given birth; P1 = a woman who has born one child etc.
Perinatal	The period around the time of birth.
Pessary	A vaginal suppository which may contain a therapeutic drug.
Post-dates pregnancy	Pregnancy which progresses beyond the expected date of delivery (EDD).
Posterior pituitary gland	Part of a hormone- producing gland situated in the hypothalamus of the brain.

Post-term pregnancy	A pregnancy that has extended beyond 42 completed weeks.
Pre-eclampsia	A disorder specific to pregnancy, typically characterized by hypertension and protein in the urine. It is potentially fatal in extreme cases.
Pre-labour rupture of membranes (PROM)	The spontaneous rupture of the fetal membranes prior to the onset of labour.
Presenting part	The part of the fetus which presents at the cervical opening: usually the head.
Pre-term/premature	Born before 37 completed weeks of pregnancy.
Primiparous	A woman who has given birth once. In midwifery terms, this is often incorrectly used to refer to a woman who is pregnant or in labour with her first viable infant.
Prostaglandin	A hormone-like secretion that affects a range of physiological functions. Prostaglandin E₂ (PGE₂) is a pharmaceutical preparation given vaginally to induce labour by causing the cervix to efface and dilate and to stimulate uterine contractions.
Pyrexia	A raised body temperature.
Rupture of membranes	The breaking of the membranes surrounding the fetus.
Spontaneous labour	Labour which begins without any form of intervention.
Supervisor of midwives	An experienced midwife who has undergone further training to enable her to clinically supervise other midwives in accordance with the requirements of the Nursing and Midwifery Council.
Term	Between 37 and 42 completed weeks of gestation.
Third degree tear	A tear sustained during childbirth which extends from the vaginal wall to the anal sphincter.

Unfavourable cervix	The state of a woman's cervix indicating that the spontaneous onset of labour is not imminent. The cervix is assessed using the Bishop's score .
Uterine rupture	A rare and life-threatening condition in which the uterus ruptures during contractions.

Definition of terms used in this thesis

The definition of some of these terms may be contentious – particularly ‘normal labour’ and ‘natural birth’: the meanings of these terms have been much debated by lay people and health professionals and there may be discrepancies in interpretation between the two groups. The definitions I have used are those which are common to people I have worked with over the years.

Health professional: a midwife, doctor, antenatal teacher or other formally qualified person providing health care at one or more points in the childbearing cycle.

Medical induction: a process of artificially initiating the onset of labour using medical or surgical procedures undertaken by a midwife or doctor.

Natural birth: a spontaneous vaginal birth which follows a normal labour.

Normal labour: labour which is spontaneous in onset, which is not artificially augmented and which progresses without the development of risk factors and without epidural analgesia.

Post-dates pregnancy: a pregnancy which extends beyond 40 completed weeks (the expected date of delivery).

Post-term pregnancy: a pregnancy which extends beyond 42 completed weeks.

Term pregnancy: a pregnancy ending between 37 and 42 completed weeks.

The Trust: the NHS Trust from which the participating sample was identified and the maternity unit at which all participants gave birth.

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1. Introduction and background

Introduction

Induction of labour is one of the most commonly performed interventions in pregnancy, affecting over 23% of births in the UK and rates have been rising slowly but steadily over the past five years (BirthChoiceUK Professional, 2014). A wealth of literature exists on the physiological aspects of induction, but very few studies have been published on women's experiences and understanding of it. The current guidelines for induction by the National Institute for Health and Clinical Excellence (NICE) state that:

Women who are having or being offered induction of labour should have the opportunity to make informed decisions about their care and treatment, in partnership with their healthcare professionals (National Institute for Health and Clinical Excellence, 2008, p.4)

This chapter will describe the practice of labour induction, situating it within its historical and present-day context. The conceptual framework which underpins this study will be presented followed by a personal reflection. The undertaking of this research will then be justified and the aims and objectives of the study set out. This chapter concludes with a short overview of each of the subsequent chapters.

Definition of induction of labour and its indications

Induction of labour is an intervention to initiate the onset of labour in situations where the benefits of ending the pregnancy are believed to outweigh those of continuing it and where vaginal birth is considered appropriate (National Institute for Health and Clinical Excellence, 2008; Rimmer, 2009). Indications for recommending induction are based on a medical model of risk assessment and include numerous non-acute fetal and maternal conditions, the most common of which are listed overleaf:

Table 1: Indications for induction of labour

Table 1: Indications for induction of labour

Pregnancy beyond 42 completed weeks

Hypertension

Diabetes

Pre-labour rupture of membranes

Intrauterine growth restriction

Fetal death

(McCarthy & Kenny, 2013; National Institute for Health and Clinical Excellence, 2008; Rimmer, 2009)

Induction is contraindicated where medical opinion deems that the continuation of the pregnancy is in the best interest of woman and baby, or where obstetric complications mean that the risks of a vaginal birth are greater than those of caesarean section (McCarthy & Kenny, 2013). Indications for induction are usually agreed at local level and incorporated into medically decided policies. Requests for induction for social reasons are not routinely honoured in NHS hospitals (National Institute for Health and Clinical Excellence, 2008).

A full-term pregnancy normally lasts between 37 and 42 weeks. According to the NICE guidelines on induction of labour, there is “*strong evidence*” of the increasing risk to mother and baby of pregnancy beyond 40 weeks, although this risk remains very small and increases very slowly up to 42 weeks (National Institute for Health and Clinical Excellence, 2008). A more recent Cochrane review advises that births after 42 weeks are associated with an increased chance of neonatal death, although the absolute risk remains small (Gulmezoglu, Crowther, Middleton, & Heatley, 2012). Due to the length of time that induction may take, it is usual practice in NHS maternity units to offer induction at 41+ weeks to ensure that the baby is born before 42 completed weeks. The NICE guidelines state:

Women with uncomplicated pregnancies should usually be offered induction of labour between 41+0 and 42+0 weeks to avoid the risks of prolonged pregnancy. The exact timing should take into account the woman's preferences and local circumstances. (National Institute for Health and Clinical Excellence, 2008, p.6)

Induction for post-dates pregnancy accounts for the majority of inductions in the UK (Cheyne, Abhyankar, & Williams, 2012; Grivell, Reilly, Oakey, Chan, & Dodd, 2011; Stock, Duffy, Ford, Chalmers, & Norman, 2012) but in the absence of complications, this remains a controversial issue among those who espouse the notion of normal birth (Wickham, 2014).

An historical overview

There is a long folk history of women using non-invasive measures to stimulate the onset of labour (Hall, McKenna, & Griffiths, 2012a; Schaffir, 2002) and many methods are still in current use alongside conventional medicine. This will be explored in more detail in chapter two. In contrast, up until the 1930s, medical methods of induction used mechanical devices inserted through the woman's cervix to forcibly dilate it. This was superseded by amniotomy in the 1940s, along with castor oil and injections of oxytocin (Nabi, Aflaifel, & Weeks, 2014). Castor oil was later abandoned due to unpleasant side-effects and injected oxytocin replaced by intravenous synthetic oxytocin. From the 1980s, prostaglandins began to be used for cervical ripening prior to amniotomy (Nabi et al., 2014) and remain the first medical method of choice today (McCarthy & Kenny, 2013; National Institute for Health and Clinical Excellence, 2008).

Methods used for induction in the UK

Up to four separate stages may be involved in the induction process: membrane sweeping, the administration of vaginal prostaglandins (PGE₂) amniotomy and intravenous oxytocin. Not all women will require all four procedures. Mechanical methods involving the insertion of catheters through the cervix still exist but are not

currently recommended for routine use in the UK (National Institute for Health and Clinical Excellence, 2008).

Prior to commencing induction, the condition of the woman's cervix is assessed using the Bishop's Score: a rating system to assess the likelihood of success in inducing labour. A score of 0-3 is given for each of the following criteria: the stage of cervical dilatation, the length, the consistency and the position of the cervix and the station of the presenting part in relation to the ischial spines (Jay & Hamilton, 2014). The Bishop's score is assessed during a vaginal examination and a high score indicates a 'favourable' cervix, predicting a greater likelihood of a shorter, successful induction (Gulmezoglu et al., 2012; McCarthy & Kenny, 2013; National Institute for Health and Clinical Excellence, 2008). In such cases, it may be possible to induce contractions through amniotomy alone, followed if necessary by intravenous oxytocin (Gulmezoglu et al., 2012) and some obstetricians prefer this to PGE₂; however, the NICE guidelines state that vaginal PGE₂ is the preferred method of induction regardless of cervical state or whether or not the membranes surrounding the fetus are intact (McCarthy & Kenny, 2013; National Institute for Health and Clinical Excellence, 2008). PGE₂ is a synthetic form of prostaglandin, a hormone-like substance which promotes cervical effacement and dilatation, leading to a greater likelihood of successful induction (Ndala, 2005). Determining the Bishop's score is highly subjective: the accuracy of this and the success of performing amniotomy are dependent upon the skill of the midwife or doctor.

Membrane sweeping

In order to avoid medical induction, the NICE guidelines currently recommend that a membrane sweep is offered to all nulliparous women between 40 and 41 weeks gestation, which has been found to reduce the need for medical induction without significantly increasing other risks (National Institute for Health and Clinical Excellence, 2008; Rimmer, 2009). Membrane sweeping (also known as cervical sweeping) involves the insertion of a gloved finger through the woman's cervix and rotating it to separate the membranes from the lower uterine segment. This causes the release of prostaglandins which stimulates the effacement and dilatation of the

woman's cervix (Knoche, Selzer, & Smolley, 2008; McCarthy & Kenny, 2013). Comparative studies have shown it to be effective and safe when performed appropriately and in the absence of contra-indications (Boulvain, Stan, & Irion, 2005; Knoche et al., 2008), however, side-effects include bleeding, discomfort and non-progressive, irregular contractions (Boulvain et al., 2005; McCarthy & Kenny, 2013; Rimmer, 2009). Where membrane sweeping is not possible due to a closed cervix, massaging the area around the cervix may have a similar effect (National Institute for Health and Clinical Excellence, 2008).

Vaginal Prostaglandins (PGE₂)

The use of vaginal PGE₂ in the form of a tablet, gel or slow-release pessary, is recommended for all inductions unless there are contraindications (National Institute for Health and Clinical Excellence, 2008). The Trust where this research was conducted generally uses the pessary, although at the time of data collection a minority of consultants were using the gel form. Standard procedure, according to NICE, is to administer one dose of PGE₂ in tablet or gel form followed by a second dose six hours later if labour is not established. If a pessary is used, one dose is given over 24 hours. If, after the set period of time, labour is not established, induction may be said to have 'failed' and the woman is re-assessed by the obstetric team and either the cycle is repeated or a joint decision is made to do a caesarean section (National Institute for Health and Clinical Excellence, 2008).

The length of time from initiation of induction using prostaglandins to onset of early labour has many variables, including the woman's Bishop's score at the outset, the number of times PGE₂ is applied and any intervening delays (Cheng, Delaney, Hopkins, & Caughey, 2009; Edozien, 1999). Current guidelines anticipate that (in the absence of delays) most women will enter labour within 24 hours of one cycle of prostaglandin administration (National Institute for Health and Clinical Excellence, 2008) however, induction lasting several days is not unknown (Cheng et al., 2009).

Amniotomy and intravenous Oxytocin

Amniotomy is thought to stimulate changes to the cervix partly through hormonal reactions and partly due to the increased pressure of the fetal head on the cervix. The procedure is conducted using a plastic Amnihook™ inserted through the woman's partly-opened cervix to break the bag of membranes surrounding the fetus. Once ruptured, the fetus' protective barrier against infection is lost: for this reason, unless contractions begin spontaneously within a few hours, it is usual practice to commence an intravenous oxytocin infusion to stimulate contractions (Rimmer, 2009).

Oxytocin is a hormone secreted by the posterior pituitary gland: it has numerous functions, one of which is to cause the myometrial muscles of the uterus to contract (Rimmer, 2009). Exogenous oxytocin (Syntocinon™) is given via a slow intravenous drip, with the dose titrated against contractions according to local protocol until regular contractions are established (McCarthy & Kenny, 2013; Rimmer, 2009).

Side-effects and risks of induction

Medical induction of labour is not without risk: this includes increased pain and use of analgesia in labour (Bramadat, 1994; Fleissig, 1991; Heimstad, Romundstad, Hyett, Mattson, & Salvesen, 2007; Hildingsson, Karlstrom, & Nystedt, 2011; National Institute for Health and Clinical Excellence, 2008; Shetty, Burt, Rice, & Templeton, 2005; Wickham, 2004) and the likelihood of further intervention, including instrumental birth (Cheyne et al., 2012; National Institute for Health and Clinical Excellence, 2008; Rimmer, 2009). PGE₂ and Syntocinon™ have unpredictable side effects, including hyper-stimulation of the uterus which can, very rarely, lead to uterine rupture and thus require careful monitoring (Cheyne et al., 2012; Rimmer, 2009). More commonly, women experience nausea, diarrhoea or transient abdominal cramps which begin roughly an hour after the insertion of PGE₂ and gradually fade over time (Sykes, 2014). A Syntocinon™ infusion usually causes contractions to rapidly become more intense and this may be perceived as more painful than the gradual build-up of contractions in a spontaneous labour.

Induction policy for nulliparous women at the NHS Trust from which participants were recruited

The maternity unit has a policy of offering induction to all women with uncomplicated pregnancies at 40 weeks plus twelve days. Inductions are normally booked by the woman's community midwife during an antenatal appointment and midwives are expected to provide women with written and verbal information and to support them to make an informed decision, in accordance with the NICE guidelines. Discussions about induction should take place at the woman's 38 week antenatal appointment, allowing her time to consider her options in case induction is indicated in the future. Indications for induction are similar to those listed in the NICE guidelines (see page 2), although the Trust routinely offers induction at 40 weeks to women aged over 40.

The Trust policy states that all women should be offered a membrane sweep at 41 weeks, followed by further sweeps if not effective. Vaginal PGE₂ in pessary or gel form is the preferred method of induction where the woman has a Bishop's score of less than seven. Once beyond this threshold, the woman is transferred to the delivery suite for amniotomy and Syntocinon™. The policy recommends that women be offered an epidural before commencing the Syntocinon™ infusion. If, after four hours of Syntocinon™ at the maximum dose the woman's cervix has dilated less than 2cm, a caesarean section may be considered.

Women who decline induction are offered at least twice-weekly fetal monitoring with cardiotocography (CTG) and ultrasonography (USS) to assess the volume of amniotic fluid in accordance with NICE (2008) guidelines.

Conceptual framework: informed choice and decision-making in maternity care.

Choice in maternity care: the historical context

From its inception in 1948, NHS maternity services were based upon a paternalistic, medical model of care maintained by a powerful hierarchy of doctors, which

promoted this as the safest option for childbirth (Lupton, 1994; Martin, 2001). As hospital births became almost universal in the latter part of the 20th century and the power of the medical profession increased, the autonomy of midwives to care for women in childbirth was gradually eroded (Kitzinger, 1988). Opposition to this began in the 1950s among middle-class women and gradually gained momentum (Oakley, 1993), reaching a wider audience from the 1970s through the agency of feminist writers (Langan, 1998). Evidence of women's desire for more choice in childbearing began to mount from the 1970s onwards (Cartwright, 1979; Kirkham, 2004a). Pressure groups such as the Maternity Alliance and the National Childbirth Trust began to challenge the rights of obstetricians to dictate routine patterns of maternity care and lobbied policy-makers for change (Langan, 1998; McCourt, 2009a; Oakley, 1993). This culminated in the so-called Winterton Report of 1992 which decided that since childbirth was now safer than ever before, future patterns of maternity care should not automatically follow medical models, but should be focused on what women actually want, including information, choice and control (Walton & Hamilton, 1995). This was crystallized in the subsequent Changing Childbirth report by the Expert Maternity Group (Department of Health, 1993), which was acclaimed as an opportunity for midwives to provide woman-centred care with a particular emphasis on informed choice (Kirkham, 2004a; Sandall, 1995; Walton & Hamilton, 1995). Subsequent government documents have built upon Changing Childbirth, making the commitment to information and choice a key feature of maternity policy in the 21st Century (Department of Health, 2004b, 2007b, 2008; Royal College of Obstetrics and Gynaecology, 2008).

Choice and the consumer society

The concept of choice in maternity care stems from the prevailing neo-liberal policies of successive UK governments in the latter part of the 20th century, from which arose the notion of a consumer society in public services (Clarke, 2004). Implicit within this notion is the empowerment of the individual through the exercise of choice in a free-market society (Clarke, 2004; Oakley, 1993). However, a consumer can only choose from the range of options on offer, which is determined by the supplier and then only when choices are known (Kirkham, 2004a). Choice is thus dependent on

information, with those who hold the intellectual capital also holding the power to control choice by sharing or withholding information.

Concepts of informed choice

Informed choice has been a key feature of maternity policy in the UK since the Changing Childbirth report of 1993 (Department of Health, 1993). Subsequent policies built on this, reinforcing the principles of information and choice (Department of Health, 2004b, 2007b, 2008; Royal College of Obstetrics and Gynaecology, 2008). The concept has been widely adopted by the midwifery profession and is enshrined in The Code which sets out standards for midwifery education, practice and conduct throughout the UK (Nursing and Midwifery Council, 2008). Informed choice has been defined in numerous ways and is a much-debated and complex issue influenced by multiple factors. No over-arching definition has been found, but the general consensus is that in order to make genuine choice, women need to know what options are open to them and what these involve (Kirkham, 2004a). However, there has been much debate about the nature of informed choice and whether or not it is more than just empty rhetoric (Anderson, 2002; Jomeen, 2007; Kirkham, 2004a; Page & Penn, 2000; Skyrme, 2014).

Constraints to informed choice

In order to make choices women need trustworthy information which is accessible and meaningful to them (Churchill & Benbow, 2000; Levy, 1999d), however, it has been argued that this is inhibited by prevailing models of maternity care which limit contact time between women and midwives, forcing midwives to work through a set agenda and thus reducing the opportunities for discussion (Kirkham, 2004a; Levy, 2004). Insufficient staffing and short antenatal appointment times mean that time for information-giving and discussion is severely curtailed in many NHS practices and whilst midwives may be unable to deny requests for information from the more assertive women, those who are less articulate may be overlooked (Kirkham, 2004a; Stapleton, Kirkham, & Thomas, 2002). Furthermore, where time is short, midwives have been shown to make subconscious judgements about women's capacities to

understand the information needed to make choices and to assume decision-making responsibility on their behalf (Stapleton, 2004). In addition, in systems where midwifery autonomy is curtailed, they may steer women towards 'safe' choices which may not necessarily reflect the woman's wishes, but which absolve the midwife from criticism by those in senior positions (Kirkham, 2004a; Lukes, 2005). Conversely, holistic, midwifery-led models of care, such as case-loading, may be more conducive to information which is tailored to individual need and thus to the promotion of informed decision-making (McCourt, 2006).

In 1977 the Department of Health called for more opportunities for women to make fully informed choices about induction (Department of Health and Social Security, 1977). However, UK studies published since this report indicated that women still lacked sufficient information about induction, implying a barrier to fully informed decision-making (Cartwright, 1979; Shetty et al., 2005). The 2008 NICE guidelines on induction (National Institute for Health and Clinical Excellence, 2008) repeated the call for informed choice, yet to date, the effectiveness of this has not been evaluated.

Personal reflection

Prior to commencing this doctoral work, my embodied knowledge of induction stemmed from my own experience as a mother and from the privilege of having cared for many women facing or undergoing induction during my career as a midwife. I came to midwifery in the mid-1990s, after having completed my family. Two of my children were born following induced labour for pre-eclampsia at term. At the time, I had no nursing or medical background and therefore experienced induction much as many of my later clients would do: with minimal knowledge and understanding of what the process entailed and of the potential risks. Reflecting on my own experience of induction, there was no element of choice and no information or discussion was offered: it was simply part of the routine care package. Despite being well-educated and articulate, it never occurred to me to question induction or to seek out further information from other sources. My two experiences of induction

were 'text-book' in their simplicity and swiftness and I had no reason to doubt that this was the case for all women.

When I began my midwifery career it became evident that in many cases, induction was far from the straightforward experience I had known: although the actual process differed little, I noted that it was often a lengthy and emotionally draining experience. Complaints from frustrated and worried partners were everyday events and much time was spent explaining, comforting and apologizing for delays which were outside my control. I was particularly struck by the disparity between women's expectations of induction and their actual experience. The rapid descent from hope, via frustration to despair was deeply unsettling and logically led me to consider how women were prepared for induction and whether they had made truly informed decisions. As a parent educator, I ensured that induction was covered in detail in my own antenatal classes, but had no control over what happened elsewhere.

After a career move into higher education, I developed a deeper appreciation of the need for individualized information and its impact on decision-making; however, I was aware that this was something I could not offer in large antenatal classes. The launch in 2008 of the NICE guidelines on induction of labour (National Institute for Health and Clinical Excellence, 2008) formally acknowledged the need for woman-centred care during induction:

Treatment and care should take into account women's individual needs and preferences. Women who are having or being offered induction of labour should have the opportunity to make informed decisions about their care and treatment [...] Good communication between healthcare professionals and women is essential. It should be supported by evidence-based written information tailored to the needs of the individual woman (National Institute for Health and Clinical Excellence, 2008, p.4)

However, verbal evidence from students and midwives suggested that despite the prevailing discourse on informed choice, many women facing or undergoing induction were no better aware of what to expect than I had been some 25 years

earlier. It was this that led me to consider the extent to which the ideals of the NICE guidelines were being met in relation to women's lived experience of induction.

Justification for this study

A comprehensive literature review revealed that although much research has been conducted on medical aspects of induction over the years, little is known about how women in the UK acquire knowledge of induction, make decisions about it or live the experience. In the light of the current discourse on informed choice and woman-centred care (NICE, 2008; Department of Health, 2007; Department of Health, 2008; Nursing and Midwifery Council, 2008), this study set out to provide up to date evidence about how women receive information about induction, how they make choices, how they experience induction and how this affects their overall birthing experience and early transition to parenthood.

The chosen methodological approach for this study reflects the epistemological view that to understand women's subjective experiences, their voices must be heard. For this reason, a data collection method was used which enabled women to focus on aspects which were of most significance to them (Rees, 2011; Rogers, 2008). The outcome of this study is expected to provide evidence which will be of relevance to those planning and implementing maternity care and ultimately to childbearing women and their families.

Aims of this study

This study aims to explore how first-time mothers experience induction of labour, with particular reference to acquiring information and decision-making.

Objectives

- To discover how first time mothers acquire knowledge of induction
- To explore how and why women consent to induction
- To explore women's experiences of undergoing the induction process

- To explore how induction affects women's overall perception of their birthing experience and transition to parenthood
- To compare the experiences and perceptions of a group of women who have attended a pre-induction class with those of a similar group who have not attended a class.

Conclusion

In this chapter the rationale for induction of labour and its practice in the UK and in the NHS Trust from which the study participants were drawn has been defined and explained. The conceptual framework around which this study was built has been presented, followed by a personal reflection of the embodied experience of induction. A justification for the study has been offered and the aims and objectives set out with key terms defined in relation to their use within this thesis. This chapter concludes with a short overview of each of the subsequent chapters.

Chapter two: Literature review

In this chapter an exploration and critique of the literature is presented. This begins with a critical discussion of studies on induction from the mid-1970s onwards and extends to consider the literature relevant to the conceptual framework, with particular reference to how concepts of informed choice, power and control operate within the maternity encounter and shape women's ability to make decisions. Literature pertaining to the relative risks and benefits of induction is presented in order to highlight its controversial nature, but it is not the intention of this study to argue for or against its use in any particular circumstances.

Chapter three: Methodology

This chapter presents the rationale for the chosen methodological approach to the study, demonstrating how this was chosen in relation to the aims and research questions. Ethical challenges of conducting research whilst holding multiple roles are

discussed. The process of data analysis is described, with specific reference to the maintenance of academic rigour.

Chapter four: Anticipating induction in late pregnancy

Chapters four to six present the findings of this study. Chapter four addresses the lead up to induction, with a focus on how women acquired information and perceived choices about induction, how this fitted into their expectations of childbirth, how and why they decided to accept induction and finally how women engaged with self-help methods.

Chapter five: The induction experience

The focus of this chapter is women's lived experiences of induction from admission to hospital until the onset of established labour. Discrepancies between women's expected trajectory of induction and the reality they encountered are considered, as are women's perceptions of treatment by hospital staff and the extent to which women felt involved in their own care.

Chapter six: Reflections on the induction experience

This chapter focuses on women's reflections on their feelings and overall impressions of their induction experience and explores how the unexpectedly high rate of operative births may have affected women's perceptions of induction and attitudes to future pregnancies. Women's suggestions for improving the induction experience are presented.

Chapter seven: Discussion

This chapter discusses the key themes which emerged from the findings of this study in relation to the conceptual framework and explores the implications for midwives and doctors involved in induction. Suggestions for improvement at institutional and interpersonal levels are offered.

Chapter eight: Conclusion

This chapter demonstrates how the research questions have been met and how the findings contribute to the current body of knowledge. Limitations of the study are explained, followed by suggestions for further research.

2. Literature Review

Introduction

In this chapter an exploration and critique of the literature is presented in relation to the aims of the study and the research questions. A detailed explanation of how the literature review was conducted is given, followed by a critical discussion of studies from the mid-1970s onwards concerning women's experiences of induction. This leads into an exploration of how risk in relation to induction influences women's decision-making. Concepts inherent within the framework of informed choice and woman-centred care are presented and discussed in relation to induction and their influence on women's ability to make decisions. This section culminates with a review of women's use of complementary and alternative medicine in relation to induction, followed by a presentation of the research question.

Conducting the literature search

There is debate over whether or not a comprehensive literature search should be conducted at the outset of a study (Holloway & Wheeler, 2010; Silverman, 2010). A number of recent authors concur in their opinion that some methodologies (typically grounded theory) demand that the subject be approached without pre-existing ideas and knowledge and indeed with little more than a broad view of related areas, so that the researcher approaches the subject with fresh eyes (Holloway & Wheeler, 2010). However, much was already known about induction from a personal and a clinical perspective. In order to develop a focused and apt research question therefore, it was first necessary to assess the scope of existing research and to identify gaps in current knowledge (Henn, Weinstein, & Foard, 2006; O'Leary, 2010).

An initial search of the literature was conducted at the start of the study using the database PubMed. A small number of search terms were used in a variety of combinations, including the words "induction, labour, experience and woman" in the title or abstract. This resulted in several hundred 'hits', however, the resulting articles

were largely medically based, focusing on clinical aspects of induction rather than the subjective experiences of women. In order to narrow the search, further terms were added, including “feelings”, “attitudes” and “perceptions”. Boolean operators and truncation symbols were applied to cover all variations in spelling and verb declensions (O’Leary, 2010). A list of inclusion and exclusion criteria is contained in table 2:

Table 2. *Literature search: inclusion and exclusion criteria*

Inclusion criteria	Exclusion criteria
All items relating to women’s experiences or perceptions of induction of labour	Items not published in English
All types of original research, literature reviews, professional guidelines, expert opinion, discussion and practice articles	Studies on medical aspects of induction e.g. trials of different inducing agents.
Items from all countries	Opinion-based items not supported by evidence.
Items from any year of publication	Obsolete professional guidelines

Initially, fewer than 20 studies were identified which specifically addressed women’s perceptions or experiences of induction. Among those, a study by the Institute for Social Studies in Medical Care, conducted in the mid-1970s and later written as a book (Cartwright, 1979), emerged as a landmark study which was cited by the authors of most subsequent literature. Cartwright (1979) acknowledged two smaller, contemporaneous studies (Kitzinger, 1975; Lewis, Rana & Crook, 1975), but observed that hers was the first wide scale, systematic assessment of women’s personal experiences of induction, encompassing women from all social and economic backgrounds. To ensure that no earlier works had been inadvertently

missed, a further database search was conducted, limited to articles published prior to the period of Cartwright's study. This identified only articles on clinical aspects of induction which were not considered relevant. It was possible that some early studies which pre-dated the age of the Internet may have been missed, but as Cartwright's own literature review was of this era, it is likely that she would have incorporated and referenced any accessible publications from an earlier period.

Repeated searches using a wider range of search engines and databases were conducted at various stages throughout the course of the present study in order to identify fresh research. To ensure consistency, online databases accessible via the University of Hertfordshire or with known credibility were searched: these included the Cumulative Index to Nursing and Allied Health Literature (CINAHL), Google Scholar, PubMed, the Department of Health website, Web of Knowledge, Scopus and the Cochrane Database. Publishers' websites, such as Science Direct were also accessed.

Numerous search terms were used in a variety of combinations and Boolean operators and truncation symbols were applied (O'Leary, 2010). Due to the apparent scarcity of relevant literature, no date or country filter was used; all works written in English were considered. In addition, a hand search was conducted of relevant journals and books which were not published in electronic format and a process of 'back chaining' (searching through reference lists and citations) was undertaken to identify further works of interest. Articles and books not accessible online via the University were obtained from the British Library or purchased privately. Articles of potential relevance were generally identified through reading the abstract or executive summary (in some cases, it was necessary to read the whole article). Following Aveyard's (2014) recommendation, these items were then sorted into categories identified as: original research, literature reviews, practice articles (including expert opinion, discussion and ethical argument) and guidelines. (Aveyard, 2014). References were stored systematically using the software EndNote X5.

In total, 26 original studies from the UK and overseas which specifically related to aspects of women's experiences of induction or perceptions of induction were identified as suitable for inclusion in this review (Appendix 1). One of these

(Bramadat, 1994) was primarily a review of previous studies, but included a report of the author's own, previously unpublished research. Three items (Green & Baston, 2003; Jacoby, 1987; Jacoby & Cartwright A, 1990) were chiefly focused on women's broader experiences of childbirth, but included important insight into the induction experience. Several studies contained findings which supported those of earlier research, but each one included original material and due to the dearth of published studies, at no point was saturation reached.

It will be noted that the majority of early literature was of UK origin: relevant studies from overseas did not become apparent until the 1990s. Although policies on induction vary worldwide, it was evident from these studies that the processes of induction and the drugs used were very similar and largely evidence-based.

Furthermore, all overseas studies were from countries where, in common with the UK, the childbearing population is generally literate, educated at least to school-leaving age and has access to good medical and maternity care (Devries, Benoit, Van teijlingen, & Wrede, 2001; Noonan, Corman, Schwartz-Soicher, & Reichman, 2013). For these reasons, it was considered that evidence from these studies was relevant to the induction experience of UK women and therefore included in this review. No relevant studies were identified from outside Europe or Anglophone countries.

The research articles comprised seven qualitative studies, six conducted using face-to-face interviews and one which analyzed retrospective reports of women's birth experiences. The remaining 19 studies were quantitative in nature, the greatest number being prospective cohort studies (nine). Other quantitative studies included two RCTs, five retrospective surveys (with or without control groups), one longitudinal study and two interventional studies. There was considerable variation in the length of the reports and in the quality of the research, particularly among some of the older studies where ethical approval and methods were not always clearly explained. Aveyard (2014) discusses the use of critical appraisal tools when conducting a literature search and concludes that although helpful to the novice reviewer, these have numerous limitations and expert opinions differ on whether qualitative studies and quantitative studies can be appraised using the same tool (Aveyard, 2014). No single tool was employed to critically analyse research articles,

instead each one was individually evaluated. Although every study was unique, the aims of each could be classified into one or more of six categories (see table 3). Total numbers add up to more than 26 as most studies had more than one aim.

Table 3: *Aims of the 26 reviewed studies including countries of origin*

Aim	Number of studies	Countries of origin
To explore women's knowledge and information needs in relation to induction	7	UK, Aus., USA, Fin.
To explore women's expectations of and attitudes to induction	12	UK, Can., USA, Fin.
To investigate influences on women's decision-making	4	USA, NZ
To understand women's preferences for induction or expectant management	3	UK., USA, NL
To explore women's experiences of induction	13	UK., USA., Can., Aus., Nor., Swe., Eire, Fin.,
Interventional studies exploring the effects of information on decision-making in relation to induction	2	USA, Aus.

A comparative discussion of existing studies into women's experiences and perceptions of induction since 1975

Induction of labour is one of the most commonly performed medical interventions in pregnancy in the UK, yet despite a plethora of research into clinical aspects of induction, women's voices on this major intervention in childbirth have rarely been heard. Rates of induction rose rapidly in the latter half of the 20th Century, following the introduction of relatively safe and effective procedures, and peaked at around

40% of all births by the mid-1970s (Cartwright, 1977). Widespread opposition to this and to the medicalisation of childbirth in general (Bramadat, 1994; Langan, 1998; Oakley, 1993) prompted the first UK studies designed to investigate women's experiences of induction.

The earliest published studies specifically focused on women's experiences of induction are from the UK: two were questionnaire-based surveys, undertaken from a medical perspective (Lewis et al., 1975; Stewart, 1977) and two were qualitative studies with a sociological focus (Cartwright, 1979; Kitzinger, 1975). Despite these differences, every study highlighted a need for more information about induction in the antenatal period in order to manage women's expectations. Lewis et al (1975) surveyed 200 women at a single hospital between the 24th and 36th week of pregnancy and then again post-birth in order to compare knowledge and attitudes to induction between those who attended antenatal classes and those who did not. A positive correlation was reported between attendance at classes and knowledge of induction and women who attended classes were more likely to find induction acceptable. Post birth, the majority of those who were induced favoured this method for subsequent births. Stewart's (1977) study aimed to investigate women's attitudes to induction. 137 women from a single hospital were questioned about their knowledge and attitudes shortly before induction, during induction, within 12 hours of giving birth and at 48 hours post-birth (Stewart, 1977). The findings highlighted a lack of information about induction, although on reflection, women's experiences of induction generally exceeded expectations.

In contrast to the above studies, social anthropologist Sheila Kitzinger (1975) investigated women's experiences of and attitudes towards induction before, during and after the birth. This retrospective study was based on unstructured reports by 614 women from National Childbirth Trust antenatal classes whose labours had been induced, plus a control group comprising 224 reports of non-induced labour. Women's reports were written spontaneously and not as part of a planned study. General themes included a lack of opportunity for discussing induction and a perceived lack of information about the nature and purpose of induction and its implications for women and babies. Even where a choice was offered, decisions

were usually uninformed (Kitzinger, 1975). Kitzinger's report concluded with a recommendation to the Department of Health and Social Security that each woman should receive '*full and frank information in a way that she can understand and that time is set aside to answer her questions*' (p 38).

Despite the large sample, Kitzinger's study was unrepresentative of the population, consisting chiefly of articulate, middle-class attendees at NCT classes (Bramadat, 1994; Kitzinger, 1975). This shortcoming was addressed by social anthropologist Ann Cartwright, in a study commissioned in 1975 by the Institute for Social Studies in Medical Care, consisting of a comprehensive survey to assess women's broad feelings about induction (Cartwright, 1977, 1979). In this study, a random sample of over 2,000 women was selected from 24 areas across England and Wales. Interviews were mostly conducted between three and five months post-birth, using a structured questionnaire. Just less than 24% of the sample had experienced induced labour. Cartwright found that overall, women were less healthy and happy after induced labour compared to spontaneous labour. In contrast to the findings of Lewis et al (1975), only 17% of women who had been induced reported that they would prefer induction in future. Almost two thirds of those induced believed they had no choice in the matter, whilst two fifths identified a perceived lack of adequate information (Cartwright, 1979). This was despite a Department of Health recommendation which stated that women should "*....have every opportunity of discussing [induction of labour] with professional advisers*" in order that they may be enabled to "*...make a fully informed decision about it*" (Department of Health and Social Security, 1977, cited in Cartwright, 1979, p.163). Furthermore, in comparison to women who laboured spontaneously, those who had been induced had a small, but significantly higher likelihood of suffering depression or anxiety (Cartwright, 1979). Like Kitzinger (1975), Cartwright surmised that although most women wanted more involvement in decision-making, they felt inhibited by the perceived power imbalance between themselves and maternity staff.

Aspects of Cartwright's sampling strategy which were pertinent at the time might have less relevance in the 21st Century – such as the inclusion of only legitimate births: moreover, due to differences in record keeping at the time, there were

significant difficulties in distinguishing between induced and augmented labour, thus the percentage of women having induced labour may have been unreliable. Nevertheless, Cartwright's study remains a seminal work which has been cited as a point of reference in most subsequent investigations.

In the wake of widespread concern about the rising medicalisation of childbirth, rates of induction began to fall in the late 1970s and subsequently remained fairly stable for over three decades at around 20% of all births (BirthChoiceUK Professional, 2014). This stability may partly account for the paucity of fresh enquiry during this period.

Two further UK-wide surveys were conducted by the Institute of Social Studies and Medical Care in 1984 (Jacoby, 1987) and 1989 (Jacoby & Cartwright A, 1990) to assess new mothers' views on various obstetric procedures, including induction of labour. Each collected data via postal questionnaires to random samples of over 1000 women. Jacoby (1987) found that induction was among the least popular interventions, with fewer than 50% of those who had been induced reporting satisfaction with the management of their labour. Evidence of an increased incidence of depression associated with induction supported one of Cartwright's (1979) earlier findings. The 1989 study primarily aimed to investigate contraceptive practices, but also included obstetric preferences (Fleissig, 1991; Jacoby & Cartwright A, 1990). Women whose labours were induced were found to need more analgesia and further interventions than those who laboured spontaneously and had increased feelings of anxiety and powerlessness, plus a decreased sense of personal control. Negative feelings were particularly notable among primiparous women (Fleissig, 1991; Jacoby & Cartwright A, 1990).

In each of these studies, the authors acknowledged the difficulties of interpreting data collected retrospectively and the possible influence of a happy outcome on the subsequent evaluation of childbirth, a phenomenon increasingly recognised by later researchers (Heimstad et al., 2007; Murtagh & Folan, 2014; Nuutila, Halmesmaki, Hiilesmaa, & Ylikorkala, 1999; Shetty et al., 2005; Van Teijlingen, Hundley, Rennie, Graham, & Fitzmaurice, 2003).

In the first prospective study to explore the wider expectations and experiences of childbearing women and to compare these with postnatal psychological outcomes, detailed questionnaires were posted to an opportunistic sample of over 700 women due to give birth in one of four UK Health Districts (Green, Coupland, & Kitzinger, 1998). In relation to induction, 64% of women reported that they knew '*quite a bit*' or '*a great deal*' about induction antenatally, although the investigators suspected some confusion with accelerated labour. Furthermore, only 3% expressed negative feelings towards the hypothetical notion of induction at 42 weeks of pregnancy. In contrast to the findings of Jacoby (1987) and Cartwright (1975), a postnatal survey of the same sample found no direct association between induction and depression; however, it was concluded that women were unhappy when interventions were unwanted or where they lacked a sense of control. A strong association was noted between positive perceptions of childbirth and information, with the most satisfied women being those whose information needs had been fully met antenatally (Green et al., 1998).

A cluster of national and international case-controlled studies from the latter years of the 20th Century and first decade of the 21st Century sought to compare the attitudes, expectations and experiences of women undergoing induced labour with those who laboured spontaneously. A small-scale questionnaire survey of women from a Finnish hospital concluded that at least one third perceived a lack of information about induction and wanted more control over its method and timing (Nuutila et al., 1999). However, induction was perceived as a positive experience for the majority of those surveyed, with 80% stating that they would find it acceptable in a future pregnancy. Similarly, in a Norwegian study, telephone interviews conducted six months after the participants gave birth found that 84% of those in the induction group found this a positive experience, with most stating that they would prefer this option in future pregnancies (Heimstad et al., 2007). A large-scale RCT conducted across six countries involving over 5,000 healthy women with pre-labour rupture of membranes at term who were randomly allocated to either routine induction or expectant management, found that in all outcomes of statistical significance, induction was favoured over expectant management (Hodnett et al., 1997). This contrasts with an earlier, Canadian study comparing expectations and perceptions of

childbirth among a group of 91 primiparous women (Bramadat, 1994). In this study, 75% of women whose labours had been induced described their experience as worse than anticipated, however, the article omits details of the methodology, making the findings difficult to evaluate.

A large case-control UK study found that although spontaneous labour resulted in a more positive experience than induction, over two-thirds of women who had been induced were satisfied with their labour (Shetty et al., 2005). However, as in Nuutila's study, over one third of women were dissatisfied with the information they had been given about induction. The investigators identified a significant need for better information and greater involvement in decision-making to promote realistic expectations of induced labour. Similarly, a longitudinal Swedish study involving 936 women surveyed at various stages of pregnancy and the postnatal period observed that induced labour resulted in lower rates of maternal satisfaction and a less positive birth experience (Hildingsson et al., 2011). However, the lack of a control group hindered the conclusiveness of the findings.

Other studies have focused largely on women's attitudes towards induction in healthy, term and post-term pregnancies. A Norwegian survey of 508 women over a two-year period in which women were randomly allocated at 41 weeks of pregnancy to either induction or expectant management (Heimstad et al., 2007) found that 74% of all women would have preferred immediate induction, if available. Women's motives for choosing elective induction were investigated in a Dutch survey of 237 women and found that those who opted for induction held negative expectations of labour and lacked trust in their own bodies, preferring the safety of a known date for giving birth (Out, Vierhout, Verhage, Duidenvoorden, & Wallenburg, 1986). However, this study did not explore whether attitudes became increasingly negative as pregnancy progressed. This aspect was addressed by Roberts and Young (1991) in a prospective questionnaire survey of 500 women at a single UK hospital, where low-risk women were offered a choice of induction at 42 completed weeks or expectant management. Findings showed that 44.2% of women were favourably inclined to expectant management at 37 weeks, falling to 31.15% by 41 weeks, indicating an increasing preference for induction as pregnancy progressed beyond term.

The findings of all these studies suggest an increasingly positive attitude to induction among women in very late pregnancy; however, it is perhaps not surprising that as pregnancy becomes increasingly uncomfortable in the latter stages, women are less favourably inclined to a 'watch and wait' approach. Moreover, as Hodnett (1997) observed, having been informed of the possible risks associated with expectant management, women allocated to this group had longer to ponder this, which may have led to greater anxiety and negative feelings towards natural birth.

Limitations of the aforementioned studies

Nearly all the aforementioned studies relied on closed-question surveys which limited the range of responses. Whilst this method of data collection is appropriate for studies involving large numbers of participants or where very specific information is sought, it offers only limited insight into the lived experience of induced labour and cannot delve deeply into women's feelings or explore reasons behind individual responses (Thomson, Dykes, & Downe, 2011). Furthermore, the reliability of some findings may be questionable: for example Lewis (1975) and Roberts and Young (1991) make no mention of ethical considerations in the recruitment of participants, whilst Nuutila et al (1999) have been criticised for interviewing women on admission to hospital, at which point they may have been especially vulnerable to suggestion (Dover, 1999). The same criticism may be applied to the study by Stewart (1977), who furthermore failed to state whether the midwives collecting data from participants were the same as those who cared for them. In each of these studies, the conduct or timing of data collection raises questions about the validity of the findings.

Differences in sampling methods also complicate comparison between studies, as some included only low-risk women, whilst others made no distinction. Many made no differentiation in their presentation and analysis of data between parity or between women who had previously undergone induction and those being induced for the first time. This may be viewed as a shortcoming of these studies, since prior experience may have influenced women's knowledge and expectations of childbirth.

Qualitative studies in the 21st Century.

In contrast to the reductionist approach of the aforementioned quantitative studies, research into induction in the 21st century has increasingly been undertaken by midwives and nurses with a growing emphasis on a 'whole woman' approach, consistent with the philosophies of these professions.

The qualitative approach focusses on "*aspects of human thinking, learning, knowing ...and ways of understanding*" (Kvale, 2009: 12). This is based on the epistemological view that the optimum way to understand the lived experience of a particular situation is through an in-depth exploration of the individual's perception of it and of the motivations that govern their actions (Henn et al., 2006; Mason, 2002). It is thus fitting for researchers seeking an holistic view of a situation in order to understand not simply what needs to be changed, but why. Such studies, however, tend to be localized and small-scale, which limits their generalizability to the wider population. The remainder of this section summarises and discusses the five qualitative studies published since 2000.

An Australian study consisting of phased interviews with 23 primiparous women booked for induction sought to explore the experiences of women undergoing induction for post-dates pregnancy. Two key dimensions to women's experiences were identified: firstly, a sense of being subjected to an externally-determined time-limit and secondly a "*shift in expectations*" from their original birth plan and the loss of a natural birth experience (Gatward, Simpson, Woodhart, & Stainton, 2007). A need for more meaningful information at the time induction was booked was noted, to enable women to manage their expectations when pregnancy progressed beyond term (Gatward et al., 2007). This latter theme reflects the findings of some earlier quantitative studies (Bramadat, 1994; Nuutila et al., 1999; Shetty et al., 2005).

Lack of information and a gap between women's expectations of induction and the lived reality was also noted in a Dublin-based study of nine primiparous women, interviewed shortly after giving birth (Murtagh & Folan, 2014). An unexpectedly passive attitude to induction was highlighted, marked by unquestioning deference to medical authority. Women's concerns for their baby's wellbeing were paramount and

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the investigators concluded that a physically good outcome often came at the expense of an emotionally positive birthing experience. In contrast, a contemporary Scottish study of similar size and methodology found that although some women experienced a “*loss of ideal*” (Gammie & Key, 2014, p.16) similar to that noted by Gatward et al (2007), women generally felt well informed and prepared for induction, citing midwives and information leaflets as effective information sources (Gammie & Key, 2014). However, the findings of this study were limited by lack of any consideration of women’s post-birth feelings. The timing of recruitment of participants (and by implication, of data collection) on admission to hospital, when women were perhaps at their most vulnerable, raises questions about the validity of these findings.

A contemporaneous study from the USA used grounded theory to explore influences on induction and women’s induction experiences (Moore, Kane-Low, Titler, Dalton, & Sampsel, 2014). A sample of 29 primiparous women scheduled for medical or elective induction were interviewed pre and post-birth (Moore et al., 2014). In common with the findings of Gatward et al (2007) and Murtagh & Folan (2014) a lack of prior discussion about induction was identified, leading to uninformed decision-making and a sense of unpreparedness. As in Gatward et al’s (2007) study, hospital protocol appeared to dominate, with induction being presented as a routine ‘check list’ procedure. However, many women were happy with the decision to be induced and in accordance with the findings of Murtagh & Folan (2014), placed great trust in their care providers (Moore et al., 2014).

On a divergent theme, Canadian researchers Westfall and Benoit (2004) interviewed 27 women purposively selected for their high sense of self-efficacy and general antipathy to the idea of induction. Data from pre and post-birth interviews highlighted a conflict between women’s desire to determine their own care and their need to comply with social expectations (Westfall & Benoit, 2004). The authors concluded that whilst these women did not regard prolonged pregnancy as a medical problem, they felt under pressure not to allow their pregnancy to progress beyond socially acceptable limits, highlighting the sense of isolation felt by those who challenged accepted norms. In order to avoid the perceived social stigma of medical induction, women adopted self-help measures to induce labour (Westfall & Benoit, 2004), a

phenomenon which, it is claimed, has become increasingly widespread in recent years as women seek more 'natural' and non-invasive means of stimulating the onset of labour (Hall et al., 2012a; Schaffir, 2002). This theme will be explored further at the end of this chapter.

Studies on antenatal interventions to inform women about induction

Various studies have commented in the ineffectiveness of standard antenatal education classes in preparing women for induction of labour. For example, Kitzinger (1975) and Nuutila et al (1999) commented on the surprising lack of preparedness among women who attended classes. Likewise, a large-scale US-wide survey found that the majority of mothers knew little about the complications of induction, including those who had experienced it. This was despite that fact that the majority of women, at some time, had attended antenatal classes (Lothian, 2007). Another US survey of 102 women at a group of prenatal clinics found that exposure to 'folk beliefs' about methods of inducing labour was widespread among women of every parity and social background, yet these were rarely discussed with health professionals (Schaffir, 2002).

A New Zealand study, comprising an open-ended questionnaire survey of 79 primiparous women, investigated the influences on women's decision-making in relation to induction (Austin & Benn, 2006). Only 38% of women had heard about induction from antenatal classes and one third of those recalled little about it (Austin & Benn, 2006). In particular, there was limited knowledge of the negative effects of induction. Clinicians' ways of giving information was a significant influencing factor in women's' decision to accept induction (Austin & Benn, 2006). This theme was taken up in an unpublished PhD thesis by Stevens (2010), in which it was hypothesized that *directive* communication (biased in favour of induction) would result in a greater uptake of induction for pregnancies over 41 weeks (Stevens, 2010). Although the study design used hypothetical scenarios rather than real situations, the hypothesis was proven, suggesting that communication style has a major influence on women's decision-making.

Little is known about the most effective means of informing women about induction. Two recent studies investigated the effects of antenatal interventions aimed to improve knowledge of induction and thereby foster informed decision-making. The first of these, conducted in the USA, aimed principally to explore why women opted for induction without medical reason (a practice rare in the UK). A short education session was incorporated into a series of antenatal classes for nulliparous women, concerning the relative risks and benefits of elective induction versus spontaneous labour (Simpson, Newman, & Chirino, 2010). Rates of elective induction were subsequently compared between women who had attended classes with a control group of non-attenders. Results showed a marked reduction in elective inductions among class attenders following the intervention (Simpson et al., 2010).

A quasi-experimental, controlled trial was conducted among a non-random sample of 50 Australian women of mixed parity (Cooper & Warland, 2011). Those in the intervention group were given a specially designed brochure explaining the induction process, including side-effects, risks and further interventions. Results showed that whilst women in the control group harboured unrealistic expectations of induction, amongst those in the intervention group, a statistically significant improvement in knowledge was noted (Cooper & Warland, 2011). It may be deduced from the findings of this and the work of Simpson et al (2010) that evidence-based information on the process and the relative risks of induction may positively influence women's knowledge of this intervention whilst simultaneously promoting realistic expectations and informed decision-making.

Summary and limitations of existing studies

Recurrent themes from the 26 reviewed studies centred on the need for improved information about induction, for more involvement with decision making, and the need to be able to manage women's expectations of childbirth when pregnancy extends beyond term. Women's acceptance of induction as part of routine care, fear for the safety of their babies and trust in professional opinion were frequent findings. Although some studies report a less favourable perception of induction compared to expectant management, others report induction as generally satisfactory. Evidence

is emerging to support the use of targeted information to improve informed decision-making on induction. From studies conducted in the UK, there is little to suggest that women's overall experiences of induction have improved significantly since Cartwright's seminal work in the 1970s.

Variations in the country of origin, the circumstances and the reasons for induction limit the drawing of reliable conclusions from this review. In the majority of earlier studies, reasons for induction were not distinguished and distinctions between primiparous and multiparous women were not always apparent. Since such factors may influence women's knowledge and perception of induction, the conclusion of some studies may be questionable. Despite similar standards and expectations of care in many European and commonwealth countries, the structure of maternity services is not identical to the UK, therefore generalisation across countries cannot automatically be assumed. There was no consistency in the timing of data collection, which ranged from 48 hours (Stewart, 1977) to eight months (Heimstad et al., 2007). As there appears to be no consensus of opinion on the optimal time to capture women's post-birth feelings, it is possible that different results may have been achieved had women been surveyed at an earlier or later date. This issue will be discussed in more depth in chapter 3.

The following sections will explore various questions arising from the literature review in relation to the factors which influence women's perception of induction and their ability to choose and make informed decisions. This will draw upon national guidelines, empirical studies, and practice articles identified by a wider search of the literature.

Perceptions of risk and decision-making in post-dates pregnancy

There are several pathological conditions for which induction may be recommended, based on an individualised assessment of the woman and fetus; these include diabetes, pregnancy-induced hypertension and pre-labour rupture of membranes. In these circumstances, the dangers of continuing the pregnancy are usually fairly clear and uncontroversial (Cheyne et al., 2012). However, around half of all inductions in

the UK are performed routinely to prevent prolonged pregnancy in otherwise uncomplicated pregnancies, which exposes women to the known risks of intervention (Cheyne et al., 2012; National Institute for Health and Clinical Excellence, 2008; Wickham, 2004). In order to make an informed decision, therefore, women need to be able to assess the relative risks of induction versus expectant management and the value they attribute to these risks (Cheyne et al., 2012).

The 2008 NICE guidelines claim “*strong evidence*” (p.26) of the increasing risk to mother and baby of pregnancy beyond 40 weeks, however the supporting evidence indicates that this risk is very small and increases very slowly up to 42 weeks. At 39 weeks the risk of neonatal death is cited as 5.3/1000 and as 6/1000 at 41 weeks (National Institute for Health and Clinical Excellence, 2008). The guidelines note no significant difference in rates of caesarean section between women who labour spontaneously and those who are induced, but advises that induction is associated with a labour that is more painful and less efficient, with a higher chance of interventions and instrumental birth (National Institute for Health and Clinical Excellence, 2008).

The NICE evidence update of 2013 cites new studies which show a positive association between induction at 41 weeks and reduced risk of caesarean section and neonatal morbidity (National Institute for Health and Care Excellence, 2013). However, some of the studies which informed the review were very old or conducted in countries with very different systems of care to European and Commonwealth countries: furthermore, a moderate risk of bias was present overall (Gulmezoglu et al., 2012). A more recent meta-analysis of 31 randomised clinical trials (RCTs) agreed with the association between induction and reduced risk of caesarean section, but found no significant differences in other outcomes compared to women who labour spontaneously (Wood, Cooper, & Rossa, 2013). However, inconsistency was noted between the indications for induction among trials. A retrospective cohort study of over one million women in Scotland over a 26 year period suggested that elective induction at term was associated with a reduced chance of perinatal death without any increase in caesarean section, but noted an increased risk of neonatal admission to special care baby units (Stock et al., 2012). In contrast, other large

database studies have found that induction for non-medical reasons at all gestations between 37 and 41+ weeks is associated with an increased risk of caesarean section and instrumental birth (Glantz, 2010; Grivell et al., 2011).

The practice of routine induction at 41 weeks has been described as “*an enormous scattergun approach [...] to prevent the loss of a very few babies*” (Wickham, 2004, p.8). This is illustrated by one of the main sources of evidence underpinning the NICE guidelines which cite a number needed to treat to benefit (NNTB) figure of 410, meaning that 410 inductions would be needed to prevent one neonatal death at term or post-term (Gulmezoglu et al., 2012). An even higher figure of 1040 was cited by Stock et al (Stock et al., 2012). This contrast may be explained by methodological differences (Cheyne et al., 2012) but suggests a lack of certainty in this area. What is certain, however, is that whether or not the evidence in favour of induction at 41+ weeks is wholly reliable, a great number of women are subjected to the risks and discomforts of induced labour when in all probability their baby would not have been harmed by allowing pregnancy to run its natural course. The question is how to ensure that women understand this so that they can make genuinely informed decisions about whether or not to accept induction.

Risk awareness

Little is known about exactly how women understand risk in the context of induction as few studies have specifically addressed this, but there is evidence in the literature to suggest that risk awareness is often limited and unbalanced. For example, Austin & Benn (2006)’s study found that risk perception focused largely on the risks to the baby of prolonged pregnancy rather than the risks of interventions associated with induction. Fear of potential harm to the baby has been found to be a key motivator in women’s decision to accept induction for post-dates pregnancy (Cheyne et al., 2012; Shetty et al., 2005; Wickham, 2014). However, it appears that the comparative risks of induction and expectant management are rarely made explicit to women, despite recommendations to this effect in the NICE guidelines (Cheyne et al., 2012; Shetty et al., 2005; Wickham, 2014). This may be an example of how professional groups ‘create’ fear as a means of maintaining control by failing to explain or contextualize

risk (Gigerenzer & Muir-Gray, 2011; MacKenzie-Bryers & van Teijlingen, 2010). The counter-argument to this, however, is that poor risk communication stems from a generally weak ability among clinicians to interpret and evaluate probability and risk (Cheyne et al., 2012; Gigerenzer & Muir-Gray, 2011). In some areas of care, such as the provision of antenatal screening tests for fetal abnormalities, midwives are trained to convey risk in an objective and unbiased manner which is meaningful to women. However, unlike most screening tests, induction is a procedure which carries risks to both woman and fetus, yet such risks are less clearly defined and may be contentious, giving scope for confusion and personal preference on the part of clinicians.

It is argued that a prevailing culture of emphasising collective rather than individual risks, as illustrated by the NNTB figures (see previous chapter) leads to a lack of appreciation that for individual women and their babies, the risks of continuing an uncomplicated pregnancy may be considerably higher or lower than statistics indicate (Edwards, 2008; Gigerenzer & Muir-Gray, 2011). However, at present there is no process for accurately assessing probability for every woman (Cheyne et al., 2012).

Whilst the risks of continuing a pregnancy in the presence of certain medical complications may be indisputable and easy to convey, the risks of continuing an uncomplicated, post-dates pregnancy are complex and contentious and therefore less easy to present in a meaningful fashion. Two intervention studies cited earlier in this chapter highlighted the positive association between the provision of balanced information about the risks and benefits of induction and women's ability to make informed decisions (Cooper & Warland, 2011; Simpson et al., 2010). More information is needed about how women receive and make sense of information about risk in relation to post-term pregnancy and induction and how they use this to inform their decision-making. This is an area which the current study aims to address.

Influences of the risk-averse society

It has been argued that a 'risk society' exists, whereby uninformed perceptions of risk lead to disproportionate fears of what might go wrong (Furedi, 2006). This leads to a low tolerance of risk which is manifested in the commonly-held belief that all pregnancies should result in a perfect child and that adverse outcomes are unacceptable (Klein, 2006; MacKenzie-Bryers & van Teijlingen, 2010; Rooks, 2006). Women are further enmeshed in this risk culture due to a felt moral imperative to do everything possible to avoid harm to the fetus: non-compliance with standard care is often viewed as selfish and irresponsible by peers as well as health professionals, leading to fears of recrimination (Furedi, 2006; Mitchell, 2010; Rooks, 2006; Shapiro et al., 1983; Thornton, Van den Borne, & de Bruijn, 1996). The general lack of differentiation between individual and collective risk may deter women from questioning medical interventions (Edwards, 2008; Gigerenzer & Muir-Gray, 2011; Sakala, 2006).

It may be argued that perceptions of risk are driven by the prevailing medical model of maternity care which views childbirth as essentially dangerous (Arney, 1982; MacKenzie-Bryers & van Teijlingen, 2010; Oakley, 1993) and by the dominance of clinical governance and risk-management in the NHS, which puts midwives and doctors under pressure to practice defensively, steering women away from all but the policy-sanctioned 'safe' options for care. This in turn may fuel a belief among women that their reproductive system is untrustworthy and requires medical intervention to function properly (Edwards, 2008; Mitchell, 2010; Oakley, 1993; Sakala, 2006; Wickham, 2004).

It has been suggested that as the average age of first childbirth increases, fertility problems rise and a higher premium is placed on healthy babies, driving women to become more risk-averse and thus more inclined to rely on medical opinion (Furedi, 2006; Rooks, 2006). Clinicians therefore need to develop a better understanding of the comparative risks of induction and expectant management in healthy, post-term pregnancies and better ways of communicating risk. However, Cheyne et al argue that merely providing women with balanced information will not improve decision-making (Cheyne et al., 2012). Women's concepts of risk are situated within a context of personal values, which include physical, emotional and social elements

(Department of Health, 1993; Edwards, 2008; Leap, 2009; Mitchell, 2010). From this standpoint, it may be assumed that women's perceptions of safety and what constitutes an acceptable risk may not always coincide with medically-accepted opinion. In such instances, women may feel under pressure to make decisions which go against their better judgement, leading perhaps to a sense of loss of control and dissatisfaction with their birthing experience. This highlights the need for a holistic decision-making culture within the health service, involving unbiased information-sharing and the exploration of options. However, information alone is not enough: an environment is needed in which women can feel empowered and supported even where their decisions do not coincide with standard practice.

The concept of risk perception in relation to induction has been only minimally explored to date, yet evidence suggests that it is a powerful driving force behind women's decision-making. This notion will therefore be used to inform the analysis of data in the current study and the discussion of findings, considering women's understanding of risk and the influence of this on their decision-making in relation to induction of labour.

Power relationships and decision-making

This section explores the literature on power relationships within the maternity services and how these may affect women's choices and decision-making in relation to induction. Philosophical concepts of power are extensively discussed and debated in the literature on healthcare and numerous models and definitions exist (Shapiro et al., 1983); however, as these take on different shades of meaning in different contexts (Fahy, 2002; Lukes, 2005) there is no single overarching definition. Two theories dominant within the literature on health care will be discussed here.

The first of these is Foucault's concept of disciplinary power, which is said to operate invisibly in most hierarchically structured organisations (Fahy, 2002). Fahy posits that in the maternity care setting, this is illustrated in a system whereby women are subtly led to believe that compliance (for example, accepting the offer of induction) leads to the 'reward' of a healthy baby, whilst dissent may result in the 'punishment' of a stillborn or sick baby (Fahy, 2002). By focusing on the remote possibility of

stillbirth, midwives and doctors have been accused of so-called 'shroud-waving' - instilling fear as a means of coercing women into complying with induction or other interventions (Skyrme, 2014). The effects of disciplinary power may be enhanced by limited understanding of risk among the non-medical population.

The notion of disciplinary power applies equally to the relationship between senior and junior staff, with subordination maintained by fear of criticism (Edwards, 2004; Fahy, 2002; Hollins-Martin & Bull, 2006). Midwives in particular are subject to ever-increasing surveillance in the form of supervision, audits and reflection (Bradbury-Jones, Sambrook, & Irvine, 2008) making it increasingly difficult to deviate from standard policies without fear of reprimand.

The second theory to be addressed here is that of Lukes' three dimensions of power. Like Foucault, Lukes theorises that power as a concept operates on different levels (Levy, 1999a; Lukes, 2005). Foucault's theories of power do not always present it as a repressive force, but one which is ethically neutral and necessary to maintain social function (Levy, 1999c), Lukes, however, dismisses this notion (Lukes, 2005). In Lukes' first dimension, power rests with dominant individuals and groups who are able to make decisions and policies which reflect their values rather than those of others lower down the hierarchy (Levy, 1999b; Lukes, 2005). This is evident in maternity care policies based on a doctor-led, medical model rather than a midwife-led, holistic model. In Lukes' second dimension, powerful individuals control the agenda of what may be discussed (Levy, 1999b; Lukes, 2005). This is illustrated in the midwife/woman encounter where the midwife acts as a gatekeeper to information. This may be done for benevolent reasons, such as to protect women from having to make distressing decisions, but nevertheless, tends to work in favour of the institution rather than the individual (Levy, 1999b). According to Foucault's theory, knowledge and power are intimately connected (Bradbury-Jones et al., 2008; Fahy, 2002) thus those who hold the intellectual capital occupy a position of power.

Lukes' third dimension theorises that subordinate groups are subtly coerced into accepting ways of working which may be against their best interests (Levy, 1999a, 1999c; Lukes, 2005; Shapiro et al., 1983). The subliminal nature of this form of power makes it difficult to recognise and therefore difficult to oppose, but is

exemplified in systemic practices inherent within the medical model of childbirth (Levy, 1999c; Shapiro et al., 1983). Routine induction of labour at 41+ weeks may be seen as example of Lukes' third dimension of power in action: whilst there is evidence that collectively it reduces risk of neonatal death, the risk to the individual is small, whereas risks of morbidity due to induction are relatively high (Cheyne et al., 2012), however, there is a widespread understanding that because an intervention (such as induction) is standard practice, it must be for the best (Hodnett et al., 1997; Sakala, 2006). Lukes' theory of three-dimensional power provides a framework for understanding the pervasive and persuasive power of the obstetric institution and why it is so difficult to challenge.

Recurring themes from previous studies of women's experiences of induction may be interpreted in the light of Lukes' theories of institutional power. Overt power of the institution over the individual may be exemplified in the 'routinisation' of induction for post-dates pregnancy and the domination of hospital protocol (Gatward et al., 2007; Moore et al., 2014) whilst more subtle examples may be identified by the call for more information and involvement in decision-making (Cartwright, 1979; Gatward et al., 2007; Murtagh & Folan, 2014; Nuutila et al., 1999; Shetty et al., 2005). This may imply that the information agenda is controlled by those in a position of influence, thereby limiting the power of women to make autonomous decisions. It is perhaps ironic, in this context, that much of the current knowledge about women's experiences of induction has been acquired through methods such as questionnaire-based surveys, using an agenda set by the investigators. Such methods arguably disempower women by limiting their responses and denying them the opportunities to express what is important to them. The current study aimed to go some way towards addressing this deficit, by encouraging women to express their views without restriction. The findings will be analysed and interpreted from the conceptual framework of informed choice and in relation to theories of power and their influence on decision-making.

Woman-centred care

The Changing Childbirth report (Department of Health, 1993) sought to empower women to make informed choices in maternity care and this notion has underpinned the ensuing discourse in subsequent years (Department of Health, 2004b, 2007a, 2007b, 2007c, 2008). Concepts of empowerment are much discussed in the literature, but most theories tend to agree that power can (and should) be devolved to individuals enabling them to exercise autonomy and control over their own health needs (Cooper & Lavender, 2013; Levy, 1999c). According to Leap, empowerment is best achieved when care is tailored to the needs of the individual: so-called woman-centred care (Leap, 2009). The concept of woman-centred care originates from the feminist movement of the 1970s and situates women within their family and social context, centring on the importance of empowering women to achieve self-determination, involvement in and control over their care and to make informed, autonomous decisions (Fahy, 2012; Foureur, Brodie, & Homer, 2009; Leap, 2009; Sandall, Devane, Soltani, Hatem, & Gates, 2010). Evidence suggests that when fully implemented, the result is increased satisfaction with maternity care, reduced interventions in childbirth and reduced morbidity (Foureur et al., 2009; Johnson, Stewart, Langdon, Kelly, & Yong, 2003; Sandall et al., 2010).

As with informed choice, the notion of woman-centred care is deeply embedded in current discourse on childbirth, yet is similarly subject to speculation as to whether or not it is little more than empty rhetoric. To deliver woman-centred care, midwives require the time and opportunity to explore and discuss women's needs, which non-holistic patterns of maternity care rarely provide (Kirkham & Stapleton, 2004). In relation to induction, not only do midwives need time, but also understanding of risk and the ability to communicate this in an unbiased manner, which in turn requires a working culture which supports midwives to support women to make autonomous, informed decisions, even those not endorsed by hospital policy (Skyrme, 2014). To empower women, therefore, midwives themselves need to work within a system that empowers them (Hollins-Martin & Bull, 2006).

Information, choice and decision-making

Key factors underpinning the notion of woman-centred care are the promotion of informed choice and autonomous decision-making. This section explores what is currently known about this in relation to induction of labour and how this compares to the findings of other studies in the field of maternity care.

Information

Cartwright's seminal work on women's experiences of induction probably remains the most comprehensive of this type. Conducted among over 2,000 women who gave birth in 1975, the study found that around 40% would have liked more information about the process (Cartwright, 1977). This echoed the findings of earlier studies by Lewis et al (1975) and Kitzinger (1975) and a contemporaneous study by Stewart (1977), which found that approximately one third of women surveyed lacked information at the time of induction. In Cartwright's study, three fifths of women had not discussed induction with a health professional and only two fifths felt they had received adequate information (Cartwright, 1979). A correlation existed between information needs and women's overall evaluation of labour, with those who described their induction as "*a pleasurable experience*" being less likely to perceive a lack of information in retrospect (Cartwright, 1979, p.101). Despite some shortcomings in distinguishing between induced and accelerated labours, Cartwright's work remains a yardstick against which more recent evidence can be measured. It was therefore disappointing that 30 years later, a pre-induction questionnaire based survey found that 34.7% of women whose labours were induced perceived information to be lacking (Shetty et al., 2005). This represents barely any improvement since the 1970s and is reflected in the outcomes of various overseas studies (Austin & Benn, 2006; Lothian, 2007; Nuutila et al., 1999).

In Shetty et al's pre-induction questionnaire, 50% of women cited a midwife as the key source of information, whilst data from the post-induction questionnaire showed a figure of 82%. This is perhaps not surprising, since women would have had considerably more contact with midwives during their hospital stay. This contrasts with the findings of Cartwright (1979) who found that only 26% of women had

discussed induction with their midwife, with books cited at the most common source of information. In Shetty's et al's study there was a noted disparity between expectations of induction and actual experiences of it, particularly in terms of duration, pain and medical interventions (Shetty et al., 2005). The authors concluded that women needed improved information to counter unrealistic expectations. More recent, smaller studies have highlighted the importance of meaningful information in preparing women for the realities of induction (Austin & Benn, 2006; Gatward et al., 2007).

Good quality written information and decision aids are thought to have an important role in promoting informed choice and realistic expectations of health care (Cooper & Warland, 2011; Gigerenzer & Muir-Gray, 2011; O'Cathain, Walters, Nicholl, Thomas, & Kirkham, 2002b; Stapleton et al., 2002). A recent Australian study found that information leaflets given at the time induction was booked enhanced women's knowledge and increased realistic expectations (Cooper & Warland, 2011). In contrast, a large Department of Health funded study evaluating the effects of MIDIRS *Informed Choice* leaflets on promoting informed choice in maternity care (Kirkham & Stapleton, 2001; O'Cathain et al., 2002b) found that these made no difference to women's sense of having exercised informed choice. Suggested reasons for this include the manner in which the leaflets, which covered a range of topics, were presented; often at inappropriate times during pregnancy, hidden amongst other notes and without explanation or discussion (Stapleton, Kirkham, Curtis, & Thomas, 2002a).

Women and clinicians may have different agendas in relation to information and there is evidence that women may consciously avoid or defer receiving information which threatens their own sense of wellbeing or which is not perceived as relevant at the time (Levy, 1999d). This may partly explain the positive effects of timely information, as found by Cooper and Warland (2011) in contrast to the negative findings of Stapleton et al (2002a).

The importance of the midwife/women interaction is paramount to the successful transfer of information and promotion of choice (Hindely & Thomson, 2005; Hollins Martin, 2007; Johnson et al., 2003; Jomeen, 2007; Levy, 1999d). Stapleton et al's

study highlighted ways in which midwives erected barriers to conversation and discussion: this was typically conveyed by body language indicative of 'busyness' and by limiting eye contact (Stapleton et al., 2002a; Stapleton, Kirkham, Curtis, & Thomas, 2002c; Stapleton, Kirkham, Thomas, & Curtis, 2002b). Not surprisingly, women spoke of their reluctance to 'trouble' the midwife for information: only when a relationship of trust had developed were women likely to initiate discussions (Stapleton et al., 2002c). Where information was given, this was often unbalanced and risk-focussed (Stapleton et al., 2002b). The findings of this study concur with learned opinion which suggests that the combined pressures of time, fear of litigation and the medically-driven agenda militate against full and unbiased discussion of information, limiting choice and manipulating women towards compliance with normative practices (Howes, 2004; Pincus, 2006; Rooks, 2006; Simkin, 2006; Skyrme, 2014; Stapleton et al., 2002a; Stapleton et al., 2002c; Stapleton et al., 2002; Stapleton et al., 2002b).

Induction and choice

There is evidence that many women welcome the offer of induction for post-dates pregnancy for a variety of reasons: these include physical discomfort (Knight, 2008; Moore et al., 2014; Shetty et al., 2005), being tired of pregnancy (Gammie & Key, 2014; Knight, 2008; Moore et al., 2014; Roberts & Young, 1991; Shetty et al., 2005; Stewart, 1977), concern for the baby's wellbeing (Heimstad et al., 2007; Moore et al., 2014; Murtagh & Folan, 2014; Roberts & Young, 1991) and the need to fit in with family arrangements (Homer & Davis, 1999; Knight, 2008; Roberts & Young, 1991). Women in the UK are not usually offered the choice to 'opt in' to induction: this is reserved for those who meet certain medical criteria or whose pregnancies go beyond 41 weeks. For those not happy to be induced, little is known about what influences their decision to accept this intervention, but from Cartwright's study onwards, women have highlighted a need for more choice and involvement in decision-making (Bramadat, 1994; Cartwright, 1979; Moore et al., 2014; Shetty et al., 2005).

The current philosophy of maternity care appears to reject the paternalistic, medicalised philosophy characteristic of the service in the 20th Century. Instead, the rise in consumerism (Clarke, 2004) has promoted the notion of women as service-users rather than patients (Department of Health, 2004b, 2007a, 2007b) and this is reflected in the language of maternity care, implying a new power differential driven by the ability to make choices and exercise control. The NICE guidelines on induction of labour enshrine this:

Women who are having or being offered induction of labour should have the opportunity to make informed decisions about their care and treatment, in partnership with their healthcare professionals (National Institute for Health and Clinical Excellence, 2008, p.4)

The NHS choice agenda, however, is limited by what is sanctioned by the bodies which inform clinical practice. For most interventions, including induction, the choice is one-directional: women can opt out but not in (Knight, 2008; National Institute for Health and Clinical Excellence, 2008; Royal College of Obstetrics and Gynaecology, 2008) therefore any discussion of choice in relation to induction implies the choice to refuse or accept the intervention, but not to request it. To date, no studies have identified the proportion of women refusing the offer of induction. Pertinent to the present study is the question of how women make choices in relation to induction and what informs such decisions.

Concepts of informed choice and barriers to choice

Informed choice is a complex concept that has been defined in numerous ways, yet remains contentious. The concept of choice stems from the social, as opposed to the medical model of care, placing the emphasis on the client rather than the professional (Kirkham, 2004b). Since the Changing Childbirth report of 1993, the term 'informed choice' has been widely adopted by maternity care policies at local

and national levels and the rhetoric is widely espoused throughout the hierarchy of health professionals. There exists no overarching definition of informed choice; however, Dormandy, Hooper, Michie and Marteau (2002, p.109) developed the following description:

An informed choice is one that is based on relevant knowledge, consistent with the decision maker's values and behaviourally implemented (Dormandy, Hooper, Michie, & Marteau, 2002)

The significance of this definition is that it moves beyond simply giving information and acknowledges the importance of the chooser's personal beliefs (Nolan, 2009). Other definitions found in the literature on health are generally consistent with this, recognising the importance of supportive health professionals in promoting autonomous decision making (Ahmed, Bryant, & Cole, 2013).

Concepts of informed choice have been investigated largely from the perspective of health professionals rather than clients or patients and are generally context-specific. In Stapleton & Kirkham's study of the use of MIDIRS *Informed Choice* leaflets, participants were invited to describe their understanding of the term. Responses from doctors and midwives were varied and included the controversial view that the onus was on women to request choice rather than on the clinician to offer it. Some clinicians regarded choice only in the context of opposing standard care, whilst others expressed the opinion that informed choice was a misnomer, given the lack of available options at local level (Stapleton, 2004).

Wiggins and Newburn (2004), also investigating the use of MIDIRS *Informed Choice* leaflets, conceptualised the key elements of informed choice as encompassing full involvement in decision-making, awareness of available alternatives and reliable, unbiased information (Wiggins & Newburn, 2004). However, in order to give reliable information on which to base informed choice, clinicians must have the competence to evaluate the risks and benefits of different options and to convey these meaningfully to their clients (Green & Spiby, 2009). In the absence of this

understanding, unintentional bias may be expressed, thus obstructing informed choice.

In a different context, Ahmed et al (2013) investigated midwives' perceptions of their role in facilitating informed choice in relation to antenatal screening. In that study, midwives understood the concept of informed choice to be based on non-directive information and support, but identified frequent barriers to implementing this including the lack of time to make considered decisions and the lack of a structured approach to giving information (Ahmed et al., 2013). This study adds to the growing body of research which illustrates the current tension between the rhetoric of informed choice and the practices which impede its implementation.

The Changing Childbirth report (Department of Health, 1993) was welcomed by many who believed it to be the start of a new era of maternity care, introducing a culture of choice and partnership between service-users and clinicians. However, despite the growing discourse on informed choice in recent years, it has been argued that little has actually changed in the culture and structure of maternity care, which remains largely bound in a hierarchical and technocratic mode (Mander & Melender, 2009; McCourt, 2006; Page & Penn, 2000). Edwards (2004) suggests that choice is determined by the intersection of ideology and available resources (Edwards, 2004): it therefore follows that lack of resources, as evidenced by progressive cutbacks in NHS spending and shortages of staff in maternity units and in the community results in limited options for women. This is reflected in reduced contact time between women and midwives and reduced continuity of carer leading to a lack of opportunities for midwives and women to build a relationship of trust (Edwards, 2004; McCourt, 2006; Page & Penn, 2000). Under such circumstances, midwives are unlikely to be able to fully ascertain women's emotional, social and psychological needs and thereby provide individualised care plans. Arguments that midwives lead women towards compliance with 'routine' patterns of care are therefore not surprising: the structure of care provision in maternity units may leave them with little choice.

Jomeen (2007) observes that although choice has been emphasised in government reports over the past 20 years, to the point where 'informed choice' has become

something of a mantra in NHS policies at both local and national level, choice is not equitable. Women of lower socio-economic status in particular are disenfranchised through poverty, restricted access to sources of information and stereotyping by clinicians who may withhold information from those deemed unlikely to benefit from it or to make the 'right' choice (Jomeen, 2007). This supports Stapleton's observations on inequality of choice, arguing that it is open only to those women who are able to communicate their needs and understand their options (Stapleton, 2004). Where midwives place little value on the empowerment of women, informed choice is unlikely to be supported.

Studies on power and powerlessness in nursing and midwifery have identified multiple complex processes which maintain the subordination of junior staff to those perceived as more powerful (Bradbury-Jones et al., 2008; Hollins-Martin & Bull, 2006). It is no surprise, therefore, that in systems of maternity care built around the technocratic model and primarily led by obstetricians, midwives may find themselves conforming to the expectations of the institution and providing women with only officially sanctioned information and options for care. To facilitate and support fully informed choices under these circumstances would challenge authority, thereby exposing midwives to criticism and sanctions (Anderson, 2002). In such circumstances, therefore, it may be argued that the interests of the institution override those of the service-users and inhibit free choice. (Kirkham, 2004b).

The discourse on informed choice has, in theory, underpinned UK maternity and obstetric policy at both national and local level for many years and is enshrined in the NICE guidelines on Induction of labour (National Institute for Health and Care Excellence, 2013; National Institute for Health and Clinical Excellence, 2008). However, the term 'informed choice' has become something of a cliché in midwifery circles in the past two decades and many have argued that it is expressed more strongly in rhetoric than reality. This conflict between the ideal and actuality has been thoroughly argued by Kirkham (Kirkham, 2004a) and echoed by more recent authors such as Ahmed et al (2013), Jomeen (2007) and Skyrme (2014). However, since Cartwright's seminal study in the mid-1970s, there has been a dearth of investigation into issues of informed choice in relation to induction of labour. Gammie & Key (2014) touched upon this, but not in any great depth or breadth. The current

study aims to address this deficit, hence the decision to use the notion of informed choice and decision-making as a conceptual framework from which to explore women's experience of induction and a theoretical lens through which to analyse the data.

Influences on women's choices during pregnancy

Numerous intrinsic and extrinsic factors affect women's capacity to make informed choices: the former include women's intellectual capacity, communication skills, assertiveness, ability to access information and the value they and their families place on the subject in question. Among multiparous women, the embodied evidence from previous childbearing experiences also has a significant influence on decision making in subsequent pregnancies (Stapleton, 2004) Extrinsic factors include the influence of family members and significant others, as well as perceptions of societal norms (Green & Baston, 2007; Rooks, 2006; Sakala, 2006; Skyrme, 2014). It has been argued that Induction of labour for post-dates pregnancy has now acquired normative status in the UK and therefore is rarely questioned (Heimstad et al., 2007; O'Cathain, Thomas, Walters, Nicholl, & Kirkham, 2002a; Skyrme, 2014). Moreover, societal pressures impose a moral imperative on women not to take risks in pregnancy for fear of being labelled irresponsible, thus encouraging compliance with the presumed safe option of normative care patterns (Furedi, 2006; Mitchell, 2010; Rooks, 2006; Shapiro et al., 1983; Thornton et al., 1996).

Chief amongst those who influence women's decisions are midwives, through their power to supply, limit and control information (Austin & Benn, 2006; Hindely & Thomson, 2005; Hollins-Martin & Bull, 2006; Johanson, Burr, & Leighton, 2000; Jomeen, 2007; Levy, 1999d; Mander & Melender, 2009). Levy's grounded theory study of midwives engaged in antenatal care identified a process of 'protective steering' whereby midwives used a number of different techniques in order to guide women through the dilemmas of choice (Levy, 2004). By prioritising and selecting the release of information according to their understanding of women's needs, midwives steered women towards making the choices which they (the midwives) believed to be the safest and most aesthetically desirable. This was largely done for

altruistic reasons, but also to safeguard the midwives' own professional territory and credibility (Levy, 2004).

Stapleton's study found that women's inherent faith in midwives ensured that any care offered or options advised were almost invariably accepted unquestioningly: indeed Stapleton argues that the very act of offering a form of treatment was interpreted as a recommendation to accept it, which undermined the notion of autonomous choice (Stapleton, 2004). Both Levy (2004) and Stapleton identified how midwives' communication patterns shaped women's concepts of what constituted normative or safe care pathways, thereby steering women towards choosing the approved option. Stapleton (2004) noted how midwives used their power to positively or negatively weight evidence-based information in order to guide women's decisions. This was further demonstrated in McCourt's work on communication in antenatal booking clinics, where long-established screening practices were treated as routine rather than as options and were presented as the 'normal' choice to make (McCourt, 2006).

The examples in this section illustrate how, despite the current discourse on informed choice in maternity care, this is expressed more in rhetoric than in practice with many midwives and doctors systematically steering women towards what Stapleton et al (2002) termed "*informed compliance*" (Stapleton et al., 2002, p.5)

Organisational influences on choice

Mavis Kirkham's comprehensive work on informed choice in maternity care examines the issue from the perspective of differing studies in this field (Kirkham, 2004a). Kirkham attributes the discrepancy between rhetoric and reality to the prevailing culture within maternity services in the UK, which, she argues, militates against the promotion of informed decision-making, especially in large, consultant-led maternity units.

Kirkham's argument supports earlier theories that hierarchical power structures within maternity care define the available choices and create an atmosphere that subordinates midwives into colluding with obstetrically led policies (Kirkham, 2004b;

Levy, 1999a; Stapleton, 2004). This also concurs with Anderson's (2002) argument that there exists a clear sense of right and wrong choices in maternity care, with women invariably steered towards the 'right' decision as defined by medical authority rather than in accordance with their holistic needs (Anderson, 2002).

Kirkham argues that: "*Occasions for choice are defined by the service*" (Kirkham & Stapleton, 2004, p.267). However, Kirkham postulates that the problem lies not with individuals within that service, but with the structure of the organisation. In recent years maternity services have become increasingly centralised within large, obstetric-led units where care becomes fragmented and lacks the continuity and trust typical of smaller, local midwifery-led units. Standard patterns of care become entrenched as rules and policies to the detriment of individualised care.

Centralisation leads to packages of care based on routine and limited opportunities for women and midwives to meet. Faced with an increasing workload and dwindling resources, routine becomes a coping mechanism for staff (Kirkham, 2004b).

Pressure of time and the requirement to work through a set agenda further limits opportunities for discussion and encourages midwives to steer women towards compliance with normative care patterns rather than exploring other options. As Kirkham (2004b) argues, midwives are torn between the needs of the institution for order and routine and the diverse needs of individual women. The superior power of the former has the greater influence and leads midwives to adopt the rhetoric of informed choice whilst actually steering women towards the 'right' choice as determined by the organisation (Kirkham, 2004b).

Choice may be further restricted by the dominance of clinical governance and risk-management in the NHS (Kirkham, 2004a). Underlying the notion of choice is the uncomfortable fact that maternity service providers are financially constrained (O'Sullivan & Tyler, 2007). Fear of litigation drives care providers towards patterns of care with the lowest risk of generating legal action which might result in substantial pay-outs (Austin & Benn, 2006; Gigerenzer & Muir-Gray, 2011; Kirkham, 2004b; MacKenzie-Bryers & van Teijlingen, 2010). Large bureaucratic organisations abhor risk (Furedi, 2006), thus pressure to minimise risk becomes all-pervasive.

Boundaries of acceptable risk set by senior personnel thereby limit the options available to women and discourage midwives from pushing the boundaries to

support women through fear of reprimand should harm occur as a result of women making a 'wrong' choice. The outcome of this is that by focusing on risks to the unborn baby, especially without contextualising such risks, women perceive their options to be limited and are systematically encouraged to place their trust in the establishment rather than in their own bodies, thus perpetuating the power of the organisation over the individual (Gigerenzer & Muir-Gray, 2011; MacKenzie-Bryers & van Teijlingen, 2010).

In relation to induction for uncomplicated, post-dates pregnancy, it may be surmised from the above-mentioned arguments and from the findings of studies into women's experiences of induction that women are being systematically guided by clinical staff into routinely accepting induction as part of the 'package' of maternity care. Where risk cannot be individualised and where opportunities for sharing and discussing information are lacking, institutional pressures are likely to prevail. In recent years, challenges have been launched against the ubiquitous presentation of induction for post-dates pregnancy as part of 'routine' care, arguing that this is leading to it becoming normalised, despite being a major intervention carrying risks in its own right (Howes, 2004; Skyrme, 2014; Wickham, 2012). However, as there is little research-based evidence about women's current attitudes to and beliefs about induction, further investigation is needed to uncover and explore the factors which influence women to accept it. This study aims to take up this challenge.

What choice means to women

Despite the high premium currently placed on notions of choice in maternity care, a clear relationship between informed choice and satisfaction with the birth experience is not always apparent (Clarke, Newman, Westmarland, & Smith, 2004; Jewell, Sharp, Sanders, & Peters, 2000; Jomeen, 2007). Jomeen (2007) concluded that the physical and psychological outcomes of pregnancy and birth were unaffected by the choices women made, whilst a recent study of women's experiences of induction for post-dates pregnancy found that having a healthy baby was perceived as more important than either informed choice or a positive birth experience (Murtagh &

Folan, 2014). It may be posited therefore that women's understanding of the meaning of choice differs between individuals, being dependent upon the value they place on the outcomes and issues relating to it.

Choice may be an active or passive process: for some women, too much responsibility for decision-making may have negative outcomes similar to those of insufficient choice (Green et al., 1998; Weaver, 1998). In such cases, women may opt to delegate choice to health professionals (Green & Baston, 2003; Jomeen, 2007). Cartwright's study revealed a social gradient, with women in the lowest socio-economic groups preferring to delegate decision-making to doctors (Cartwright, 1979) although a later study of women's expectations of childbirth refuted this (Green et al., 1998). O'Cathain et al (2002a) found that women who were able to delegate choice to health professionals were, paradoxically, more likely to feel that they had made an informed choice (O'Cathain et al., 2002a). This raises questions about whether or not care providers recognise that informed decisions may be active or passive; whether they appreciate the potential harm of forcing passive choosers to make active decisions and how clinicians can empower women to make or to delegate decisions according to their needs and wishes.

Choice and Control

The literature makes frequent reference to the association between choice and a sense of control during childbirth. Walker, Hall and Thomas (1995) identify control as the balance between having support when required but being able relinquish it when desired (Walker, Hall, & Thomas, 1995), therefore the act of delegating decision-making to trusted others may be seen as a deliberate means of taking control (Green, 1999; Green et al., 1998; Murtagh & Folan, 2014).

Namey and Lyerly (2010) identified five key domains of control which include the ability to make choices and to access and use information. The importance of this was illustrated by the Great Expectations study, one of the findings of which was that lack of information and involvement in decision-making led to loss of control (Green et al., 1998). This was further developed in Green and Baston's study, which

identified key indicators of personal control as the ability to participate in decision-making (Green & Baston, 2003).

A loss of control has been associated with a negative birth experience (Arney, 1982; Namey & Lyerly, 2010; O'Hare & Fallon, 2011; Oakley, 1980) and this has been applied to induction, particularly among first-time mothers (Fleissig, 1991; Jacoby, 1987; Jacoby & Cartwright A, 1990). There is evidence that a supportive relationship with the midwife may be crucial to a woman's sense of control during pregnancy and childbirth (Green et al., 1998; Kjaergaard, Foldgast, & Dykes, 2007; Mander, 1992; Westfall & Benoit, 2004). This underlines the need for a system of care which supports and enables midwives to build trusting relationships with women to empower them to exercise choice and control in the manner best suited to their needs.

Women's use of self-help methods to avoid medical induction

It has been theorised that some women exercise covert control by outwardly conforming to conventional patterns of care whilst adopting self-help measures in the form of complementary and alternative medicine (CAM) (Adams et al., 2009; Gatward et al., 2007; Hall, Griffiths, & McKenna, 2011; Levy, 1999d; Schaffir, 2002). The term CAM is often used to cover all forms of non-medical therapies which may be of a physical, psychological or spiritual nature.

Many researchers and authors refer to the sense of empowerment generated by use of self-help methods, enabling women to exercise choice and control over their wellbeing and to lessen their dependence on health professionals (Hall et al., 2011; Hall, McKenna, & Griffiths, 2012b; Mitchell, 2010). Although there is little evidence about the clinical effectiveness of many forms of CAM, the psychological benefits may be a key factor in their continuing popularity. It has been reported that alternative therapies promote self-awareness and enable women to play an active role in maintaining their health, resulting in a better childbirth experience (Adams et al., 2009; Calvert & Steen, 2007; Hall et al., 2012b). This is exemplified in Calvert and Steen's study of homoeopathy, where the knowledge that they had a tool at their

disposal and under their control, reduced women's feelings of helplessness (Steen & Calvert, 2007). Studies of self-help methods and health locus of control (HLOC) found a positive association between their use and an internal HLOC, suggesting that either the methods themselves are empowering, or that those who use them are more empowered than those who eschew them (McFadden, Hernandez, & Ito, 2010; Sasagawa, Martzen, Kelleher, & Wenner, 2008)

Induction of labour, or more precisely, a desire to prevent prolonged pregnancy leading to medical induction is one of the common indications for use of self-help methods (Hall et al., 2012b). Schaffir's survey of 102 women at a group of antenatal clinics in the USA about their exposure to 'folk beliefs' regarding means of inducing labour, indicated that this was widespread among women of every parity and social background, yet rarely discussed with health professionals (Schaffir, 2002). Few of the remedies had any scientific basis, a point also noted in a comprehensive literature review by Hall et al (2012a). A more recent survey of US women found that nearly 30% used some form of self-help measures to initiate labour, but there is no clear evidence on whether or not these were successful (Kozhimannil, Johnson, Attanasio, Gjerdingen, & McGovern, 2013). In contrast, Austin and Benn's (2006) study of 79 women from a single New Zealand hospital found that 66% of women had one or more method, covering a wide range of ingested substances and physical activities. As all participants had labour medically induced, it is assumed that none of the self-help methods was successful. A broad spectrum of self-help methods for induction of labour exists, ranging from simple dietary supplements to therapies inspired by oriental medicine.

The NICE (2008) guidelines address the matter of non-pharmacological measures for induction of labour only insofar as to advise professionals against the recommendation of those which lack supporting evidence for either their effectiveness or harm: these methods are; herbal supplements, acupuncture, homoeopathy, castor oil, hot baths, enemas and sexual intercourse (National Institute for Health and Clinical Excellence, 2008). No guidance is offered on other methods, but as the exact number of self-help methods is unknown, comprehensive guidance is unlikely to be achievable. More recent sources of evidence generally

support the recommendations of NICE, although some suggest that acupuncture and raspberry leaf may, in fact, be beneficial (Hall et al., 2012a).

There are likely to be numerous reasons why women choose to use self-help methods to avoid medical induction. This may reflect an underlying distrust of medical intervention, a fear of harm or an attempt to re-claim the natural birth they had originally hoped for (Hall et al., 2012a; Mitchell, 2010; Schaffir, 2002). In some circles, a sense of social obligation may drive women to seek alternative methods to induction (Westfall & Benoit, 2004).

Various studies have shown that many pregnant women do not disclose the use of self-help methods to their midwives (Adams et al., 2009; Hall et al., 2011; Schaffir, 2002; Tiran, 2006). This may reflect a mistaken belief that all forms of CAM are safe; alternatively, women may choose not to disclose their practice for fear of attracting criticism (Hall et al., 2011; Tiran, 2006). Mitchell (2010) cites evidence of pregnant women reporting undercurrents of disapproval when alternative therapies were disclosed.

The NMC Code requires midwives to ensure that any complementary medicine is safe and in the best interest of the woman (Nursing and Midwifery Council, 2008). It is argued that some midwives suggest alternatives to conventional medicine without a full understanding of the risks and benefits, thus exposing themselves to accusations of negligence should any harm be caused (Cant, Watts, & Ruston, 2011; Hall et al., 2012b; Tiran, 2006). There have been calls for better education for midwives in this field (Kozhimannil et al., 2013; Tiran, 2006).

The research question

The preceding review of the literature has revealed that despite numerous quantitative studies on women's experiences of induction, there is very limited qualitative research in this field. Large-scale studies have limited the emergence of knowledge to that which falls within the defined parameters of closed- questions surveys; hence the findings reflect only those issues identified as pertinent by care-

providers. There is no scope within these studies for women to voice matters of individual importance or concern to them.

Factors integral to women's experience of induction include perceptions of risk, empowerment, choice and involvement in decision-making. The literature on these topics is extensive and comprehensive, but little of it relates directly to induction of labour. Despite a few small-scale studies in recent years, little is known about the experience of induction from women's own perspectives, especially how attitudes to induction are formed and re-formed, how information is acquired to make choices and decisions and perhaps most significantly, how women's expectations of induction compare to the lived experience. Verbal evidence from local NHS trusts suggests that the gulf between expectations and experiences is a growing source of dissatisfaction and complaints. In addition, there is almost no information about specialist pre-induction classes (where these exist) and the impact of these on women's subsequent experience of induction.

From the 1970s onwards there has been a drive from governmental and professional bodies to promote informed choice and woman-centred care (Department of Health, 1993, 2007a, 2007b, 2008; Department of Health and Social Security, 1977; National Collaborating Centre for Women's and Children's Health, 2008; Nursing and Midwifery Council, 2008); however existing research suggests that in relation to induction of labour, these ideas are not being fully met and further research into women's experiences of induction has been called for (Gulmezoglu et al., 2012; National Institute for Health and Clinical Excellence, 2008).

In view of the lack of current, qualitative (and high quality) evidence, especially from UK sources, the research questions for this study have been designed to explore the overall phenomenon of induction from the perspective of women who have recently experienced it. The over-arching question is: **Women's experiences of induction of labour: how do they acquire and use information to make decisions and what impact does this have on their experience of childbirth and early parenthood?** This is then broken down into the following specific questions:

- How do women expecting their first baby acquire knowledge about labour induction?

- How does this knowledge impact on their decision making about induction?
- How do women's decisions about induction affect their subsequent experience of labour, birthing and early parenthood?
- How does antenatal preparation for labour induction (in the form of a specialist pre-induction education class) affect women's experience and perception of induction?

Summary of chapter two

This chapter has explored, presented and critically discussed the existing studies on women's experiences of induction and the key themes which link them. Each of these has been explored in relation to the theoretical framework of informed choice and decision-making. Recurrent themes identified from the literature review include the need for more information for women faced with induction, for better understanding of risk and for more involvement in decision-making. Evidence suggests, however, that this is impeded by the current patterns of maternity care and power differentials between women and care-givers. Justification for the chosen research questions has been demonstrated.

3. Methodology

Introduction

This chapter explains how the study was designed and discusses the overarching philosophical stance which helped shape the methodological approach and research questions. Strategies of data collection are explained and discussed, with particular reference to the ethical challenges of conducting research whilst holding multiple roles and the effects of this on the participant/researcher relationship. Finally, the process of data collection, analysis and interpretation are described, demonstrating how academic rigour was maintained. Throughout this thesis real names are replaced with pseudonyms, which do not necessarily bear any relation to the actual name, the nationality or any other characteristic of the participant.

Design and methodology

Research textbooks are not always consistent in their use of terminology: in particular, the terms *design*, *methodology*, *approach* and *paradigm* are sometimes used interchangeably, which is confusing to the research student. I have chosen to adopt Henn et al's (2006) definition of research design as '*the plan or strategy of shaping the research*' (p. 49) which I interpret as an over-arching plan encompassing the paradigm, conceptual framework, approach and methods. Rather than use (or misuse) the term methodology, I prefer Savin-Baden and Howell-Major's (2013) term **research approach** which they define as '*the particular kind of qualitative research study undertaken, such as ethnography or phenomenology*' (p. 40). To avoid confusion, I have also adopt Savin-Baden and Howell-Major's (2013) definition of methods as the processes undertaken to obtain data.

Design

Identifying the researcher's philosophical stance is the first step in designing a research project and should be compatible with the researcher's ideas of the world and the nature of knowledge (Mason, 2002; Savin-Baden & Howell-Major, 2013). My

own philosophical stance adopts the ontological view that reality is subjective and defined by the individual, and the epistemological view that knowledge stems from the experiences of individuals and that the optimum means of discovering how individuals understand their life world is through an in-depth exploration of personal experiences (Henn et al., 2006; Mason, 2002; O'Leary, 2010; Silverman, 2010). Applying this philosophical stance to the question of women's experiences of induction logically pointed me to a qualitative rather than quantitative study design.

From reading the literature on qualitative methodology, it appears that the thought processes involved in designing research are not necessarily sequential. Models of research design tend to be depicted in linear fashion, starting by defining a philosophical stance, through identifying subject area, defining research questions leading to data gathering methods and analytical frameworks (e.g. Mason, 2002; Savin-Baden & Howell, 2013). However, Mason (2002) also suggests that research questions may steer the design and direction of research in line with the researcher's ontological and epistemological viewpoint, arguing that qualitative research design is characteristically fluid and flexible and less rigid than quantitative research design. This does not, however, imply that it should be haphazard or lacking in direction. My decision to explore induction of labour, and specifically, women's experiences of it, was made prior to reflecting on and coming to an understanding of my own ontological and epistemological view. Embryonic research questions were already beginning to emerge in my mind prior to deciding on a research paradigm and became pivotal to my subsequent methodological decisions. At each stage of the research design it was necessary to reflect on how this fitted with preceding stages and how it would steer subsequent ones. My approach to designing and planning my study may thus be described as spiral rather than linear.

Choosing qualitative research

There is no commonly agreed definition of qualitative research: it has been variously described as a means of exploring behaviour, perspectives and human experience (Holloway, 1997) and as focussing on ways in which people think, learn and develop

understanding (Kvale & Brinkmann, 2009). Unlike quantitative research, the qualitative approach does not view reality as objective and waiting to be discovered: it regards reality as subjective and seeks to investigate how people interpret their lifeworld (Savin-Baden & Howell-Major, 2013). Barbour (2008) states that qualitative methods can (and should) provide explanations which go beyond descriptions of the lived experience. My aim was to explore women's experience of induction within the context of the discourse on informed consent, particularly on how women acquire and use knowledge of induction for the purpose of making decisions and negotiating their options. In keeping with my ontological and epistemological stance, therefore, I recognised that a qualitative approach would best enable me to access rich data from which to build a meaningful interpretation of how women understand and experience induction of labour.

Using a conceptual framework

It has been argued that the inclusion of a conceptual framework increases academic rigour by providing a basis for designing the study and a lens through which the data may be analyzed (Savin-Baden & Howell-Major, 2013). Distinct from theoretical frameworks common to quantitative studies, the conceptual framework is developed from a systematic search of the literature and synthesis of existing knowledge. It enables the qualitative researcher to maintain a clear focus and to make links between the data, the research questions and emerging theories (Miles & Huberman, 1994; O'Leary, 2010; Savin-Baden & Howell-Major, 2013). My conceptual framework centres on the notion of informed choice in maternity care. This was derived from a thorough reading of existing studies on women's experiences of induction and also from a wider reading of the midwifery literature on choice published since the 1993 *Changing Childbirth* report (Department of Health, 1993). Chief amongst these was Mavis Kirkham's work on informed choice in maternity care (Kirkham, 2004a; Kirkham, 2004b). Key concepts within this framework include constraints to informed choice, choice and decision-making and the influence of power hierarchies on informed choice (see chapters 2 and 7). My choice of conceptual framework thus situated my study alongside recent evidence

and the wider discourse on informed choice, providing a focus for my research questions.

Embryonic research questions arose early on in the planning stage, whilst becoming familiar with local and national policies and guidelines on induction, and were honed through discussion with research supervisors. The process of designing and planning the study was not linear and at various stages prior to submitting a research proposal, I reflected on my choice of question until finally deciding on the format detailed at the end of chapter 1.

The research approach

Mason (2002) comments on the close link between the research design, approach and methods, arguing that strategic planning at the design stage involves formulating a methodological approach to answer the research questions, acknowledging that other approaches might have been possible and justifying why these were rejected.

I initially considered an ethnographic design, using a participant observation method to study women and midwives in clinical settings from the initial booking of induction and throughout the induction process. Ethnography has been described as particularly suited to studies encompassing clinical practice and professional /client interaction (Mason, 2002; Silverman, 2010) and to research where a power imbalance is implied (Pope & Mays, 2006). At first, this seemed an ideal means of exploring the induction experience. However, as ethnography is essentially the study of cultural groups (O'Leary, 2010), I realised that this was incongruent with my aims to explore how individual women experience and understand induction. Any plans to use a participant observation approach, either within an ethnographic or any other qualitative design came unravelled when it became clear that a period of prolonged observation in the clinical field was incompatible with my work commitments.

I next considered what was the most practical and expedient means of gaining answers to my research questions. I decided that one-to-one interviews with postnatal women would enable me to explore women's experiences of induction in

depth and was congruent with my epistemological stance and the qualitative paradigm. Furthermore, this approach has a sound history of use in health and sociological research involving women e.g. (Finch, 1984; Hunt, 2004; Oakley, 1980; Ribbens & Edwards, 1995).

Part of the process of planning my research approach involved choosing an appropriate paradigm (or model). By conceptualizing my research questions from a positivist angle, I would have needed to assume that the participants answers to interview questions related to an external reality rather than a felt experience (Silverman, 2010). As this did not fit with my intention to explore the lived experience of induction, I first considered adopting an **emotionalist** paradigm.

As one of the four qualitative paradigms or 'idioms' identified by Gubrium and Holstein (1997), emotionalism may be seen as the extreme opposite of positivism: it does not seek objective facts, but aims to elicit an authentic account of the individual's subjective experience and to enable the reader to "feel" that experience through the conveyance of raw emotion (Gubrium & Holstein, 1997; Silverman, 2006). Unstructured, open-ended interviews are the method of choice for studies based on an emotionalist paradigm (Silverman, 2006). However, whilst many qualitative researchers emphasise the need to develop a rapport with interviewees in order to encourage openness (Easter, Henderson, Davis, Churchill, & King, 2006; Eide & Khan, 2008; Henn et al., 2006; Hunt, 2004), emotionalism demands a much deeper relationship, developed over time, plus a high level of personal disclosure from the researcher and in-depth probing of interviewees. (Gubrium & Holstein, 1997; Silverman, 2006). This raised ethical issues about possible psychological distress to participants and the extent of professional and academic boundaries (Goodwin, 2006). Furthermore, the development of a relationship over time implied a time commitment beyond the scope of my study and raised questions of how to ethically break off the relationship at the end of the research period. An emotionalist paradigm was therefore not appropriate.

A constructivist paradigm, falling between the two extremes of positivism and emotionalism, seemed to suggest a more appropriate conceptualisation of my research question. Constructivism (as distinct from constructionism) is defined as

one of the key paradigms of social research (Guba & Lincoln, 1994). It is based on the understanding that individuals socially construct meaning from their lived experiences and that in order to understand this, the researcher must explore the individual experience in order to find out how knowledge and meaning are constructed (Charmaz, 2000; Savin-Baden & Howell-Major, 2013). This seemed to fit well with my aim to explore not only the experience of induction, but also how women received and assimilated information and how this affected the induction experience. Constructivism also concurred with my ontological view that reality is subjective and defined by the individual.

Having decided on a constructivist paradigm, I needed to identify a suitable approach to interviewing women. Grounded theory sits within the constructivist paradigm (Charmaz, 2000) and invites the researcher to seek the essence of the induction experience 'from the ground upwards' in order to generate theory directly from the data through an inductive process, without reference to a conceptual framework generated from an extensive literature search (Dey, 2007; Glaser & Strauss, 1967; Henn et al., 2006; Savin-Baden & Howell-Major, 2013). Grounded theory's focus on the first-hand experience of participants and openness to the development of new ideas aligned with my philosophical stance, but conflicted with my decision to use a conceptual framework. I believed that one was necessary not only to demonstrate academic rigour, but also to meet the demands of future publishers and conference organisers who increasingly expect this (Savin-Baden & Howell-Major, 2013). I also considered that in order to provide data that might one day help shape practice, I needed the clear focus provided by a conceptual framework.

Having rejected grounded theory, I considered a phenomenological approach, as this is commonly adopted by health and social care researchers as a means to explore the human experience without necessarily generating a hypothesis or theory (Cresswell, 2007; Savin-Baden & Howell-Major, 2013). Phenomenology seeks to discover commonalities between participants who experience a particular phenomenon in order to arrive at a description of the essence of that phenomenon and facilitate understanding of how it is lived (Cresswell, 2007; O'Leary, 2010). However, whilst the phenomenological approach generally includes an initial

literature search, it eschews a conceptual framework, as it is believed that this imposes presuppositions on the interpretation of data (Savin-Baden & Howell-Major, 2013). Furthermore, the commonly adopted phenomenological practice of undertaking multiple, unstructured interviews, often accompanied by other qualitative methods would have been difficult to achieve satisfactorily within the time constraints of my planned study. For these reasons, I rejected a phenomenological approach, but drew upon its concept of shared understanding in my interpretation of data and identification of themes.

Seale, Gobo, Gubrium and Silverman (2004) argue that good quality social research is achievable without the adoption of a single, named approach and that rather than forcibly applying rules, the research design should be situated in a '*position of dialogue*' (p.8) with them. It has been argued that the boundaries between qualitative designs are often blurred (Savin-Baden & Howell-Major, 2013) and many studies, especially in health research, contain overtones of more than one methodology (Sandelowski, 2000). Whilst my study was situated within the constructivist paradigm, emotionalism was drawn upon to heighten my awareness of women's feelings during data collection and analysis. In chapters 4-6, examples of data are provided to illustrate the emotional impact of induction. My research approach has what some researchers term a 'cast' (Sandelowski, 2000) of phenomenology, but strict phenomenological principles were rejected. My chosen approach may be said to resemble that which Sandelowski (2000; 2010) terms **qualitative description**: a name applied to a pragmatic combination of sampling, data collection and analytical strategies which aim to portray a clear picture of the phenomenon in question. Claims that this is over-simplistic and merely celebrates the data rather than analysing it are countered by arguing that, like all qualitative research, it requires data to be interpreted and rigorously analysed (Sandelowski, 2010). Although qualitative descriptive research need not commit to a particular paradigm, it should be informed and influenced by a sound understanding of theoretical perspectives (Sandelowski, 2010; Seale, 2004; Seale, Gobo, Gubrium, & Silverman, 2004), as I have attempted to demonstrate throughout this section.

The research methods.

I chose to use a single, face-to-face interview with each participant as my primary source of data collection. This method is widely regarded as one of the key tools of the qualitative researcher (Barbour, 2008; Savin-Baden & Howell-Major, 2013). I adopted a semi-structured format, using a flexible schedule of open-ended questions, allowing participants to control the quantity and extent of information given (Rees, 2011; Rogers, 2008). An unstructured approach was rejected as too broad, given the specific nature of the research questions developed from a framework of existing knowledge. It has been suggested that a standardized schedule of questions helps to ensure consistency (Mason, 2002), but this does not require identical questions in the manner of a structured interview: indeed, such an approach would be counter-productive by preventing the pursuit of other lines of enquiry as data emerged and by not allowing deeper probing where appropriate (Anderson, 2011; Britten, 2006; Mason, 2002).

In order to explore the induction experience from a wider angle, I also searched women's maternity records (with their consent and with ethical approval) for entries relating to induction. Justification for this and a reflection on its effectiveness is included further on in this chapter.

The researcher stance

The literature on qualitative research recognises that the researcher is integral to the research process and cannot remain outside the subject. It was important therefore, to adopt a reflexive stance: a self-conscious analytical scrutiny of myself as a researcher and how my position in relation to the subject and the participants might influence not only the emergence of data but also my understanding of it. (Mason, 2002; Pink, 2007; Savin-Baden & Howell-Major, 2013; Silverman, 2006). Reflexivity, according to Savin-Baden & Howell-Major (2013, p.76) enables the researcher to acknowledge that they are '*both integral to and integrated into the research*'. It was

therefore important when considering my research design to acknowledge my position as a midwife, mother and teacher as well as a researcher and how this might influence not only participants' perception of me – and hence the scope and nature of their disclosure– but also my reaction to and interpretation of the data. The need for a reflexive stance required strategies to help maintain reflection and reflexivity, hence my decision to use a field diary to record my impressions and feelings as part of my data collection strategy.

Ethical approval

One of the principles of research is that it should be broadly beneficial, whilst causing no harm (Ledward, 2011). However, many forms of qualitative research generate ethical tensions and dilemmas, especially when the researcher has multiple roles and responsibilities (Rogers, 2008). Sinclair (2011, p.3) states that health practitioner-researchers “...*must be accountable for ensuring that all logical and auditable steps have been taken to demonstrate that their research is ethical, rigorous and commensurate with good clinical practice*”. The following sections will demonstrate how the challenges of balancing academic rigour and professional responsibility were managed within this research project.

Ethical approval was sought from the Health Research Authority (NRES Committee South Central – Oxford A) in May 2012. Included in the application were copies of a consent form and participant information leaflets which I devised and which were reviewed by volunteers from an NHS antenatal class, who had no connection with the study or with the hospital from which participants would be recruited. The purpose of this was to ensure clarity of wording and to highlight any possible omissions. Feedback from the three women who reviewed the documents was favourable and suggestions for minor changes to clarify the wording were incorporated into the final versions.

The application for ethical approval was accepted for proportionate review by the sub-committee, which demanded short additions to the participant information leaflet and consent form; namely a statement indicating that the study was to be conducted

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on first-time mothers (participant information leaflet) and statements to consent to audio recording and the use of anonymised quotes (consent form). These changes were subsequently made. The sub-committee also made suggestions for additions to the inclusion/exclusion criteria, however, after some deliberation, I decided not to incorporate these as they were either irrelevant to the aims of the study, already included or were unnecessarily intrusive. I noted that no members of the ethics committee appeared to have specific knowledge of midwifery, which might explain the inappropriateness of the suggested additions.

Full ethical approval was granted on the 31st May 2012 (reference 12/SC/0316), followed in July 2012 by approval from the Hertfordshire Hospitals R & D Consortium and permission to conduct research (Letter of Access) from the hospital from which participants would be recruited (see Appendix 5). An extension to the period of data collection was later granted, due to the difficulty in recruiting sufficient participants within the original timeframe (see Appendix 5).

Sampling and recruitment

My plan was to interview an opportunistic sample of around 30 women whose labours had been induced, comprising approximately 15 who had attended a special pre-induction education class run by the Trust and approximately 15 who had not attended. This was to allow comparison of the experiences between the two groups. Reference to the literature on research methodology confirms that a small sample size is appropriate for small-scale qualitative projects where depth and richness of data are paramount (Mason, 2002; O'Leary, 2010; Silverman, 2010) and is reflected in the sample size of other qualitative studies exploring similar aspects of induction, such as those by Gatward et al (2007) and by Westfall and Benoit (2004). I chose a total of 30 participants as an aspirational target, anticipating that the final number might be lower. Other qualitative studies in this field have mostly been conducted by two or more people, using samples of between 20 and 30 people. This suggests that my target, as a sole researcher, might have been somewhat ambitious; however, in order to compare two groups of participants, it seemed reasonable to aim for the higher end of what I considered achievable.

There is debate in the literature on qualitative research methodology about how sampling should be undertaken and indeed whether anything other than opportunistic sampling is necessary (Cooper & Lavender, 2013). For this study, a purposive sample, representing the diversity of medical and socio-demographic backgrounds within the NHS Trust area would have reduced the risk of selection bias and deliberately sought out extra-ordinary cases (Barbour, 2008; Mays & Pope, 1995). However, ethical principles which prioritise the welfare of individuals above those of research (Sherlock & Thynne, 2010) meant that many women had to be excluded either because they did not speak English, were unable to represent their own interests or were especially vulnerable due to medical or social reasons. In addition, the limited time available to visit the postnatal ward reduced the field of potential participants and it became necessary to adopt an opportunistic (or convenience) sampling approach. It was inevitable, therefore, that the sample would be skewed towards those who were healthier and less socially challenged. Rather than aiming for maximum variability, I attempted to focus meaningfully on the experiences of a few individuals in order to identify essential details of their accounts which may have implications for the wider population (Hunt, 2004; Mason, 2002; Sherlock & Thynne, 2010).

The inclusion and exclusion criteria were as follows:

Table 4 *Recruitment: inclusion and exclusion criteria*

Inclusion criteria
• Women whose labour was induced at or close to term, without prior anticipation of induction early in pregnancy • Women who had not previously given birth • Women over 18 years of age at the start of the study • Women able to speak, understand and read English • Women who were expected to remain within reasonable travelling distance of the hospital in the early postnatal period
Exclusion criteria
• All women to whom access was denied by clinical staff • Women who were initially approached antenatally, but whom the researcher deemed unfit to participate at the point of interview.

The decision to only interview first-time mothers was based on the assumption that multiparous women might have acquired a considerable amount of background knowledge of induction, either through personal experience or through their own peer network, which might have influenced their decision-making ability. Moreover, the potentially vast and variable range of knowledge and experiences undergone by a sample of multiparous women might have complicated data analysis to the point where no consistent themes emerged. This is not to discount the importance of the voice of multiparous women, but to acknowledge that for pragmatic reasons, this study required a limited focus.

For similar reasons, women who had anticipated induction from early pregnancy were also excluded: this comprised women with Type 1 diabetes and certain other medical conditions where routine induction would be expected. I considered that under such circumstances, women may have acquired a considerable body of knowledge about induction over the course of their pregnancy leading to good psychological preparation for this event.

Identifying and approaching potential participants on the postnatal ward

I visited the postnatal ward approximately once a week between August 2012 and January 2013. Access to potential participants was governed by midwives in charge of the postnatal ward acting as gatekeepers, who either permitted or denied access, depending on their assessment of each woman's suitability to be approached. The value of gatekeepers in protecting vulnerable members of the public is acknowledged, however, they have the power to deny access to those who might wish to participate, despite appearing otherwise (Barbour, 2008). The midwife in charge knew each woman's situation and used her professional judgement to decide whom it was appropriate to approach. Access was denied to those who were deemed especially vulnerable, such as women whose babies were due to be adopted or were very sick and women with severe mental health problems. Once permission was obtained, I approached the women in person after the staff midwife caring for them had ascertained that it was appropriate to do so.

Most staff midwives caring for individual women knew me as a midwifery lecturer, who often visited the ward when working with students. This seemed to give me trustworthy status despite the fact that few midwives were fully aware of my research. Ideally, all midwives working on the ward would have been fully briefed about the nature and purpose of my study, but this would have been practically impossible since the Trust employs around 200 midwives, many of whom rotate through the various clinical areas at different times. In addition, the postnatal ward is often staffed by agency midwives who only occasionally work for the Trust. The practicalities of meeting each midwife and briefing her about my study were insurmountable. For this reason, senior staff in the maternity unit and midwives in charge of the postnatal ward had been apprised of my study and given detailed information, in the hope that they would cascade this to their staff. Posters advertising the nature and aims of the study were also displayed in relevant staff areas. Despite this, I found at the time of data collection that many staff midwives were not aware of my research and required a brief 'on the spot' résumé of its

purpose. In retrospect, an information leaflet for staff midwives would have been a useful tool.

Women on postnatal wards have for many years been routinely approached by representatives from organisations such as Bounty, whose interests are commercial rather than philanthropic. Such people have free access to women and do not require the agency of midwives to make their introduction. My aims as a researcher were ultimately philanthropic and therefore even after receiving permission to approach women, I used my professional judgement and discretion to avoid those who had visitors, were resting or were clearly otherwise occupied. This doubtless resulted in some potential participants being missed, but as Ledward (2011) argues, the prime concern of a researcher (and of a midwife), is the participants' wellbeing (Ledward, 2011).

On introducing myself to women, I explained the nature and purpose of my study and offered them a participant information leaflet (See Appendix 3). Barbour (2008) and Silverman (2010) recommend using some form of information sheet in a format that potential participants can easily understand, but caution against information overload. The information leaflet set out the exact method of data collection and the use to which data would be put. It clearly stated the right to refuse to participate or to withdraw from the study at any time, without jeopardizing any aspect of care. It also assured anonymity and confidentiality in any written work and gave details of the methods of storage and destruction of data. My contact details were included on the leaflet and women were encouraged to get in touch if they required further information later on.

Some women whom I approached were clearly not interested and refused a leaflet, in which case I thanked them for listening and moved on. However, the majority were very receptive. Those who showed interest in participating were invited to complete the Expression of Interest form attached to the information leaflet (See Appendix 3) which gave permission for me to contact them postnatally. I explained to women that at this stage, I was not actually recruiting for the study and that by signing the form they were not making any commitment to participate.

Issues with identifying potential participants

Midwives on the postnatal ward were unfailingly helpful in identifying potential participants. This was doubtless helped by the fact that I am known to the staff on the ward, having worked alongside them at various times as a colleague, student or tutor. As an insider (Sherlock & Thynne, 2010), I was therefore privileged in having a position of trust within the maternity unit: despite this, the process of identifying women who met the inclusion criteria was unexpectedly tortuous. Bed-state information, in the form of a handover sheet and the bed-state board did not identify women whose labours had been induced and as induction was not generally considered relevant to post-natal care, most midwives were unaware of which women had been induced. At that stage of data collection, I did not have access to women's maternity records.

This problem was largely solved by negotiating access to the induction of labour record book and cross-referencing it against the names of newly delivered first-time mothers. This book includes only names, parity, reason for induction and planned date of induction. However, a minority of potential participants had been admitted directly from the antenatal clinic, by-passing the antenatal ward and were thus not recorded in the induction of labour record book. A few such women were identified fortuitously due to the recall of helpful midwives, but it is likely that some were missed. Furthermore, some women who were recorded as having been admitted for induction had been found to be in spontaneous labour on arrival and thus by-passed the induction process entirely. This was not always clearly documented and only came to light when I approached the women themselves.

Identifying potential participants from pre-induction classes

One of the study aims was to compare the experiences of women who had attended a pre-induction education class with women who had not attended. Pre-induction education classes were available on a weekly basis to all women in late pregnancy. Women were informed of these via a sticker placed inside their hand-held maternity notes earlier in pregnancy. At the time of data collection, this was a fairly recent innovation, having been instigated some six months previously. Of those women who chose to attend the class, it was inevitable that some would have gone into

spontaneous labour. I therefore faced the difficulty of identifying those women who had attended classes *and* subsequently had their labour induced.

My plan was to be present at the end of every weekly class, when other commitments allowed, and to approach those women identified by the class facilitator as meeting the inclusion criteria and to offer information about the study. On occasions when I could not be present, the facilitator (a midwife who was fully appraised of my study) would distribute information leaflets and collect Expression of Interest forms (see Appendix 2). The facilitator was aware of the ethical importance of not attempting to recruit women herself, but of simply acting as a conduit for information. The facilitator was asked to encourage women to contact me directly if more information about the study was required.

Uptake of the classes was, however, far less enthusiastic than anticipated: classes were frequently cancelled due to lack of attendees and when they did run, normally comprised only one or two women, some of whom did not meet the inclusion criteria for my study. The poor uptake of classes might have been due to lack of interest, as women would not necessarily see them as relevant unless induction had already been booked. Alternatively, information may have been missing from women's notes, but this is pure speculation. On several occasions, I visited the class as planned, to find that no women had turned up. It later transpired during the course of data collection that for unexplained reasons, many eligible women were unaware of the existence of the classes.

The following tables illustrate the success rate of the various stages leading up to recruitment of participants:

Table 5 *Identifying potential participants*

Potential participants identified between August 2012 and January 2013 on the postnatal ward	
Women who refused a participant information leaflet	6
Women to whom access was denied by clinical staff	11
Women who met the inclusion criteria but were busy or resting at the time of visiting the ward	5
Women who signed an Expression of Interest form*	33
Women interviewed	20
* See Appendix 3	
Potential participants identified between August 2012 and January 2013 via pre-induction education classes	
Women who accepted a participant information leaflet*	3
Women who refused a participant information leaflet	0
Women who signed an Expression of Interest form	3
Women interviewed	1
* See Appendix 2	

Discussion of recruitment issues

Table 5 shows that of the 36 women in total who signed an Expression of Interest form, 15 did not proceed to give interviews. Some of these women were non-contactable postnatally and some declined to participate for various reasons, such as ill health or an early return to work. In total, 23 women agreed to be interviewed, but this number was reduced to 21. On arriving at one woman's home, it was clear that she was unwell and I offered to postpone the interview, to which she agreed. With her permission, I tried to contact her at a later date but was unable to do so and

after two attempts abandoned the effort, as an over-zealous pursuit of participants might have been construed as coercion (Ledward, 2011) or even harassment. On another occasion, I arrived at a woman's front door to be greeted by her four year old son: she had evidently misread the information leaflet and not realised that multiparous women were not included in the study. I made my apologies and left, but later reflected on whether or not I had made the exclusion criteria explicit verbally as well as in writing. I decided that in future, when making arrangements to interview participants, I would repeat the inclusion criteria so that women could de-select themselves if necessary.

My original intention had been to recruit around 30 women: 15 who had attended a pre-induction class and 15 who had not attended. In fact, 21 women in total were recruited, only one of whom had attended a pre-induction class. It had become apparent fairly early on in the recruitment phase that attendance at pre-induction classes was low and therefore I sought a larger sample of women from the non-attendance group. However, despite making several visits over my Christmas vacation and obtaining an extension for the data collection period from the Research Ethics Committee, I achieved only 21 interviews.

The maternity unit of the NHS hospital in question oversees around 5,400 births per year (BirthChoiceUK Professional, 2014). At the time of writing, figures from BirthChoiceUK show that the rate of all induced labours at the Trust was 23%. From these figures it can be assumed that the maternity unit cares for around 1,242 women with induced labour per year; therefore in the six month period in which data collection took place, there would have been approximately 621 women who underwent induction. At face value, it may seem as if my recruitment strategy was ineffective; however, around half of all such women would have been multiparous and therefore not eligible for inclusion. Of those remaining, an unknown number would not have met other aspects of the criteria or would have been deemed 'out of bounds' by gatekeepers. Furthermore, many potential recruits were inevitably missed as most women leave hospital within 48 hours of giving birth and I was only able to visit the postnatal ward once week.

Sample characteristics

A total of 21 women were interviewed. All were aged between 26 and 41 years. Sixteen described their nationality as British; one as Irish, one as Canadian, one as Lithuanian, one as Hungarian and one as British Indian. All except the latter were white. All women were living with a male partner within a radius of approximately fifteen miles of the hospital where they gave birth. Marital status was not asked, but around two-thirds of women volunteered that they were married. In terms of educational status, fifteen women held first or higher degrees; two held post A' level qualifications; one had left full time education after A' levels and two after GCSEs. All but one among the sample group had been in employment prior to maternity leave: fifteen had managerial/senior managerial or professional occupations; five were in retail, clerical or service occupations and one described herself as a full-time housewife. According to their maternity records, all women had been classified as obstetrically 'low-risk' at the time of booking their antenatal care.

Seeking Informed consent

Consent to be contacted by the researcher

Seeking and obtaining informed consent is central to the conduct of ethical research (Ledward, 2011). Participation must never be coerced and participants (or potential participants) have a right to know the full nature of the research and to withdraw from it at any time with impunity (Polit & Hungler, 1999; Ryen, 2007). Ethical principles demand that when seeking consent, the researcher should strive to promote the autonomy of potential participants, ensuring that they understand what is being asked of them before making any commitment (Anderson, 2011; Ledward, 2011).

In this study, the principles of informed consent applied to the signing of the Expression of Interest form (see Appendices 2 and 3) as well as to the actual gaining of consent to be interviewed. However, genuine consent relies upon the assumption that the individual has the power to make an autonomous choice. It was necessary,

therefore, to ensure that any woman whom I approached was able to represent her own interests and communicate her decision (Draper, 2004). I was denied access to any women whom clinical midwives deemed especially vulnerable or unable to communicate effectively, but in all other cases, I worked on the assumption that, in accordance with the Mental Capacity Act 2005, women were capable of giving consent unless proven otherwise (Department of health, 2005). At the initial contact, I explained the nature and purpose of the study and offered women an information leaflet. I emphasized that I was not actually seeking their consent to participate at this stage, only consent for me to contact them at a later date.

I offered women at least half an hour to read the information leaflet before returning to ask whether they wished to sign the Expression of Interest form. Women's partners were generally present and I encouraged discussion between them (National Institute for Health and Clinical Excellence, 2008). Some of the women I approached were not native English speakers and where necessary, I repeated or re-phrased some information (Ledward, 2011) until I was confident that they had fully grasped the nature of what they might be agreeing to. Several women insisted on signing without fully reading the leaflet, proclaiming that they were eager to tell their story. Others required longer than half an hour, in which case I offered them a stamped, addressed envelope to return the form to me at their leisure. As an alternative, I provided a box for returned forms at the midwives station. Women were reminded that their consent to participate was not being sought at this stage and were encouraged to take home the leaflet and to discuss it with significant others so that a considered decision could be made.

Information for women attending pre-induction classes was given by the facilitator, who had been fully briefed about my study and was willing to co-operate. As a Supervisor of Midwives, she held a position of particular trust within the maternity unit and I was confident that she would not apply any pressure on women to complete the Expression of Interest form or to take part in the study. Women were given a stamped, addressed envelope and encouraged to post the form back to me at their leisure.

Consent to be interviewed

The Economic and Social Research Council states that “*consentis continually open to revision and question*” (ESRC, 2005 pp 23-5 cited in Silverman, 2010), thus being a dynamic process, consent needs to be reviewed throughout the research process: it was therefore important not to assume that women who had signed the expression of interest form would automatically consent to being interviewed.

At around 3-4 weeks postnatally, I contacted each woman via her preferred means of communication to ask whether she would be willing to be interviewed. Of those who were contactable, the majority were keen to participate, therefore I reiterated the nature and purpose of the study, inviting questions and then agreed a mutually convenient date, time and location to meet. I reminded women that if they changed their mind, they were free to do so without any repercussions or offence being taken.

On meeting with the women, I reiterated the nature and purpose of the study and drew their attention again to the information leaflet. I had brought some spare copies for any woman who had misplaced the original. Once I was satisfied that women were fully informed, I asked them to complete a consent form (See Appendix 4) and reminded them of their right to withdraw or to terminate the interview at any point.

All but one of the interviews was audio recorded, and I placed the microphone centrally, showing women how to work it and inviting them to take control of it and to switch it off at any time if they wished. This gave the women some degree of power over the interview and the assurance that they would not be recorded without their knowledge. At the end of the study, I again asked women whether they were still happy for me to use their data and all readily agreed.

Rewards

The question of reward for participation in research has long been debated, with proponents arguing that it compensates people for their time and contribution, whilst opponents argue that it may be construed as bribery or coercion (Barbour, 2008; Rees, 2011). As the latter argument appeared to be dominant at the time of the

study, no payment or other inducement was offered to potential participants, but at the close of each interview, immediately prior to leaving, I gave each participant a card and a very small (and inexpensive) box of chocolates to thank them for their hospitality. I decided this was appropriate, if only because it is customary in the UK to bring gifts to new mothers. It would have felt unethical to have left without leaving a token gift. The card contained my work contact details and women were encouraged to contact me at any time in the future should they wish to see a copy of my final report or any articles which might proceed from it. Women were touchingly grateful for the chocolates, which seemed to confirm that they had not expected any form of reward or recompense.

Anonymity and confidentiality

It is essential for researchers to assure participants of their right to privacy and to take methodological steps to ensure that this is not breached during the research process or after publication (Rees, 2011). This is of particular importance in small-scale studies, where there is a greater risk of an individual being identified (Baker, 2006). Women were therefore assured that all names of people and places would be replaced with pseudonyms and that any published article would include information in such a way that the risk of identifying individuals was as remote as possible. To further reduce the risk of accidental disclosure, I omitted all proper nouns from the transcribed interviews and ascribed pseudonyms to each woman. These were also used when transcribing field notes and notes from maternity records. I also obscured the sex of the participants' babies by replacing names and pronouns with 'baby/baby's' in the transcribed interviews. Only one record linking women to their pseudonyms was made and is held securely in accordance with the University of Hertfordshire policy on managing personal and confidential data (University of Hertfordshire, 2011). I explained that anonymised quotations might appear in a published report and consent to this was sought via the written consent form (See Appendix 4).

Participants were also assured both verbally and in the information leaflet of the safe and confidential storage of data (Rees, 2011; Sherlock & Thynne, 2010). To ensure

confidentiality, I transcribed audio recordings myself or used the services of a University of Hertfordshire recommended transcription service which uses a legally binding confidentiality agreement. I assured women that information would not be divulged to any third party without their consent, unless a serious risk to a child or vulnerable adult was identified. This is in keeping with the Midwives' professional code of conduct (Nursing and Midwifery Council, 2008). I further assured women that I would only view their maternity records with their written permission (via the consent form) and that only information relevant to the study would be sought.

Data protection

In order to comply with the Data Protection Act and the University of Hertfordshire policy on the management and storage of personal data (University of Hertfordshire, 2011), all audio recordings were erased as soon as transcription and checking were complete. To prevent the risk of cross-referencing, biographical data was stored separately from transcripts. All electronically held data files were encrypted on a password protected lap-top and hard copy data stored in a locked filing cabinet, held within a private office which is locked when not in use. On completion of the study, all data will be stored for ten years in accordance with the terms of the ethical approval for this study.

Timing of interviews

My decision to interview women at around 3-6 weeks postnatally was influenced by Oakley's study of women's reactions following the birth of their first child (Oakley, 1980, 1993). Oakley chose to conduct interviews at five weeks, theorising that memories of the birth would still be clear, yet women would be sufficiently recovered to tolerate the intrusion of an interview. I further theorised that by this stage, women would have been discharged from midwifery care, thus reducing the risk of role-confusion. In her earlier works on antenatal care, Oakley highlights the mismatch between medical perspectives on childbirth and women's own accounts, thereby pioneering the value of examining women's own standpoint on birth and maternity care (Graham & Oakley, 1981).

Previous studies of women's experiences of induction show no consistency of timing in the collection of data (see chapter 2) and from a wider reading of the literature, there appears to be no consensus of opinion on the optimum time to interview women after childbirth. There is evidence that women's perceptions of their birth experience do not remain static over time. Feminist writers such as Miller (1998) and Ribbens (1998) have remarked on how not only hindsight and experience, but also prevailing social discourses and expectations lead to '*shifting layers*' of narratives over time (Miller, 1998, p.58). In a comparison of women's responses to a birth experience questionnaire conducted shortly after their first childbirth and repeated 15-20 years later, Simkin (1991, 1992) found that detailed memories of the birth were retained for many years. Women were more likely to recall feelings and perceptions than precise clinical detail, but these were mostly consistent over time (Simkin, 1991; Simkin, 1992). Simkin (1991, 1992) observed, however, that the significance attached to negative events seemed to intensify in the longer term. This echoes an earlier study by Bennett (1985), who found that women's feelings became more negative after the birth of subsequent children. It has been posited that the 'halo effect' of a healthy baby and relief that labour is over contributes to a positive perception of childbirth in the early days (Bennett, 1985; Hodnett, 2002; Simkin, 1991; Simkin, 1992; Waldenstrom, 2003). Robinson (2004), however, attributes this to women's initial desire to believe that carers were acting in their best interests, which fades with hindsight as they assimilate the birth experience and perceive incongruities in their early evaluation (Robinson, 2004).

Other studies have supported the notion that whilst great variation exists in women's recall of events at an individual level (Waldenstrom, 2003), women generally retain strong memories of their global birth experiences, but become more negative and critical of their care over time, especially following unplanned interventions (Baston, Rijnders, Green, & Buitendijk, 2008; Jacoby & Cartwright A, 1990; Lundgren, Karlsdottir, & Bondas, 2009; Shields et al., 1998; Van Teijlingen et al., 2003; Waldenstrom, 2003; Waldenstrom & Schytt, 2008). The optimum time for interviewing women about their birth experiences may therefore depend on the aims of the study (Hodnett, 2002).

I was primarily concerned with the global experience of induction: recall of the minutiae of clinical procedures was less important. This might be seen to justify interviewing women at a later stage; however, there were some areas which I sought to explore in more exact detail, notably in relation to women's knowledge and sources of information about induction. Had I chosen to interview women some months or years retrospectively, some of this detail would probably have been lost. I acknowledge that interviews conducted at a later stage might have yielded more negative reflections: however, it is not possible to identify which individuals may have changed their views (Waldenstrom, 2003), nor at what stage such changes might have occurred. Moreover, in order to obtain data which might be used to improve the care of women in the short term, I needed evidence of recent rather than historic experiences. Longitudinal studies have provided valuable insight into women's experiences of childbirth in the context of the transition to motherhood (e.g. Miller, 1998). However, induction is a discrete event and whilst a longer term study might offer an interesting insight into how women's feelings change over time, it would have less benefit in terms of providing a basis for the immediate improvement of women's care.

Conducting face to face interviews

All interviews but one took place in the women's homes (or temporary place of residence), at their request. It was important to ensure that interviews were conducted at a time and in a place freely chosen by the participants (Britten, 2006) so that they felt at ease and in control of their environment. One woman (Karen) requested to be interviewed by telephone: the reasons for this were not entirely clear, but as this was Karen's choice, I did not feel justified in questioning her.

The interviews were comprised of semi-structured, open ended questions, which had the advantage of allowing the participants to decide the pace themselves (Silverman, 2006). All interviewees were asked a similar opening question in order to set the tone (Mason, 2002). Thereafter, a schedule of topics was followed, based on the research questions (See Appendix 6). Britten (2006) notes the importance of being sensitive to the vocabulary used by participants, particularly in a health-related

setting and therefore where necessary, questions were re-phrased to aid comprehension. A flexible approach was adopted with regard to sequence of questions to fit within the context of the conversation.

Questions became more individualized as each woman identified issues of personal relevance, so as to remain as faithful as possible to each woman's experience and perceptions (Henn et al., 2006; Lavery, 2003). For example, Fay mentioned that she had been born with a rare medical condition, not related to the reasons for her induction, which caused her some anxiety during pregnancy; therefore this line of enquiry was pursued:

AJ: *Were you at all anxious about it (the medical condition) prior to going in for your induction?*

Fay: *(pause for thought) I was more anxious about the birth to be honest, than anxious about the epidural and anxious about the drugs they give you, just because of my medical history, I didn't know what effect these drugs would have on me so to be honest I wasn't that fussed about anything apart from what the drugs would do to me and my baby.*

AJ: *Yes, and had they discussed with you the effect that your condition or the condition you were born with might have on the induction at all?*

Fay: *No, well they'd never really heard of anything that I had done, you know, "We don't really know what it is," so I just spent like nine months trying to get hold of the surgeon that performed the operations on me, literally at 38 weeks I managed to find him because he's retired now from (xxxx) and I managed to get hold of him through this bizarre website in South Africa, some reason he wrote to me saying, "No, you'll be fine, go with whatever the Consultant said," so I said, "Okay," whether or not he remembered me who knows, 31 years ago, 30 years ago.*

I used contextualising questions to elicit more information about women's feelings, such as enquiries about how women felt at the time of certain events. As Barbour (2008) recommends, I occasionally summarised key points from the narrative and reflected them back to the participant to help to clarify my understanding of the situation (Barbour, 2008). An example is illustrated in the follow excerpt from the interview with Vicky:

Vicky: *He offered me to have my induction on the 12th day, 2 days after the sweep and I asked for it to be done a couple of days later because I wanted an extra couple of days to try and go into labour naturally...so I could get the pool birth and they were fully booked for the 12th day anyway, so they booked me in for 14 days after my due date to be induced*

AJ: *So you negotiated an alternative?*

Vicky: Yes

All face-to-face interviews were audio-recorded, with the participants' consent. Rapley (2007) commented that the use of audio-recordings has the potential to increase participant anxiety about the possible misuse of information therefore I gave assurance that all data would be used and stored in strict adherence to the principles of confidentiality and anonymity. Karen, who was interviewed by telephone, preferred not to be recorded, but permitted me to record as I read aloud verbatim from the consent form and sought her informed consent. (This audio file has been securely stored and will not be deleted until all electronic data is destroyed in accordance with the research protocol). Karen permitted me to make hand-written notes during the course of the interview.

On some occasions, other family members were present or nearby during the interview and may have indirectly influenced the retelling of women's stories. For example, in Gemma's case, her father was outside the room, but within earshot and she glanced towards the door whenever the conversation approached the more intimate details of induction. It is possible that his presence had an inhibitory effect

on parts of her narrative. In the most extreme instance, Vicky's husband sat beside her and actively contributed to parts of the interview: it would have been difficult to exclude him without causing offence. Although I addressed questions only to Vicky, the couple jointly constructed the story of her induction. However, as only Vicky had signed a consent form, her husband's words were not used as data. The large room in which the interview took place was occupied by several other family members watching television, but their presence did not seem to inhibit the flow of conversation or the detail with which Vicky described her experience. In all other interviews where family members were present, everyone was informed that the interview was being recorded and that background voices might be picked up, but would not be transcribed or used as data.

Addressing the power imbalance through building a rapport with participants

The relationship between interviewee and researcher generally involves a power disparity (Rogers, 2008). This is assuming that, in keeping with Foucauldian principles, the participant has the freedom to resist and is not entirely dominated by the researcher (Levy, 1999c). As discussed earlier in this chapter, adherence to the ethical principles governing selection of participants ensured that all those whom I interviewed were able to give informed consent and had the power to govern their own actions; nevertheless, I was conscious of Kvale's (1996) argument that a research interview is not a "*conversation between equal partners*" (Kvale, 1996: 6). It has been argued that a power differential is inherent within the traditional interview paradigm, as this separates interviewer and interviewee into distinct roles in which the interviewer offers only minimal self-disclosure (Kvale, 1996; Oakley, 1993). A alternative argument, however, might be that the relationship is one of donor and recipient, in which the participant, as donor, has the power to disclose only what she chooses and the interviewer, as recipient, must accept that.

It is widely acknowledged that in order to minimize any power imbalance, the interviewer must create an environment of trust: this not only enables the participant to exercise autonomy, but is also conducive to eliciting rich data (Henn et al., 2006;

Laverty, 2003; Marshall & Rossman, 1999; Silverman, 2006). It has even been suggested that in health research, a good rapport may have a therapeutic effect on the participants, even where no such benefit was offered or intended (Easter et al., 2006; Eide & Khan, 2008; Sherlock & Thynne, 2010). This may go some way to redressing the power imbalance. It was essential, therefore, to start the process of building a good relationship with participants from the first point of contact.

I made initial contact with most participants in person on the postnatal ward and later followed this up with a telephone call, text message or email. Therefore at the time of the actual interviews, we had already made each other's acquaintance.

Participants were asked to identify their preferred location for the interviews and in every case, chose their own home or place of temporary residence. This placed the participants in the position of host, giving them power to control the environment and to set the pace of the interview. I honoured my position as a guest by respecting the tacit rules of good guest behaviour such as removing my outdoor shoes and only taking a seat when invited to do so.

In order to further promote a relaxed and friendly atmosphere, I began the initial conversation with general talk, such as admiring the baby, before switching on the audio recorder and moving on to address the interview schedule. Interviews were conducted in an informal, unhurried manner, allowing each participant to break off whenever necessary to attend to her baby.

Oakley describes how, when interviewing women, a lack of reciprocity or "*giving of self*" emphasises the masculine-based hierarchy of the interview and hinders the building of a rapport, arguing instead for the adoption of a philosophy of "*no intimacy without reciprocity*" (Oakley, 1993: 235). Traditionalists may argue that this undermines academic rigour (Oakley, 1993), however, many researchers today maintain that in order to achieve rich data, the researcher should be willing to self-disclose or even offer advice where appropriate (Hunt, 2004; Rapley, 2007; Silverman, 2006). When women enquired about my personal or professional experiences, their questions were answered honestly, but in a manner which was careful not to undermine their own sense of achievement. Occasionally, I volunteered personal information where it was deemed an appropriate way of

demonstrating empathy (Oakley, 1993). For example, on some occasions I let it be known that I had experienced induced labour myself. I considered it prudent, however, not to elaborate on this, but simply to state (truthfully) that it had happened a long time ago and my memories of it were vague. This had the effect of showing empathy and common understanding, whilst maintaining the focus on the participant rather than on myself. This willingness to volunteer selected personal information appeared to reduce the social distance between us (Mason, 2002; Miller & Glassner, 2004), facilitating a good rapport. Occasionally, a participant would disclose information of a highly personal nature which was irrelevant to the study, but indicated her feelings of security in my presence.

The insider/outsider debate

Experience as a practising midwife and as a mother with experience of induced labour lent an epistemological privilege in terms of understanding the culture of labour induction and maternity care. Participants occasionally used short-cut phrases such as “*you know how it is*”, implying that there was a shared understanding which needed no explanation. There is much debate in the literature about the relative merits and drawbacks of the insider and outsider status of researchers. Arguments for the insider status suggest that it inspires trust among participants and has the advantage of shared understandings (Labaree, 2002; Rees, 2011). Anderson, in her focus group work, favoured interviewers who were closest to the topic of study over those with most research experience (Anderson, 2011). Conversely, the insider researcher may be criticised for lack of objectivity (Anderson, 2011). It has also been suggested that women who have had a positive experience of childbirth may demonstrate “*gratitude bias*” towards midwives in general, thus focusing on positive issues (Van Teijlingen et al., 2003). Kingdon (2005) identified the temptation for the insider to step out of the researcher’s role and impart midwifery knowledge to participants (Kingdon, 2005).

From a reflexive standpoint, it is easy to see how my multiple roles may have affected the participants’ view of me and what they chose to reveal and many authors recognise this as an important influence on research data (Kingdon, 2005;

Rogers, 2008). My insider status as a woman, mother and midwife is likely to have enhanced the rapport with participants: having had children and experienced induction myself may have fostered a sense of shared understanding, which would not be the case with a male or childless researcher. Being a midwife may have inspired trust and openness, knowing that I would be familiar with the intimacy of childbirth, thus reducing embarrassment. It is possible that an outsider interviewer might have elicited more detailed data due to the need to seek more explanation from the interviewees; however, it is debatable whether the same depth of mutual understanding would have been achievable (Eide & Khan, 2008). Conversely, my status as an academic and as a relatively older woman could have been seen as intimidating to some women, but if this was the case, I was unaware of it.

Managing multiple roles

It is recognised in the literature that the principles of research ethics may sometimes clash with the researcher's code of professional practice, leading to an ethical dilemma (Rogers, 2008). Ethical guidelines expect researchers to make clear distinctions between their professional and research roles, yet in practice, participants may not appreciate this distinction (Ryan et al., 2011). Various studies have shown that the health professional/researcher may have little control over how participants initially regard their role and that they may be viewed primarily as a caregiver (Easter et al., 2006; Kylma, Vehvilainen-Julkunen, & Lahdevirta, 1999; McCourt, 2006). However, the respective codes of ethics governing both health research and health professions have much similar ground in relation to the well-being of patients/participants (Easter et al., 2006) thus making the roles potentially compatible.

My status as a practising midwife, teacher and researcher was explained at the initial contact with potential participants on the postnatal ward and again at the start of each interview. In an attempt to avoid role confusion or compromise research principles, I set boundaries prior to commencing each interview by emphasising my current role as a researcher, not as a clinician (Mason, 2002). Nevertheless, a few

women overtly or implicitly sought advice on medical or child-care issues. One example relates to the interview with Emily, one of the first few women to be interviewed. It became clear during the interview that Emily was anxious about her baby's wellbeing. Towards the end of the interview, she asked for a professional opinion about a mark on the baby's scalp. Emily had already taken the baby to her GP, but wanted a second opinion. At the time, it seemed a kindness to oblige, as it might have helped to allay anxiety and was in some way a means of reciprocating Emily's hospitality (Hunt, 2004; Oakley, 1993). However, it proved impossible to give a clear reassurance about the baby's condition and I advised Emily to follow her GP's advice and return to her GP if she remained concerned. On later reflection, this did nothing to help Emily and may even have increased her anxiety. I decided that if clinical advice was explicitly sought in future interviews, I would decline to give this and would refer women directly to their GP or other appropriate professional unless there was an immediate risk to mother or baby (Eide & Khan, 2008). The NMC code (Nursing and Midwifery Council, 2008) requires midwives to prioritise the health and wellbeing of women and babies and this extends to the field of research. As a midwife, any failure to exercise this professional requirement might be deemed negligent (Nursing and Midwifery Council, 2008; Rogers, 2008; Ryan et al., 2011)

Ethical dilemmas arising during fieldwork often need to be resolved spontaneously (Ryan et al., 2011). On two occasions I saw babies that had been put to bed in a manner which was contrary to current recommendations. This presented a conflict between the midwife and the researcher roles: to have ignored the situation could have left the baby vulnerable to harm, thus putting me in breach of my professional code of conduct, whereas offering unsolicited advice - particularly where a criticism was implied - risked antagonising the women and damaging my rapport with them. To resolve this, I adopted Oakley's suggestion of speaking from a "mother to mother" perspective (Oakley, 1993). On both occasions this appeared to be well received, thus was I able to resolve the ethical dilemma in a satisfactory manner.

Several authors have acknowledged the unintended therapeutic benefit which some respondents derive from participating in research conducted by a health professional (Easter et al., 2006; Eide & Khan, 2008; Kylma et al., 1999), in particular, the cathartic effect of speaking freely to a willing and sympathetic listener (Kylma et al., 88

1999; Rogers, 2008). However, this should never be assumed (Ledward, 2011). It is not unknown for participants to view research as a form of care (Easter et al., 2006) and to solicit support from the researcher (Hunt, 2004). Some researchers have even suggested that giving supplementary health advice may be justified as a recompense for participants' time (Hunt, 2004) or that researcher/clinicians may subconsciously do this to redress the power imbalance and promote a closer rapport with participants (Eide & Khan, 2008).

During this study, I was aware of the temptation to blur the lines between research and clinical care. I was also aware that participants were vulnerable as new mothers and that to offer any form of therapeutic care might have fostered dependency and thus further shifted the balance of power towards myself. I therefore took care not to adopt a counselling or health-promotional stance, so as not to imply any therapeutic benefit to participation. An information leaflet for a self-help group The Birth Trauma Association (an independent charity) was offered to all women, with an explanation of its nature and purpose. Women who expressed a desire for more information about their birth experience were advised to contact the relevant midwifery manager at the hospital.

The principles of woman-centred care are central both to midwifery and to the treatment of research participants and by observing these and adopting a reflexive stance I was generally able to manage ethical conflicts as they arose. Through keeping reflective field notes (Ryan et al., 2011) I learnt from my experiences which empowered me to manage future conflicts.

Managing distress

Qualitative interviewing which borrows from the emotionalist approach encourages participants to reach deep into their feelings and this has the potential to be distressing when recalling painful memories (Rees, 2011). The University of Brighton identifies criteria for the types of distress which might be evident in research participants (Cocking, 2014) Using these criteria, it was evident that a minority of women had an episode of mild distress, characterised by tearfulness, restlessness

or the voice becoming choked with emotion. As Sherlock and Thynne found in their study of mental health patients, having insider status enabled me to respond in an appropriately professional and empathetic manner (Sherlock & Thynne, 2010). Where appropriate, I also offered to stop the interview; however all women were keen to carry on, so I simply paused the recording and my questioning until they were ready to continue.

Reflections on the researcher-participant relationship

It would be disingenuous to claim that I developed a strong relationship with women after one short encounter in hospital and an interview, but a good rapport was achieved, as evidenced by the depth of information I was given – some of it ‘off the record’ which has not been included in this thesis - and also by the fact that I was trusted to look after the baby on occasions when women had to leave the room. Feminist studies of women interviewing other women have found that perceptions of having insider status inspires trust and openness (Finch, 1984; Hunt, 2004; Oakley, 1993). It is likely therefore, that I was trusted because I was a midwife and mother and thus came across as “*being on their side*”. Finch (1984) identified that in such situations, the power differential between researcher and participant allows much scope for the exploitation and manipulation of women: it was necessary to maintain awareness of women’s vulnerability and not to pursue lines of enquiry that were clearly distressing.

Like Hunt (2004) in her study of women living in poverty, my embodied knowledge of induction as a mother and as a midwife enabled a level of empathy which would otherwise probably not have been possible. However, subjective comparisons between how women felt about their experiences and my emotional reactions to their stories were unavoidable (Henn et al., 2006; Kingdon, 2005). In most instances, I empathized strongly, but there were occasional differences. For example, as a midwife, Olivia’s story of a straightforward induction ending in an uncomplicated caesarean section sounded fairly standard and I was initially surprised at how negative she felt towards the event. The reverse was the case in Fay’s story, which to me as a mother sounded traumatic, although she rated her experience very

highly. Acknowledging the contrast between women's feelings and my reaction to their stories highlighted to me the subjective nature of the childbirth experience and the importance of not judging women by one's own standards, but treating them as individuals with unique experiences, perspectives and needs (Hunt, 2004). The implications of this are important both in a researcher capacity and as a midwife.

Issues of rigour

Validity

Validity in qualitative research is less easily demonstrated than in quantitative research, where the tools of data collection are standardised and measurable (Mason, 2002) nevertheless, it is important for qualitative researchers to demonstrate that their findings are credible and honestly represent that which the participants sought to convey (Henn et al., 2006). According to Mays and Pope (2006), the concept of validity encompasses not only the credibility of findings, but also the value of a piece of research (Mays & Pope, 1995). Validity can be undermined in various ways and relies on the integrity of the researcher to accurately and honestly report and interpret findings.

Henn et al (2006) suggest that over-empathizing with participants may lead to bias, thus threatening validity and this has been noted as a particular danger when conducting research from an insider perspective (Anderson, 2011; Kingdon, 2005). This was illustrated earlier in this chapter where I explained the difficulty of stepping back from the role of the midwife. Peer validation ('member checking') is frequently cited as a means to increase validity, but this was not practical in this study, due to time constraints and the risk of over-burdening participants. It is important to stress that the findings (chapters 4-6) are comprised of data filtered through my own interpretive lens (Baker, 2006; Kingdon, 2005). However, as all research is situated within a given human context (Kingdon, 2005) it would be disingenuous to suggest it can ever be totally objective: what was important was to maintain a consistent reflexive approach, acknowledging my own biases and influences and the effects

that these might have had on the data and my interpretation of it (Rees, 2011; Rogers, 2008)

Numerous strategies have been proposed to increase the validity of qualitative research, including the maintenance of a reflective diary (Henn et al., 2006) and using multiple data sources (Savin-Baden & Howell-Major, 2013; Silverman, 2010). The following sections explain how using field-notes and another source of data helped to increase the validity of this study.

Using field notes and reflexivity

The use of field notes allowed me to document events and observations which could not be captured on the audio recording, such as body language, the presence of other people in the room and reasons for any breaks in the recording. Mason (2002) proposes that field notes may also be used to develop further understanding of a situation and to this end my personal thoughts and assumptions relating to the interview process were also included. I wrote down notes as soon as possible after each interview – usually whilst in the car – in order to capture something of the feeling of each interview before it faded from memory.

Using field notes encouraged a reflexive approach, permitting me to reflect on my own interface with the participants (Mason, 2002). The literature on qualitative research highlights the need for investigators to consider their own influence on the study and to acknowledge the effects of their personal experience, knowledge and beliefs on their interpretation of data (Mason, 2002; Pink, 2007; Savin-Baden & Howell-Major, 2013; Silverman, 2006). Reflexivity, according to Savin-Baden & Howell-Major (2013, p.76) helps the researcher to consider that she/he “*is both integral and integrated into the research*”. For this purpose, my field notes included a reflective element (Henn et al., 2006; Rogers, 2008) in which I recorded my personal assumptions about what I had encountered during interviews and justified any choices and decisions made along the way, such as which questions to pursue further.

I reflected particularly on how the relationship between myself and the interviewees may have affected the nature and scope of what was disclosed (Mason, 2002). An example of this occurred during the interview with Rose: Rose found it difficult to make sense of some of the events that had happened to her during her induction and at various points during the interview she appeared to be seeking clarification. I duly explained the medical processes in a general sense – I had not viewed Rose's maternity records at this point. In this way, the narrative was jointly constructed using my medical knowledge to help Rose contextualise events pertinent to her labour. Rose responded positively to this, as it helped her make sense of events and certain aspects of the care she had received. On reflection, I felt that although I had not acted unethically, I was aware that this information inevitably altered Rose's perceptions of events and thus in a sense contaminated the raw data. I resolved that in future interviews I would be more cautious about offering explanations. In all cases, documenting and reflecting upon my immediate feelings about the interview underlined the subjective nature of the experience (Pink, 2007) and helped clarify my own stand-point and how that might affect my subsequent data analysis.

Data collection from maternity records

Further data were collected from participants' maternity records. This was undertaken with women's written permission and following REC guidelines for data protection and confidentiality. No records were seen prior to interviewing women, in order to avoid prejudging subsequent verbal accounts of women's experiences.

My rationale for using and analysing this data was to contextualise events and gain a sense of timing or sequence in cases where this could not be clearly established from women's stories. There is a precedent for this in Oakley's (1980) research into women's experience of first-time childbirth and more recently in Moore et al's (2014) study of women's experiences of induction. I had anticipated that in some cases, women's recall of specific events might be hazy due to the effects of stress or analgesia. This assumption was proved to be correct. Although many women gave remarkably detailed accounts during interviews, some had less clear recollections of detail: '*my memory's a bit rusty*' (Isobel) or directed me to their records to clarify

issues: *'Baby was in a funny position [...] you'll be able to see in my notes, I can't remember... would it be OP?'* (Emily)

On the face of it, these two methods of data collection may seem to be competing rather than complementary (Savin-Baden & Howell-Major, 2013) and it would be naïve to assume that case records could shed much light on women's felt experience of induction. However, my use of maternity records was not intended to verify or dispute women's stories, nor was it an attempt at formal triangulation (Moran-Ellis et al., 2006), but simply aimed to clarify processes and timescales where these were unclear and to provide additional material which might contextualise aspects of women's accounts. Synthesising documented data with verbal data thus enabled the building of a more cohesive picture of each woman's induction experience.

Only documentation pertinent to labour induction was read: this included records of when induction was discussed and/or booked; records of any pre-induction preparation such as specialist antenatal classes and cervical sweeps; records of hospital admission for induction and records of the process of induction up to the onset of established labour. I transcribed relevant data by hand, omitting all proper nouns and dates to reduce the risk of identifying any individuals.

In most cases, data from maternity records added little apart from clarification of timespans and medical procedures undertaken. Numerous entries were either illegible or unclear. Occasionally, however, data from records filled important gaps in women's stories which helped to make sense of the bigger picture. Vicky, for example, had been uncertain about whether or not she had actually been induced. Vicky's maternity record indicated that she had had a spontaneous labour with augmentation, not an induction; however, this had been incorrectly recorded as an induction on her birth notification. This offered a new perspective on Vicky's story, suggesting that confusion by members of staff may have contributed to her own uncertainty and subsequent anxiety.

Nina's case notes were unusual in that they included a lengthy and detailed account of conversations with midwives, documenting Nina's journey from initial resistance to induction to gradual, but grudging, acceptance of it. From my own experience as a

clinical midwife, I have encountered similar instances of exceptionally careful and detailed record keeping in the case of women considered 'difficult' or potential litigants. This is to set a clear and accurate record in the midwife's defence, should a legal case be brought. This provided another window into Nina's account of her initial determined resistance to any medical intervention and of how this had been gradually whittled away by successive encounters with her midwife. In my analysis, filtered through my own stance as a midwife, educator and researcher, it also illustrated very powerfully how a woman's autonomy and sense of empowerment had been gradually eroded by the prevailing system of care.

Other means of ensuring validity

Anonymized extracts from the transcript have been included throughout the findings chapters and elsewhere for illustration and to enhance transparency and credibility (Silverman, 2006). However, as Silverman (2010) notes, this practice attracts the criticism of anecdotalism, therefore as well as exemplary instances, negative instances have also been included; for example, Tanya (Chapter 6) is cited because she felt her partner need not have been present on the antenatal ward, whereas all other participants held the opposite view. Silverman (2010) argues for this so-called "*deviant case analysis*" as a means of maintaining the rigour of qualitative research.

Generalizability

There is debate about whether qualitative research should be generalizable to the wider population: Mason (2002) argues that it should have relevance beyond a purely local level. Silverman (2006) on the other hand, suggests that due to the very nature of studies such as this in which sampling is opportunistic, attempts at generalisation to the wider population are meaningless. This study was based on one site, the Trust in question being a large, city-centre NHS hospital serving a socially and culturally diverse population, not atypical of many other areas of the UK. Induction of labour is a common, routine occurrence in the UK and induction protocols at the Trust are common to those of other UK maternity units, as is the percentage of pregnancies which end in induction. It is therefore reasonable to

assume that the findings of this study, whilst not generalizable in the literal sense, will have some degree of relevance to midwives employed in other UK hospitals.

Managing and analyzing data

Data management

The aim of qualitative data analysis is “*to move from raw data to meaningful understanding*” (O’Leary, 2010, p. 260). This requires a systematic approach to the organization of data and the search for and interpretation of meaning. My data consisted primarily of transcriptions from audio-recorded interviews, which were supplemented with hand-written field notes and notes from maternity records. To check for accuracy, I re-read each transcript three times whilst listening to the audio-recording (Barbour, 2008; Savin-Baden & Howell-Major, 2013). Field notes made immediately after each interview were compared to transcripts and some were included as footnotes or additional notes within the text. This enabled me to gain a deeper and more empathic understanding of what participants were trying to convey (Barbour, 2008). An example is given in this annotated extract from the transcript of Emily’s account:

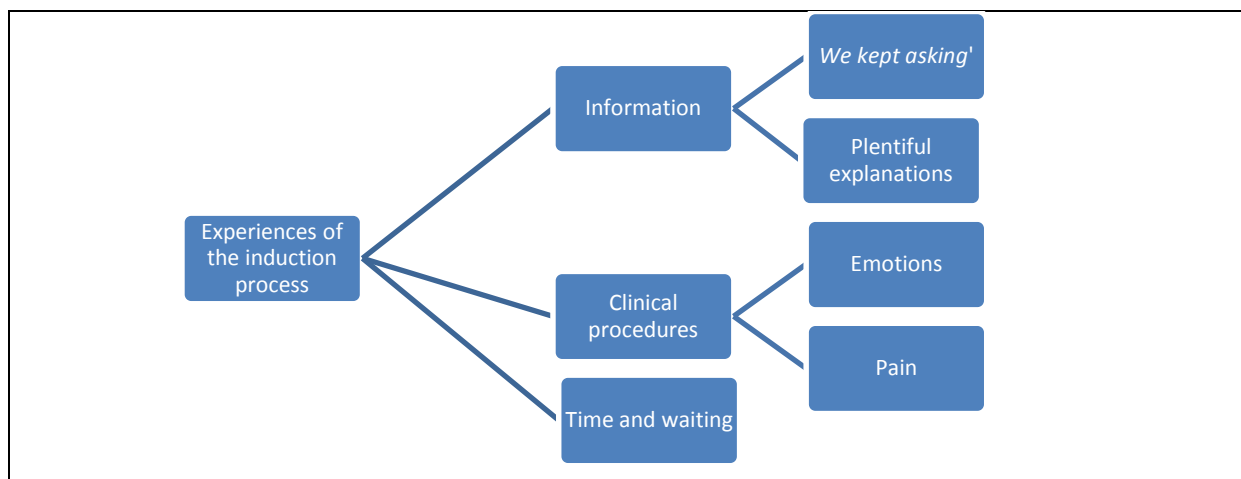
I’d been told 75% [of women] would go into labour with that [Propess©], so I felt a bit jealous – 75%! And I was actually very upset in the morning, I was crying.... (Emily) [Long pause, tears well up, participant visibly upset at this recollection]

I began organising my data using *a priori* categories formulated in relation to the questions on the interview schedule (Barbour, 2008), which reflected the overarching research questions and conceptual framework. This enabled me to maintain a focus and to establish boundaries, thereby avoiding an unmanageable amount of data (Barbour, 2008). Seale (1999) advises the use of an early indexing system to provide a preliminary framework (Seale, 1999), but warns against making it so rigid and

inflexible that creative thought is blocked, therefore where data did not fit into any of my *a priori* categories, I created new ones.

I began categorising data from the first few transcripts onwards, using what Barbour (2008, p.203) refers to as a '*broad brush*' approach, assigning data snippets into each category and then breaking these down into two levels of sub-categories in a hierarchical structure using the NVIVO10 software package. Categorising data was an iterative process: new categories and sub-categories were identified as I progressed through the data and were revised many times as data extracts were re-examined and shuffled around until I could find no further categories of meaning (Barbour, 2008; Gibson & Brown, 2009; Mason, 2002). In this way I built up a hierarchy of 15 categories, broken down into 39 sub-categories and 24 further sub-categories. Table 6 shows an example of a single category broken down into several sub-categories. For the sake of brevity, only a small selection of sub-categories are included here:

Table 6 *Example of hierarchy of data categories*



Some sub-categories were named using participants own words (e.g. '*we kept asking*': table 6) where this seemed to best capture the essence of what was being

conveyed: this then alerted me to similar instances in other transcripts. Positive and negative examples of particular data categories were identified where applicable.

Data analysis

Data were analyzed using thematic analysis - an inductive process whereby small units of data are scrutinized, interpreted and grouped into themes (Braun & Clarke, 2006; Savin-Baden & Howell-Major, 2013). Thematic analysis is widely used among qualitative researchers as it can be applied to various methodologies (Braun & Clarke, 2006; Savin-Baden & Howell-Major, 2013) and seemed to fit well with my own approach.

Having finally exhausted all identifiable categories of meaning from the data, I re-examined them and grouped them into themes. Re-listening to audio-recordings had helped me to acquire a 'feel' for the more obvious themes (Barbour, 2008; Savin-Baden & Howell-Major, 2013) which acted as a starting point. Reference to my conceptual framework and to themes identified from my review of previous studies led me to search for less obvious themes. I then re-read individual sections of data, comparing them to each other and identifying common threads. This was enhanced by searching for recurrences of relevant words or phrases using NVIVO10. For example, by typing in the word '*partner*' and using the facility for plurals and synonyms, I was able to identify and scrutinise every instance where women referred to their partner's or husband's involvement. This method is acknowledged as a means of enhancing analytical rigour by demonstrating that the entire body of data has been examined, highlighting all instances of a particular occurrence, rather than just those which support the researcher's interpretation (Barbour, 2008; Mason, 2002; O'Leary, 2010; Seale, 2010; Silverman, 2010).

Table 7 gives an example of how several categories of data were grouped into descriptive themes:

Table 7 *Example of data categories grouped into descriptive themes*

Overarching themes	Categories of data
Influences on women's decision-making	Partner/family influences Perceptions of risk Trust in professionals How information was presented • Plentiful • <i>'it's the policy'</i> • Choice • No choice Coercion by health professionals Anticipated induction Positive impression of induction
Liminality	Being alone at night Time and waiting In labour or in limbo? Confusion

I also used a form of framework analysis (Ritchie & Spencer, 1994 cited in Barbour, 2008) in which numerical instances of a particular event were counted and tabulated. Table 8 gives an example of a simple framework for instances where women reported negative treatment by hospital staff. This helped to map the various reasons for women's displeasure, to identify those which occurred most frequently and to identify any that stood out as exceptional.

Table 8 Example of framework analysis: Women who reported negative treatment by staff in the maternity unit

Reason	Woman's initial
Poor communication	E M V
Lack of information	D I K M N R V
Feeling neglected	G O V W
Feeling coerced	D E K O N
Feeling patronized, inappropriate comments	E K M
Insufficient monitoring and observation	M S V
Mismanaged care	V

Analysis using NVIVO10

A computer-assisted qualitative data analysis software package (CAQDAS) was used to facilitate the sorting, storage and retrieval of data. NVIVO10 was chosen for purely practical reasons, as the University holds a licence permitting unlimited staff access. Having undertaken a 'taster' session with this software package, I was confident that it would meet my needs and thus enrolled on a two-day training session at another University. Although I only used NVIVO10 at a basic level, it enabled me to link ideas and to develop a systematic and logically sequenced 'tree' of categories (see table 6). Furthermore, the Node Classification facility enabled me to compile a table of participants' biographical details for comparison. To protect confidentiality, the NVIVO10 file was password protected and all proper nouns replaced with pseudonyms.

Using CAQDAS has advantages in speeding up the sorting and retrieval of large amounts of data and enhancing rigour by counting instances of a particular event (Silverman, 2010). It also helps to distance the researcher from the immediate impact of the data, allowing a more objective view and enabling hitherto unnoticed ideas to emerge (Mason, 2002). However, some authorities advise caution, noting that CAQDAS cannot ascribe meaning to categories of data or create themes (Barbour, 2008; Mason, 2002; Sandelowski, 1995). Furthermore, it may impose a narrow approach to data analysis if the correct analytical procedures are not

understood (Seale, 2010; Silverman, 2010). Rather than relying purely on technology, therefore, I also continually conducted an “*inner dialogue*” (Seale, 2004 p.383) to ruminate on whether my interpretation of data was justified and how it might stand up to external scrutiny.

Data interpretation

Data interpretation is a ‘*complex, iterative process, not bound by rules and easily defined strategies*’ (Savin-Baden & Howell-Major, 2013 p.451). I interpreted the data in the light of findings from other studies and through the lens of my conceptual framework of informed choice. Mindful of criticism that this can stifle creativity (Savin-Baden & Howell-Major, 2013), I was careful not to use this as a means of narrowing my interpretation to themes which fitted neatly under the heading of ‘informed choice’. My interpretation of women’s experiences whilst awaiting the onset of labour as a new and hitherto unrecognized phase of liminality provides an example of how I recognized an interpretation of the data which went beyond my conceptual framework (see chapter 7). The principle of self-reflection was central to my analysis of data and I maintained a reflexive awareness of the influence of my own position and experiences on the interpretation process, acknowledging that an ‘outsider’ may have understood and interpreted the data from a different standpoint.

Summary of chapter three

In this chapter I have discussed and justified the reasons for my chosen study design and methodological approach, relating these to the aims of the study and the research questions. I have presented the strategies used to collect data and explored the ethical issues which were raised in this process. I have described and explained the rigorous methods adopted for data management, analysis and interpretation. The following three chapters will present the findings of my research, which for ease of management have been structured into a chronological sequence beginning with women’s anticipation of induction in late pregnancy (Chapter 4), followed by the induction experience (Chapter 5) and finally reflections on the

induction experience (Chapter 6). Chapter 7 discusses the themes emerging from the findings of this study in relation to the conceptual framework. Implications for clinical practice and for further research are set out in chapter 8.

4. Anticipating induction in late pregnancy

Introduction

This chapter and the following two chapters present the findings of a thematic analysis of the data from interviews, maternity records and the researcher's reflective diary. This chapter explores the lead up to induction, focusing mainly on how women acquired information and perceived choice about induction, how this fitted into their expectations of labour and birth, how they arrived at a decision to accept induction and finally how they engaged with self-help measures to avoid medical induction. In order to provide structure, themes have been grouped into a roughly chronological order, which does not necessarily reflect the sequence in which the topics were addressed in the interview schedule. Each theme is supported by illustrative quotations from the participants and heed has been paid to the context in which it was provided so as not to distort the original meaning. Some quotations have been truncated for the sake of brevity and where words have been omitted this is indicated thus: [...]. Care has been taken not to alter the original meaning of the quotation. A brief biographical overview of each participant and the reason for their induction is included in Appendix 7. All names used are pseudonyms and do not necessarily bear any relation to ethnicity, age or other characteristics of participants.

Sources of information about induction

Family and friends

Prior to undergoing induction, family and friends were the most frequently cited sources of information about the procedure. This contrasts with other recent UK studies in which women cited clinicians as the main providers of information (Gammie & Key, 2014; Shetty et al., 2005). The impressions gained of induction were varied and sometimes contradictory. Increased pain was most frequently cited,

but there was little consensus of opinion on other aspects; for example, four women had heard that the onset of labour would be quicker than natural labour, whilst five believed it would take longer. Two women thought that either could be the case. The likelihood of further medical intervention was rarely mentioned.

I just knew that it would...from having spoken to other Mums and Dads that it would artificially bring on the contractions....the one thing I did know was that it would all mean it would happen a lot quicker than it probably would normally and that therefore it might be a good deal more painful.... (Clare)

My mother had been induced..... I didn't really know what it was other than it was meant to be more painful than a natural birth and that they gave you something to make the baby come (Megan)

Some interviewees believed in a familial tendency to induction:

I think I always knew, like, before, because my Mum was induced with both me and my sister, so I always sort of knew about it and knew it was probably going to happen with me (Olivia)

To be honest I thought, all the way along I thought I'd go to induction...I don't know how true it is but they say, I don't know whether it runs in the family, but both my sisters were induced for all their pregnancies and I just had a feeling... (Tanya)

There is some evidence that prolonged pregnancy has a familial tendency (Ryan et al., 2011), however, the reasons for the various family members having had labour induced was not discussed. Lay beliefs about the duration of pregnancy and the onset of labour are plentiful (Schaffir, 2002) and perhaps warrant further study, as it

seems likely that they have a significant role in shaping women's attitudes to induction.

Whilst information from family members tended to focus on the negative, Sarah received positive and reassuring information about induction:

...I had family also tell me about it and they said it's okay and so I wasn't worried enough to think I need to get more information. (Sarah)

Five women had a family member in the health professions, but only Sarah and Tanya (who were related to midwives) perceived this to have given them a cognitive advantage.

Antenatal classes

All women in this study had attended some form of antenatal classes, which was not unanticipated, as there is evidence to show that first-time mothers of a higher socio-economic status are among those most likely to engage in antenatal education (Gagnon & Sandall, 2009; Lu et al., 2003). Due to their geographical locations, it is very unlikely that any of the participants had attended the same class. The majority attended classes run by local NHS community midwives. One woman (Clare) attended private classes run by the obstetric team with which she had booked as a private patient. Six women attended NCT classes only and just one (Laura) attended the Trust's own pre-induction class; this was by default as she had moved into the area in late pregnancy and no other classes had been available. Only two other women had been aware of the pre-induction class: one had forgotten about it and the other had chosen not to attend as she already felt sufficiently informed. Details about the pre-induction class are inserted into women's hand-held maternity notes early in pregnancy in the form of a small sticker on an inside page. It is not known whether those who were unaware of the classes had overlooked the sticker or had not in fact received one. Some women expressed regret that this had not been brought to their attention.

Most women recalled little coverage of induction in their antenatal classes: several were not sure whether it had been mentioned and those who did recall information perceived it to be sketchy or not very memorable.

I don't remember a lot of detail though...nothing that really sticks in my mind,..." (Donna: NHS classes)

I don't think they did [mention induction] and if they did, I don't remember it ...it wasn't memorable! (Rose: NHS classes)

Two women referred to the class leader's pessimistic attitude:

Our NCT lady who did tend to be a bit pessimistic about a lot of aspects of birth, she sort of said, "Well you're going to be on a big communal ward, you won't have your husband with you, you might be in the pain of contractions when everyone else is there watching East Enders," and so I think that idea instantly was quite a negative one and made me think oh I really hope I don't have to have that (Sarah: NCT classes)

..so we was [sic] told before, actually at our antenatal classes that it's not very good... it's not a good idea to be induced unless you really need to be (Polly, NHS classes)

Some women stated that they had not paid much attention, as they were unable to relate induction to their own situation and could not foresee it happening. This is of no surprise as antenatal classes often involve large numbers and therefore tend to focus on normative needs rather than the individual. Others have noted a similar dissatisfaction with the coverage of induction at antenatal classes (Austin & Benn, 2006).

NHS classes attracted less criticism than those run by the NCT. Most women deemed the latter to have been idealistic, patronising or not relevant to their own situation.

*NCT's very much everyone has a perfect birth and that's it....I mean, nobody had said that ... inducing you actually makes the contractions more painful.
(Megan: NCT classes)*

In NCT...we spent half an hour drawing pictures of what we thought would help induce labour, so pineapple and raspberry leaf tea... Drawing pictures! We're all in our 30s, all professionals ...and we're drawing pictures! It was not impressive, this class...so I hadn't paid much attention, or the information wasn't there to be paid attention to. (Jasmine: NCT)

It is possible that the degree of criticism levelled against NCT classes reflected the fact that as these are paid for, women might have had higher expectations of them than they would of NHS classes. Only one of the seven women who attended NCT classes felt that it had provided adequate and appropriate information about induction and welcomed the different perspectives it offered:

...and I was surprised because her [the midwife's] level of information was very different to what I was told at NCTI guess their viewpoint's different ...so I was pleased I got a different angle of it. (Nina: NCT)

Overall, only two women reported that antenatal classes had provided them with detailed, memorable and meaningful information about induction: Clare, who had attended private classes; and Laura, who had attended the Trust's own pre-induction class. In each case, the number of attendees in the group had been in single figures and women perceived the information they received to have been presented in a realistic way which they were able to assimilate into their own scheme of

understanding and relate to their own situation. The evidence from these two examples is too limited to generalize, but supports the notion that woman-centred care (Leap, 2009; Stapleton et al., 2002a), focused on the needs of the individual is the key to transmitting meaningful information.

Media Sources

The maternity unit produces an information leaflet for women facing induction. Eleven women reported reading a copy and five women supplemented this with other, non-specified written information. Two women (Isobel and Fay) reported receiving the leaflet but not having read it. One woman received it according to her maternity records, but did not mention it at interview. Clare, who was treated privately, had been given the MIDIRS *Informed Choice* leaflets (MIDIRS, 2015) and had read these, plus other sources of information. In the case of the remaining six women it is not known whether or not they had received a leaflet or referred to any printed materials for information.

Other studies have cited printed matter as a key source of information in pregnancy (Grimes, Forster, & Newton, 2014; Soltani & Dickinson, 2005) yet this was not the case here. The reasons why some women in this study chose not to engage with written information are unclear, given that all spoke fluent English and would have been unlikely to find the information intellectually challenging. This raises questions about the appeal of the Trust information leaflets (their format and presentation as well as the content) and of the way in which they were offered. One of the findings of a Department of Health funded evaluation of the MIDIRS *Informed Choice* leaflets (Kirkham & Stapleton, 2001; O'Cathain et al., 2002b) was that these were often presented without explanation or discussion (Stapleton et al., 2002a) and it is possible that this was repeated here, as the example below suggests:

[....]...I've got so many leaflets I don't know what's what anymore!...I don't remember reading one, but they might well have done and I've missed it...so I'm not sure completely! (Olivia)

It appeared that information leaflets were simply handed out by midwives rather than being used as a tool for discussion: however, any attempt at this may have been difficult within the limited time span of the antenatal appointment.

Contrary to expectations, electronic media were mentioned by just seven women. Two women (Beth and Sarah) used 'Apps' and found them helpful, whereas those who searched websites generally found them of limited benefit, partly due to difficulty in finding credible websites, but also because of difficulty relating the information to their own situation:

.....and then, obviously, you look on the internet and there's so many... lots of horror stories ...and other people were saying how it wasn't that bad...but it didn't really help me, because it was going to be my experience anyway!
(Donna)

I tried really hard to find sort of official like NHS ones or the Baby Centre details... but generally, all you get is like Yahoo questions and answers there and you get sort of people's opinions and stuff [...].(Olivia)

An exception was Nina, who, despite not having used websites, identified chat rooms as potential sources of 'real' information:

[..] .I wouldn't look so much at the scientific evidence, I would look at the forums and the chat websites where mums talk about their experiences...coz that's the real truth isn't it? (Nina)

Only Clare appeared to have conducted a detailed and extensive internet search, seeking objective information in order to prepare herself for the “*different scenarios for labour*”.

All 21 participants had mobile phones, whilst PCs, i-pads or laptops were evident in most homes: it is therefore surprising that more use was not made of media sources, as other evidence suggests that the internet is increasingly being used to supplement information about childbirth (Lagan, Sinclair, & Kernohan, 2011). However, women seemed wary of the reliability of internet sources; furthermore, the short time span between booking for induction and admission to hospital may have limited the opportunities to conduct a thorough search.

Overall, women appeared to have learned more about induction from family and friends than from official sources. Women seemed to find anecdotal knowledge more memorable and were better able to relate to the stories of real people, as these were perceived as relevant and fitted within their scheme of understanding, whereas information from official sources was seen as theoretical and out of temporal context.

Information from health professionals at the time of booking induction

The NICE guidelines on induction of labour state that healthcare professionals should give a full explanation of the reasons for induction, the induction process, risks and benefits and alternatives to induction. The guide goes on to advise that women should be given time to explore information and consider other options, to ask questions and to discuss the information with their partner before making a decision (National Institute for Health and Clinical Excellence, 2008).

Only seven of the 21 participants appeared to have been offered more than very basic information from health professionals: four of these received this from their midwife or doctor, one had been informed by her private obstetric team, one had attended a pre-induction class and one had been exceptionally assertive in seeking information from health professionals. All of these women felt that they had been well informed. The remaining 14 women, despite having received only rudimentary information about induction, did not necessarily perceive this as a problem **at the time**. There were, however, several specific aspects of induction which, with hindsight, women would have preferred to have known more about in advance. These are included in chapter 6, in the section entitled “Suggestions for improving the induction experience”.

Several women had difficulty recalling what information had been given at the time of booking and some appeared to confuse this with information given later in hospital. In most cases, verbal information was, at best, perfunctory:

...No, I have to admit, there was next... no information about the induction and what was going to happen. (Tanya)

Not really, I think we were given a sheet of paper to read, but not really other than...I mean, I was actually told 'You'll be put on a drip'[...] And it could happen in six hours, it could happen in 24 hours, it might not work, and that was about all I was told. (Megan)

There was no suggestion that anyone apart from Nina had actually been invited to take time to consider their options in accordance with NICE guidelines: in many cases it seems to have been assumed that a decision would be made on the spot. In Donna's case, for example, it appeared that information was actually given **after** the decision had been made to book induction:

[...] he (the doctor) told me to go to see the midwife at the desk who then gave me a leaflet to read while she went and booked it (the induction). (Donna)

In some cases, midwives appeared to have been too busy to offer much explanation; a phenomenon also noted in other studies (Stapleton et al., 2002a)

[...]...I think she was quite busy, she always...just seemed a bit rushed, so we didn't really get to talk a lot but...yeah, I didn't really know anything. (Olivia)

I think she assumed that I knew about it and I sort of didn't really get asked if I knew about it but I... yeah, that was it, it was all quite a quick appointment, I think they had others waiting. (Sarah)

Few women sought further information from clinical staff. The exception was Jasmine, who experienced pre-labour rupture of membranes at 33 weeks of pregnancy and following conservative management, was admitted for induction three weeks later. Jasmine reported that she took every opportunity to “grill” staff about the relative risks and benefits of induction until her information needs were met. Jasmine’s situation was unusual in that due to her circumstances, she had more contact with the hospital than other women and thus more opportunities to seek information. Jasmine also gave the impression of being more assertive than the other participants and less prone to intimidation by the hierarchy of the hospital and this may have empowered her to seek the information she needed.

Information avoidance

One possible explanation for the apparent general lack of interest in seeking more information may have the fear of knowing too much:

...to be honest, I didn't want to know too much about it, because I didn't want to get too worried – hung up on it, so I just said “let's talk about it next week if I have to come back to you we'll talk about it then” That was it really. So the information was there, but I didn't want to go into too much detail. (Nina)

...sometimes with these things I think it's better to not delve into it too much. (Wendy)

In retrospect, other women commented that although there were gaps in their knowledge about induction prior to the event, there were certain details that they would not wish to have known about in advance:

Honestly ...if I was going into it I would probably ratherknow less than I do now [...] Because if... if I'd known that within the course of that day that I'd have ended up having a CaesareanI probably would have been a lot more....tense and.... (Clare)

Clare's attitude reflected her need to be in control of knowledge, seeking enough to provide the information she needed, but avoiding that which might cause undue anxiety. This supports the theory that in order to maintain an emotional equilibrium, women may avoid or ignore information that might upset them and tend to ignore information which seems irrelevant (Hallgren, Kihlgren, Norberg, & Forslin, 1995; Levy, 1999d). This might explain why many were not receptive to generalised information from antenatal classes or the media and strengthens the argument for providing information that is tailored to individual needs and wishes. The question is how to facilitate this within a rigid system of care that allows limited contact time between women and midwives to explore and discuss information needs.

Expectations of childbirth and attitudes to induction

All of the participants in this study had been considered low-risk at the time of booking for antenatal care and had originally hoped for a natural birth with minimal interventions. Nine women had hoped for a water birth and one (Nina) had planned to give birth at home. Some, like Isobel had a rather idealized image of what labour would be like:

I'm hoping [sic] for a nice breezy water birth, gas and air and that's it! That's what I wanted. (Isobel)

More than one third of women had not considered the possibility of their pregnancy ending in induction:

I just thought, I won't be induced, it'll come on time! It'll come not on time, because baby was late, but it will come, I won't have to be induced, so I just wasn't...I just didn't...I thought I know they've said it, but I didn't think it would happen. (Rose)

...Of all the things that I was hoping for in a labour, I didn't even think about induction really..... (Isobel)

However, most women appeared not to have set a very high value on their ideals and attitudes to unplanned interventions (including induction) were generally philosophical:

Yeah, I mean to be honest when I got pregnant [...] I didn't have a birth plan or anything like that, I was like, you know what, whatever happens has to happen so if baby doesn't come out then I'll have to be induced, if it has to be a caesarean it has to be a caesarean. (Fay)

...it wasn't my first choice. I would have rather gone through a different way, different route, but I kind of figured once I got overdue by a week that that was going to be what happens so... (Beth)

I didn't really want it. I didn't have a big birth plan, I wasn't one of these people that had this fantastic idea of what labour was going to be like and all calm and everything. I pretty much had said from the beginning that anything that needs to be done I'm happy to have done, whether that, you know, whether that be inducing, [...]. (Hannah)

In the case of five women (Sarah, Polly, Laura, Gemma and Tanya) induction was welcomed as a timely end to an uncomfortable pregnancy. This supports other studies which have shown that women's attitudes to induction shift as pregnancy progresses beyond the expected date of delivery and they become more receptive to the idea as pregnancy starts to become uncomfortable (Heimstad et al., 2007; Hildingsson et al., 2011; Murtagh & Folan, 2014; Roberts & Young, 1991)

I actually felt a bit exited, coz I knew it wouldn't be long from then ...coz by that point I was desperate! (laughs) so, yeah, I was quite exited. (Olivia)

You kind of reach the point where you just [...] I was just bored (laughs) [...] it's such a long wait isn't it? to meet them... (Tanya)

In contrast, a minority of women were deeply unsettled by the prospect of induction, either through feeling unready to give birth or because they had made extensive plans for a natural birth:

... in my mind (baby) was going to be two weeks late and I still had another four weeks to go... I'd only finished work on the Friday beforehand as well ... it was just sort of we had it all planned out that it was going to happen differently and things, I hadn't had my hair cut! (Megan)

So obviously I'm feeling very, very, very anxious knowing what's coming and just...not feeling ready for it...that's just me in my mind not being ready to have a baby just yet, even though I was three days away from potentially having baby anyway. (Hannah)

I was very disappointed that we had to have this conversation [about induction] I think if I ...had wanted a natural birth [...] or I was just having a standard birth I don't know how I would have felt differently, but in fact I had my water pool here...it was right here...it was heated, it was filled with water, it was ready to go, it put a lot of pressure, a lot more pressure I think ...because... it was there ready and waiting. (Nina)

I [...] didn't want to go down that route – I'd done my hypnobirthing course and I wanted to have a natural birth if I could ... (Emily)

Hannah's feelings contrast with her earlier, more relaxed attitude to intervention, suggesting that it was not induction *per se* which caused her anxiety, rather the sudden change of plan which upset her equilibrium. This supports the findings of a similar sized Australian study indicating that induction represented a major shift in women's expectations of childbirth (Gatward et al., 2007). This was most keenly felt by those who had invested emotionally and financially in a natural birth, notably, Emily, who had attended hypnobirthing classes and consulted an alternative therapist and Nina, who had planned a home birth and hired a pool. Both of these women, in common with Hannah and Megan had very negative experiences of induction which suggests a possible association between expectations and experiences. This implies the need for better preparation and support antenatally in order to help women manage their expectations of childbirth (Gatward et al., 2007). Comparisons between women's expectations and subsequent experiences will be addressed in chapter six.

Influences on women's decision-making

Reasons for induction

Post-dates pregnancy was the most common reason for induction, involving 15 women. Five were induced for medical reasons and one for being aged 40. Interestingly, there were two women of this age with no other risk factors: each had a different consultant, one of whom had a policy of inducing all women aged 40+ before 40 weeks gestation whilst the other treated them no differently to other women. In each case, the women were aware of their consultant's policy and were happy to accept it.

The following table gives details of those women who were induced for medical reasons:

Table 9 Women who were induced for medical reasons

Name	Risk factor
Donna	Gestational diabetes
Hannah	Pre-eclampsia
Jasmine	Pre-term, pre-labour rupture of membranes
Megan	Pre-labour rupture of membranes at term
Polly	Reduced fetal movements

Induction as part of the care 'package'

Most women saw induction as an inevitable component of the care 'package', especially for post-dates pregnancy. Where it was presented as a choice, there was a noted bias towards compliance:

...it was presented as a choice but they were definitely encouraging me to strongly consider it rather than waiting. (Clare)

Some women had reportedly been "told" that they would be induced, thereby pre-empting any choice. Others used phrases such as "*it's the policy*" or, to quote Karen: "*the system just took over*" suggesting that women were simply swept along in the tide of routine practice and expected to conform. There was little evidence of any discussion of other options.

...I think it was just sort of this is what's going to happen rather than ...yeah...no. I don't remember there being a choice. (Donna)

....there is no choice and if that's what they're booking then that's what you have to go with. (Sarah)

I knew, like you generally get induced if you go 2 weeks over, so I just took it that's what happens...so, yes, I was fine with it. (Olivia)

Beth *I think at the time I would have liked to have said no I'd rather, rather not, but...*

AJ *What stopped you from saying "no, I'd rather not?"*

Beth *I just thought that was the way it went!*

When asked whether they had felt involved in the decision to be induced, half of the women answered affirmatively, but sometimes their words suggested that that this involved little more than agreeing to a plan: their fate had already been sealed.

I was kind of part of the decision, I was there when she made the phone call to the hospital but it, other than that it was 'oh, if you haven't gone into labour by this date then this is what's gonna happen' and that was, I was like 'oh, OK. (Gemma)

These findings lend weight to arguments that since induction has become increasingly routine, it has become part of women's expectations and is rarely opposed or questioned (Skyrme, 2014; Stevens, 2010). Although some women were aware of their right to choose, this was generally overridden by a perceived obligation to comply with the system or fear that refusal might compromise the baby's safety. Furthermore, rather than being encouraged to evaluate their options with significant others and arrive at an informed decision (National Institute for Health and Clinical Excellence, 2008), most women were either overtly or subtly steered towards compliance.

Women who challenged routine

Two women successfully negotiated minor changes to the timing of induction:

I said to them "if...you do not think at this precise moment in time that I'm huge risk then I'd rather go home". So they let me go home but I had to then be monitored every few days... (Hannah)

She offered me to have my induction on the 12th day, 2 days after the sweep and I asked for it to be done a couple of days later because I wanted an extra

couple of days to try and go into labour naturally...so I could get the pool birth and they were fully booked for the 12th day anyway, so they booked me in for 14 days after my due date to be induced (Vicky)

Only Jasmine and Nina challenged the suggestion of induction. In Jasmine's case, this centred on a need for assurance that induction was the best option: as previously stated, she repeatedly "grilled" staff for information:

So I got to the [...] ward and was asking them not about the process of induction, but why I had to be induced that day, rather than allowing me to cook, grow the baby a bit more. And of course the risk with infection was the reason. [...] I asked everybody. I found a registrar that... I insisted on seeing more than one person, so asked the midwives, I asked a registrar, and then I collared [consultant] in the corridor and asked her. (Jasmine)

Once satisfied that she was making the right decision, Jasmine readily agreed to induction. Nina, on the other hand, was unique in resisting the idea of induction (for post-dates pregnancy) for as long as she could, until she was eventually worn down by the continuing pressure to conform, as illustrated by the excerpts below:

AJ Yes, when the midwife was booking induction, did you feel that you had a choice to say "yes I'll go ahead with this" or "no, I'd rather wait"?

Nina Yes, because I told her at the time I'm not having it! (Both laugh) She said "don't worry, you probably won't need it but I need to book it" [...] you have to be booked in [...] the more she started going through the clinical, medical, all the medicines, I started to panic a little bit actually, I must say, because that's really not what I'm about and so opposite from my home birth, so it was a lot of information and I started to panic that's why I said "I don't want this, I don't want this" and she said [...] you can talk to people when you get there, this is just standard procedure [...]

Nina was offered the option to delay induction, but only within the parameters of hospital guidelines:

[...] she just said “you can try and delay it but (Trust’s) guidelines are [...] so she did run through that we could go back in and be monitored every day and talk to a consultant but that was about it to be honest, she more went into detail about what we could do now, so ...the walking and the sex and the pineapple! And all these silly things [...] (Nina).

Other midwives whom Nina saw during the last weeks of pregnancy reinforced the need to book a date for induction, whilst simultaneously appearing to encourage her to keep her options open:

[...] I went in for a couple of sweeps as well and they said “look, (name), whatever you do, go to your booking, even if you don’t want to be induced, just go to your booking because at least then they’ll know that your baby’s healthy and we can look after you [...] (Nina).

The pressure to conform to expectations combined with the stress of trying to avoid medical induction eventually caused Nina to capitulate:

[...] they did say I could push my induction date back, but because I kept going in every day and all the stress of the curries and the this and the that, when it came to it I was like “do you know what? Let’s just do it, I can’t deal with this stress any more [...] (Nina).

In contrast to other participants, Nina's community midwife had offered detailed information about the rationale for induction as well as the process and had apparently striven to encourage choice and engagement with self-help measures to avoid medical induction: however, beneath the rhetoric, the underlying pressure to conform was clear.

Perception of risk and trust in medical opinion

For women induced for medical reasons, the risks of continuing the pregnancy against those of expectant management had been made explicit: only Jasmine needed further convincing, whilst others complied without question:

....I mean, I knew from NCT, I'd been told 'You can always say no'...but I think when you're told 'risk of infection' you just do it. (Megan)

Women who were offered induction for post-dates pregnancy were mostly non-specific about the risks they perceived in continuing their pregnancy. Those aged 40 referred to their age as a risk-factor. Only two women mentioned the risk of stillbirth:

Not, I wouldn't want to leave it longer because I know that there's higher risks of, you know, stillbirths and all sorts of things so, and also the longer you're leaving it obviously the bigger the baby's gonna be. (Wendy)

...I actually know of two people who have had stillbirths, so that was a kind of shadow that hangs over us, hangs over me and one of them was quite, fairly recent and so I just thought "gosh, you know" and they were older, they were my age so I thought I don't want my placenta to wear out and I'm a bit of an anxious person ... (Emily)

It is possible that this fear lurked at the back of many minds, yet was not expressed due to the social taboo about mentioning death. All women apart from Nina believed that induction was in their baby's best interest and trusted the word of professionals. In most cases, this was done unhesitatingly, implying that concern for the baby's wellbeing overrode any aspirations for a natural birth experience, a phenomenon noted in several other studies (Heimstad et al., 2007; Moore et al., 2014; Murtagh & Folan, 2014; Roberts & Young, 1991).

[...] at the penultimate antenatal appointment I thought well no, I have to do this, I have to take the advice of the people sitting in front of me....that me being worried about not having a kind of a natural labour versus the welfare of the baby...that has to come first. (Clare)

[...] I don't know anything about medicine; they're saying it for my benefit and the baby's benefit, so I'll just go with whatever the medical people say. (Rose)

...and it (the App) just says also about some of the risks if you are overdue like past 42 weeks about the baby's health and I think that's when I just thought, right, it needs to be now and that was my paramount focus was (baby) being okay. (Sarah)

Trust in professional opinion was very strong and risk was generally seen only in terms of possible dangers to the baby of prolonged pregnancy, fuelled by 'Horror stories' from family and friends. No mention was made of how likely that risk was perceived to be: a minimal risk situation seemed to be the only one acceptable.

In contrast to the other participants, Nina held a different view about safety, arguing that home was the safest place for her baby to be born. Furthermore, Nina

contended the midwife's estimation of her baby's expected date of birth and thus perceived no risk to prolonging her pregnancy:

So in our mind our baby just wasn't ready to come out, there was no danger aspect for us [...] And I was just asking her "what can I do to avoid it?" and that's how it first came up, [...] I was adamant I wasn't going to be induced.
(Nina)

Nina's view supports the argument that for some women the concept of safety is not solely based on the avoidance of physical harm, but encompasses wider aspects such as social or psychological safety (Department of Health, 1993; Edwards, 2008). Nina's belief that home was the safest place for her to give birth was consistent with her sense of self-efficacy, whereas the other participants felt safer putting their trust in health professionals and the hospital system.

Influence of partners

It is known that families play a significant role in influencing women's decision-making around the time of childbirth, yet the role of partners in women's decisions to accept induction has not been explored in previous investigations. In most cases, the impression given was that husbands/partners had passively supported the women in their decision to accept induction, having few strong feelings of their own. There was no reference to any men having wanted to avoid induction. Some women mentioned that the decision had been a joint one or involved negotiation:

We decided both... together. (Amy)

...I think my partner was more interested in it than me! (Laughs) I think he thought ... can we just like book it now? And I went, no, I really don't want that

to happen... [So he was keener than you?] Yes, definitely! He just wanted the baby, I think. He just wanted (baby) to come out. (Beth)

...and when I spoke to (partner), he was the one to sort of realise I needed a bit of a prod and, you know [...] they're saying to you baby is ready...so we need to do it [...] as soon as we heard that the benefits for the baby are not as great as the risk of infection, he said, "You haven't got a choice," which was the pushing over the cliff sort of thing..." (Jasmine)

I think he was very much 'It's got to be done', you know, we were being told 'Risk of infection, you have to be induced within 48 hours', it's got to happen." (Megan)

Beth's and Jasmine's initial hesitation to accept induction was overcome by their partners giving them "a *bit of a prod*" as Jasmine put it, steering them towards what they saw as the safe option. In both cases, the men seem to have seen induction in fairly simplistic terms – a logical choice for the sake of safety and possibly expediency – whereas Beth and Jasmine's feelings were more complex. Overall, it appears that partners played a significant role in influencing decision-making, notably by reflecting the medical viewpoint and encouraging women to accept the plan of care which was offered.

Women's use of self-help methods to stimulate labour onset.

Methods used

The use of complementary and alternative medicine (CAM) is becoming increasingly evident among childbearing women, particularly as means to avoid prolonged

pregnancy or medical induction (see chapter two), (Adams et al., 2009; Cant et al., 2011; Hall et al., 2012b). Eighteen women stated that they had tried at least one self-help method, as illustrated in the following table:

Table 10: Number of self-help methods used by women

Name	Number of self-help methods used
Amy	2
Beth	3
Clare	2
Donna	0
Emily	6
Fay	2
Gemma	3
Hannah	3
Isobel	2
Jasmine	0
Karen	2
Laura	2
Megan	1
Nina	7
Olivia	2
Polly	0
Rose	3
Sarah	5
Tanya	4
Vicky	5
Wendy	4

Of those women who did not attempt self-help methods, Jasmine had experienced pre-term rupture of membranes and needed to maintain her pregnancy until induction was clinically indicated, whilst Polly and Donna had only a very short time-span between booking their induction and admission to hospital, which left little time to explore self-help methods. In common with the findings of other studies, antenatal classes, midwives and family or peer networks were the most common sources of information about self-help methods (Adams et al., 2009; Austin & Benn, 2006; Hall et al., 2011; Schaffir, 2002; Westfall & Benoit, 2004). The methods cited or used are listed in the following table:

Table 11 Types of self-help methods used or known of by participants

Method	Actually used	Known of but not used
Eating curry/chilli/spicy food	14	0
Going for walks/being active	11	2
Bouncing on birthing/gym ball	7	0
Pineapple	6	5
Sexual intercourse	5	5
Raspberry leaf tea	6	1
Housework	2	0
Nipple stimulation	2	0
Raspberry leaf capsules	2	0
Hot baths	1	1
Reflexology	1	0
Sparkling wine	1	0
Clarysage	1	0
Castor oil	0	3
Acupuncture	0	1

There were no real surprises: apart from sparkling wine, all of the methods listed above are frequently cited in the literature and anecdotally as among those most widely believed to stimulate the onset of labour (Kozhimannil et al., 2013; Schaffir, 2002). The most frequently mentioned methods compare similarly to those found a New Zealand study by Austin and Benn (2006). There is currently no evidence to support the recommendation of any of these methods, although evidence is emerging to suggest that acupuncture and raspberry leaf may be effective (Hall et al., 2012a).

Women's attitudes to self-help methods

It was notable that women who portrayed themselves as having have a stronger need for personal control (such as Nina, Emily and Vicky), typically used a wider range of self-help methods than those who were happier to defer to clinical opinion from the outset (such as Isobel, Amy and Fay). For Nina, using self-help methods in preference to conventional medicine was a way of life:

...I'm not one for the medical... way of life really, I never take medicine, ever, I never go to the doctor and I'm never sick... (Nina)

Despite her eagerness, however, Nina's enthusiasm eventually waned:

The lot! We tried everything we tried the...um... the Clarysage as well, because they said that helped... I had the pineapple and the pineapple juice, we had sex, I went for lots of walks, I have a dog – I go for walks anyway – I sweeps, I had the curry, I had...what else is there? [...] Oh I had the tea! I had the tea, yup, I had everything – you name it! [...] and I was just desperately eating curry every day and I was exhausted by the end of it and it didn't work! And I just thought.....I'm not doing this next time. (Nina)

Nina was one of just three women who had tried every method they knew of, whilst the others “cherry picked” only those methods which appealed to them. Many women adopted a humorous or cynical tone when talking about self-help methods, giving the impression that there was an underlying social expectation to “give it a go” even though they did not express much faith in it:

Yeah, we did the, all the traditional things (laughs) with the pineapple and the curry ...that was all silly...” (Beth)

In the end I actually got kind of bored trying all this stuff because it’s tiring trying to work out what I can do and I thought ‘well baby’ll just come along when it’s ready’...”. (Gemma)

Emily was rather more earnest in her approach, but like some others, seemed to have held back for fear of causing harm:

...I felt I did everything a bit... I had tried reflexology two days before I had the appointment, with [alternative therapist].... we tried walks... we had sex once or twice, I drank some raspberry leaf tea, but I think I felt, I hadn’t done any of these things really in extreme fashion, perhaps because I didn’t want to sort of...push things...(Emily)

...but I knew that all of the things, like the curries and the pineapple, always upsets your stomach...I was nervous enough about having (baby) without having diarrhoea. (Megan)

Yeah, no I'm quite laid back, I just said, "Oh I don't want to mess anything up so I'll deal with it with nature. (Fay)

This apparent fear of causing harm supports the earlier observation that concern for the baby's safety was paramount. This challenges theories which suggests that women use self-help methods as means of managing the anxiety and uncertainty associated with childbirth (Mitchell, 2010). There was a sense that women regarded self-help methods as faintly ridiculous and it is possible that awareness of the interviewer's status as a midwife and an educator may have made them wary of appearing too enthusiastic for fear of being perceived as gullible or foolish. However, it must be remembered that all of these women, apart from Vicky, progressed to a medically-induced labour, therefore, in terms of fulfilling their intended purpose, none of the self-help methods had been successful, which is very likely to have coloured women's attitude to them in retrospect.

Summary of chapter 4

This chapter has presented the findings of this study relating to women's experiences during the lead up to induction, focusing particularly on how women acquired information and made decisions about induction, how this fitted with their expectations of labour and birth and how they engaged with self-help methods in an attempt to avoid medical induction.

Formal information about induction from health professionals was generally neither meaningful nor memorable, as most women were unable to relate to it in the same way as anecdotal information from family and peers. Exceptions were noted where women received targeted, individualized information from health professionals with a special interest in induction. This highlights the need for woman-centred information tailored to the needs and wishes of each individual in order to support informed decision-making in accordance with NICE (2008) recommendations.

There was very little evidence of discussion between woman and health professionals and induction was generally presented as part of the routine package

of care, particularly for women with post-dates pregnancies and no other risk factors. The relative risks of induction versus continued pregnancy were poorly understood, implying a need for improved communication of risk to promote informed decision-making. The overarching impression of women's experiences with health professionals is that rather than empowering women to take ownership of their care, women were systematically steered towards compliance with expected norms. This was enhanced in some cases by women's partners and by their own awareness of what constituted the accepted norm.

Attitudes towards induction were mostly pragmatic and faith in health professionals and hospital systems was strong. Despite the growing discourse on informed choice, fewer women were inclined to question induction than in the "Great Expectations" study conducted some 20 years ago (Green et al., 1998). Engagement with self-help measures was extensive, although attitudes towards it were highly ambivalent. This suggests that rather than being an expression of individual agency, this was more of a reflection of widespread social expectations.

5. The induction experience

Introduction

This chapter presents and discusses themes relating to women's experiences during the induction process. Women were invited to talk about their induction experience from the time they were admitted to hospital: no end-point was specified. Some stopped at the point where they were transferred to the delivery suite, whilst others spoke about the whole birthing experience, typically where they perceived a direct cause and effect between induction and later events in labour and birth. This was clearly important to them and contributed to their overall evaluation of the induction experience (see chapter 6).

Women were encouraged to tell their own stories of how their induction happened and how they felt at the time. A chronological sequence of events was not always apparent; therefore in order to present these findings systematically, they have been grouped into themes, beginning with an overview of the methods of induction which were used.

The induction process

A description of the methods used to induce labour has been given in chapter one. At the time of data collection, outpatient induction of labour had not been introduced by the Trust. Eighteen women in this study began their induction with admission to the antenatal ward: the others were admitted directly to the delivery suite. In Clare's case, this was in accordance with the preference of her private consultant, whereas Hannah went straight to the delivery suite due to dangerously raised blood pressure. Megan was given PGE₂ on the delivery suite as her membranes had ruptured, but was then transferred to the antenatal ward to await the onset of labour

Methods of induction

Sixteen women began their induction with vaginal Prostaglandin (PGE₂), either in pessary form (Propess™) or as a gel (Prostin™). Of the five women who received no PGE₂, three (Rose, Karen and Vicky) were deemed not to require it due to a high Bishop's score or to the spontaneous onset of contractions and were eventually transferred to the delivery suite for artificial rupture of the membranes (ARM). Jasmine received Syntocinon™ alone as she had experienced pre-term rupture of membranes. Clare, who was under the care of a private team, fitted the criteria for induction with PGE₂, but was admitted straight to the delivery suite for ARM and Syntocinon™ in accordance with her consultant's plan. Clare was aware that this was a deviation from the usual protocol: she reported that her consultant had told her: "*We don't mess around giving you the pessary*", which Clare interpreted as meaning a speedier onset of labour. As she had heard "*horror stories*" of long-drawn out labours, Clare was happy to accept this. Eleven women subsequently received an intravenous oxytocic (Syntocinon™) after transfer to the delivery suite, either as part of the induction process or to augment labour.

Membrane sweeping

Membrane sweeping (also known as cervical sweeping) is a commonly used method of stimulating the onset of labour without recourse to medical means (see chapter 1). Prior to admission to hospital, nine women had been given a membrane sweep on one or two occasions by their community midwife or at a Saturday drop-in centre. In the case of four women, a sweep was attempted but abandoned as the cervix was inaccessible. In the case of a further four women, a sweep was either contra-indicated or not attempted. Of the nine women who received a sweep, only three subsequently did not require PGE₂.

Most women referred to the sweep in a very matter-of-fact way, implying that it had been presented as a routine part of their care. Women's impressions of the purpose of a sweep were that it would "*get things going*" (Polly) or "*kick-start labour*" (Isobel), but little reference was made to any discussion about its effectiveness or the

possible side-effects. Some were aware that it might be uncomfortable, or, as Rose put it: *“a bit worse than a smear test”*,

NICE recommends offering membrane sweeps at 40 and 41 weeks, yet only four women received more than one sweep, even though all but two of those for whom it was indicated were over 41 weeks of pregnancy by the time they were admitted for induction. Reasons for this were unclear and highlight scope for improvement in the documentation of this process.

Three women were uncertain whether or not a sweep had been carried out and this could not be confirmed from their maternity records: this raises questions about informed consent, as it implies that women had, at some stage, been examined internally (otherwise they would have known that no sweep had been undertaken) but had not been informed of the reason for this. Lack of documentary evidence is of some concern, as this fails to provide a clear and continuous picture of the treatment given which may have implications for subsequent treatment (Nursing and Midwifery Council, 2008). It also leaves midwives exposed to criticism should their care be questioned.

The Waiting Game

Delays in starting induction

Women had been given specific instructions about arriving at the hospital at a particular time - typically between 8 and 10 a.m. This is in keeping with the NICE guidelines, which recommend that induction is commenced in the morning, as this has been associated with greater maternal satisfaction (National Institute for Health and Clinical Excellence, 2008). However, the onus on timekeeping seems to have operated only in one direction, resulting in some inductions beginning late in the evening. Nine women reported delays of several hours between the time of admission and the time of receiving PGE₂.

[...] they told me to go in at nine o'clock I think it was, so we got there and... I was told to just sort of get myself settled in and then that someone would come and sort of run through it all but I think they were quite busy that day, but the girl that was actually looking after us, she was a bit scatty to be quite honest, so nothing much actually happened, I wasn't given the pessary or anything 'til two o'clock... (Wendy)

So we got there at 8 o'clock in the morning, and we then had to literally sit on that bench till half past nine, when we then got put into one of the delivery suite rooms [...] So we were sitting outside the delivery suite rooms, in the waiting corridor at (X) for an hour and a half. We then got put into one of the delivery rooms and we probably sat there for another half an hour, and then the nurse came or the Midwife came and said 'This is the plan' [...] (Megan)

Reasons cited for the delays included staff shortages, a busy ward and lack of rooms on the delivery suite, a problem which is not peculiar to the Trust in question (Mittal, Zachariah, & Lamb, 2014) . For safety reasons, it is usual practice to delay inductions where adequate staffing cannot be guaranteed (National Institute for Health and Clinical Excellence, 2008) consequently when emergencies occur or when maternity units are short-staffed, inductions may be delayed. However, many women were not prepared in advance for the possibility of delays and a few were not informed of the reasons for starting their induction later than expected, leading to anxiety and frustration:

I was told I'd havethis, this tab thing.[...]I'd have that inserted, sort of in the morning and I didn't actually get it until like 3 or 4 in the afternoon... but all the other ladies had had theirs done in the morning, so I was a bit sort of...I didn't quite understand why I was a bit later (Olivia)

Yeah, coz we were just like “why have you told us to come so early?” and we’re just sitting here waiting (Rose)

Others, however, perceived the initial treatment to be quicker than expected or were happy to accept reasons for any delay:

It was three hours from getting there to when they actually put the pessary in ‘cos they were obviously... I think they kept saying they were quite busy [...] it was quick compared to what I was thinking it was going to be (Sarah)

...it was a lot of waiting but obviously we understood that they were really busy... so nothing actually ended up happening until...I think it was about 10 O’clock that night (Polly: admitted at 08.30)

Delays in the progress of induction

Most women in this study received PGE₂ in the form of a pessary. According to local policy, women are re-assessed 12 hours after insertion of the pessary and again at 24 hours. If their cervix has effaced and dilated to the point at which artificial rupture of the membranes (ARM) is possible, women transfer to the delivery suite for the next phase of induction – ARM and intravenous oxytocin infusion. If insufficient progress has been made, women are offered further PGE₂ in gel form or referred to the obstetric consultant for review. However, several women who were ready to be transferred to the delivery suite experienced lengthy delays due to emergencies or lack of beds. This was another source of anxiety and frustration:

...it all went a bit wrong because I was ready for my next stage, I was ready for my waters to break but they couldn’t take me up to the maternity ward because it was full...it did delay my labour by about 5 hours, 5 to 6 hours, coz

it wasn't until... 11.30 at night that I went up and... I felt the hospital really let me down actually. (Nina)

Although it is inevitable that emergencies and staff shortages will occur in any clinical setting, there is clearly a need to manage expectations antenatally, and consider ways of minimizing delays during the induction process.

Unrealistic expectations

Of the sixteen women in this study who were induced with prostaglandins, only seven spent less than 24 hours on the antenatal ward; eight women were there for between 24 and 48 hours and five remained for between 48 and 72 hours. Some women came armed with plenty to keep them occupied, suggesting that they had been prepared for the possibility of a long induction; however, many had unrealistic expectations of the duration of induction; a finding common to several other studies (Cooper & Warland, 2011; Gatward et al., 2007; Shetty et al., 2005). These were exacerbated by pressure from family and friends who were anticipating the birth on the day of induction:

...it puts a lot of pressure on you, everyone thinks you're having the baby today or tomorrow, so everyone's texting you and you're like Oh my God! What's going on!?![...] (Nina)

Anecdotal evidence suggests that this is a common misconception, particularly among the non-childbearing population and is a source of frustration and anxiety to women who may feel that they have failed to live up to other people's expectations. This highlights the need for improved information antenatally to ensure that women approaching induction do so with realistic expectations of its duration and progress

Comparison with other women

It was inevitable that in the enforced intimacy of a four-bedded antenatal ward, women would compare their progress to that of other women. In some cases, this led to feelings of envy, frustration and self-doubt:

I had women going into labour all around me and um ...so I felt jealous because I wasn't going into labour. (Emily)

The other 2 had at least got dilated by 1cm, I was the same! And I was so....I was....I felt near enough depressed, I felt very low, I felt very angry that I was stuck in the hospital for nothing, it felt like for nothing [...] you're like Oh my God! What's going on! What's wrong with me? You think it's you...um....especially as there were lots of women being wheeled in and out while I was still sitting there and you think "well why isn't mine working?" (Nina)

Women assessed the likely trajectory of their own labour from witnessing others at more advanced stages of induction, which added to their anxiety:

So I was like, OK, they're in real pain now; I've got about an hour and a half to go! ...So I could sort of work out what was happening. (Olivia)

That was another disadvantage being in this communal ward and hearing other women's pain, because if you haven't had that yourself you're thinking, right, I'm going to be like that. (Sarah)

Comparison with other women inevitably increased women's anxiety in a way which would not have happened had women been in a situation of privacy. As anxiety is known to interfere with the physiological progress of early labour (Hodnett, Gates,

Hofmeyr, & Sakala, 2013; Kitzinger, 2005; Sakala, 2006; Wuitchik, Kakal, & Lipschitz, 1989), this adds fuel to current arguments for commencing induction in the home, in otherwise low-risk women.

Chapter 4 discussed the lack of meaningful information that women received about induction in the antenatal period, but concluded that at the time, women were generally content with this. The data from this section, however, demonstrates that once they began to experience the reality of induction, women became acutely aware of how unrealistic their expectations had been and the extent of their lack of information and preparation in the late antenatal period.

The in-patient experience

Having a first baby is often a woman's first experience as a hospital in-patient (Oakley, 1980) and requires rapid adaptation to new and unfamiliar surroundings, especially for those with no background in the health services. The restricted movement and activity which a hospital stay demands has been associated with feelings of isolation, anxiety and loss of control over pregnancy (Richter, Parkes, & Chaw-Kent, 2007). It was not surprising, therefore, that many aspects of the in-patient experience were found to be sources of anxiety.

Sharing a bay

Some women had not been expecting to be on a four-bedded bay and found the experience of living and sleeping in close proximity to strangers and the inevitable lack of privacy both uncomfortable and embarrassing, especially as they went into early labour:

I was aware that everybody else was having their dinner and going to sleep and I was making a lot of noise! (Nina)

...You can hear everything that's going on,[...] I know the other three in my ward were all going through exactly the same, but that, I'm not keen on being in rooms with other people in that sort of situation. (Megan)

[...] so this was the bit that I didn't like at all, I was on the (X) ward, it was visiting time, and there were obviously 3 other people – I had my curtains round me – but I was sort of pacing up and down in loads of pain". (Donna)

Like Donna, some women felt that being in pain on a shared ward full of strangers made it harder to cope, as they felt obliged to remain quiet for fear of disturbing other women. Sarah, in contrast, enjoyed the camaraderie and found that it made the experience of pain more bearable:

[...] that wasn't so bad, I mean the other ladies you could hear that they were in a bit of pain, they didn't sort of tell me off if I was making noises and vice-versa, so it wasn't as bad as, it was better than it was portrayed to me. (Sarah)

Shared bays inevitably meant night-time interruptions from the movement of others and from monitoring and observations. Amy reported having no sleep at all in 24 hours, whilst more than one third of women had difficulty sleeping. Emily perceived this to have had an adverse effect on her labour:

... I mean, my problem right at the end was that I didn't push effectively and I always wonder was it partly because I hadn't had enough sleep and food that evening and that then led to the forceps and the episiotomy which we're still living a bit with the results of those things ...so, there are some...there is a bit of blame there in a way... (Emily)

Sleep deprivation is known to be associated with emotional disturbance and it has been suggested that this may even contribute to post-natal depressive illnesses (Oakley, 1980). Despite this, routine monitoring continued throughout the night and as beds became available on the delivery suite, women were transferred regardless of the hour, which was disturbing to others trying to sleep.

Invisible rules

The institutional nature of maternity units imposes a system of routines, regulations and power hierarchies with which women are expected to comply (Oakley, 1980). Unfamiliarity with the hospital system meant that many women came up against unexpected rules which were a source of considerable stress. A few had been expecting to go to the low-risk birthing unit once in labour and were disappointed to be told that this was not permitted. Restrictions on the use of certain types of analgesia meant that Entonox™ was not available on the antenatal ward, although the more powerful drug Pethidine was allowed. The reasons for these restrictions were never explained. A rule requiring all visitors, including partners, to leave the ward between 20.00 and 08.00 meant that women on the antenatal ward were deprived of the company of their partners between these hours, which was particularly distressing to some:

The trouble with the...with this whole induction thing and perhaps the biggest problem with it is your partner can't be there at night [...] the scary bit is you're going to start labour totally on your own, surrounded by strangers. (Emily)

...everybody else that goes into labour naturally, they have their husband or partner with them, whereas if you're induced you're just sort of left to get on with it on your own, which...I suppose that's just the way it is really, but it's not that nice. (Wendy)

I had a new midwife that came in the evening and she tried to make (husband) leave because she said “you’re on this ward and visitors have to leave at 8 [...] he has to go because if he stays all the husbands will want to stay” so that was really stressful and made no sense because I didn’t want to be on that ward, I wasn’t meant to be on that ward and they made...I didn’t feel they made any allowance for that...it was stupid really [...] (Nina)

The social model, on which much of the current discourse on childbirth is based, assumes that partners share the whole experience of childbirth. This is emphasized in antenatal classes and the media, therefore women naturally assumed that their partner or husband would be with them throughout. The prospect of starting labour alone and in unfamiliar surroundings was at odds with women’s anticipations and left many feeling frightened and alone at a time when support and familiarity was most needed. Had the regulation about partners been explained to women antenatally, it is possible that they would have adjusted their expectations and been less distressed by this restriction.

Challenging the rules

Unexpected rules were generally accepted without question. However, a few of the more assertive women challenged the rules, with varying degrees of success. Megan, whose membranes had ruptured, had been expecting to begin her induction with Syntocinon™, as advised by her community midwife, but once in hospital, was told that she would be given PGE₂. Megan questioned this decision:

Megan: *Well why can’t you just put me straight on a drip, get it over with?*

AJ: *And she didn’t explain why she couldn’t put you on the drip?*

Megan: *Well that was... to be fair we should have pushed it a bit but we didn’t, we didn’t question it, we just sort of said ‘Oh do you really have to?’*

'Yes'. 'Fine, okay, do it'. You sort of trust them; you think 'Well they should know what's best. (Megan)

Trust in the wisdom of the professionals and concerns for her baby's wellbeing led Megan to submit to the new plan of care without having received a satisfactory explanation, but in retrospect she regretted not having pursued her challenge. In contrast, Nina was persistent in her challenges, having resisted from the outset the idea of conforming to a policy which was at variance with her own philosophy of health. As explained in chapter 4, Nina had a strong aversion to medicalised care and had planned a home birth, but as her due date passed, her resistance was gradually worn down by sustained pressure to conform. It seems likely that Nina's continued challenges to the hospital system were her means of trying to claw back some sense of control over her situation. This was expressed on several occasions, notably on being told that her partner had to leave the antenatal ward at night. The situation was diffused when a bed became available on the delivery suite, but only after a confrontation:

I would not have let him leave, no way, I was in the middle of labour, I really was, I just think that was unacceptable ...there would have been a fight...actually there was a fight because they had to get someone down from the actual maternity ward to talk to us, coz I wasn't having any of it. (Nina)

In another example, Nina challenged the policy on pain relief on the antenatal ward, this time, with the help of a midwifery manager:

[...] but there was a....hospital manager who happened to walk past the bay and (husband) grabbed her because they were only allowed to give me Pethidine and I didn't want Pethidine, but they weren't allowed to give me gas and air ... and I said "well that makes no sense" [...] so she ran away, came back with the gas and air and said "don't tell anyone" [...] (Nina)

On the delivery suite, rules appeared more flexible and some women were able to negotiate small changes, but only at the discretion of those in positions of power:

I said ...“is there any possible way I could have the epidural before you break my waters?” and she [the midwife] said “we don’t usually, the anaesthetist doesn’t usually like to but we’ll see, you know, in your circumstance if he will” so they went off and asked him...he said “yes, that’s fine, we’ll do it. (Polly)

These examples suggest that some midwives were willing to act as advocates for women who challenged the rules and to negotiate on their behalf with senior staff. In Nina’s example, the midwife even colluded with her to break the rule on pain relief. In saying “*don’t tell anyone*” it is implied that she was putting herself at risk of reprimand. This supports the notion that midwives are also subject to the power of rules, making it difficult to deviate from standard practice without fear of reprisals from those higher up the power hierarchy (Edwards, 2004; Fahy, 2002; Hollins-Martin & Bull, 2006).

Invisible women

A hierarchy of priorities was evident in women’s description of life on the antenatal ward. Women were aware that their position in the hierarchy correlated with the amount of attention they received from midwives. Those who were lower down the order of priority sometimes felt overlooked or forgotten, especially when the ward was busy.

so I had to wait until the shift change... before some, before I could tell somebody... because they were all rushing around giving a handover and I think ‘hang on a minute, don’t forget me’ (Gemma)

I was like “why are we being forgotten? You’ve asked everyone else and they’re just waiting to be induced ... [...]...I’m in there...like, nearly screaming every 10 minutes having contractions, they never came to see me...no.
(Vicky)

[...] you’re only high priority once you’re actually in labour. (Emily)

A minority felt they had to remind midwives to undertake routine observations and fetal monitoring:

I think (baby) wasn’t monitored particularly well once I’d had the pessary, and it was us that had to ask them to check the heart rate.... And check my blood pressure and my temperature a bit more than they did, we really did have to go and say ‘Please can you come and do it’ (Megan)

The general impression was one of a frantically busy and often understaffed antenatal ward where midwives were often forced to adopt a “fire-fighting” mode of working, tending only to those in greatest need with little time to explain what was happening or to give attention to those lower down the priority chain. This inevitably caused some women to feel sidelined, which emphasized the powerlessness of their situation. Although most women felt well informed of their plan of care most of the time, not knowing what was happening and being unable to get the attention they sought was clearly a source of much anxiety.

Information and communication

Most women felt that they were kept well informed all or some of the time during their induction and this was reflected in predominantly positive feelings towards the midwives who cared for them:

[...] and they did explain to me, this lovely young midwife explained to me a bit about what was going to happen and if it didn't work what would happen after that. (Sarah)

Yes, yeah, they were very good and my husband asked, had a couple of questions, they answered it and they went through the process again just because he wanted clarification of a few things, I have to say the Midwife there, she was lovely, or the Nurse, I think it was a Midwife, yeah, she was really lovely. (Fay)

There was a marked association between impressions of individual midwives as “lovely”, “sweet”, or “really nice” and perceptions of having received plentiful information. One explanation may be the ‘halo effect’, a cognitive bias in which one positive perception of a person results in an assumption of other good qualities (Forgas, 2011). It is possible, however, that the halo effect was earned as a direct result of those midwives being attentive to women’s individual needs and keeping them well informed.

Where information was perceived as lacking, there was a tendency for women to posit explanations or to imply that midwives themselves were relatively powerless:

...I didn't feel there was a lot of information given to be honest...I mean all they could tell me was that they didn't really know when anything was going to happen [...] (Donna)

...I think she was quite busy; she always...just seemed a bit rushed, so we didn't really get to talk a lot. (Olivia)

AJ: *So you feel that really you didn't get enough information?*

Isobel: *Well, I don't know really because like I say earlier, I didn't ask, so I didn't get, really...*

AJ: *But no-one volunteered any information?*

Isobel: *No, no-one volunteered. But then perhaps, it's a big hospital ...they don't have the time. (Isobel)*

The inclination to offer excuses for inadequate information and explanation was notable in a minority of other interviewees. This may have indicated what Van Teijlingen termed the “*Gratitude bias*”, whereby the birth of a healthy baby creates a generous attitude towards those involved and a tendency to minimize any shortcomings in standards of care (Van Teijlingen et al., 2003).

Problems in communicating information

Although communication was generally perceived positively by women, where information was imprecise or incomplete, this led to frustration and stress:

...when my pessary didn't work, I was so frustrated and angry... because in all the information you get given about being induced, no-one tells you it might not work straight away, so even then, when I came in to be induced and the midwife was there telling me about the pessary, she never once said it might not work. (Nina)

In some cases, women were told about procedures as they were being done, but without any accompanying explanation:

I didn't have any info on the hormone drip - what it is, what does it mean, how does it work – I didn't know, I didn't know that. They just said "we're gonna give you a hormone drip. (Rose)

There appeared to be an assumption among some midwives that women arrived primed with the necessary information: as Emily noted:

...sometimes people in institutions expect you to know their system. (Emily)

The more assertive women were able to acquire the information or explanations they needed through sheer persistence. However, this met with resistance from certain midwives who appear to have adopted conversational styles which reinforced their dominant position. Emily's narrative illustrates this:

I said could you actually talk me through what the process is, because I hadn't known, as I say, about this pessary and this gel, and...and then she came back as she said "you spoke to so-and-so last week" and I didn't know who that person was and that had been a midwife who I'd spoken to who was in (X) clinic, well, I didn't know her name and she hadn't explained the process fully, as I say, she'd only told me about the drip, she hadn't explained the whole process and I felt a bit I was being told off for asking again. (Emily)

The midwife in this instance may have been concerned that a full explanation would take time away from her many other tasks, but her deflection of Emily's request belittled Emily and made her feel foolish. A similar controlling tendency was found

throughout Megan's story: the following extract occurred after she had received her PGE₂ on the delivery suite:

[...]and we'd just been told that 'You'll go down to the antenatal Ward at 10 o'clock, and then six hours later you'll come up [to delivery suite], and whatever's happened, if you're far enough gone we'll let you have the baby, if not we will induce you then'. (Megan)

The implication was that Megan's body was no longer under her control, but that of the staff, who had the power to 'allow' her to give birth, thus reinforcing the notion that her body was somehow not to be trusted to function unassisted (Simkin, 2006). When Megan finally arrived on the delivery suite (several hours late due to lack of beds and after much chasing of information), she had developed an infection requiring antibiotics and was disappointed to be told: "*Oh you should have been up here six hours ago*" (Megan). Although there was no implication that this was said in a scolding manner, this belittling remark conveyed a sense of blame which was not only likely to have undermined Megan's self-confidence, but could have been carried over to the postnatal period after the baby became unwell as a result of Megan's infection.

Uncertainty and confusion

Most women were happy to be guided by the protocol and by advice from staff during their induction. This tendency to 'go with the flow' has been noted in other studies, suggesting a high level of trust in the opinion of clinical staff and the system of maternity care (O'Hare & Fallon, 2011). Others, however, needed more precise information:

[...] .between my partner and myself I was "what happens next"? We kind of discussed amongst ourselves and then we called the midwife back and go "what happens now" and then ...oh yeah, that's gonna happen... you know? We kind of...I think it would ...I needed a little flow chart (laughs). This happens, and this happens. (Beth)

Yeah, I mean I asked because I wanted to know what every scenario would be in that sort of sense, so if the pessary didn't work, what would be the next step? If that didn't work, what would be the next step and what would happen?
(Tanya)

...I was trying to grill people for [information], "What's the statistics? ... I said, "If you're pre-term induced, what's the likelihood of C-Section?" and there was no statistics at all [...] If this happened to men, there would be every stat, every research, I promise you there would be, 'cos men love stats, but also it would just be, "We need to know." (Jasmine)

In the examples quoted above, these women had clearly defined needs and were able to get the information because they were not intimidated by the power imbalance in the maternity unit and had the tenacity and articulacy to pursue staff until they were satisfied. Not all women were so assertive and some were less successful in their pursuit of information. Vicky, for example, was not aware of her plan of care and felt that her concerns were not being listened to:

[...] to be honest I was really confused about why I was there ...I was in labour and... it was just, I didn't know what was going on. I thought "am I going to be moved to (birth centre) to have it naturally, or am I staying here? And if I'm staying here, why am I going to be induced because I'm in labour? [...] I was so confused the whole time; I just didn't know what was going on. (Vicky)

Vicky had been booked for a routine induction for post-dates pregnancy, but was already experiencing contractions on admission, therefore was not given PGE₂. As the delivery suite was unable to accommodate Vicky, she was left on the antenatal ward for over 24 hours, and by her account, received minimal attention, despite her protests that she was in labour and in pain. By the time she was eventually

examined, her cervix was 4cm dilated and she was transferred to the delivery suite where her membranes were ruptured and Syntocinon™ was commenced. Although Vicky believed she had been induced, all the documentary evidence indicates that in fact, she had a spontaneous labour which was subsequently augmented, for reasons which were not clear. On the delivery suite, Vicky's bewilderment and distress increased:

...and she was looking at the thing [CGT]...and I remember saying "why does that woman keep coming in?" I was so scared, I was like "why does that women keep coming in? What is she doing" coz of the way she was looking at it [...] (Vicky)

The underlying cause of Vicky's distressing experience was the perceived lack of information, which kept her in a state of ignorance and fear, preceded by an apparent refusal of midwives to acknowledge her labour whilst on the antenatal ward. Vicky became increasingly distressed throughout labour and eventually gave birth by emergency caesarean section due to fetal compromise. The importance of psychological wellbeing to the physiological progress of labour is not in dispute (Kitzinger, 2005; O'Brien, Rauf, Alfirevic, & Lavender, 2013; Oakley, 1980; Wuitchik et al., 1989). An association between Vicky's emotional state and the outcome of her labour cannot be assumed, but is possible.

There were many unanswered questions in Vicky's story, but it is clear that she had a sense of being suspended in a liminal state where she had no idea of what was happening and felt that no-one listened to her concerns or acknowledged her labour. Nina and Megan had similar experiences of not being believed or taken seriously when they were in pain which left them feeling distressed and let-down.

What we did keep saying to the midwives was "Look, I'm in real pain", and they were saying "Oh no you're not, this is nothing, it's going to get worse"....and (partner) kept saying to them "Well can't she have gas and air, because (she's) in agony?" "No, no, she's alright". (Megan)

I had a new midwife that came in the evening and she tried to make (partner) leave ...and I said "well, I'm in labour" and she said "no you're not". (Nina)

These examples reflect the findings of Barnett, Hundley, Cheyne and Kane (2008), who noted that the early phase of labour is often undervalued by midwives, leaving women feeling "*neglected and uncared for*" (Barnett, Hundley, Cheyne, & Kane, 2008). This may stem from epistemological differences in the concepts of labour. The medical model, which requires set parameters to labour rather than acknowledging it as a continuum, classifies established (or active) labour as a cervical dilatation of 3-4cm in the presence of regular contractions becoming progressively stronger and longer (McCormick, 2009). The irregular, painful contractions and general discomfort which precedes established labour is classed as the latent phase and therefore not regarded by clinicians as 'true' labour. This may equally apply to women in the early stages of induction. However, as women may be unaware of the concept of the latent and active phases of labour (McCourt, 2009c), their definitions of being in labour often relate to what they instinctively feel. It is therefore hardly surprising that differences of perspective caused women to feel as if their experiences were being dismissed. This indicates a need for midwives to value women's experiences of early labour, to proactively offer information about what is happening and what may be expected in the near future.

Women's perceptions of choice and involvement in decision-making during induction

Most women were satisfied with their level of involvement in decision-making throughout the induction process; however, when asked specifically about choice, many women answered hesitantly and appeared slightly baffled by the question: more than one third of women implied that they had not expected any choice, except in relation to methods of pain relief:

...hospitals do what they do really don't they? I don't really think I got a say in it really ...they just do it...keep me safe, keep the baby safe, that's all I worry about really. (Isobel)

I still don't think we really had a choice, I don't think there was any choice, it had to happen. [...] Possibly we weren't told exactly what to expect, and it's more the information about what's going to happen than having the choice. (Megan)

...but, you know, I don't think there's that much I could've done tomake the process of induction more about me I mean it's a medical procedure. (Clare)

Many women reported that they were content to delegate decision-making to health professionals when it suited their interests, indicating that they felt able to place their trust in clinical staff. Several women spoke of “*going with the flow*” (O'Hare & Fallon, 2011), implying that they were willing to be guided by midwives and doctors:

Wendy *I mean I don't know whether I was involved in the decisions as such, but then for me I, you know, I'm no expert and I'd rather let people that know what they're doing make the decisions.*

AJ *So you felt happy to let other people make those decisions on your behalf, did you?*

Wendy *Yes.*

...The midwives told me what was going to happen; I don't think I was really... I think I just wanted them to take charge which obviously they did. (Sarah)

The deliberate delegation of decision-making by articulate women who did not appear to be intimidated by the hospital system was not associated with negative feelings and may have been evidence of women exercising choice and control (Green & Baston, 2003; Green et al., 1998; Walker et al., 1995). Vicky, in contrast, appeared to have lacked any feelings of control or involvement throughout her induction:

I would have liked to have been more involved in... why I wasn't allowed to go onto the (birth centre)...when I would be allowed to go up to the labour ward?... that would have been by them examining me, and saying "you're now 4cm do you want to go up?" and me saying "yes", that would have been nice, I'd like to have been more involved in that, and then when I was up there, being more involved in what they were doing, why they were doing it, and why my baby was distressed and why the heart rate was dropping? ...and ...yeah...how to use the gas and air properly, how ...just everything. (Vicky)

This exceptional case supports the notion that lack of involvement in decision-making is associated with feelings of loss of control, leading to a negative birth experience (Arney, 1982; Namey & Lyster, 2010; O'Hare & Fallon, 2011; Oakley, 1980)

Summary of chapter five

Women's experiences of induction were as varied as the length of time spent on the antenatal ward. Most women felt involved in their care all or some of the time. However, in common with the findings of other studies (Bramadat, 1994; Gatward et al., 2007; Murtagh & Folan, 2014; Nuutila et al., 1999; Shetty et al., 2005), there was a discrepancy between women's expected trajectory of induction and the reality they encountered, which was a source of anxiety and frustration. Unfamiliarity with hospital culture and rules, particularly the banning of partners overnight on the antenatal ward, led to a sense of powerlessness. The institutional environment, lack

of privacy and enforced intimacy with others confounded expectations of how labour would begin and may have militated against the progress of physiological labour.

Relationships with midwives affected women's overall perceptions of care. Most midwives were perceived as kind and empathetic, but a minority demonstrated controlling behaviour. Discrepancies between women's and midwives' definitions of labour were a source of considerable distress to a minority, who felt they were not being listened to or taken seriously.

The most frequently mentioned source of dissatisfaction was delays on the antenatal ward, exacerbated by understaffing and an over-stretched delivery suite. The situation which many women found themselves in may be likened to the departure lounge of an airport, when passengers, desperate to take off, find their flight inexplicably and indefinitely delayed and are trapped in a noisy, crowded, uncomfortable place full of strangers with limited refreshments and basic hygiene facilities. They are at the mercy of well-meaning but powerless ground staff who keep them under their constant gaze, but cannot inform them of progress.

6. Reflections on the induction experience

Introduction

At the end of each interview, women were asked to look back on their overall experience of induction and to reflect on their general feelings and impressions. In particular, women were asked whether, in hindsight, more knowledge or information would have been helpful. Women were also asked how they would react if advised to have an induction in a future pregnancy. This was later expanded to include suggestions for what could be done to improve the experience.

Women's perceptions of childbirth are not static and change over time. Several studies have noted the positive effect of a healthy baby on women's retrospective impressions of induction and labour (Heimstad et al., 2007; Murtagh & Folan, 2014; Nuutila et al., 1999; Shetty et al., 2005). However, it has been postulated that impressions become more negative over time (Baston et al., 2008; Jacoby & Cartwright A, 1990; Van Teijlingen et al., 2003). These interviews were undertaken when all babies were around four to six weeks of age, when women's impressions were likely to have been relatively fresh. It is possible that after having compared birth stories within their social network, women's perceptions may have shifted, hence if repeated sometime later, some of the findings of this study may have been different.

This chapter begins by considering women's general feelings about their induction experience and the main factors which influenced their feelings. The next section describes of the outcomes of each woman's labour and the relationship between this and their subsequent feelings about induction. This is followed by an analysis of the key themes which emerged from women's reflections and concludes with suggested improvements to the current system of induction.

General feelings about the induction experience

Of the few studies to date which have surveyed women's impressions of induction, most used a closed-question format, providing statistical data which does not explore the nuances of women's feelings. The aim of this study was to dig deeper into the lived experience of induction. As this was a qualitative study, participants were not asked to rate or to rank specific aspects of their experience, but to summarise their overall impression of induction in their own words.

Positive feelings

For six women (Jasmine, Laura, Amy, Rose, Sarah and Fay) the experience of being induced had been a positive one in all or most respects. Comments such as the following left little room for doubt:

[...] It was all fab. (Jasmine).

If any woman is considered [sic] about the induction, just go for it...For me, it was a good experience and nobody should be afraid about this... (Laura)

I would say that the whole birth side of it was fantastic, the phenomenal Midwife, really lovely, made me feel really comfortable, answered any questions that I had, answered any questions my husband had and all the time in the world, they were fantastic. (Fay)

In five cases, favourable comments were reinforced by a joyful attitude and positive body language such as smiling, eagerness and leaning towards the researcher. In Rose's case, however, although her evaluation of the experience was good; *"I've been quite happy"* her general demeanour suggested otherwise. Although Rose was very keen to talk, the atmosphere during the interview was tense and Rose

repeatedly returned to the subject of 'the drip'. It seemed that Rose was comparing her experience to those of friends who had had worse experiences at other hospitals, but the impression gained was that Rose had unresolved issues with her own birthing experience. Similar features were observed in the interviews with Tanya and Isobel, whose feelings about induction were mixed. Both women made some positive comments whilst displaying signs of agitation such as fidgeting, looking away or becoming noticeably tense. One likely explanation for these apparent discrepancies is the researcher's status as a midwife with links to the hospital where the women gave birth: although assurance of confidentiality and anonymity had been given, it is possible that some women felt insecure about this. Alternatively, these women may not yet have assimilated the whole birthing experience and were reflecting on certain aspects for the first time. These discrepancies highlight the uncertainty of the timing of post-birth interviews (Hildingsson et al., 2011; Jacoby & Cartwright A, 1990; Simkin, 2006; Van Teijlingen et al., 2003) and the importance of acknowledging this in data analysis.

Mixed or negative feelings

For most women, reflecting on induction released a mixture of positive and negative feelings depending on areas of care, processes or personnel:

"If I can just say my delivery experience was great and my postnatal experience was great at (Trust) the midwives were wonderful and the doctors were very nice ...I ended up in theatre and that was all, you know, very efficient, but the antenatal induction bit was not so good, I wasn't so happy with it, it dragged on for a long time. (Emily)

Yeah... the actual induction I think, I can't say I had a bad experience, it was just more around the mechanics in the hospital that I'd look back and say 'No, it wasn't good. (Megan)

Positive feelings towards staff (especially midwives) seem to have partly compensated for the trauma of complications and adverse events. Only three women (Hannah, Vicky and Olivia) found the overall experience of induction to be predominantly negative.

When we've talked about what we went through we can't think of one thing that we wish they hadn't done differently or better, even down to the smallest things like fitting my cannula in my arm [...] (Vicky)

Hannah found it painful to reflect on certain aspects, particularly on how ill and frightened she had felt:

The memories of my birth, you know, are very, very hard to get over [...] every time I talk to anybody about it I get a little bit upset. (Hannah)

Like Hannah, a few women became visibly upset at some point during the interview. On each occasion, the offer was made to end or to pause the recording, but the women were very keen to continue and seemed to find it cathartic to tell their stories. This supports the notion that this type of research may have unintended therapeutic benefits to participants, even when the aims of the study are purely academic (Easter et al., 2006; Eide & Khan, 2008; Kylma et al., 1999)

Relationships between events during labour, outcomes of labour and women's feelings about induction

Outcomes of labour

Induced labour is associated with more complications than spontaneous labour, due to the frequent need for further interventions (Cooper & Warland, 2011; National

Institute for Health and Clinical Excellence, 2008; Shetty et al., 2005). The following table sets out the type of birth experienced by each one of the participants and any diagnosed pathological condition that arose directly from the birth.

Table 12 Mode of birth and conditions arising from the birth

Name	Type of birth	Diagnosed conditions arising from the birth
Amy	SVD	None
Beth	CS	None
Clare	CS	None
Donna	Forceps	None
Emily	Forceps	Infection (mother and baby)
Fay	CS	Infection (mother and baby)
Gemma	CS	None
Hannah	CS	Infection (mother)
Isobel	CS	Post-natal depression
Jasmine	SVD	None
Karen	Forceps	None
Laura	SVD	None
Megan	SVD	Infection (mother and baby). Pyrexia
Nina	CS	Pyrexia
Olivia	CS	None
Polly	CS	Infection (mother and baby)
Rose	CS	None
Sarah	Ventouse	None
Tanya	Forceps	Third degree tear
Vicky	CS	None
Wendy	Forceps	None

Rates of caesarean section and assisted birth following induction were higher than expected: just over 50% of the sample group had a caesarean section whilst six women had an assisted birth (forceps or ventouse) representing almost 29% of the total. This compares unfavourably with the NICE guidelines which cite a caesarean section rate of 22% following induction and a rate of assisted birth at around 15% (McCarthy & Kenny, 2013; National Institute for Health and Clinical Excellence, 2008). The data implies an association between high rates of operative/instrumental births and induction practices in the maternity unit in question: however, this cannot be assumed, due partly to the small sample size and the lack of a comparison group comprising women who had not been induced. Furthermore, participants were self-selecting, which may have resulted in a disproportionate response from women who had complicated births and wanted to tell their story. The average age of participants (mean = 32.9) was slightly higher than the national average for first-time mothers (mean = 30), which may have had some bearing on the high rate of complications. Additionally, the number of women with a fetus in the Occipito-posterior (OP) position – seven confirmed and three possible – was unusually high and this may have been a contributing factor, as OP positions are associated with longer and more complicated labours (Coad & Dunstall, 2005; Coates, 2009).

Pain and pain relief

Several women requested pain relief on the antenatal ward, but as Entonox™ was not provided, they were offered either oral analgesia or Pethidine. Four women (Olivia, Vicky, Sarah and Donna) received Pethidine at the midwife's encouragement:

[...] it got to about 6 o'clock and I was offered Pethidine, [...] and I remember thinking before I didn't really want the Pethidine, but the midwife – I wouldn't really say she persuaded me to have it but she said it would help me to relax, so... but it didn't, coz it just made me feel really horrible and it didn't change the pain, it just made me feel a bit spaced out [...] I did feel a bit coerced into

having the Pethidine ...maybe if I'd had, been able to have the tablets, and maybe some gas and air that would have calmed me down a bit more whilst I was on the actual ward , and I may have not automatically wanted the epidural. (Donna)

Of the four women who used Pethidine, three found it ineffective or unpleasant and in Olivia's case this featured strongly in her impression of the whole induction experience. It seemed that these women had not been fully aware of the side-effects of Pethidine and thus made uninformed decisions which they later regretted. Sarah, in contrast, felt fully involved in the decision to have Pethidine. However, this may have been influenced by the fact that unlike the others, she found this a pleasant experience:

"[...] and she said, "A lot of ladies do have Pethidine just to help you sleep because you're going to need your energies and so on," [...] And she said "Because you're only two centimetres it won't affect your baby and it will help you sleep [...] I was fully involved about the pain relief at the start, [...] and it was nice to hear an actual midwife recommending the Pethidine because I'd heard the negative things [from the NCT] so it was nice to hear that it worked for lots of ladies and I'm so glad I had it because it actually made the rest of the experience less daunting, it actually really put me completely at ease. (Sarah)

During the antenatal period, most women had idealized about a natural birth with minimal intervention, however, once induction became a reality, attitudes changed and women became more favourably disposed towards epidural analgesia, often after speaking to family and friends. Nineteen women had an epidural at some point in labour, sometimes encouraged by midwives using negative images of labour without it:

...the lead midwife pretty much sold me an epidural, I mean she was quite firmly advising me to have an epidural because, she said it was going to be one minute contraction, one minute off, I thought gosh! That's not much break in between contractions ...and then she said if you're getting back pains it could well be that you're going to have a back labour...the first midwife said 50% of women have the epidural and she said 99% in this situation have an epidural...I just thought yeah, OK! if that's what she's advising me and she's seen women in it, then I'll do that. (Emily)

Like Emily, six other women had a fetus in the Occipito-posterior (OP) position. In a further three cases this seemed probable from women's accounts, but could not be verified from the records. It is possible that this was a causative factor in the need for epidurals. The decision to have an epidural represented a major change of plan for some women:

And (X) said 'do you want an epidural?' and...at the back of my mind, I didn't want one, I didn't want one, I didn't want one, but there was no way I was gonna get through anything without it, so I said 'yes'. (Gemma)

I hadn't wanted to have any pain relief; I just wanted to have gas and air, so I had to have an epidural. I suppose I didn't have to, but I did have to (laughs) because it was very painful. (Megan)

Emily rationalized this by differentiating between the circumstances of natural and induced labour:

Well I just felt it was a different situation from a natural birth so I just didn't feel confident about handling it really ...especially 8 hours with a contraction every other minute! (Emily)

Despite their change of plan, no woman expressed any deep regret at having accepted an epidural and some felt that with hindsight, they wished they had requested it sooner rather than later. Although there appeared to be element of persuasion from midwives, there was no sense that women felt they had succumbed to pressure or had made an uninformed decision. Most were only too relieved to be out of pain and some were pleasantly surprised by the effectiveness of the epidural:

[...] at NCT they tell you all the negatives ...how awful it is and ...not that you're not doing it right, but they sort of make out there's no reason why you need it really, it's sort of in worst-case emergencies...erm...and actually, it felt amazing! (laughs)I felt normal again! (Nina)

The two women who laboured without epidural analgesia (Laura and Amy) both had uncomplicated labours which progressed swiftly to spontaneous vaginal births. One had requested an epidural, but gave birth before the anaesthetist arrived. Both women had very positive views of their whole induction and birthing experience. It may be relevant that both Laura and Amy were recent immigrants from Eastern European countries where women's expectations of pain relief in childbirth may be very different to those of women born in the UK.

In summary, analgesia was universally used, with all but two women having an epidural at some point. Some pressure was applied by staff to accept analgesia, which may reflect the expectations of those working within a medicalised environment, but` also exposes the vulnerability of women undergoing induction. However, this was not necessarily viewed negatively and epidurals in particular were mostly welcomed and found to be effective.

Relationship between events during labour and overall evaluation of the induction experience

There was no obvious relationship between the reasons for induction and women's retrospective evaluation of the experience. Most women experienced some unanticipated interventions once labour was underway and those who had the most interventions tended to reflect more negatively on the overall induction experience. However, most of the women who had suffered adverse events in labour or after the birth associated these with the mode of birth or with interventions during labour, but not necessarily with induction *per se*:

....I wouldn't say the induction itself, no, [...] it was a very stressful experience all in all, but I don't know whether that was just the delivery more than the actual induction itself..... (Donna)

[...] I don't blame them, I don't blame anybody or the process even, I don't blame the process it's just one of those things. (Tanya – referring to long labour and 3rd degree tear)

Obviously I'm suffering a bit of PND at the moment now, but I don't know whether that's anything to do with the induction or anything like that. More a reaction to the caesarean more than anything really coz I didn't like that at all....Not being mobile and stuff like that, made me feel quite... (trails off) (Isobel)

Emily and Megan, in contrast, perceived a clear cause and effect between induction and subsequent problems:

The thing that I could never understand – I still don't understand was why they had to break my waters, [...] but I don't really know why because it seems to

me that it raised the risk of infection [...] and I think ...that in the end [baby] had a small infection and I think it was Strep B which [baby] probably got from my vagina which would have been because the waters had broken. (Emily)

Had we not had the induction, I think if it had been normal, we'd have gone home that night. [...] The way I see it is linking the induction with what happened afterwards, and I see it that if we hadn't had the induction (baby) wouldn't have gone to special care. [...] And that's how I see the impact of induction...If we hadn't had to have been induced we wouldn't have had all the stress afterwards. (Megan)

Hannah blamed induction for her infection, but not for her caesarean section:

AJ: *[...] do you think the induction was the cause of where your labour went or...?*

Hannah : *No I don't, but obviously I think it was the reason why I got an infection. I think the reason why I got a fever [...] I'm assuming that because I had my waters broken at 4 o'clock in the morning that by the time I actually gave birth to baby at 11 o'clock at night the waters had been broken quite some time and obviously I was so unwell that I can only put it down to that, that being the reason.*

Of the three women (Hannah, Vicky and Olivia) who reported little or nothing positive about their induction experience, all had undergone an emergency caesarean section. Furthermore, Hannah had been acutely unwell during labour, whilst Vicky suffered acute emotional distress due to perceived suboptimal care. Both Hannah and Vicky experienced further problems in the early puerperium and it seems likely that these unfortunate events influenced their overall perceptions of induction as well as the entire birthing experience.

Conversely, of the five women who had either an SVD or a ventouse birth without further complications (and therefore the fewest interventions in labour), four (Amy, Jasmine, Laura and Sarah) stated that their induction was a good experience and were generally very satisfied.

It is tempting to draw conclusions about adverse events during labour affecting women's retrospective perceptions of induction, although it was impossible to tell, in many cases, whether these complications would have arisen in a spontaneous labour. Moreover, there was a confounding case; Fay, whose reflection on her induction was very positive, despite having had an emergency caesarean section and a subsequent infection. It is important to acknowledge the individual nature of each woman's account, arising from her own unique perspective and to recognize that overall perceptions of induction were affected by multiple factors, including women's individual personalities, comparison with prior expectations and treatment by staff.

Perceptions of treatment by midwives and doctors

It has been suggested that as nowadays, labour usually results in a healthy baby, women's evaluations of the childbirth experience owe more to emotional experiences than to physical events (Nuutila et al., 1999). Relationships with health professionals are therefore highly significant.

Over half of the participants made positive comments about the midwives (and a few doctors) who cared for them during their induction. Some remarks were made when women were asked to evaluate their overall experience, but others occurred spontaneously during their induction story. These have been gathered together here to provide a more comprehensive picture. It was notable that women whose overall impressions of induction were generally positive tended to have positive impressions of staff, particularly with regard to communication and the provision of information, as explained in the previous chapter. Other factors which contributed to a positive impression included making women feel comfortable, answering questions, enquiring about women's wellbeing and being friendly and approachable. Adjectives such as

“nice”, “sweet”, “fantastic”, “lovely” and “helpful” were frequently used. The examples below are typical of the many positive comments made:

...you couldn't have paid for this...they were so caring...You know, we said it's the heart and soul parts that you can't buy on BUPA. (Jasmine)

No, but they were brilliant at (X), I must say they actually were brilliant. (Tanya)

Even women who had experienced a complicated and traumatic labour were able to draw distinctions between hospital processes and personnel. Polly, for example, had been acutely ill, yet her overall impression of induction was enhanced by the care and attention of staff:

Yeah, the process itself wasn't nice for me personally, but the way that they dealt with everything, every single one of them was so nice...really nice. (Polly)

It is possible that the arrival of a healthy baby had some influence on positive impressions of treatment, as previous studies have indicated a link between this and overall impressions of childbirth (Heimstad et al., 2007; Jacoby & Cartwright A, 1990; Murtagh & Folan, 2014; Nuutila et al., 1999; Shetty et al., 2005; Van Teijlingen et al., 2003). However, the fervour with which women described these favourable impressions and the fact that the names of some individual midwives were repeatedly mentioned suggests that this was a genuine reflection of the care and attention with which these women were treated.

Negative perceptions of treatment related almost exclusively to the antenatal ward and involved mainly poor communication, such as a lack of information or

dismissive attitudes (Emily, Nina, Megan) or to a lack individualised attention, causing women to feel ignored (Vicky, Olivia). This has been discussed in the preceding chapter.

In summary, most women spoke favourably of some or all of the staff who cared for them: good communication, kindness and attentiveness were highly praised and it seems that perceptions of staff attitudes played a significant role in women's perceptions of the induction experience.

Effects of the induction experience on early motherhood

Events during childbirth and the ways in which women perceive them can have lasting effects on women's health and on their relationship with their baby (Melender, 2002; O'Hare & Fallon, 2011). One of the aims of this study was to discover whether induction affected women's experiences of early motherhood and caring for their baby. Several women volunteered such information spontaneously; however, on some occasions when the subject was raised, women bridled noticeably, as if it implied some doubt about their parenting abilities. Consequently, it felt uncomfortable asking this as a direct question, as probing too deeply may have risked damaging the participant/researcher rapport. Caution was therefore applied when broaching this subject, as it was feared that this might sow seeds of doubt and undermine women's confidence. On reflection, this particular research question might have been better addressed if there had been scope to develop a deeper relationship with the participants over the course of two or more interviews.

Some women spoke of the difficulties in caring for their baby in the first few hours or days:

[...] as soon as something wasn't right (baby) was straight into SCBU, and that kept us in hospital for three days. [...] I know it wasn't their fault, they had the crash caesareans, but because of that it just was a nightmare; silly things,

like (baby) now won't breastfeed as a result of having to have a tube down (baby)'s nose. (Megan)

Yeah, no the downsides were just the after birth, you know, after the birth, feeling I couldn't really look after (baby) 'cos I was wired up to all sorts of things and your legs, that's the downside of the pain relief. (Sarah)

However, most women attributed these problems to the medical interventions rather than the induction itself. In contrast, two women poignantly expressed a sense of having let down themselves and their baby by having an induction:

Coz you do feel a bit like...you know...I failed as a human, as a mother because I can't even, my body can't even give my child a natural birth . That's how I felt. (Nina)

Yeah, I felt like I hadn't been able to have my baby as I wanted to have it and I felt like I hadn't fulfilled my role. (Vicky)

These comments demonstrate the demoralizing effect of women's perceived failure to live up to the standards which they had set themselves and the resulting feelings of guilt. It will have been evident from the preceding sections that both Nina and Vicky's experiences stood out as particularly traumatic: despite this, neither woman stated or implied any ongoing physical or emotional difficulties or problems bonding with their babies and both appeared happy and confident mothers at the time of interview. The implication, however, is that better information and support with decision-making and closer attention to their individual needs during the induction process might have helped these women to manage their expectations and to reduce or avoid feelings of inadequacy and self-blame.

Women's perceptions of their partner's feelings and involvement during induction

Husbands or partners (all male) were present for much of the time during each woman's induction, especially on the delivery suite. Partners were universally regarded as having been supportive and good advocates during induction and labour. In some cases, partners seem to have acted as the 'voice of reason', encouraging women to view the situation from a different viewpoint or helping them to make decisions about their care (see chapter 4):

I wasn't originally going to have an epidural but my husband said, "Obviously why, what are the reasons for you not having it?" And I couldn't really give him a particular answer. (Tanya)

Women were acutely aware of their partners' feelings, particularly when these were negative. Boredom and frustration were mentioned on several occasions. Women generally felt dependent on their partners for support and needed to have them present, which was a source of conflict with visiting regulations on the antenatal ward (see chapter 5). Whilst partners were welcomed in principle by the hospital, they were reportedly not well catered for on the antenatal ward and some women feared that they felt awkward and out of place:

Yeah, I think he felt like a bit of a, just like a spare part... It almost seems like a waste of time him being there in the nicest possible way [...] I would possibly recommend not bothering, you know, the husband not bothering to come in because even when you're induced...it's not as if it's like "oh my God you're going to have the baby now. (Tanya)

On the delivery suite, partners were often perceived to have felt frightened by what was occurring:

[...] I could just tell by my partner's face that he was REALLY worried because he actually said that he thought that the baby may not have made it because the heart-rate was that bad...but obviously he didn't tell me that he kept saying "no, everything's fine, everything's fine" but I knew it wasn't.
(Polly)

And I also remember thinking 'oh my God, (X) is here, he can see all this, he must be, this must be terrifying for him to see me like this', because by then I had no,... there was nothing... that I could do, I, it was just...[...] he said 'I hated watching every minute of that, I hated to see you in that way, I hated...' he said it was a very traumatic thing for him to watch. (Gemma)

Partners were very much wanted and needed to provide support and encouragement throughout the induction process, however, women were acutely aware of their negative feelings and this added to women's own anxieties. This implication is that if partners are to be encouraged to support women and to share the induction experience, more needs to be done to provide a welcoming and supporting environment for them.

Comparison between women's expectations of induction and actual experiences

Studies have shown that women's overall perception of induction is often affected by a disparity between their expectations and the reality they experience (Cooper & Warland, 2011; Gatward et al., 2007; Murtagh & Folan, 2014; Nuutila et al., 1999; Shetty et al., 2005). Verbal evidence from midwives working at the maternity unit in question and at other nearby units suggests that this is a common phenomenon; therefore the interview schedule specifically addressed this matter.

Four women (Amy, Beth, Wendy and Clare) felt that their experience of induction had more or less met their expectations. Surprisingly, Hannah shared this belief, although the pain was greater than she had expected:

[...] No, I mean I think it pretty much was exactly as I thought it was going to be. The only difference being is I didn't actually realise how much it was going to hurt to be induced, not how it makes the labour, you know, the actual breaking of the waters and all of that sort of stuff. I never contemplated how painful that would be. (Hannah)

Jasmine had been well prepared for induction, due to earlier admissions for pre-labour rupture of membranes, but found her experience was better than expected. This feeling was shared by Laura and Sarah, who found their labours quicker and less painful than anticipated:

[...] my main idea of it was from what I'd heard about NCT about, you know, about the downsides, erm... but it wasn't that bad because the midwives were really nice, and it was nice to know you could go for pain relief and that was never really sort of mentioned at NCT... it was better than it was portrayed to me. (Sarah)

Fay, Gemma, Olivia and Rose stated that they had no solid expectations of induction and had approached the event with an open mind.

Yes, as I said I didn't really have birth plans, like you know, I just go with the flow...well if you go in not expecting anything then you can't be disappointed. (Fay)

I mean I've got nothing to compare it to, I've only got what other people might be able to tell me about it, or their experience of childbirth, so I did have no, ... no way of knowing really... (Gemma)

For Clare, the outcome of her induction confirmed her decision to opt for private care in order to meet her need for control and assurance:

For me it underlined...the fact that my decision to go with the private team was right because I really needed that reassurance...them knowing who I was, them knowing my fears...and ...me having some degree of control but them being there to just talk me through it (Clare)

The remaining women found that much of their induction experience was generally worse than expected, particularly in relation to two key issues: duration and pain. Six women had expected their induction to be much quicker than it actually was:

I was thinking it was going to happen, I was going to go into active labour the next day, that was how I was thinking I was going to have the baby the next day, that was kind of in my mind!.... just surprised by how long it took really... (Donna)

I literally went in expecting to have the baby within 24/48 hours...Yeah, and it was a shock when the midwife said that it could potentially be four days. (Tanya)

Some women found induction more painful than anticipated. This related to the pain of interventions, such as vaginal examinations, early labour discomfort (see chapter

one) as well as labour contractions which for some were more intense than expected:

Um....no...I'd say it was a lot more uncomfortable, painful, obviously you just don't know coz it's never happened before but I think I was more thinking "Oh, that's fine, I'm being induced, you know, this is fine, but when it actually got to it, I just wanted it over with, it was horrible...it wasn't nice ...just where I was so uncomfortable and in lots of pain. (Polly)

The timing of epidural analgesia may have had some bearing on women's experiences of labour as being more or less painful than anticipated. Those who accepted an epidural early on in labour generally spoke of pain in a less emotive way than those who waited until it became unbearable.

In summary, less than half of all participants felt that induction was worse than they had imagined it, which was an unexpected finding. However, preconceived ideas about induction were limited and women had no any previous experience against which to measure it. Of those who rated it worse than expected, pain and duration of induction were key factors. Nearly every woman experienced some intervention which they would have preferred to avoid, but a few were pleasantly surprised by the contrast between their expectations and reality, especially in relation to epidurals. Most women adopted the pragmatic view that what had happened was necessary for the baby's sake; a sentiment common to the findings of other studies: as Clare said:

I think it was an example to me that you can't always cling to your principles of what you deem to be the ideal... (Clare)

It is evident however, that the gap between expectations and reality could be considerably narrowed by better provision of focussed information at an appropriate stage in the antenatal period.

Considering the future

Feelings about future pregnancies

Chapter four discussed women's attitudes to induction at the end of pregnancy and summarised that most women held a fairly pragmatic view of induction as something "*that was sometimes necessary*" (Laura); however, as most women had either hoped for or anticipated a natural birth, induction represented a shift in their expectations of childbirth. To provide a fuller picture of how (or indeed whether) attitudes had changed, women were asked how they would feel if induction was suggested in any future pregnancy. This question provoked much thought and answers were sometimes complex and ambiguous. There was no obvious indication in any woman's case that induction would be contraindicated in future. The following table illustrates the preferences of each woman in relation to future births:

Table 13 *Women's preferences in relation to future births*

Would readily consider induction	Would reluctantly consider induction	Would ask for Caesarean	No further pregnancies planned	Assumed automatic Caesarean In future	Uncertain
Amy	Donna	Tanya	Clare	Fay	Olivia
Sarah	Megan	Beth			
Laura	Isobel	Rose			
Jasmine	Hannah	Vicky			
	Nina	Emily			
	Wendy	Polly			
	Karen	Gemma			

There was a marked difference of opinion among women. Five of those who had undergone a caesarean section stated that they *never* wanted to undergo an induced labour again and an elective caesarean section would be their preference. The other six women who had a caesarean section were less certain and gave the impression was induction would be reluctantly accepted as a last resort, as concern for the baby's wellbeing outweighed any personal preferences:

I would, well as I say, you know, if it's for the health of me and the baby I would obviously let it be done again in a heartbeat, but I would prefer to not be induced just because I'm late. (Hannah)

Of the women who had the least complicated births (SVD or ventouse) four indicated that they would readily accept induction again if necessary:

Yes, yes I would, I'd have to go in open-minded and think actually it might not be as quick as the first time, and... but no I'd be happy 'cos the pessary was bearable and I now know a bit more what to expect and I feel more confident and yeah, no I'd definitely do it again if I had to. (Sarah)

I'd accept it more quickly, probably [...] Yeah, I would go along with it, you know, if it needed to be done. I would probably attempt more things if I was term. I would definitely do reflexology and acupuncture. (Jasmine)

Regardless of mode of delivery, women who remained open to the idea of induction in future pregnancies demonstrated that their experience had furnished them with more assertiveness and knowledge, leading to a more cautious and questioning approach:

I think maybe I would put my foot down and wait longer next time ...coz they were, they were quite flexible at the hospital, they would have given me more time. (Nina)

[...] I think it would depend again for the reason, but I think I would probably want [...] I would maybe want to try and speed things up myself first maybe [...] I think I would want to know would it be absolutely necessary I think the next time, if it was suggested, I don't think it would be something I would jump into as quickly unless it was, you know, vital for the baby at the time...depends on the reasons, really. (Donna)

The theme common to most responses was that in future, women would demand more control over the mode of giving birth, would ask more questions and be less vulnerable to persuasion.

Of the 21 women in the sample, seven stated that in future, they would prefer an elective caesarean section to another induced labour. This included some women who had not had a caesarean on this occasion. Reasons given included the convenience of a planned operative birth on a known date, but were mostly related to a desire to avoid the distress caused by lengthy labours and subsequent complications.

It's just easier, I mean I know there's more to think about afterwards, with stitches and...and stuff being more careful, but...it's just easier, I think! (Rose)

[...] if we decide to have another one and I'm overdue with the next one I will ask 'can I please have a caesarean without having to go through all of that' [...] Because there's no way that I ever want... to have a drug, basically a drug-induced labour again I don't want, I don't want that to happen (Gemma)

And people keep saying “major abdominal surgery” and so on, but I met a friend from NCT classes ...and she’s just got a small scar which is a little bit itchy and that’s that and she feels fine ...whereas I’ve got a scar where all the stitches have fallen out because it got infected when I was in hospital ...and it’s still there and it’s still a little bit infected and I’ve had to have 2 lots of antibiotics and I think, well, you know, maybe a c-section would have been better ...I don’t really know, why they’re so sure that they want you to have this vaginal birth? (Emily)

Emily’s example illustrates an apparent change of heart, which was noted in several other women, especially those whose antenatal classes had emphasized the benefits of natural birth. The reality of their experiences was subsequently deflating and disappointing.

Suggestions for improving the induction experience

Many women offered suggestions for what could be done to improve the induction experience and when this was not volunteered, a direct question was asked. Only two women felt that nothing more could have been done: Laura, who had had an unequivocally positive experience and Isobel, who had a less happy time, but did not attribute this to any shortcomings in care and thus could not envisage scope for improvement.

The need for more detailed information about induction was frequently cited, which reflects the findings of several other studies from Cartwright (1979) onwards. This related either to general information or to more specific aspects which affected decision-making. There was awareness that more information could lead to greater fear and anxiety, but for some, this was an acceptable trade-off:

Rose: *I think just more info at 38 weeks ...don’t just say “you might get induced” just explain it in detail, spend a bit more time.*

AJ: *You don’t think that would have frightened you at the time?]*

***Rose:** It probably would have, but then at least you know...at least you know. It's better to have info than ...not. (Rose)*

...So there's no point scaring the life out of people. But then obviously it's quite nice sometimes knowing the worst case scenario. (Tanya)

The possible time span and trajectory of induction was another key area identified in which more knowledge would have been helpful in managing expectations or negotiating the date of their induction:

I think I definitely probably would have waited. If I'd known it could potentially take three days, four days.... But if I'd known that prior to that, I probably would have waited 'til possibly day 13 to be induced... (Tanya)

...I just wish it was maybe a little more clear exactly what the process was probably from the beginning [...] Almost like I need a little handout to say "this will happen now...this will happen next. (Beth)

A few women stated that they would advise others facing induction to wait longer before agreeing to be induced.

Individual women cited specific areas in which more information antenatally would improve the induction experience. Nina suggested the provision of statistics on the rate of induction to help with decision-making; Rose felt that more information was needed about the effects of drugs and also suggested postnatal de-briefing.

Information about the chances of increased pain and the likelihood of needing an epidural were mentioned by Vicky, whilst Donna suggested warning women about the lack of sleep in the early stages of induction.

In terms of practical suggestions for improvement, Two women (Sarah and Gemma) recommended closer monitoring of fetal and maternal observations during induction, as each felt that this would reduce anxiety; Donna and Megan highlighted the need for more privacy and individual rooms and four women (Emily, Nina, Olivia and Vicky) felt strongly that there was a need for more flexible visiting times for partners, particularly at night.

The general themes that emerged were a need for care to be individualized and to include specific information at appropriate stages throughout the induction process. In particular, women wanted to know about the possible trajectory of induction. The desire for flexibility within the organisation of care was a running theme. This included a need to acknowledge and value women's early labour symptoms and to provide appropriate support and care regardless of whether or not they met the official criteria for being "in labour". In short, women with symptoms of labour needed to be treated as if they were in labour.

Summary of chapter 6

Retrospective impressions of induction ranged from the highly positive to the extremely negative, with most falling somewhere in between. Not surprisingly, women who suffered the most complications and interventions tended to view their experience more negatively in retrospect, but there was not always a direct correlation. It was clear that although physical events had a significant effect on perceptions of induction, relationships with staff members also played an important role. The disparity between expectations of induction and reality was less marked than anticipated, although many women were under-prepared for the duration of induction, the intensity of contractions and subsequent complications of labour.

Women in this study had a higher than expected rate of emergency caesarean sections and instrumental births which conflicts with the findings of some other studies (Gulmezoglu et al., 2012; Wood et al., 2013) Most had some form of further intervention during labour and nearly half suffered complications in the early postnatal period. Most women found that this did not interfere with their ability to care

for their baby, although two women sensed personal failure for not be able to give birth naturally.

The induction experience changed many women's attitudes towards interventions in childbirth. Epidural analgesia was used by nearly all women and was generally viewed favourably, countering negative images given by antenatal classes. Although just over 50% of women stated that they would consider induction in a future pregnancy, one third would prefer an elective caesarean section. The implications of this shift towards acceptance of interventions have major implications for women, for maternity services and for midwives, who may need to reconsider what women most value about their childbirth experience.

Suggestions for improvements highlighted the necessity of woman-centred care, focusing on individual rather than institutional needs and in particular, for women experiencing symptoms of labour to be treated in accordance with their own needs rather than those of the maternity unit. The support of partners was universally acknowledged and appreciated, but there was a call for more flexible policies to meet their needs and to enable them to offer optimum support. There appears to be much scope for better information antenatally to prepare women for the realities of induction and to assist in decision-making. Since the Changing Childbirth report (Department of Health, 1993) there has been a continuous discourse on the need for individualized, woman-centred maternity care. However, it is apparent from the findings of this study that where induction of labour is concerned, the needs of the institution tend to be prioritised over individualised care, as evidenced by inflexible policies and routines. This was exacerbated by an under-staffed and over-stretched workforce who was mostly willing, but often unable to provide individualised care.

7. Discussion

This study aimed to explore how first-time mothers experience induction of labour, with particular reference to acquiring information and making decisions. Recurring themes centred on the lack of information throughout the induction experience, perceptions of risk and safety, trust in health professionals and the insidious normalisation of induction as part of the maternity care ‘package’. Experiences of undergoing induction as an in-patient were varied, but were often fraught with anxiety and confusion due to the institutional environment and unexpected delays. Differences between women’s attitudes to induction before and after the experience and discrepancies between women’s expectations of induction and the lived reality were also important themes, casting new light on a hitherto under-explored field. The over-arching theme was the need for woman-centred care. This chapter focuses on the key themes arising from the data, culminating in suggestions for improving the induction experience in future.

Lack of informed decision-making

The conceptual framework for my study centres on the notion of informed choice and decision-making in maternity care and how this is influenced by the obstetric model (see chapter 2). It is through this lens that much of the findings of this study will be discussed.

A major influence on my conceptual framework was the work of Mavis Kirkham. In her book *Informed Choice in Maternity Care* (Kirkham, 2004a), Kirkham brings together key research from the turn of the 21st century, indicating that despite professional and governmental initiatives driving the discourse on informed choice, the reality is that this is far from the norm. Although the projects described in Kirkham’s book were undertaken several years ago, the findings have continuing relevance in the present day and are reflected in the findings of this study. Kirkham argues that despite the rhetoric of informed choice in maternity care, women are systematically steered towards ‘*informed compliance*’. However, even this may be

optimistic: compliance can hardly be said to have been ‘informed’ where women possess only the most basic of information. In this thesis I have demonstrated a notable lack of information exchange prior to induction and the subsequent effects of this on women’s decisions and experiences. The majority of women simply complied with standard patterns of care with little or no meaningful information on which to base any choice.

At the time of booking induction

Kirkham (2004b) argues that choice is defined by the service which offers it and is only possible when individuals are aware of the available options. As most nulliparous women know little of their options or of what to expect from those open to them (Jomeen, 2007; Newburn, 2003) they are especially vulnerable to persuasion and many may not consider alternatives unless these are brought to their attention (DeVries, Salvesen, Wieggers, & Williams, 2001). It is the responsibility of the health professional to offer information and facilitate informed decision-making (National Institute for Health and Clinical Excellence, 2008).

Induction is an invasive procedure (see chapter 1) which is not without risk to both woman and baby and is not always successful. In order to make an informed decision about whether to accept, refuse or defer the offer of induction, women need to be aware of the implications of each option to their own as well as their baby’s wellbeing. The discourse on informed choice recognises the need for unbiased information, presented in a meaningful manner and cognizant of the individual’s personal values and beliefs (see chapter 2). Women need time to absorb this information and to apply it to their own situation and set of values. The NICE guidelines and quality standards emphasize the need for a thorough explanation of the reasons for induction, the processes, the relative risks and alternative options (National Institute for Health and Care Excellence, 2014; National Institute for Health and Clinical Excellence, 2008) They specify that women should be given time to discuss the information with their partner, to explore wider information, to ask questions and to consider other options. Women in this study reported receiving very limited information around the time that induction was booked and many could

recall little or nothing that was meaningful to them, relying instead on anecdotes from friends and family for information. In contrast to the recommendations of the NICE guidelines, few women mentioned being offered an opportunity to discuss induction either with a health professional or their partner before making a decision: in many cases, it was an on-the-spot decision prompted by feelings that it was the right thing to do for the baby's sake. It appeared that midwives and doctors rarely presented induction as a choice, rather as an inevitable event, with consent a foregone conclusion.

Few women reported being offered options for delaying or refusing induction, even in the case of uncomplicated, post-dates pregnancy. Where discussion did occur, this appears to have been prompted by challenges from the women: although some knew of the option to refuse, induction was perceived as inevitable for the sake of the baby (see chapter 4). This concurs with other studies which have shown that, having few other points of reference, nulliparous women tend to assume that what is offered must be in their best interests (Edwards, 2008; Hodnett et al., 1997; Jomeen, 2007; Sakala, 2006). Levy argues that midwives act as gatekeepers, controlling the release of information (Levy, 2004). Although this may be done for benevolent reasons (such as to avoid creating anxiety), it exemplifies Foucault's theory of the connexion between knowledge and power (Bradbury-Jones et al., 2008; Fahy, 2002; Foucault, 2000) and neatly illustrates Lukes' second dimension of power (Lukes, 2005): by failing to share knowledge about other options or to discuss the finer details of induction, midwives were effectively suppressing empowerment (Johanson et al., 2000). This had the effect of steering women towards officially sanctioned, normative care patterns rather than encouraging them to make autonomous decisions.

It would be easy to blame midwives for not fulfilling the NICE agenda, yet midwives work within a structure which is time-constrained (Kirkham & Stapleton, 2004). The standard 10-15 minute antenatal appointments limit the amount of information that can be provided. Unsurprisingly, women stated that midwives often appeared busy and had others waiting, which may have inhibited them from seeking further information. This supports Kirkham's argument that systems of care based around short, task-oriented appointments compel midwives to control the agenda and limit

discussion to ensure that appointments do not overrun (Kirkham, 2004b; Levy, 2004). This leads to a reactive rather than proactive approach to discussion, favouring the more assertive woman, as exemplified by Nina and Jasmine (chapters 4 and 5). Furthermore, women demonstrated a very high level of trust in clinicians and as Kirkham theorized, the offer of a particular care pathway is often seen as an endorsement of that option (Kirkham, 2004a). It is therefore not surprising that when induction was offered, most women accepted it without question.

Most participants, regardless of the indications for induction, reportedly felt that this was not a matter of choice: it was perceived as a *fait accompli*. This supports Kirkham's belief that '*normative practice means that many choices are made by default*' (Kirkham, 2004b, p 267). On the rare occasions where it was presented as a choice, there was a notable bias towards compliance:

[...] it was presented as a choice but they were definitely encouraging me to strongly consider it rather than waiting. (Clare)

In common with the findings of other studies, midwives seem to have adopted a style of communication which blurred the boundaries between choice and coercion (McCourt, 2006; Stapleton et al., 2002). Most women, however, did not express a sense of having been coerced and despite not perceiving any choice, accepted induction unquestioningly and resignedly, as evidenced by phrases such as '*it's the policy*' and '*it's what happens*'. This attitude contrasts with Green et al's (1998) study in which 20% of women questioned the decision to induce labour. This may reflect a shift in attitude towards induction in the intervening years, supporting those who fear that it is now becoming normalised and accepted as part of routine maternity care (Howes, 2004; Skyrme, 2014; Wickham, 2012). This theme will be discussed in more detail later on in this chapter.

Information avoidance

Although most women reported receiving limited information antenatally, most were not unhappy with this *at the time* and took few, if any, steps to further their

knowledge. Several did not read the information leaflet and although all had access to the Internet, few made use of it for this purpose. This contrasts with an earlier study which found that well-educated women (i.e. most of those in this study) attached high importance to information (Green et al., 1998). It is difficult to make general assumptions, but it is possible that having accepted induction as inevitable, some women felt no need to enquire further. Others however, suggested that they were afraid of finding out things that might fuel their anxiety and there is evidence in the literature to confirm the use of avoidance tactics as a means of self-protection from emotional harm (Hallgren et al., 1995; Levy, 1999d).

Information, choice and control

Kirkham (2004) argues that women are unlikely to enquire about options which are not volunteered by clinical staff and that information is commonly slanted towards promoting compliance rather than stimulating discussion. However, it has been argued that too much information and responsibility for decision-making can have effects similar to those of insufficient choice, leading to anxiety and loss of control (Green et al., 1998; Weaver, 1998). This raises the possibility that by not proffering information about induction, midwives were practising '*protective gatekeeping*': the withholding of information which, they believed, might upset women (Levy, 2004). Viewed from Lukes' theory of the second dimension of power (Lukes, 2005), this may be seen as disempowering and controlling in denying women wider information about induction, particularly in relation to risks and other options. However, there were instances of women choosing not to seek information and opting to delegate decision-making to clinicians (e.g. Isobel and Rose). Evidence suggests that in such cases, women may be more likely to feel that they have exercised informed choice (Jomeen, 2007; O'Cathain et al., 2002a). This raises questions about the value that individual women place on information and decision-making and whether they would actually have welcomed more information and choice had it been offered. It also poses the problem of how best to ensure that women have ready access to adequate, unbiased information *when they want it* and are empowered to delegate decision-making as and when they feel the need.

Information from antenatal classes

Women's recall of information about induction from antenatal classes suggests that they were unable to retain or assimilate that which did not seem relevant to them at the time. Antenatal classes are often large and therefore by necessity, information may be generalised rather than personalised. Moreover, women typically attend antenatal classes between 30-35 weeks of pregnancy; well before the question of induction would seem relevant. Studies into the provision of information during pregnancy and childbirth have highlighted the supreme importance of the appropriate timing of information to ensure that women can relate to it (Cooper & Warland, 2011; Maher, 2008; Stapleton et al., 2002a). Although Maher's (2008) focus was on women in labour, some of her findings have wider relevance, in particular the suggestion that specific issues may be understood differently in antenatal classes than in the throes of labour. Maher (2008) underlined the importance of communicating information according to women's requirements at critical times: too much information may be as bad as too little.

The only women who reported receiving information at a level close to that proposed by the NICE guidelines on induction were Clare, who had received private care and Laura, who had attended a pre-induction antenatal class. Both had been part of small groups and appeared to have received information relevant to their individual circumstances. The pre-induction class which Laura attended had been available to all women, yet most had been unaware of its existence. As this was a new innovation at the time, it is possible that some community midwives were also unaware of it. Alternatively, as the classes were advertised via a sticker in each woman's hand-held maternity records, it might have seemed reasonable for a time-pressed midwife to assume that women had read the information and that no discussion was needed. However, maternity records at the Trust in question are extensive, complex and difficult to navigate even for health professionals: it would not be surprising if women had simply failed to spot the presence of the advertising sticker.

Laura's experience, although an isolated case, suggests that pre-induction classes can make a positive difference to women's understanding of induction and the promotion of informed decision-making, however, a proactive approach to promoting them needs to be undertaken. Pre-induction education does not appear to be widespread in the UK, and there is almost no literature on this subject. This is an area worthy of further research in the UK.

The inverse care law

In their evaluation of the MIDIRS *Informed Choice* leaflets, Kirkham, Stapleton, Curtis and Thomas (2002) observed a bias, whereby the more articulate and assertive women received more information than the more reticent (Kirkham, Stapleton, Curtis, & Thomas, 2002). Findings from the present study support this, as the women who repeatedly questioned staff found that persistence eventually paid off, whilst the least assertive reported feeling less well-informed overall. This concurs with Hart's 'inverse care law' of the relationship between the need for care and its provision (Hart, 1971, cited in Kirkham et al, 2002). Some of the less assertive women deflected blame away from midwives or blamed themselves:

[...] I didn't ask, so I didn't get, really, [I] could have perhaps said to ask something [...] I would say I was given enough written information at classes, but I didn't read them, so it was actually my fault! (Isobel)

The antenatal ward was reported to be perpetually busy with midwives constantly under pressure, thus as in the antenatal clinics, some midwives adopted a reactive rather than proactive approach to information-giving. As Kirkham et al (2002) observed, time constraints '*favoured the articulate woman*' (p 509). Whilst midwives were generally perceived as kind and empathetic, the dominant pattern of care appears to have been merely humanized rather than empowering.

Summary

It appears that although many women did not question the need for induction and chose not to seek further information, most 'did not know what they did not know'. There was a systematic lack of opportunities for health professionals to volunteer information and to discuss options. What information was offered appears to have been limited and routinized to fit the agenda of antenatal appointments or standard antenatal classes. According to theories which associated information with power (Foucault, 2000; Lukes, 2005), women therefore occupied the very bottom rung of the power hierarchy. The antenatal period was recently criticized by the Care Quality Commission report for poor provision of information in general, but no solutions were offered (CQC., 2013). This mis-match between the ideal and reality places the midwife in a challenging position and implies the need for a shift in the infrastructure of care to allow midwives time to present women with honest, unhurried and unbiased information, personalised according to individual need so that women are empowered to assess the risks and benefits of induction in relation to their physical, social and emotional needs: without this, women cannot be expected to make fully informed choices and decisions.

Self-help methods

The use of self-help methods in pregnancy is widely hailed as evidence that women want to exert control over their bodies and lessen their dependence on health professionals (Hall et al., 2011; Hall et al., 2012b; Mitchell, 2010). Although most women had tried one or more alternative methods in an attempt to avoid induction, attitudes towards these were ambivalent. It is possible that with hindsight, the obvious failure of self-help methods to initiate labour coloured women's attitudes, however there was a subtle impression that many women had been simply going through the motions. Westfall and Benoit's (2004) study of a group of Canadian women found that the use of self-help methods to induce labour was partly in response to societal expectations to try to avoid prolonged pregnancy and medical induction (Westfall & Benoit, 2004) and it is possible that some women in the present study had acted under a similar sense of social obligation. A few women reported

that midwives had suggested certain alternative therapies, but without offering any supporting information, it seems likely that they had been simply paying lip-service to the notion. This is an area which warrants further research: if there is a genuine desire to try alternative methods to avoid induction, strategic measures need to be instigated at institutional levels to provide proper training to midwives and antenatal teachers and opportunities for women to access evidence-based information.

The influence of risk perception on decision-making

Cheyne et al (2012, p.3) observe that “*decision-making in relation to induction of labour is highly risk-averse*. All but one of the women in this study had been convinced that continuing their pregnancy was risky to their baby and this was the main deciding factor in their acceptance of induction.

Childbirth has long been recognised as a period of uncertainty and thus of potential risk to both mother and baby, where lives may hang in the balance. Anthropological studies have shown how this notion of danger is deeply entrenched in both spiritual and physical contexts throughout many cultures where modern medical practices are recent introductions (McCourt, 2009b). Women in industrialised countries are no less immune from this fear, despite the relative safety of childbirth. It has been postulated that the notion of risk is maintained and even exaggerated by those in positions of authority as a force of power for ensuring compliance with normative patterns of care (Edwards, 2004; Gigerenzer & Muir-Gray, 2011; MacKenzie-Bryers & van Teijlingen, 2010). Fahy (2002b) argues that power is exercised over women, by nurturing an often unspoken belief that compliance leads to the ‘reward’ of a healthy baby, whilst dissent may result in the ‘punishment’ of a sick baby or stillbirth (Fahy, 2002). Examples of these were not explicit in any of the data in this study, yet many women alluded to the powerful influence that any mention of risk had on their decision to accept induction:

[...] when you're told 'risk of infection' you just do it. (Megan)

In cases such as Megan's, where the prospect of a normal labour is confounded by medical complications, the benefits of induction are usually clear (Cheyne et al., 2012). However, evidence for the benefits of routine induction at 41+ weeks is less strong and indeed controversial (see chapter 2) whilst the risks of continuing the pregnancy are low compared to the potential iatrogenic effects of induction (Cheyne et al., 2012). Effectively, induction for post-dates pregnancy is prophylactic rather than therapeutic and involves a trade-off of risks and benefits. Women need to be able to weigh up the relatively low probability of a severe outcome (such as stillbirth) against the much higher probability of a less serious adverse event (such as instrumental birth) resulting from induction. Unless both sides of a risk argument are presented, women are likely to passively accept the normative pattern of care on the assumption that what is offered must be best (Kirkham, 2004b). In such circumstances, any decisions made cannot be said to have been informed.

Cognizant of the need for women to make informed decisions, the NICE guidelines advocate a full discussion of the risks and benefits of induction before any decision is made (National Institute for Health and Clinical Excellence, 2008). However, in this study, except where a discussion had been prompted by a challenge from individual women (for example in Jasmine's case), there was little evidence of any discussion or evaluation of risk having taken place with any health professional at any time prior to induction.

It may be argued that by failing to provide sufficient information to enable women to balance the relative risks of induction against those of expectant management, clinicians acted unethically and effectively manipulated women's decision-making (Austin & Benn, 2006; Skyrme, 2014). However, in accordance with theories of disciplinary power, it is likely that midwives, being fairly low in the power hierarchy, felt pressured to present only the benefits of induction rather than the risks, for fear of being held responsible for any adverse outcomes should women have chosen not to follow the normal care pathway (Bradbury-Jones et al., 2008; Levy, 2004; Lukes, 2005).

Kirkham (2004b) makes the point that evaluating the evidence needed to make informed decisions may be challenging when this is complex. It has been argued that poor understanding of probability statistics is endemic throughout the health professions (Cheyne et al., 2012; Gigerenzer & Muir-Gray, 2011; Thornton et al., 1996) making it difficult not only to assess risk on an individual basis, but hampering the ability to communicate it to others. Whilst midwives are routinely trained to understand and convey risk in relation to antenatal screening for fetal abnormalities, this does not usually extend to other areas of care. Midwives need a thorough understanding of risk and probability and the ability to adapt information to suit each woman's capacity for understanding (Cheyne et al., 2012; Skyrme, 2014). This has implications for midwifery education and staff training. Furthermore, midwives need to feel empowered to offer a balanced discussion of risk, safe in the knowledge that they will not be penalised if women choose not to comply with the expected norm (Skyrme, 2014).

Although an understanding of probability statistics may provide a logical basis for choice, women's decision-making in relation to induction is influenced by numerous other factors, not least the value which women place on choice and control (see chapter 2). Midwives need to be aware of this in order understand how women make decisions (Cheyne et al., 2012; Skyrme, 2014). Unfortunately, as Kirkham and others have observed, the current structure of maternity care in obstetric-led units, with short appointments and lack of continuity of carer provides neither the time nor the opportunities for midwives and women to build a trusting relationship conducive to the understanding of women's personal values.

Trust in the professionals and compliance with the medical culture

In common with the findings of some other recent studies (Moore et al., 2014; Murtagh & Folan, 2014), most women reported that they had not challenged the offer of induction. Even those with strong anti-interventionist views eventually succumbed. This was somewhat surprising, as most women in this study were from the higher end of the socio-economic spectrum, where women might be expected to be more

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articulate and questioning when their expectations of childbirth are thwarted (Kirkham et al., 2002).

Various explanations may be posited for women's compliance and lack of challenge, not least of which is the argument that, with few other points of reference, nulliparous women tend to assume that what is offered must be in their best interests (Edwards, 2008; Hodnett et al., 1997; Jomeen, 2007; Sakala, 2006). Moreover, as Levy (2004) observed, the stereotypical image of a midwife tends to inspire trust: in the present study, this was doubtless helped by the plethora of popular television programmes about midwifery which were current at the time. Recent studies, however, have shown how concerns for the baby's wellbeing tend to override all other matters in justifying the decision to accept induction (Hildingsson et al., 2011; Moore et al., 2014; Murtagh & Folan, 2014). This raises speculation about whether women were motivated less by trust and more by fear based on their limited understanding and skewed perception of risk (see previous section).

Theories of power relationships offer an alternative explanation for women's readiness to comply. In accordance with the Parsonian concept of the 'sick' role, the clinical environment places women in a relationship of dependence with care-givers, where cooperation is expected and power is entrusted to clinicians (McCourt, 2009b; Parsons, 1951). As Kitzynger (1975) observed, it is perhaps natural that in their vulnerable position, women should have wanted to adopt modes of behaviour that would promote good relationships with their caregivers, even at the expense of personal autonomy.

The question of why women with strong anti-interventionist views should succumb to medical models of care was previously explored in an ethnographic study by anthropologists Machin and Scamell (1997). Viewed from the perspective of ritual theory, Machin and Scamell (1997) noted how women with previously high levels of self-confidence and ideals for natural birth tended to relax their attitudes as they crossed the threshold from pregnancy to labour. When feeling overwhelmed, women sought reassurance from '*the white coats and medication*' (Machin & Scamell, 1997, p.83). This implies that the medical culture has become an archetypal symbol of reassurance at times of vulnerability, which offers a way of understanding why

women are reluctant to challenge medical interventions, even in uncomplicated pregnancies.

Lost in the system: the culture of the maternity unit

Kirkham and others have demonstrated how the prevailing culture of obstetrically-led maternity units hinders informed decision-making and woman-centred care through a hierarchical system which disempowers both women and midwives (Kirkham, 2004b; Kirkham & Stapleton, 2004; Stapleton, 2004). In the current study, a reported lack of information and unspoken rules appeared to have combined to keep women in a state of relative ignorance and powerlessness, particularly from admission to hospital and throughout the earlier part of the induction process.

Like many women having their first baby, few of the participants in this study had much experience of life as an in-patient and therefore faced the challenge of adapting to the unfamiliar culture and priorities of the hospital. Having reportedly received limited information about induction antenatally, women were largely unprepared for what to expect after admission to hospital: several indicated that they had expected the induction process to begin immediately on arrival, to proceed swiftly into labour and to give birth the same day. The realisation of finding themselves in an apparently slow-moving queue for induction was often cited as a source of discomfort and anxiety. Numerous writers have compared the maternity care system to a factory production line (McCourt, 2009b) and although not made explicit, an impression was gained that women felt they were being processed through a system with no clear picture of where this was leading.

Although treatment from midwives was generally perceived positively, women were not always aware of their plan of care or of what to expect and a few reportedly felt inhibited from asking questions. In one case, (Emily) it was reported that a midwife used strategies to avoid conversation (see chapter 5), but more commonly, women appear to have empathised with the apparently over-stretched staff and wished to avoid increasing their burden. This concurs with the findings of Kirkham and

Stapleton (2004) who found that women were reluctant to trouble midwives for information when obviously busy.

Rules and regulations

A system of routines and regulations is traditionally maintained in hospitals as a means of maintaining order (Oakley, 1980). Kirkham (2004) argues that whilst this provides a coping mechanism for staff, women are required to fit in with the service in order for the system to function smoothly. Although the rhetoric of woman-centred care is widely proclaimed, care in hospitals is governed by protocols and routines and many women found themselves confronted with unexpected rules which threatened their autonomy. These rules were largely invisible because they were contained in policies to which women did not have access and were not explained. This was a cause of frustration:

[...] sometimes people in institutions expect you to know their system...
(Emily)

Examples included the non-availability of Entonox™ or access to the low-risk birthing unit (see chapter 5). Rationales doubtless existed, but no women reported being made aware of them or given opportunities to negotiate alternatives. The findings support Kirkham and Stapleton's (2004) observation of how, in a hierarchical structure, policies quickly become crystallized into rules. Going into hospital separates women from the normal context of their lives: rules and regulations further this severance, encouraging the adoption of passive patienthood or a 'sickness role' (McCourt, 2009b; Parsons, 1951). This runs counter to the description, much vaunted in the midwifery literature, of childbirth as a normal, physiological process and the concept of partnership between women and midwives.

Of all the invisible rules, the one most frequently cited as a source of stress was the ban on partners on the antenatal ward at night, causing women to feel isolated and alone at a time when they most needed support. The Care Quality Commission Report (2013) found that being separated from significant others was a frequent cause of unhappiness among women during induction (CQC., 2013). Other studies

have found that long periods of discomfort and isolation from their usual support networks cause women to be physically and emotionally drained by the time labour is fully established (Barnett et al., 2008; McCourt, 2009c). Furthermore, feelings of insecurity may lead to dysfunctional labour, due to the effects of stress hormones inhibiting the production and release of oxytocin (Hodnett et al., 2013; Kitzinger, 2005; Sakala, 2006; Wuitchik et al., 1989). Following this line of argument, it is logical to hypothesize that the high rates of further interventions suffered by women in this study may, in some cases, have been exacerbated or even caused by the emotional effects of separation from loved-ones and thus strengthens the argument for introducing out-patient inductions or exploring more woman-centred systems of care.

Time

The passing of time was a recurring theme throughout women's accounts of their induction experience. This concurs with other studies which have highlighted women's acute awareness of time as the expected date of birth is passed. In Gatward et al (2007), for example, women used phrases such as being '*on a clock*' to describe their sense of having moved onto a new timescale.

Sociological and anthropological studies have explored the concept of time in hospitals, identifying it as a tool of power and control by placing the patient on a new and unfamiliar time trajectory. Walsh (2009) and Arney (1982) draw parallels between obstetric models of care and the industrial models of Fordism and Taylorism, whereby tasks are broken down into their component parts, each undertaken by different workers within a rigid timeframe. Wendy Simonds (2002), in her analysis of discourses on time in the U.S. childbirth literature, argued that the obstetric model '*fractures [the] procreative experience*' (p. 560) by imposing artificial timescales and fragmenting the birthing process into incremental units, ignoring the physiological fluidity of labour. Time thus becomes an objective assessment tool of the medical hierarchy, exerting control over the potentially hazardous process of parturition (Downe & Dykes, 2009; McCourt, 2009b; Simonds, 2002b; Stevens, 2009). This denies women's innate sense of time and often contrasts with women's

intimate knowledge of their own body and physical sensations of the onset and progress of labour. In the current study this was exemplified by Nina's account of how her knowledge of her date of conception (and thus her EDD) was denied in favour of the dates determined by routine ultrasonography (chapter 4).

The notion of time as a tool of power is particularly pertinent to the subject of induction for post-dates pregnancy, exemplifying the medical perception of a pregnancy which exceeds the textbook definitions of normality as deviant and in need of correction. Simonds (2002) refers to this as the '*library book model*' (p. 564) in which 'overdue' pregnancies are subject to penalties in the form of interventions. The focus on the potential negative outcomes of post-dates pregnancies is emphasised over and above the adverse effects of any interventions (Simonds, 2002a).

Vicky's story gave an example of how women may be manipulated into an industrial time-pattern in order to maintain the equilibrium of hospital systems: in this case, the antenatal ward:

[...] they said that they couldn't examine me because...they were worried that they would break my waters...And then I wouldn't fit in with when I was supposed to be getting induced... (Vicky)

It seems that midwives were afraid that once Vicky's waters broke, she would officially cross a threshold and enter a new timescale. Alternatively, if Vicky had been found to be undeniably in labour, midwives would have had the added stress of trying to accommodate a labouring woman on the antenatal ward. Vicky was therefore both out of time and out of place, representing a threat to the status quo of the ward and to staff workload.

In contrast to the 'masculine', medical model of time, the midwifery model (in its ideal), has been described as holistic, cyclical and 'feminine' in nature; guided not by the clock, but by the biological rhythms of the woman and fetus/baby (Simonds, 2002a; Walsh, 2009). Anthropological studies have demonstrated how in cultures

not dominated by modern obstetrics, pregnancy and birth are seen to progress in a non-structured, non-linear fashion, outside of chronological time. For example, Becker's study of aboriginal peoples in Northern Canada demonstrated how traditional concepts of time are not linked to the clock, but to a sense of when the time is 'right' in relation to other factors (Becker, 2009). Traditional midwifery, in these societies, does not involve clock-watching, but relies on intuition, family support and patience (Becker, 2009).

In contrast, women in the current study seem to have had a very linear concept of time and expected the entire induction process to be completed within a day and to be home the following day: these women became disappointed or anxious when induction failed to follow their envisaged trajectory:

I think the delay and the anxiety, being told that there's a risk if it doesn't come out, then not actually cracking on with that process. (Emily)

Others, such as Megan and Gemma, became much focused on the clock and the regularity of monitoring, to the extent that they felt the need to remind midwives to monitor them. This supports the association between time and risk (Maher, 2008; Simonds, 2002a): women had absorbed the message that deviations from the expected trajectory of pregnancy and labour pose a risk to the fetus, thus their expectations and sense of safety were governed by the calendar and the clock.

These findings may suggest that induction (or indeed medicalised childbirth in general) robs women of their innate, holistic sense of time and imposes a culture of linear, medicalised time. However, sociologist JaneMaree Maher (2008) argues that women's attitudes to time in childbirth are complex and cannot always be explained from a dualistic perspective. Maher argues that women draw on '*multiple temporalities*' (p. 130) to make sense of time during childbirth, which includes a mixture of medical and social narratives on the progress of labour (Maher, 2008). The experiences of women in this study underline the need for more information and discussion in the antenatal period about the likely time trajectory of induction and its

implications, so that women may better manage their expectations and reduce unnecessary anxiety.

In labour or in limbo?

The preceding sections explored how rules, regulations and time became a source of anxiety for women on the antenatal ward: in a few cases, these negative feelings were exacerbated by a sense of bewilderment, being out of place or feeling abandoned. These experiences may be analysed from the perspective of Van Gennep's (1960) theory of rites of passage.

From his studies of pre-industrial societies in the early 20th Century, Arnold Van Gennep (1960) identified rites of passage as social and cultural practices which occur at significant thresholds of human existence, such as birth, coming of age and death, in order to assist the passage from one state to the next (Kenworthy-Teather, 1999). Van Gennep (1960) observed that passage through these life stages was associated with danger and was therefore punctuated with ritual to ensure a safe passage both spiritually and physically. Rites of passage involved three distinct stages: separation, transition and incorporation: these typically involve removal to a special or sacred place in preparation for the transition, before being reincorporated into society in a new status (Kenworthy-Teather, 1999; Winchester, McGuirk, & Everett, 1999). During the transitional phase, a liminal state is entered in which normal order is suspended: the person undergoing change is displaced from their everyday context and previously held beliefs may be inverted (Van Gennep, 1960). As such, it is seen as an especially dangerous and vulnerable time, requiring rituals for protection and control (Machin & Scamell, 1997).

Latter-day anthropologists such as Lomas (1978), Davis-Floyd (1990), Machin and Scamell (1997) and McCourt (2009c) have developed Van Gennep's (1960) theory and applied it to contemporary childbirth. The separation stage is exemplified by withdrawal from practices which may be deemed harmful to the fetus, by the reduction in social activities and ultimately, physical removal to the maternity unit. Labour represents the transitional stage, whilst the early postnatal period may be seen as a time of reintegration. Routine medical procedures such as clinic

appointments, scans and screening tests may be seen as rituals within the rite of passage of pregnancy and childbirth. In her study of birth in the USA, Davis-Floyd (1990) argues that in a medicalised system of care, transition rites associated with childbirth serve less to protect the woman and baby during this liminal phase, than to protect staff from the potential hazards of an unpredictable biological process: rituals and routines thus impose a semblance of order and control which serve the interests of the institution above those of the woman. This may be evidenced by the practice of restrictive visiting times, routine observations and the imposition of time-limits on labour (McCourt, 2009c).

Liminality and induction

Labour is widely recognised by midwifery researchers, as well as anthropologists, as a liminal state, when a woman is neither 'only' pregnant, nor yet the mother of a newborn (Cote-Arsenault, Brody, & Dombeck, 2009; Downe & Dykes, 2009; Parratt, 2008). This concept of liminality has been extended to the state of breastfeeding (Mahon-Daly & Andrews, 2002) and to the experience of parenting a very pre-term baby in a neonatal intensive care unit (Finlayson, Dixon, Smith, Dykes, & Flacking, 2014; Watson, 2011).

Evidence from the current study suggests that hospital-based induction may now be identified as a new and previously unacknowledged phase of liminality, similar in some respects to that experienced during labour, but distinct in others. Time spent awaiting induction or waiting for the inducing agent to take effect is often unexpected, unplanned and outside women's schema of labour and childbirth: it is effectively 'time out of time', where women are on the cusp of labour, but displaced from the context in which they had anticipated beginning their journey to motherhood.

Van Gennep's concept of liminality has spatial connotations, involving the ritual removal from one space to another (Kenworthy-Teather, 1999; Winchester et al., 1999), which in the case of induction, is represented by admission to the antenatal ward. More than any other place within the maternity unit, the antenatal ward is a place of waiting: it embodies anticipation, uncertainty and a sense of being on a

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threshold. Hence women undergoing induction occupy a liminal space both biologically and physically.

Whilst awaiting the initiation of induction or the onset of labour women are treated as patients, yet are neither sick (in most cases) nor in labour: they may not go home, yet cannot progress to the labour ward until given permission to do so: worse, they may not claim the status of being in labour or have access to labour support until this is officially sanctioned. Labour holds many uncertainties, but women know that once established, the birth will occur within a matter of hours: they usually have the exclusive company of a birthing partner and the frequent attentions of a midwife, from whom reassurance and information can be sought. Evidence from this study, however, has revealed that women undergoing induction are frequently left alone for long periods of time, deprived of their partner's company at night and confounded by unexpected rules which enhance their anxiety and confusion. Unlike established labour, induction may fail or be postponed indefinitely for reasons not always made clear. The analogy of the airport departure lounge, (see end of chapter 5), perhaps best depicts this situation of suspension between two states and the sense of being able to move neither forwards nor backwards without the agency and permission of a higher power.

Induction and disruption

As well as established medical rituals (see above) the transition to motherhood is punctuated by social ritual, the importance of which has been highlighted in earlier studies (Machin & Scamell, 1997; Van Hollen, 2003; Wilson, 1995). In the UK, such rituals are culturally situated and evolving and may include landmark events such as the baby shower (a recent import from the USA) or personal preparations for going to hospital such as buying new nightwear, beauty treatment and packing the hospital bag. Findings from this study illustrate the potential of induction to upset women's sense of equilibrium by disrupting their imagined trajectory of pregnancy and labour through the obstruction of social rituals. For example, Gemma reported feeling unready to give birth as her induction was booked before she had time to visit the hairdressers in preparation for going into hospital. Nina, meanwhile, found that her

extensive preparations in setting up a suitable environment for a home birth were no longer necessary (chapter 4). It is likely that the loss of personally significant rituals of preparation may lead to a sense of loss of control over childbirth, subsequently contributing to negative birth experiences.

Implications for the care of women undergoing induction of labour

Recognition of the experience of hospital induction as a new and hitherto unacknowledged liminal state carries implications for care providers and tensions between the medical and social models of childbirth need to be addressed.

In order to better support women undergoing induction, health professionals must first acknowledge its nature as a liminal state and recognise that even where women are happy to be induced, induction is often an unexpected disruption to their planned trajectory of labour and birth. Preparing women for what to expect during induction and particularly for the likelihood of and reasons for delays and interruptions is of key importance in enabling women to adapt their expectations of labour. Suggestions for this are explored in more detail towards the end of this chapter.

There is a need for greater recognition of the experience of early labour, as evidence from the current study and elsewhere suggests this is frequently undervalued (Barnett et al., 2008; Green & Spiby, 2009; Hunt, 1995). Early labour can be a time of anxiety and uncertainty, made worse when women's own innate understanding of being in labour conflicts with the medical definition and is ignored or trivialised (see chapter 5). There is evidence that women in the latent phase of spontaneous labour cope better emotionally when their pain is acknowledged as a positive contribution towards labour progress (Barnett et al., 2008), whereas dismissal of women's feelings may leave them feeling unsupported and exhausted by the time labour is formally diagnosed (Green & Spiby, 2009; McCourt, 2009c). Given the known influence of stress on oxytocin release, this may adversely affect the physiological progress of labour (Hodnett et al., 2013; Kitzinger, 2005; Sakala, 2006; Wuitchik et al., 1989), which in turn may lead to further unwelcome and possibly traumatic medical interventions which may damage women's psychological adaptation to motherhood (Cartwright, 1979; Lawrence Beech & Phipps, 2004; Oakley, 1980).

One solution may be to relax the boundaries between antenatal and labour wards so that women undergoing uncomplicated induction could progress seamlessly through their labour without the anxiety of being 'out of time and out of place' and minus the disruption of moving to another part of the building. This would require a complete rethinking of ways in which maternity units make use of space, deploy staff and categorize risk but is worthy of future consideration by planners of maternity care.

Current initiatives to move routine post-dates induction out of the institutional setting and into the community offer an opportunity to enable women to experience early labour in a situation more in keeping with their expectations and with less disruption to their social environment. Within their own familiar setting women may experience less stress, have a greater sense of control and thus cross the threshold into established labour without experiencing the prolonged liminality of the antenatal ward.

Changing attitudes to interventions

Until the very end of pregnancy, all women in this study had harboured the ideal of a broadly 'normal' birth with minimal interventions. Once in established labour, however, all but two women accepted epidural analgesia, yet there were no regrets and despite earlier misgivings, feelings about epidurals were universally positive. Even Nina, who had been most vociferous in her desire to avoid interventions change her mind:

"[...] it felt amazing! [laughs] I felt normal again!" [Nina]

This apparent shift in attitude was to some extent reflected in attitudes to future pregnancies, in the event of induction being suggested again. Just over half the women stated that they would agree (albeit some very reluctantly) to induction in future. However, some were very insistent that they would *never* have an induced labour again and one third stated that they would prefer an elective caesarean

section. Two women wanted a caesarean next time around regardless of whether or not induction was recommended.

Earlier studies have found that over 70% of women surveyed would prefer or would consider another induced labour (Heimstad et al., 2007; Shetty et al., 2005). The contrast between these and the current study may be due to methodological differences: alternatively this may reflect the unusually high number of operative and instrumental births among women in this study (see chapter 6). However, it was impossible to be certain whether or not these interventions were a direct result of induction or would have happened had the women laboured spontaneously. What is crucial, however, is the belief among many that induction caused adverse events and their determination to avoid it in future.

Many of the women who stated a preference for caesarean section over induction were well-educated professionals who might be able to make a persuasive case for an elective caesarean. Some would possibly have the means to opt for private care if necessary. If the findings of this study reflect attitudes in the wider population, it is possible that increasing rates of induction will lead to increasing demands for elective caesarean sections. In view of the uncertain future of the NHS and rising hospital insurance premiums fuelled by a rise in litigation, it is not inconceivable that if the current discourse on informed choice is taken to its logical extreme, a policy of caesarean section on demand may soon become the norm. Not only would this undermine the drive to promote normality in childbirth, but the increased costs of employing more obstetricians and theatre staff might be offset by a corresponding reduction in the number of midwives. This would result in a poorer midwifery service which in turn, may undermine public confidence and increase demand for technological birth. This has implications for the future of the midwifery profession in its current form.

A changing concept of childbirth?

The change in some women's attitudes to interventions following induction presents something of a paradox: one interpretation suggests that the emotional and physiological sequelae of induction and the effects of subsequent interventions

undermined women's confidence in their ability to give birth normally in future (MacKenzie-Bryers & van Teijlingen, 2010). However, it may be argued that their experiences empowered them to make decisions and stimulated their determination to demand more control over the mode of future births.

The almost universal uptake of epidurals and the preference for future caesarean sections among one third of the group may support assertions that, despite the increasing discourse on promoting normality in childbirth, women are becoming more willing to accept medical interventions (Green & Baston, 2007). Women spoke with passion and conviction about their intentions for future pregnancies, seeming to contradict the argument that 'passive' rites of passage, such as induction and labour under epidural analgesia, lead to unassertive and compliant women (Leap & Anderson, 2008). An argument is emerging that the binary concept of childbirth as fitting either the obstetric or the midwifery model may no longer strictly apply; that a cultural change may be taking place among the childbearing population, in which ideals of a good childbirth experience are being reconstructed.

Anthropological studies from non-western cultures provide evidence of women on the brink of a new understanding of childbirth norms. Van Hollen's (2003) study of poor women in Tamil Nadu, for example, demonstrated how they have adapted to the encroachment of medicalisation in a society in which pregnancy and childbirth are traditionally regarded as sacred states, surrounded by ritual. Despite the historical gulf between traditional and medicalised childbirth practices, medicalisation is not necessarily regarded as oppressive and women are choosing to select aspects of it that coincide with cultural ideas of safety – particularly induction and augmentation of labour. Both interventions have associations with shorter labours in a society which views long labours as dangerous (Van Hollen, 2003). By increasingly demanding induction and augmentation, it is argued that women are becoming active participants in change rather than merely passive compliers (Van Hollen, 2003).

There is a need for further investigation into how women in the UK conceptualise normal childbirth in the 21st Century and the extent to which they, like the women in Van Hollen's study, are embracing and actively participating in change. Discourses

on the promotion of 'normality' need to take account of women's ideals and preferences, rather than those of childbirth 'experts' and to consider the implications of these for the future of maternity care.

Opportunities to improve the induction experience

Events during labour and birth can have lasting physical and psychological sequelae for women (Kirkham, 2004a; Oakley, 1980) and several studies, including the current one, have demonstrated that induction of labour is a significant contributor to the overall birthing experience (Baston et al., 2008; Murtagh & Folan, 2014; Shetty et al., 2005). Findings from this study highlight several areas at strategic and local levels where opportunities for improvement could be grasped.

Recurrent themes throughout the conversations with women focused on the need for more information antenatally and at appropriate stages throughout the induction process. There is a particular need to enable women to evaluate the relative risks of induction and expectant management and to manage their expectations by presenting a realistic picture of the possible trajectory, duration and outcome of induction so that all decisions may be soundly based.

Information to groups

The maternity unit from which participants were recruited offered a pre-induction class to all women in late pregnancy, yet at the time of this study, uptake was extremely low. However, the account of the one woman who attended (Laura) suggests that there is potential for such interventions to provide information and allow women to explore their options within a supportive environment. Although there is very limited evidence to support this, one US study has shown promise (Simpson et al., 2010). Educational interventions also have the potential to offer information on self-help methods for avoiding induction, although this would require investment in staff training.

However, as evidence from this study and others has demonstrated, women do not always wish to engage with information which may cause anxiety, particularly if it is not perceived as relevant at the time. It is unlikely therefore that many women would choose to attend a pre-induction class on the off-chance that they might eventually be induced. Furthermore, the active promotion of pre-induction classes to all women in late pregnancy risks strengthening the creeping 'normalisation' of induction for post-dates pregnancy, which in turn encourages compliance rather than informed choice.

The findings of this study support arguments that information should be tailored to women's individual needs. As such needs are unlikely to be fully known until induction is imminent, it seems improbable that a pre-induction class would be able to fulfil this requirement unless attended only *after* induction has been clinically indicated. For women facing induction for medical reasons, the time between need arising and admission to hospital can be very short, meaning that classes would need to be offered several times a week to provide opportunities for all those wishing to attend, which has implications for staffing and hospital resources.

Individualized information

Evidence from this and previous studies has demonstrated that in order to make informed decisions, women require individualised, unbiased and comprehensible information about the processes and relative risks of induction versus continued pregnancy (Cooper & Warland, 2011; Murtagh & Folan, 2014; Nuutila et al., 1999; Shetty et al., 2005). They also need to know that they can be guaranteed support to continue their pregnancy where they believe this to be in their best interests (Skyrme, 2014). Evidence from other studies has demonstrated that where care is structured around social models, such as case-loading, midwives have more power and control over their time and are able to develop close relationships with women, get to know their individual needs and provide tailored information and support (Kirkham, 2004a; McCourt, 2006). In contrast, the more rigid, medicalised care models frustrate attempts to provide individualised care both in the antenatal period and during induction. The outcome of this, in its more extreme form, may be seen in

the examples of Nina and Vicky, where lack of individualised support in their circumstances led to feelings of inadequacy and self-blame (see chapter 6).

As Kirkham (2004) emphasizes, the answer is not to blame individual midwives or doctors for failing to implement the rhetoric of informed choice, but to address the structural inadequacies of the maternity care system. This requires a change in the organisation and resourcing of maternity services at local and national levels (Kirkham, 2004b). One interim solution at local level would be to introduce flexible appointment times at the 38 week antenatal appointment to allow women and midwives to discuss the possibility of induction in an unhurried fashion: this may not solve all problems, but would at least offer women a better chance to discuss induction in advance of its need.

Decision aids

The NICE guidelines on induction state that:

“Good communication between healthcare professionals and women is essential. It should be supported by evidence-based written information tailored to the needs of the individual woman” (National Institute for Health and Clinical Excellence, 2008: 4)

There is evidence that women value objective, structured information (Frost, Shaw, Montgomery, & Murphy, 2009) and the current information leaflet on induction supplied by the Trust contains this; however, no form of mass-produced written information could meet the requirement to be individualized (see above). Beth's suggestion (chapter 5) of some form of diagrammatic explanation of induction procedures and possible outcomes lends credence to studies which have explored or suggested the use of decision aids for women considering induction and other interventions in pregnancy and labour (Austin & Benn, 2006; Frost et al., 2009). Research into the use of well-structured decision aids in other branches of health care has found that they increase patients knowledge of their condition and of the

relative risks of treatment options and enable them to participate more fully in decision-making (O'Connor et al., 1999; Stacey D et al., 2014). A decision aid in the form of a flow-chart or some other user-friendly format would be a relatively simple and cheap innovation at local or national level and in the absence of systemic changes to the structure of maternity care, is worthy of consideration.

Place of care

Hospitalization exemplifies how the medical model of care takes ownership of childbirth away from women and families (Wray, 2006). The findings of this study have shown how the structure of care on the antenatal ward can disempower women undergoing induction by the lack of individualised care and the dominance of policy and routine. Recent innovations in practice are guiding some NHS Trusts towards outpatient induction for women with uncomplicated, post-dates pregnancies, removing the need for women to go to hospital until in labour. This is thought to have advantages not only of comfort and convenience to women, but also to Trusts in terms of cost savings (Kelly, Alfirevic, & Ghosh, 2013; O'Brien et al., 2013). Evidence on the safety and acceptability of outpatient induction is sparse: a Cochrane review concluded that there is insufficient evidence to determine whether or not outpatient induction is safe and effective (Kelly et al., 2013). However, this was based on just four clinical trials comprising 612 women. Only one trial considered women's satisfaction with outpatient induction, which showed positive results (Biem, Turnell, Olatunbosun, Tauh, & Biem, 2003). More recent evidence from a UK study confirmed that women preferred the home setting, not only because of the physical and emotional comfort it afforded, but also for the freedom and personal control it allowed (O'Brien et al., 2013).

There is a clear need for more research into women's views on outpatient induction. Since data collection ended, the Trust from which participants in this study were drawn has introduced outpatient induction for women at low risk. At the time of writing, this innovation had not been evaluated. In view of the scarcity of supporting evidence, it is tempting to speculate whether this was introduced for cost-saving reasons rather than to provide better woman-centred care.

Outpatient induction will not be appropriate for all women and based on the findings of this study, there is much scope to improve the experience for those who need to be admitted to hospital. In general terms, a more empowering, woman-focused culture is needed, centring on individuals rather than protocols and routines. Proactive communication of information is required and a change in mind-set to value women's sense of being in labour and to treat them accordingly. This, however, requires not only a shift of attitude, but sufficient midwives to be able to give women the necessary time and attention.

The current layout of many maternity units in the UK separates them into three distinct areas catering for antenatal, intrapartum and postnatal care. This reflects the medical model of care and its need for structure and organisation along industrial lines in order to provide an efficient service (McCourt & Dykes, 2009). A more holistic approach would recognise the fluidity between the different phases of childbirth, particularly between antenatal care and labour and enable women to receive seamless care from the start of induction until after the birth. Women's experiences of early labour need to be valued and appropriate care given regardless of their physical location.

Where a major restructuring of the physical environment and model of care is not possible, simple measures could be introduced to promote an environment more conducive to supporting the physiological progress of early labour: this might include aids to physical comfort such as birthing balls and baths. Entonox™, which enables women to control their own pain relief should be made available as well as Pethidine, as it is much more rapidly excreted and has fewer lasting effects on the woman and fetus (Jay & Hamilton, 2014). Visiting rules for partners need to be relaxed to provide support at this crucial time: this was an area highlighted for particular criticism by participants in this study. This would require more privacy and space, but if the majority of uncomplicated inductions were to take place in the home, more room on the antenatal ward could be freed up to provide overnight accommodation to the partners of those women requiring hospital induction.

Strengths and limitations of this study

Strengths

This study is the first qualitative work exploring women's experiences of induction to have been conducted in England since Cartwright's seminal study in the 1970s. By using face-to-face interviews rather than the more usual method of questionnaires, it was possible to explore in depth women's understanding and feelings of this new and life-changing stage event and to shed fresh light on a hitherto under-investigated phenomenon. The findings suggest that little has changed in the past 40 years, despite the recommendations of the NICE guidelines on induction of labour and the continuing discourse on woman-centred care.

The findings of this study have built on Kirkham's work on informed choice and her theories relating to the influence of the institution and medical models of care on women's decision-making. However, evidence from this study suggests that Kirkham's notion of 'informed compliance' may be too optimistic and it is instead argued that most women simply comply without seeking or receiving information. The term 'uninformed compliance' is perhaps more appropriate for the present day.

Analysing women's experiences on the antenatal ward through the lens of ritual theory offers a new understanding on induction as a phase of extended liminality within the rite of passage of childbirth. This has highlighted the efforts needed by providers of maternity care to improve the experience for women. Possible solutions have been suggested, building on ideas from the women themselves, which challenge the current provision of care.

The present study goes beyond that of much previous research by projecting into women's attitudes to induction for future pregnancies. It has demonstrated how the induction experience has coloured women's attitude to childbirth and inclined some to a preference for technological rather than natural birth. This challenges the current drive to promote 'normality' and has potentially far-reaching implications for the provision of maternity care in future.

Limitations

The sample size was small and participants were drawn from a single NHS Trust. The sample was self-selecting, thus it is possible that more articulate women or those with stronger opinions were over-represented. Most women were of a similar age and socio-economic background, being mostly white, educated and in managerial or professional occupations. It is known that such groups are over-represented in research studies (Levine, 2008). The ethnic mix of participants did not proportionally reflect that of the area in which the NHS Trust is situated; furthermore, in order to gain ethical approval, women under eighteen, those who were not fluent English speakers and those deemed vulnerable were excluded. A sizeable section of the local childbearing population was therefore not represented. Reliance on the subjective judgement of midwives acting as gatekeepers (Barbour, 2008) may have excluded some women who were deemed unsuitable, but who may have been willing and able to participate. It is acknowledged that other findings may have emerged if the sample group had included women from another hospital or geographical area. Alternatively, the recruitment of women via another means, such as through social media, may have increased the diversity of participants and of the data.

It is possible that my links with the hospital where the participants gave birth (and may wish to do so again in future) may have been an inhibitory factor for some women, particularly those with negative experiences. An 'outsider' conducting interviews may have elicited different responses. It may also be argued that my closeness to the subject matter as a midwife and a mother may have influenced my interpretation of the data (Henn et al., 2006; Kingdon, 2005). However, care was taken to adopt a reflexive stance and the use of NVIVO10 served to distance me somewhat from the immediate impact of the data, enabling a more balanced view (Mason, 2002).

Uptake of the pre-induction classes was much lower than expected and only one participant could be sourced (see chapter 3). It was therefore not possible to fully meet the final objective of this study, which was to explore and compare the experiences of women who attended a pre-induction class with those who did not

attend. Although this was disappointing, it offers scope for a future research project, should attendance at pre-induction classes increase.

Summary

This chapter has discussed and explored the themes identified from the data using the conceptual framework of informed choice. The findings support Kirkham's (2004b) argument that the structure of maternity care in obstetric units limits opportunities to provide holistic, woman-focused care and promotes passive compliance rather than encouraging women to explore options and make informed decisions. It was clear that in this respect, the recommendations of the NICE guidelines (National Institute for Health and Clinical Excellence, 2008) were not being met..

Viewed through the lens of ritual theory, the experience of induction on the antenatal ward can be understood as a prolonged liminal state, in which women are indefinitely suspended between pregnancy and labour not only in a physiologically sense, but also emotionally and spatially. This is a cause of considerable distress for some women. Some induction experiences were very negative and changed women's attitudes towards natural birth, with one third favouring elective caesarean over induction for future pregnancies. This may suggest that induction sapped women's confidence in their ability to give birth unaided: however, it may also reflect a possible growing acceptance of medicalisation in the UK and a need for a new conceptualisation of childbirth norms.

Suggestions for improvement in the provision of care have been made, centring on the need for ways of delivering individualised information in order to promote informed decision-making and providing a woman-focused environment of care. It is hoped that this will lead to an increase in positive induction experiences in future.

8. Conclusion

This study set out to explore the experiences of first-time mothers facing induction of labour, with particular reference to information and decision-making (see chapter 1). This was a small-scale, qualitative study in an under-researched area. Data pertaining to the acquisition of information, to women's perceptions of choice and to influences on decision making has been described and analysed in chapters four, five and six. The latter two chapters also presented an in-depth exploration of women's experiences during the induction process and the subsequent effects of these on women's overall birthing experience and attitude to induction for the future.

The NICE guidelines on induction emphasise the need for discussion and informed decision-making and call for more research to assess women's needs throughout the induction experience (National Institute for Health and Clinical Excellence, 2008). This study has responded to this call, providing rich insights into women's experiences, but demonstrating that without a shift in focus towards a more fluid, woman-centred model of care, the recommendations of NICE are likely to remain aspirational.

Contribution of the findings of this study to the body of knowledge

The first major studies into women's experiences of induction were conducted around 40 years ago. Chief amongst these was the seminal work of Cartwright (1979), which found that induction was generally perceived as a negative experience, associated with a lack of information and choice. Despite the growing discourse on informed choice in recent years (Department of Health, 1993, 2004a, 2007b, 2008; Royal College of Obstetrics and Gynaecology, 2008) evidence from the very few UK studies conducted since the 1970s suggested that on the whole, women were still poorly prepared for induction and lacked sufficient information to make fully informed choices. This study aimed to shed new light on this under-researched field, particularly in response to the call from NICE to promote informed

decision-making (National Institute for Health and Care Excellence, 2013; National Institute for Health and Clinical Excellence, 2008).

This study provides evidence to suggest that despite the promises of successive governments of greater involvement for women in decision-making (Department of Health, 1993; Kirkham, 2004a), little progress has been made with regards to induction of labour since Cartwright's day: women continue to lack sufficient opportunities to discuss options and make balanced decisions. Depth has been added to the findings of previous studies, demonstrating how information is unlikely to be perceived as relevant unless appropriately timed and tailored to women's individual needs. The findings build on Kirkham's work on informed choice, supporting her theory that this is restricted by routinized, medical models of maternity care and by the pressures upon middle-ranking staff, such as midwives, to promote compliance with the system (Kirkham, 2004a; Kirkham & Stapleton, 2004). However, evidence from this study suggests that Kirkham's argument that women are guided towards 'informed compliance' rather than 'informed choice' may be somewhat optimistic: most women simply complied.

This is the first qualitative study to focus solely on the experience of induction as an in-patient in an English maternity unit since the 1970s. Most previous studies have used closed-question surveys, which limit the extent of the findings to issues identified by the investigators rather than by the women themselves. In this study, using face-to-face interviews has enabled women's views, experiences and understanding to be explored in greater depth and breadth than previously, thereby widening the scope of what is currently known about this subject and highlighting areas where change to practice is needed.

This study sheds light on women's limited awareness of the relative risks and benefits of induction and expectant management for post-term pregnancies, supporting arguments that risk is often poorly understood by service-users and professionals alike (Furedi, 2006; Gigerenzer & Muir-Gray, 2011).

Findings of this study illuminate the lived experience of induction on the antenatal ward, currently a much under-researched area. Although some women were contented with the care received, for others, induction was a very negative

experience. Interpreting women's reports through the lens of ritual theory (Van Gennep, 1960) has provided a new and original outlook on the induction experience. From this perspective, it can be seen that unplanned induction disrupts women's imagined trajectory of early labour, denying them the socially important rituals of planning and preparation.

The notion of liminality has been utilized in earlier studies of childbirth in the context of pregnancy or established labour (Cote-Arsenault, Brody, & Dombeck, 2009; Davis-Floyd, 1990; Machin & Scamell, 1997; McCourt, 2009c; Parratt, 2008). This thesis adds to that literature, arguing that from the women's perspective, induction can be understood as an additional liminal state in which women are suspended between pregnancy and labour. This state may be enhanced by lack of information, by inexplicable delays in the induction process, by the physical and symbolic separation of women from their everyday lives and by the imposition of policies and rules which have the power to restrict and infantilise women.

This study has exceeded the scope of most previous studies by including women's aspirations for future pregnancies if induction were to be offered again. A change in attitude towards technological intervention, particularly epidurals and caesarean section was an unexpected finding and supports suggestions of a growing acceptance of interventions in childbirth (Green & Baston, 2007). This challenges current thinking from professional groups about the need to reduce medical interventions and invites a new discourse on women's ideals of childbirth in the 21st Century and how they conceptualise 'normality'.

Implications of the findings of this study

As the practice of induction for post-dates pregnancy increasingly becomes part of normal maternity care in the UK, it is essential that women's voices are heard and their experiences taken into account when planning and delivering care.

Findings of this study suggest that a new approach is needed to the management of uncomplicated, post-dates pregnancy. Rather than guiding women towards routine acceptance of induction, women should be given individualised information, taking

account not only of their clinical status, but also of their social and cultural background and their desire for choice and information. This implies that providers of maternity care will need to consider more flexible ways of working, allowing more contact time for women and midwives to discuss options in an unhurried and balanced manner. Additional measures could be considered, such as the use of decision aids, on-line resources or pre-induction classes (see chapter 7). This may require the recruitment of more midwives or the adoption of alternative patterns of care provision, such as case-holding. Each will have budget implications for NHS Trusts.

In order to facilitate informed decision-making, midwives and doctors need to be able to engage with women in a balanced discussion of the relative risks of induction and expectant management. However, evidence suggests that health professionals generally have a poor understanding of risk and probability (Furedi, 2006; Gigerenzer & Muir-Gray, 2011). This implies a need for Higher Education Institutions to emphasise the understanding and communication of risk as part of their undergraduate curricula. This is not an unreasonable expectation, since undergraduate midwifery education already teaches students to discuss probability in relation to antenatal screening tests for chromosomal abnormalities.

Findings from this study illustrate the negative impact of induction on women's emotional state, particularly the anxiety caused by delays, pain and separation from partners at night. This raises questions about the possible effects of anxiety on the progress of labour, given the known influence of stress hormones on oxytocin release (Hodnett et al., 2013; Kitzinger, 2005; Sakala, 2006; Wuitchik et al., 1989). It is possible that in some cases, this might have directly contributed to further medical interventions and subsequent maternal morbidity. Outpatient induction for otherwise low-risk women might reduce anxiety and therefore increase the likelihood of an uncomplicated labour. However, just as many low-risk women opt to give birth in hospital rather than their own homes, some women may prefer to be induced in hospital. The principles of informed choice imply that women should not be denied this option if that is their preference.

The acceptability of elective caesarean section for future births among one third of the women in this study may simply reflect the high rate of instrumental and operative births among the sample group, which in turn may reflect local obstetric practices. However, if this is indicative of what is happening on a wider scale, it implies that maternity services must improve the induction experience or face a surge in demand for operative births among multiparous women. This also lends support to theories that an increasing acceptance of birth technology may be part of a general population trend (Green & Baston, 2007), which challenges the current drive to reduce unnecessary interventions. The potential implications of this for the provision of maternity services in their current form have been discussed in chapter 7.

Suggestions for future research and innovations in practice

The issues raised by the findings of this study invite further research in several directions. If women are indeed becoming more favourably disposed towards some forms of technological intervention in labour, this has far-reaching implications not only for health professionals and educators, but also for funders of maternity services and most importantly, for women themselves. Wider research, encompassing all areas of maternity care is needed to explore this apparent phenomenon in more depth. It is, perhaps, time for a repeat of the 'Great Expectations' study (Green et al., 1998) to enable a greater understanding of what women actually desire and expect from their childbirth experience.

Induction is not an emergency procedure even when indicated for medical reasons and the evidence for routine induction for post-dates pregnancy is deemed by some to be controversial (see chapter 2). Evidence is emerging to support the introduction of outpatient induction and further evaluation of this from women's perspective is needed (O'Brien et al., 2013). The Trust from which women in the current study were recruited has recently introduced out-patient induction and at the time of writing, this was being evaluated. In July 2015 senior managers requested a repeat of the current study, to include women induced as out-patients as well as those induced in

hospital: this is currently under consideration as a potential collaborative project between the Trust and the University.

There is scope for the development of a decision aid to assist women in deciding whether to accept, delay or refuse induction, taking into account the relative risks and benefits from both a medical and a social perspective: this may be particularly useful where contact time between women and midwives is limited. Further innovations in practice might include the development and evaluation of pre-induction classes and the exploration of other means of providing women with information outside of routine antenatal appointments. Quasi-experimental studies from overseas, in which women were provided with targeted, evidence-based information about induction, either in brochure form or as an add-on to an antenatal class, have been shown to increase women's knowledge and to promote informed decision-making (Cooper & Warland, 2011; Simpson et al., 2010). Although such studies are limited, the outcomes are promising and offer scope to UK maternity units to undertake similar projects.

In the broad field of Complementary and Alternative Therapies (CAM), there is much folk knowledge, but little research-based evidence for any of these as means of avoiding medical induction. NICE has identified this as an under-researched area in need of further investigation (National Institute for Health and Clinical Excellence, 2008). This may have implications in terms of lowering costs to care providers by reducing the need for medical induction and also of empowering women to manage their own pregnancies.

Data on the effects of induction on women's transition to parenthood was more limited than expected (see chapter 6), possibly due to the timings of the interviews at 3-6 weeks postnatally, when women were still adjusting to their new role. This is a sensitive issue which may be better addressed at a later stage when women are perhaps more confident in their mothering skills and have had more time to assimilate the childbirth experience. Future studies may explore differences in experience between women induced for medical reasons and those induced for post-term pregnancy, or between nulliparous and multiparous women.

This study focused solely on the views and experiences of women; however, partners were frequently mentioned and it became clear that not only did they influence women's decisions, but they played a crucial role in the induction experience. Moreover, women were acutely sensitive to and affected by their partners feelings. No research has been found which specifically addresses the partner's experience during induction. In view of the current ethos of maternity care which purports to situate childbirth within the family and social context (Department of Health, 2007a, 2007b, 2011; Richter et al., 2007), future studies of induction would be enhanced by inclusion of the partner or significant others.

Different methodological approaches may offer new perspectives on the induction experience, for example participant observation of women undergoing induction or of the interaction between women and midwives when speaking about induction. Evidence has shown that whilst women retain strong memories of childbirth, the significance attached to negative events intensifies over time (Simkin, 1991; Simkin, 1992). A longitudinal study might consider women's feelings before induction, soon afterwards and some months or years later. There is a precedent for this in a Swedish survey (Hildingsson et al., 2011) (see chapter 3) but to date, no UK equivalent exists.

In order to widen the scope of enquiry, future studies might include the views of midwives and doctors, particularly in relation to issues of women's choice and of how risk is understood and communicated. Finally, it is recognised that this study was undertaken in a single NHS Trust and participants were from a very narrow social demographic. Women in their teens and early twenties, women from lower socio-economic groups and women from ethnic minorities were under-represented and consequently their voices remain largely unheard. Future research needs to be undertaken in other geographical areas to address a wider demographic in order to present a more balanced and comprehensive picture of women's experiences of induction across the UK.

Dissemination of findings

It is generally expected by sponsors and ethics committees that research findings will be shared with an appropriate audience (Barbour, 2008). To date, six conferences presentations have been given, including the Royal College of Midwives annual conference in 2014. Two papers have been published and requests for articles have been received from two leading midwifery journals. Findings have been presented to senior clinical staff at the NHS Trust from which participants were identified and at the time of writing, changes to induction procedures were being considered. Conference presentations and publications to date are listed in Appendix 8.

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Wuitchik, M., Kakal, D., & Lipschitz, J. (1989). The clinical significance of pain and cognitive activity in latent labour *Obstetrics and Gynaecology*, 73(1), 35-42.

Appendices

Appendix 1: Table of reviewed studies relating to women's experiences of induced labour.

Study	Country of origin
Austin, D., & Benn, C. (2006). Induction of labour: the influences on decision making. <i>New Zealand college of midwives journal</i> , 34, 6-10.	New Zealand
Bramadat, I. J. (1994). Induction of labor: an integrated review. <i>Health care for women international</i> , 15, 135-148.	Canada
Cartwright, A. (1979). <i>The dignity of labour? A study of childbearing and induction</i> . London: Tavistock Publications Ltd.	UK
Cooper, M., & Warland, J. (2011). Improving women's knowledge of prostaglandin induction of labour through the use of information brochures: A quasi-experimental study. <i>Women and Birth</i> 24, 156-164.	Australia
Gammie, N., & Key, S. (2014). Time's up! women's experience of induction of labour. <i>The Practising Midwife</i> , 17(4), 15-18.	UK
Gatward, H., Simpson, M., Woodhart, L., & Stainton, M. (2007). Women's experiences of being induced for post-date pregnancy. <i>Women and Birth</i> , 23, 3-9.	Australia
Green, J. M., Coupland, V. A., & Kitzinger, J. V. (1998). <i>Great expectations: a prospective study of women's expectations and experiences of childbirth</i> . Hale: Books for midwives press.	UK
Heimstad, R., Romundstad, P. R., Hyett, J., Mattson, L.-A., & Salvesen, K. A. (2007). Women's experiences and attitudes towards expectant management and induction of labor for post-term pregnancy. <i>Acta obstetricia et gynecologica</i> , 86, 950-956.	Norway
Hildingsson, I., Karlstrom, A., & Nystedt, A. (2011). Women's experiences of induction of labour - findings from a Swedish regional study. <i>Australian and New Zealand journal of obstetrics and gynaecology</i> , 51, 151-157.	Sweden
Hodnett, E. D., Hannah, M. E., Weston, J. A., Ohlsson, A., Myhr, T., Wang, E. E. I., . . . Farine, D. (1997). Women's evaluations of induction of labor versus expectant management for prelabor rupture of the membranes at term. <i>Birth</i> , 24(4), 214-220.	Canada
Jacoby, A. (1987). Women's preferences for and satisfaction with current	UK

procedures in childbirth - findings from a national study. <i>Midwifery</i> , 3, 117-124.	
Jacoby, A., & Cartwright A. (1990). Finding out about the views and experiences of maternity service users. In J. Garcia, R. Kilpatrick & M. Richards (Eds.), <i>The politics of maternity care. Services for childbearing women in twentieth century Britain</i> . Oxford: Clarendon press.	UK
Kitzinger, S. (1975). Some mothers' experiences of induced labour (report from the National Childbirth Trust). London: Department of Health and Social Security.	UK
Lewis, B., Rana, S., & Crook, E. (1975). Patient response to induction of labour. <i>Lancet</i> , 24, 1197.	UK
Lothian, J. (2007). Listening to mothers II: knowledge, decision-making and attendance at childbirth education classes. <i>The journal of perinatal education</i> , 16(4), 62-67.	USA
Moore, J. E., Kane-Low, L., Titler, M. G., Dalton, V. K., & Sampsel, C. M. (2014). Moving Toward Patient-Centered Care: Women's Decisions, Perceptions, and Experiences of the Induction of Labor Process. <i>Birth</i> , 41(2), 138-146.	USA
Murtagh, M., & Folan, M. (2014). Women's experiences of induction of labour for post-date pregnancy. <i>British Journal of Midwifery</i> , 22(2), 105-110.	Eire
Nuutila, M., Halmesmaki, E., Hiilesmaa, V., & Ylikorkala, O. (1999). Women's anticipations of and experiences with induction of labor. <i>Acta Obstetrica et Gynecologica Scandinavica</i> , 78(1999), 704-709	Finland
Out, J., Vierhout, M., Verhage, F., Duidenvoorden, H., & Wallenburg, H. (1986). Characteristics and motives of women choosing elective induction of labour. <i>Journal of psychosomatic research</i> , 30(3), 375-380.	Netherlands
Roberts, L. J., & Young, K. (1991). The management of prolonged pregnancy - an analysis of women's attitudes before and after term. <i>British Journal of Obstetrics and Gynaecology</i> , 98(November 1991), 1102-1106.	UK
Schaffir, J. (2002). Survey of folk beliefs about induction of labour. <i>Birth</i> , 29(1), 47-51.	USA
Shetty, A., Burt, R., Rice, P., & Templeton, A. (2005). Women's perceptions, expectations and satisfaction with induced labour – a questionnaire-based study <i>European Journal of Obstetrics &</i>	UK

<i>Gynaecology and Reproductive Biology</i> , 123(2005), 56-61.	
Simpson, K. R., Newman, G., & Chirino, O. (2010). Parent Education to reduce Elective Inductions. <i>American Journal of Maternal and Child Nursing</i> , 35(4), 188-194.	USA
Stevens, G. (2010). <i>Overdue Choices: How Information and Role in Decision-Making Influence Women's Preferences for Induction of Labour</i> . PhD, University of Queensland, Australia.	Australia
Stewart, P. (1977). Patients' attitudes to induction and labour. <i>British medical journal</i> , 1977(2), 749-752.	UK
Westfall, R., E. , & Benoit, C. (2004). The rhetoric of "natural" in natural childbirth: childbearing women's perspectives on prolonged pregnancy and induction of labour. . <i>Social Science & Medicine</i> , 59, 1397-1408.	Canada

Appendix 2. Form to be given at pre-induction classes

(NHS Trust name, address and logo removed)



Research into women's experience of induction of labour

The information below tells you about this research and why you are being invited to take part. If anything is not clear, you can contact the researcher on 01707-285289 or 07827-710878 (mobile) or email a.m.1.jay@herts.ac.uk

Information about the research

My name is Annabel Jay. I am a qualified midwife who works in education. I am doing this research as part of a PhD. We know a lot about how induction works, but very little about what women actually think of the experience. I am hoping that through my research, we will know more about how women feel after having their labour induced. This information may help improve care in the future.

Why have I been invited to take part?

You are a first-time mother and you have a date booked for your labour to be induced

Do I have to take part?

No. It is entirely up to you to decide and no-one will hold it against you if refuse. If you decide to take part, you can opt out at any time, without giving a reason.

What will happen if I decide to take part?

In about three to four weeks' time, I will contact you by phone, email or text. I will ask your permission to interview you.

You can decide where and when you wish to be interviewed. I will come to your home if that is the most convenient place for you. If you change your mind – that is fine.

I will ask you to sign a consent form before the interview begins. The interview will last about an hour, depending on how much you want to say.

I would like to tape-record the interview, but if you prefer, I will write notes instead.

What if I go into labour before being induced?

You will no longer be able to take part in the study.

Will taking part in this research affect my care?

No. I do not work for the hospital and my research will have no effect on your care at any time before, during or after labour

Will it affect my baby?

No. The research will have no effect on your baby.

Is there any benefit in taking part?

The interview gives you a chance to talk to the researcher about your experience of induction. This may not benefit you personally, but may help to improve care for other women in the future.

I am interested: what should I do?

Simply sign the form on the next page and return it to me in person or to the midwife leading this antenatal class. This is NOT a consent form – it is just giving permission for me to contact you.

You do not have to make any decisions now – you may prefer to discuss it with

your partner, your family or a midwife first. If you want to think about it for a few days, or wait until after your baby is born, you can post the form using the pre-paid envelope.

What if I change my mind?

You may change your mind at any time – even during the interview itself. I will understand and will destroy any notes or recordings made. This will not affect the care you receive from any health professionals

Will I need to give any personal details?

The form overleaf only requires your name, contact details and signature. If you agree to be interviewed, I will ask you for further details, but you can choose how much you wish to disclose.

Will any information about me be passed on to anyone else?

All information given will be treated in strictest confidence. I will only pass details on to another person if I believe that you or a family member is in danger.

Will anyone read my hospital notes?

I would like to read the part of your maternity notes that concerns your induction. I am not interested in any other detail. I will only read your notes with your permission.

Will my name be used in the research? Will people be able to identify me?

Your name will not appear in any part of the research. I will use a number or pseudonym (false name) to distinguish you from other people taking part in the research.

What will happen to the information I give during the interview?

The recording and write-up of your interview will be stored securely in a locked office for 10 years and then destroyed. Anything held on a computer will be password protected, so that only I have

access to it. At the end of the study, all audio recordings and computer held records will be deleted.

When the study is over, it will be written up and may be published in midwifery journals. Parts of it may appear in other journals or midwifery textbooks in later years. Quotations from people taking part in this study may be used, but no real names will appear. This means it is highly unlikely that anyone who reads about this research will be able to identify you or your family.

How do I contact you?

You can phone, text or email me:

Land line: 01707-285289

Mobile: 07827-710878

Email: a.m.1.jay@herts.ac.uk



Annabel Jay (Principal Investigator)
University of Hertfordshire
Hatfield
AL10 9AB

What if there is a problem?

If, for any reason, you decide to pull out of the study, simply contact me by phone, text or email. You do not have to give a reason and no-one will be annoyed with you.

The normal NHS complaints mechanism is available to you if you wish to complain about any aspect of the way you are approached or treated during the course of this study. Formal complaints should be addressed to:

PALS Office (Contact details of local PALS office removed to protect anonymity of NHS Trust)

(NHS Trust name, address and logo removed)
Form to be given to women at pre-induction classes.

Expression of interest form

Important:

Please read the participant information sheet before signing below.

The purpose of this form is to give the researcher permission to contact you after your baby is born. You are not committing yourself to taking part in the study.

Your full name.....

Date booked for induction.....

I am happy for the researcher, Annabel Jay, to contact me 3-4 weeks after my baby is born if my labour is induced.

I prefer to be contacted by: (please tick box)

☐ Phone (please give your number).....

☐ Text (please give your number).....

☐ Email (please give your email address).....

I confirm that I am over 18 years old and that I have not previously given birth. I have read the attached leaflet and understand its content

Signed.....

Date.....

You can return this form to the researcher in person or to the midwife leading your induction class. If you would prefer to post it, an S.A.E is attached.

Appendix 3. Form to be given on postnatal ward

(NHS Trust name, address and logo removed)



Research into women's experience of induction of labour

The information below tells you about this research and why you are being invited to take part. If anything is not clear, you can contact the researcher on 01707-285289 or 07827-710878 (mobile) or email a.m.1.jay@herts.ac.uk

Information about the research

My name is Annabel Jay. I am a qualified midwife who works in education. I am doing this research as part of a PhD. We know a lot about how induction works, but very little about what women actually think of the experience. I am hoping that through my research, we will know more about how women feel after having their labour induced. This information may help improve care in the future.

Why have I been invited to take part?

You are a first-time mother and your labour was induced.

Do I have to take part?

No. It is entirely up to you to decide and no-one will hold it against you if refuse. If you decide to take part, you can opt out at any time, without giving a reason.

What will happen if I decide to take part?

In about three to four weeks' time, I will contact you by phone, email or text. I will ask your permission to interview you.

You can decide where and when you wish to be interviewed. I will come to your home if that is the most convenient place for you. If you change your mind – that is fine.

I will ask you to sign a consent form before the interview begins. The interview will last about an hour, depending on how much you want to say.

I would like to tape-record the interview, but if you prefer, I will write notes instead.

Will taking part in the research affect my care?

No. I do not work for the hospital and my research will have no effect on your care.

Will it affect my baby?

No. The research will have no effect on your baby.

Is there any benefit in taking part?

The interview gives you a chance to talk to the researcher about your experience of induction. This may not benefit you personally, but may help to improve care for other women in the future.

I am interested: what should I do?

Simply sign the form on the next page and return to the researcher in person or place it in the box on the desk at the midwives station. This is NOT a consent form – it is just giving permission for the researcher to contact you.

You do not have to make any decisions now – you may prefer to discuss it with your partner, your family or a midwife first. If you want to think about it for a few days, you can post the form using the pre-paid envelope.

What if I change my mind?

You may change your mind at any time – even during the interview itself. I will understand and will destroy any notes or recordings made. This will not affect the care you receive from any health professionals

Will I need to give any personal details?

The form overleaf only requires your name, contact details and signature. If you agree to be interviewed, I will ask you for further details, but you can choose how much you wish to disclose.

Will any information about me be passed on to anyone else?

All information given will be treated in strictest confidence. I will only pass details on to another person if I believe that you or a family member is in danger

Will anyone read my hospital notes?

I would like to read the part of your maternity notes that concerns your induction. I am not interested in any other detail. I will only read your notes with your permission.

Will my name be used in the research? Will people be able to identify me?

Your name will not appear in any part of the research. I will use a number or pseudonym (false name) to distinguish you from other people taking part in the research.

What will happen to the information I give?

The recording and write-up of your interview will be stored securely for 10 years in a locked office and then destroyed. Anything held on a computer will be password protected, so that only I have access to it. At the end of the study, all audio recordings and computer held records will be deleted.

When the study is finished, it will be written up and may be published in midwifery

journals. Parts of it may appear in other journals or midwifery textbooks in later years. Quotations from people taking part in this study may be used, but no real names will appear. This means it is highly unlikely that anyone who reads about this research will be able to identify you or your family.

How do I contact you?

You can phone, text or email me:

Land line: 01707-285289

Mobile: 07827-710878

Email: a.m.1.jay@herts.ac.uk



Annabel Jay (Principal Investigator)
University of Hertfordshire
Hatfield
AL10 9AB

What if there is a problem?

If, for any reason, you decide to pull out of the study, simply contact me by phone, text or email. You do not have to give a reason and no-one will be annoyed with you.

The normal NHS complaints mechanism is available to you if you wish to complain about any aspect of the way you are approached or treated during the course of this study. Formal complaints should be addressed to:

PALS Office (Contact details of local PALS office removed to protect anonymity of NHS Trust)

(NHS Trust name, address and logo removed)

Form to be given to women on the postnatal ward

Expression of interest form

Important:

Please read the participant information sheet before signing below.

The purpose of this form is to give the researcher permission to contact you. You are not committing yourself to taking part in the study.

Your full name.....

Date booked for induction.....

I am happy for the researcher, Annabel Jay, to contact me in about 3-4 weeks' time.

I prefer to be contacted by: (please tick box)

☐ Phone (please give your number).....

☐ Text (please give your number).....

☐ Email (please give your email address).....

I confirm that I am over 18 years old and that I have not previously given birth. I have read the attached leaflet and understand its content

Signed.....

Date.....

You can return this form to the researcher in person or leave it in the box on the ward reception desk. If you would prefer to post it, an S.A.E is attached.

Appendix 4: Consent form

(Name, address and logo of NHS Trust removed)

Title of Project: **Women's Experience of Induction of Labour**

Name of Researcher: **Annabel Jay**

Please initial the boxes

1. I have read and understand the information sheet dated 08.06.12 (version 2) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. ☐
2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my medical care or legal rights being affected. ☐
3. I understand that the entire interview will be audio-taped unless I request otherwise. ☐
4. I understand that relevant sections of my maternity notes may be looked at by the researcher, Annabel Jay, purely for the purpose of this study. I give permission for the researcher to have access to my records. ☐
5. I understand that anonymised quotes from my interview may be used in any published work. ☐
- 6 I understand that the researcher is obliged to break confidentiality if she becomes aware of malpractice or safeguarding issues ☐
7. I agree to take part in the above study. ☐

Name of participant:.....Date:.....

Signature

Name of person taking consent:.....Date.....

Signature

When completed: 1 for participant; 1 for researcher site file; 1 (original) to be kept in maternity notes.

Appendix 5: Ethical approval confirmation letters:

- REC approval letter
- Letter of access from NHS Trust
- Letter of approval from NHS Trust
- Letter of approval from NHS Trust to extend data collection period

All wording which identifies individual NHS Trusts or NHS personnel has been obliterated.

REC approval letter



Health Research Authority

NRES Committee South Central - Oxford A

Bristol Research Ethics Committee Centre
Whitefriars
Level 3 Block B
Lewins Mead
Bristol
BS1 2NT

Telephone: 01173421331
Facsimile: 01173420445

31 May 2012

Ms Annabel M Jay
32 Derwent Road
Harpenden
Hertfordshire
AL5 3NU

Dear Ms Jay

Study title:	Women's experience of induction of labour: how do they acquire and use information to make decisions and what impact does this have on their experience of childbirth and early parenthood?
REC reference:	12/SC/0316
Protocol number:	n/a

Thank you for your letter of 25 May 2012, responding to the Proportionate Review Sub-Committee's request for changes to the documentation for the above study.

The revised documentation has been reviewed and approved by the sub-committee.

Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised.

Ethical review of research sites

The favourable opinion applies to all NHS sites taking part in the study, subject to management permission being obtained from the NHS/HSC R&D office prior to the start of the study (see "Conditions of the favourable opinion" below).

Conditions of the favourable opinion

The favourable opinion is subject to the following conditions being met prior to the start of the study.

Management permission or approval must be obtained from each host organisation prior to the start of the study at the site concerned.

Management permission ("R&D approval") should be sought from all NHS organisations involved in the study in accordance with NHS research governance arrangements.

Guidance on applying for NHS permission for research is available in the Integrated Research Application System or at <http://www.rdforum.nhs.uk>.

Where a NHS organisation's role in the study is limited to identifying and referring potential participants to research sites ("participant identification centre"), guidance should be sought from the R&D office on the information it requires to give permission for this activity.

For non-NHS sites, site management permission should be obtained in accordance with the procedures of the relevant host organisation.

Sponsors are not required to notify the Committee of approvals from host organisations.

It is the responsibility of the sponsor to ensure that all the conditions are complied with before the start of the study or its initiation at a particular site (as applicable).

You should notify the REC in writing once all conditions have been met (except for site approvals from host organisations) and provide copies of any revised documentation with updated version numbers. Confirmation should also be provided to host organisations together with relevant documentation.

Approved documents

The documents reviewed and approved by the Committee are:

<i>Document</i>	<i>Version</i>	<i>Date</i>
Covering Letter		11 May 2012
Evidence of insurance or indemnity		02 August 2011
Interview Schedules/Topic Guides	1	11 May 2012
Investigator CV	Annabel Jay	09 May 2012
Investigator CV	Marianne Mead	09 May 2012
Investigator CV	Hillary Thomas	30 April 2012
Letter from Sponsor		10 May 2012
Participant Consent Form: Consent Form	2	25 May 2012
Participant Information Sheet: Postnatal	2	25 May 2012
Participant Information Sheet: Antenatal	2	25 May 2012
Protocol	2	25 May 2012
REC application		11 May 2012
Referees or other scientific critique report		09 May 2012
Response to Request for Further Information		25 May 2012
Summary/Synopsis	1	11 May 2012

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

After ethical review

Reporting requirements

The attached document "After ethical review – guidance for researchers" gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

- Notifying substantial amendments
- Adding new sites and investigators
- Notification of serious breaches of the protocol
- Progress and safety reports
- Notifying the end of the study

The NRES website also provides guidance on these topics, which is updated in the light of changes in reporting requirements or procedures.

Feedback

You are invited to give your view of the service that you have received from the National Research Ethics Service and the application procedure. If you wish to make your views known please use the feedback form available on the website.

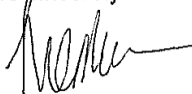
Further information is available at National Research Ethics Service website > After Review

12/SC/0316

Please quote this number on all correspondence

With the Committee's best wishes for the success of this project

Yours sincerely


 **Dr Karen Melham**
Chair

Email: scsha.oxfordreca@nhs.net

Enclosures: "After ethical review – guidance for researchers" [SL-AR2]

Copy to: Mr John Senior
j.m.senior@herts.ac.uk

Letter of access from NHS Trust

		 NHS Trust
Strictly Confidential Addressee only Ms Annabel Jay School of Nursing, Midwifery and Social Work University of Hertfordshire College Lane Hatfield AL10 9AB		Human Resources Department Tel. _____ PA direct dial _____ Email _____
12th November 2012		
Dear Ms Jay,		
Letter of Access – 'Women's experience of induction of labour' study		
This letter confirms your right of access to conduct research through NHS Trust for the purpose and on the terms and conditions set out below. This right of access commences on 3rd July 2012 and ends on 2nd July 2013, unless terminated earlier in accordance with the clauses below. You have a right of access to conduct such research as confirmed in writing in the letter of permission for research from this NHS organisation. <i>Please note that you cannot start the research until the Principal Investigator for the research project has received a letter from us giving permission to conduct the project.</i> The information supplied about your role in research at _____ NHS Trust has been reviewed and you do not require an honorary research contract with this NHS organisation. We are satisfied that such pre-engagement checks as we consider necessary have been carried out. You are considered to be a legal visitor to _____ NHS Trust premises. You are not entitled to any form of payment or access to other benefits provided by this NHS organisation to employees and this letter does not give rise to any other relationship between you and this NHS organisation, in particular that of an employee. While undertaking research through _____ NHS Trust you will remain accountable to your employer, the University of Hertfordshire, but you are required to follow the reasonable instructions of your nominated manager in this organisation _____ or those given on her behalf in relation to the terms of this right of access. Where any third party claim is made, whether or not legal proceedings are issued, arising out of or in connection with your right of access, you are required to co-operate fully with any investigation by this NHS organisation in connection with any such claim and to give all such assistance as may reasonably be required regarding the conduct of any legal proceedings. You must act in accordance with _____ NHS Trust policies and procedures, which are available to you upon request, and the Research Governance Framework. You are required to co-operate with _____ NHS Trust in discharging its duties under the Health and Safety at Work etc Act 1974 and other health and safety legislation and to take reasonable care for the health and safety of yourself and others while on _____		
	Guidance Resources\General\Human Resources\LETTERS\2456.doc	

NHS Trust premises. You must observe the same standards of care and propriety in dealing with patients, staff, visitors, equipment and premises as is expected of any other contract holder and you must act appropriately, responsibly and professionally at all times.

You are required to ensure that all information regarding patients or staff remains secure and *strictly confidential* at all times. You must ensure that you understand and comply with the requirements of the NHS Confidentiality Code of Practice (<http://www.dh.gov.uk/assetRoot/04/06/92/54/04069254.pdf>) and the Data Protection Act 1998. Furthermore you should be aware that under the Act, unauthorised disclosure of information is an offence and such disclosures may lead to prosecution.

You should ensure that, where you are issued with an identity or security card, a bleep number, email or library account, keys or protective clothing, these are returned upon termination of this arrangement. Please also ensure that while on the premises you wear your ID badge at all times, or are able to prove your identity if challenged. Please note that this NHS organisation accepts no responsibility for damage to or loss of personal property.

We may terminate your right to attend at any time either by giving seven days' written notice to you or immediately without any notice if you are in breach of any of the terms or conditions described in this letter or if you commit any act that we reasonably consider to amount to serious misconduct or to be disruptive and/or prejudicial to the interests and/or business of this NHS organisation or if you are convicted of any criminal offence. Your substantive employer is responsible for your conduct during this research project and may in the circumstances described above instigate disciplinary action against you.

NHS Trust will not indemnify you against any liability incurred as a result of any breach of confidentiality or breach of the Data Protection Act 1998. Any breach of the Data Protection Act 1998 may result in legal action against you and/or your substantive employer.

If your current role or involvement in research changes, or any of the information provided in your Research Passport changes, you must inform your employer through their normal procedures. You must also inform your nominated manager in this NHS organisation.

Yours sincerely

Deputy Director of Workforce

cc:

Human Resources, University of Hertfordshire, College Lane, Hatfield,
Hertfordshire, AL10 9AB.



G:\Human Resources\General\Human Resources\Jo\LETTERS\7450.doc

Dear Ms Jay

IRAS Project Code: 77064

Project Reference Number (UKCRN)	RD2012-41
NRES Reference Number	12/SC/0316
Research Ethics Committee Approval Letter date	31 May 2012
Sponsor	University of Hertfordshire
Trust	

May we remind you that the Principal Investigator is responsible for ensuring that research is conducted in accordance with the Department for Health Research Governance Framework. It must also comply with the law, all internal Trust policies and processes and any relevant good practice guidance, including ICH GCP. The research may be subject to internal or external monitoring. Indemnity arrangements are in place.

- Serious Adverse Events / SUSARS
- Amendments
- Progress Reports
- Closure of Study
- Planned audits by Sponsor

Best wishes for a successful project.

Yours sincerely,

Chief Executive Officer

CC. Prof Hilary Thomas

Date 2/7/02

Approved Documents:

Documents	Version	Date
Interview Schedules / Topic Guides	1	11 May 2012
Participant Consent Form: Consent Form	2	25 May 2012
Participant Information Sheet: Postnatal	2	25 May 2012
Participant Information Sheet: Antenatal	2	25 May 2012
Protocol	2	25 May 2012
Summary / Synopsis	1	11 May 2012
Investigator CV	Annabel Jay	09 May 2012
Investigator CV	Marianne Mead	09 May 2012
Investigator CV	Hilary Thomas	30 April 2012

Letter of approval from NHS Trust to extend data collection period

[REDACTED]

NHS

Research & Development Department

[REDACTED]

Ms Annabel Jay
University of Hertfordshire
The University of Hertfordshire
College Lane
Hatfield
Hertfordshire
AL5 3NU

Dear Ms Jay

REVISION OF STUDY DOCUMENTATION

R&D Ref:	RD2012-41
Full Title:	Women's experience of induction of labour: how do they acquire and use information to make decisions and what impact does this have on their experience of childbirth and early parenthood?
Short Title:	Women's experience of induction of labour. Version 1.
Date of original R&D Approval to commence study:	27/06/2012

The following document regarding the extension of the study to July 2013 has been approved by [REDACTED] NHS Trust Research & Development Department:

Document	Version	Date
REC Approval		22 April 2013

Signed: [REDACTED]

Name: [REDACTED] Position: R&D Assistant Date: 23/04/2013

PROTOCOL AMENDMENT

Appendix 6: Interview schedule

Women's experience of labour induction

Interview Guide

Opening comments:

Aim: to set the tone, build a rapport and cultivate an atmosphere conducive to in-depth interviewing

Example:

“Thank you for inviting me to your home, I really appreciate it. How are you enjoying being a Mum? “

Biographical details

Please could you tell me a bit about yourself?

- Age
- Whether living alone or with significant others
- Occupation
- Highest level of education
- Reason for induction
- Method of induction
- Date induction commenced
- Date of baby's birth
- Self-declared ethnicity
- First language

Guide to topic areas

- 1 When/how/by whom was the subject of induction first raised and how did the woman feel about this?
- 2 What background knowledge of induction did she have before this time and where did it come from?
- 3 What did the health professional tell her about induction – how was the information presented e.g. as a choice or inevitable?

- 4 How did she make the decision to accept induction?
- 5 If an antenatal induction class was offered, what was her opinion of the class?
- 6 What did she do in the time between being booked for induction and being admitted to hospital? *Probe: Did she try self-help methods to get labour started?*
- 7 What did the process of induction involve? (E.g. did the midwife offer a cervical sweep?) How did she feel during this time? What information was she given? How long did it take?
- 8 Did the reality of induction differ from her expectations?
- 9 How involved did she feel in the process of making decisions?
- 10 Has being induced has any effect on being a mother?
- 11 Looking back, what are her general feelings about her induction?

The following topic areas were added after having been mentioned by the first few participants.

- 12 What were her partner's feelings about induction/during induction?
- 13 How would she feel if induction was suggested in any future pregnancy?
- 14 Suggestions for improving the induction experience

Finally, is there anything else you would like to tell me about your experience of being induced?

Thank you very much for taking part in this interview.

Appendix 7: Outline Biography of Participants

Please refer to the Abbreviation and Glossary for definitions of medical terms

All women were resident in the UK and lived within a 15 mile radius of the hospital at which they gave birth. All were married or cohabiting with a male partner and none had previously given birth. All women and their babies appeared healthy at the time of interview, except where indicated below. Some details from field notes have been included in order to present a fuller picture of each participant; however, these have been kept to a minimum to lessen any risk of accidentally identifying individuals.

Amy

Age group:	30-34
Occupation:	Chef
Antenatal classes attended:	NHS
Ethnicity:	White Lithuanian
Reason for induction:	Post-dates pregnancy
Method of induction:	Unsuccessful attempt at sweep. PGE ₂
Duration of induction to established labour:	Less than 24 hours
Pain relief in labour:	None
Postnatal morbidity:	None
Type of birth:	SVD

Notes: At the time of interview, Amy was a recent immigrant to the UK. Amy claimed to speak fluent English and seemed to understand the interview questions perfectly, however, she had difficulty articulating some answers and frequently appeared to be translating her thoughts in her head before speaking, suggesting that her English vocabulary was limited. It was difficult to elicit detailed responses from Amy, hence the scarcity of quotations. Amy stated that overall, her induction was “a good experience”.

Beth

Age group:	30-34
Occupation:	Primary school teacher
Antenatal classes attended:	NHS
Ethnicity:	White Canadian
Reason for induction:	Post-dates pregnancy
Method of induction:	PGE ₂
Duration of induction to established labour:	Less than 24 hours
Pain relief in labour:	Epidural
Postnatal morbidity:	None
Type of birth:	Emergency CS (slow progress)

Notes: Originally from Canada, Beth had lived in the UK for some years at the time of interview. Beth was distracted by her baby's need for attention and was feeding throughout the interview; therefore some of her responses were rather brief. I had explained to all participants that their baby's needs came first.

Clare

Age group:	40-45
Occupation:	Company director
Antenatal classes attended:	Private
Ethnicity:	White British
Reason for induction:	Age over 40
Method of induction:	ARM and Syntocinon©
Duration of induction to established labour:	Less than 24 hours
Pain relief in labour:	Epidural
Postnatal morbidity:	None
Type of birth:	Emergency CS (slow progress and fetal compromise)

Notes: Clare received her maternity care from a private obstetric team from 30 weeks of pregnancy onwards. Clare attributed this decision to her anxious nature and need for continuity of care. The birth took place in an NHS hospital which does

not have a private delivery suite, but Clare remained under the care of her obstetric consultant throughout her induction and labour. Clare was generally satisfied with her induction experience.

Donna

Age group:	30-34
Occupation:	Mortgage underwriter
Antenatal classes attended:	NHS
Ethnicity:	White British
Reason for induction:	Gestational diabetes
Method of induction:	PGE ₂
Duration of induction to established labour:	48-72 hours
Pain relief in labour:	Epidural
Postnatal morbidity:	None
Type of birth:	Forceps (fetal compromise)

Notes: Donna was initially disappointed at the suggestion of induction and felt that the decision had been rather rushed. However, she appeared to have reconciled herself to this very quickly. Donna was relaxed in her recall of events and of her feelings and appeared to have assimilated the induction experience.

Emily

Age group:	40-45
Occupation:	College lecturer
Antenatal classes attended:	NCT
Ethnicity:	White British
Reason for induction:	Post-dates pregnancy
Method of induction:	Unsuccessful attempt at sweep. PGE ₂
Duration of induction to established labour:	48-72 hours
Pain relief in labour:	Epidural
Postnatal morbidity:	Infection (mother and baby)
Type of birth:	Forceps (slow progress)

Notes: Emily became distressed when recalling the fear she had felt during her labour, but was eager to talk about her experience and this appeared to be cathartic for her. Emily had nurtured high expectations of her birth and was very disappointed when this did not go as anticipated. Emily contrasted her own traumatic experience with that of a friend who had undergone an elective CS with minimal trauma. This led her to question the emphasis placed by midwives and parent educators on the importance of 'normal' birth. Emily appeared anxious throughout the interview: she was particularly concerned for her baby's health and sought my opinion on this. I advised her to contact her GP and Health visitor for advice.

Fay

Age group:	30-34
Occupation:	Nursery teacher
Antenatal classes attended:	NHS
Ethnicity:	White British
Reason for induction:	Post-dates pregnancy
Method of induction:	PGE ₂
Duration of induction to established labour:	Less than 24 hours
Pain relief in labour:	Epidural
Postnatal morbidity:	Infection (mother and baby)
Type of birth:	Emergency CS (fetal compromise)

Notes: Fay had been born with a rare medical condition which had resulted in numerous hospital stays as a child. Fay had suffered no qualms about induction and appeared very relaxed when recalling her experience: it is possible that her years of experience with hospitals had made her less vulnerable to anxiety in the clinical environment and instilled trust in medical personnel. Fay's condition had no bearing on her pregnancy or induction. Although Fay had an emergency CS after which both she and her baby developed an infection, Fay's overall impression of her induction was highly positive.

Gemma

Age group:	35-39
Occupation:	Police officer
Antenatal classes attended:	NHS
Ethnicity:	White British
Reason for induction:	Post-dates pregnancy
Method of induction:	PGE ₂
Duration of induction to established labour:	Less than 24 hours
Pain relief in labour:	Epidural
Postnatal morbidity:	None
Type of birth:	Emergency CS (maternal ill health)

Notes: Gemma volunteered the information that she had agreed to participate as a means of de-briefing from her birthing experience. Gemma's father was present in the house and was within earshot throughout much of the interview, which may have had a slightly inhibiting effect on Gemma when retelling the more intimated details of her induction. Gemma's overall feelings about her induction appeared mixed. Her account was given in a very deliberate, methodical and rather detached manner, which she explained was a result of her training as a police officer.

Hannah

Age group:	30-34
Occupation:	Secretary
Antenatal classes attended:	NHS
Ethnicity:	White British
Reason for induction:	Raised blood pressure
Method of induction:	Sweep and PGE ₂
Duration of induction to established labour:	24-48 hours
Pain relief in labour:	Epidural
Postnatal morbidity:	Infection (maternal)
Type of birth:	Emergency CS (maternal ill health)

Notes: Hannah had become acutely unwell during the course of induced labour and recalling this caused her to become distressed, which was evident in her body language and off-record conversation. Hannah reported that her overall experience of induction was negative due to events during labour, but unrelated to the care received. I gave Hannah the Birth Trauma Association leaflet with rather more deliberation than usual. I also reminded her of the Trust's system for postnatal debriefing if required.

Isobel

Age group:	30-34
Occupation:	Retail assistant
Antenatal classes attended:	NHS
Ethnicity:	White British
Reason for induction:	Post-dates pregnancy
Method of induction:	Sweep and PGE ₂
Duration of induction to established labour:	24-48 hours
Pain relief in labour:	Epidural
Postnatal morbidity:	Postnatal depression
Type of birth:	Emergency CS (fetal compromise)

Notes: Isobel had a communication disability, but was highly articulate and but did not perceive this to have been a barrier to communication during pregnancy or her induction. It did, however, affect her experience on the postnatal ward. During the interview, Isobel disclosed that she had experienced postnatal depression, but was receiving effective treatment. She did not attribute this to her induction experience.

Jasmine

Age group:	35-39
Occupation:	Sales manager
Antenatal classes attended:	NCT
Ethnicity:	White British

Reason for induction:	Pre-labour rupture of membranes
Method of induction:	Syntocinon©
Duration of induction to established labour:	Less than 24 hours
Pain relief in labour:	Epidural
Postnatal morbidity:	None
Type of birth:	SVD

Notes: Jasmine had experienced several visits to the antenatal ward prior to induction due to pre-labour rupture of membranes. She was therefore familiar with the surroundings at the time of her induction, which she noted as a positive factor. Jasmine's overall impression of her induction experience was highly positive and exceeded her expectations, especially in relation to the care received. Jasmine had used her assertiveness to question thoroughly the need for induction prior to agreeing to it and appeared to have been more concerned with ascertaining the rationale than with the actual procedure.

Karen

Age group:	35-39
Occupation:	Senior finance manager
Antenatal classes attended:	NCT
Ethnicity:	White Irish
Reason for induction:	Post-dates pregnancy and raised blood pressure
Method of induction:	Sweep. ARM and Syntocinon©
Duration of induction to established labour:	Less than 24 hours
Pain relief in labour:	Epidural
Postnatal morbidity:	None
Type of birth:	Forceps (reason not known)

Notes: Karen wished to be interviewed by telephone for reasons which she chose not to disclose. Karen agreed to the recording of her giving consent to be interviewed, but did not wish the interview itself to be recorded, hence the scarcity of quotations from this interview.

Laura

Age group:	25-29
Occupation:	Retail assistant
Antenatal classes attended:	NHS Pre-induction class
Ethnicity:	White Hungarian
Reason for induction:	Post-dates pregnancy
Method of induction:	Unsuccessful attempt at sweep. PGE ₂
Duration of induction to established labour:	Less than 24 hours
Pain relief in labour:	Entonox©
Postnatal morbidity:	None
Type of birth:	SVD

Notes: At the time of interview, Laura was a recent immigrant to the UK. Her English was fluent. Laura had been in temporary employment prior to giving birth: she was a qualified Social Worker and keen to return to the field. Due to a house move, Laura had booked at the hospital very late in her pregnancy and attended the pre-induction class primarily because no other antenatal class was available at the time. Laura's overall impression of her induction was extremely positive.

Megan

Age group:	30-34
Occupation:	Chartered accountant
Antenatal classes attended:	NCT
Ethnicity:	White British
Reason for induction:	Pre-labour rupture of membranes at term
Method of induction:	PGE ₂
Duration of induction to established labour:	Less than 24 hours
Pain relief in labour:	Epidural
Postnatal morbidity:	Infection and pyrexia (mother and baby)
Type of birth:	SVD

Notes: At the time of her pregnancy, Megan had a family member who was a medical student and had been a source of some information about induction. Megan had been keen to seek information at the time of induction, but had limited success in meeting her needs. Megan reported that staff on the antenatal ward had not believed her perceptions of being in labour: on admission to the delivery suite she was already 5cm dilated. Megan initially believed induction was the reason for her baby's subsequent infection and admission to SCBU, but on probing, attributed this to the PROM.

Nina

Age group:	30-34
Occupation:	Advertising executive
Antenatal classes attended:	NCT
Ethnicity:	White British
Reason for induction:	Post-dates pregnancy
Method of induction:	Sweep. PGE ₂
Duration of induction to established labour:	48-72 hours
Postnatal morbidity:	Pyrexia (Maternal)
Pain relief in labour:	Epidural
Type of birth:	Emergency CS (fetal compromise)

Notes: Nina had originally planned a home birth, but as her pregnancy progressed beyond 41 weeks, induction was advised. This was very much against Nina's philosophy of birth, especially as she had contested the expected date of delivery as calculated by the hospital. Nina had tried multiple self-help methods to induce labour, but eventually, reluctantly agreed to accept medical induction. In retrospect, Nina felt that she had in some way failed as a mother for being unable to labour naturally. Despite her disappointment, Nina's report of her experiences was not all negative and she remained cheerful throughout the interview.

Olivia

Age group:	25-29
Occupation:	Community manager
Antenatal classes attended:	NHS
Ethnicity:	White British
Reason for induction:	Post-dates pregnancy
Method of induction:	Sweep. PGE ₂
Duration of induction to established labour:	24-48 hours
Pain relief in labour:	Pethidine and epidural
Postnatal morbidity:	None
Type of birth:	Emergency CS (fetal compromise)

Notes: Olivia gave a very relaxed account of her induction, yet overall, rated it as a bad experience. Olivia was one of the few participants to have used Pethidine and her experience of this was particularly unpleasant and featured strongly in her evaluation of her induction.

Polly

Age group:	25-29
Occupation:	Housewife
Antenatal classes attended:	NHS
Ethnicity:	White British
Reason for induction:	Reduced fetal movements
Method of induction:	Sweep. PGE ₂
Duration of induction to established labour:	24-48 hours
Pain relief in labour:	Epidural
Postnatal morbidity:	Infection (mother and baby)
Type of birth:	Emergency CS (fetal compromise)

Notes: Polly's mother was present throughout most of the interview and at times, clearly wanted to contribute, although no questions were directed to her. She was

aware that the interview was being recorded. As she had not signed a consent form, her input has not been transcribed. Polly's father was also present in an adjoining room, within earshot, but this did not seem to inhibit Polly's account of events. Polly was given a single side room on the antenatal ward as the bays were full; therefore her partner was able to stay overnight. Although Polly experienced complications during labour, her impression of the care she received was very favourable.

Rose

Age group:	35-39
Occupation:	Communications manager
Antenatal classes attended:	NHS
Ethnicity:	Asian British
Reason for induction:	Post-dates pregnancy
Method of induction:	ARM and Syntocinon©
Duration of induction to established labour:	Less than 24 hours
Pain relief in labour:	Epidural
Postnatal morbidity:	None
Type of birth:	Emergency CS (slow progress)

Notes: Rose reported that her overall experience of induction was positive, although the account she gave suggested otherwise. Rose appeared to have complete trust in health professionals and to have delegated all control to them. She appeared confused about some aspects of her induction. Although Rose stated that she believed she was sufficiently well informed prior to induction, during the process of reflecting, Rose came to revise this opinion. Rose appeared anxious throughout the interview and seemed to be seeking clarification from me of events which had occurred, in order to contextualise and make sense of them. Rose mentioned that she would have welcomed the opportunity to formally de-brief from her labour.

Sarah

Age group:	35-39
Occupation:	Senior school teacher
Antenatal classes attended:	NCT
Ethnicity:	White British
Reason for induction:	Post-dates pregnancy
Method of induction:	PGE ₂
Duration of induction to established labour:	Less than 24 hours
Pain relief in labour:	Epidural
Postnatal morbidity:	None
Type of birth:	Ventouse

Notes: Sarah had a family member in the midwifery profession who had been a source of much information antenatally. Sarah's overall experience of induction was reported as very positive.

Tanya

Age group:	30-34
Occupation:	Finance manager
Antenatal classes attended:	NHS
Ethnicity:	White British
Reason for induction:	Post-dates pregnancy
Method of induction:	Unsuccessful attempt at sweep. PGE ₂
Duration of induction to established labour:	48-72 hours
Pain relief in labour:	Epidural
Postnatal morbidity:	3rd degree tear
Type of birth:	Forceps (fetal compromise)

Notes: Tanya became gradually more and more agitated as she reflected in depth on her birth experience. This is not noticeable in the transcript, but was apparent from her body language – fiddling with jewellery, twisting her hair, blinking, looking away –

clearly recalling painful experiences. However, like others, she was keen to persevere with the interview and seemed to find it a cathartic experience.

Vicky

Age group:	25-29
Occupation:	Underwriting technician
Antenatal classes attended:	NHS
Ethnicity:	White British
Reason for induction:	Post-dates pregnancy
Method of induction:	Sweep. Labour onset spontaneous. Augmented with Syntocinon©
Duration of induction to established labour:	N/A
Pain relief in labour:	Epidural
Postnatal morbidity:	Other
Type of birth:	Emergency CS (fetal compromise)

Notes: At the time of admission to the antenatal ward for induction, Vicky was already experiencing contractions. Due to a full delivery suite, Vicky could not be transferred for two days, by which time she was apparently in established labour. Once on the delivery suite, Vicky's labour was augmented for reasons which were not clear either from her account or from her records. Although Vicky's birth notification states that her labour was induced, documentary evidence and Vicky's account suggests that it was, in fact, only augmented. Vicky's overall reporting of her induction and birthing experience was extremely negative.

The interview was conducted in a crowded and noisy room, but all those present (family members) were aware that the interview was being recorded. Vicky's partner was very keen to participate, but as he had not signed the consent form, his data has not been transcribed or used. Like some other participants, Vicky appeared to find the interview a cathartic experience which helped her to make sense of events

around the time of birth. The conversation veered from the subject of induction on several occasions, as Vicky and her partner clearly needed to externalise their feelings.

Wendy

Age group:	30-34
Occupation:	Account manager
Antenatal classes attended:	NHS
Ethnicity:	White British
Reason for induction:	Post-dates pregnancy
Method of induction:	Sweep. PGE ₂
Duration of induction to established labour:	Less than 24 hours
Pain relief in labour:	Epidural
Postnatal morbidity:	None
Type of birth:	Forceps

Notes: this was a very relaxed interview, in which Wendy responded to questions in a measured and deliberate fashion. Wendy displayed no strong feelings about her induction and appeared to have accepted it and assimilated the experience.

Appendix 8: Publications and conference presentations

Jay, A. (2012). *Women's Experiences of Labour Induction: a Qualitative Study*. Poster presentation. RCM conference, Brighton. November 2012.

Jay, A. (2012). Women's experience of induction. Oral presentation. Trinity College, Dublin.

Jay, A. (2013). Experiencing induction *Midwives: 16(2)*. 42-3

Jay, A. (2013). *Women's experiences of Labour Induction: one year on*. Oral presentation. Postgraduate student research conference, University of Hertfordshire. July 2013.

Jay, A. (2014). Whatever would induce you...? (Comment). *The Practising Midwife*. 17(4), 5

Jay, A. (2014). *Women's experience of induction of labour: a qualitative study*. Oral presentation. RCM conference, Telford. November 2014

Jay, A. (2015). *Women's experiences of induced labour*. Poster presentation. European Congress on Intrapartum Care, Porto, Portugal. May 2015

Jay, A. (2015). *Wearing different hats*. Oral presentation. Postgraduate student research conference, University of Hertfordshire. July 2015