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1 **Introduction and background**

2 Induction of labour is one of the most frequently performed interventions in
3 pregnancy, accounting for around 25% of all births in England (NHS Digital, 2017).
4 Induction carries the risk of further interventions and is associated with increased
5 pain in labour and an increased likelihood of instrumental delivery (Cheyne,
6 Abhyankar, & Williams, 2012; National Institute for Health and Clinical Excellence,
7 2008; Shetty, Burt, Rice, & Templeton, 2005).

8

9 Epidemiological evidence from numerous studies in Europe, Israel and the USA has
10 shown a gradually increasing risk of perinatal mortality in pregnancies exceeding 40
11 weeks, however, the absolute risk remains very low (National Collaborating Centre
12 for Women's and Children's Health, 2008). It is concluded that the potential health
13 benefits to women and babies of inducing labour after 41 weeks outweigh the
14 additional costs to the maternity care provider (National Collaborating Centre for
15 Women's and Children's Health, 2008). Where medical conditions such as pre-
16 eclampsia or type 1 diabetes exist, the dangers of continuing the pregnancy may not
17 be controversial (Cheyne et al., 2012). However, around half of all inductions in the
18 UK are performed for uncomplicated, post-dates pregnancy, where the risk of
19 perinatal death is low (2-3:1000). In these situations the risk of maternal morbidity
20 resulting from induction is relatively high, compared to spontaneous labour (Cheyne
21 et al., 2012; National Collaborating Centre for Women's and Children's Health,
22 2008). In keeping with the principles of client-centred care (Department of Health,
23 2007), the decision to induce labour or continue with the pregnancy rests with the
24 woman. Guidelines from the National Institute for Health and Clinical Excellence
25 (NICE) state that:

26 *Women who are having or being offered induction of labour should have the*
27 *opportunity to make informed decisions about their care and treatment, in*
28 *partnership with healthcare professionals (NICE, 2008, p.4)*

29

30 There is evidence that many women welcome the offer of induction for post-dates
31 pregnancy, through concern for the baby's wellbeing, because of physical discomfort
32 or for social reasons (Gammie & Key, 2014; Heimstad, Romundstad, Hyett, Mattson,
33 & Salvesen, 2007; Moore, Kane-Low, Titler, Dalton, & Sampsel, 2014; Murtagh &
34 Folan, 2014; Shetty et al., 2005). For others, however, induction represents a
35 significant and unwelcome change to their anticipated trajectory of pregnancy and
36 labour onset (Gatward, Simpson, Woodhart, & Stainton, 2007).

37 **Literature review**

38 Early UK studies identified a need for more information and involvement in decision-
39 making relating to induction (Kitzinger, 1975; Lewis, Rana, & Crook, 1975; Stewart,
40 1977). Cartwright's UK-wide study of over 2,000 women found that around 40% of
41 participants would have liked more information (Cartwright, 1977). Despite the
42 growing discourse on informed choice since the 1970's, recent studies continue to
43 highlight these issues. A comparative survey of 900 Scottish women by Shetty et al.
44 (2005) found that 34.7% of women who had their labour induced perceived
45 information to be lacking and noted a disparity between expectations of induction
46 and women's actual experiences of it, particularly in terms of duration, pain and
47 interventions. This suggests that the information women received about induction did
48 not enable them to build realistic expectations (Shetty et al., 2005). A mixed-
49 methods study, involving secondary analysis of data from over 5,300 women from

50 across England identified a lack of information and involvement in decision-making
51 about induction (Henderson & Redshaw, 2013). Overseas studies have noted similar
52 findings (Gatward et al., 2007; Moore et al., 2014; Nuutila, Halmesmaki, Hiilesmaa, &
53 Ylikorkala, 1999). However, evidence from the UK remains scarce and is mostly
54 derived from quantitative research, limiting the emergence of knowledge to that
55 which falls within the parameters of closed-question surveys. The present study
56 therefore set out to add depth and context to existing knowledge by delving into the
57 ways in which first-time mothers acquire information about induction, how and why
58 they consent to the procedure and how they experience it. Findings from this study
59 relating to women's experiences of induced labour have been published elsewhere
60 (Authors, 2017). The present paper focuses on information and decision-making.

61

62 **Methods**

63 The conceptual framework underpinning this study centred on the notion of informed
64 choice in maternity care: a qualitative methodology was considered the most
65 appropriate means of obtaining insight into women's perceptions of choice and how
66 decisions were made. The face-to-face interview method of data collection is widely
67 regarded as one of the key tools of the qualitative researcher (Barbour, 2008) as it
68 allows for both depth and breadth of data. A semi-structured approach was adopted,
69 using a flexible schedule of open-ended questions (e.g. *'tell me about how you made*
70 *the decision to go for induction'*) which allowed participants to control the extent of
71 disclosure (Rees, 2011; Rogers, 2008). Ethical approval was granted by the Health
72 Research Authority, England (NRES Committee South Central – Oxford A) and the
73 local Research and Development committee.

74

75 Interviews were conducted during the autumn/winter of 2012/13. Participants, who
76 were identified from the postnatal ward of a maternity unit in the south of England,
77 consisted of primiparous, English-speaking women over the age of 18, who had
78 experienced induced labour at or close to term. Multiparous women were excluded,
79 since they might be expected to have acquired a broader knowledge of induction
80 through personal experience or their expanded peer network. No distinction was
81 made in respect of the reason for induction, but all women had been classed as low-
82 risk at the start of pregnancy and none had requested induction. All women were
83 living with husbands or male partners. The first investigator visited the postnatal
84 ward once a week for six months. All women who met the inclusion criteria were
85 approached via the agency of a senior midwife who was fully appraised of the study.
86 Access was denied to women who were deemed especially vulnerable (such as
87 those whose babies were sick or going to foster care). An information leaflet was
88 offered and after reading it, women who expressed an interest in participating were
89 asked for their written consent to be contacted again 3-4 weeks after discharge.
90 Women were assured of their option to withdraw from the study at any time without
91 consequences for their subsequent care.

92

93

94 Table 1. Demographic details of participants (*n*=21)

Age range	25-29 (<i>n</i> =4), 30-34 (<i>n</i> =10), 35-39 (<i>n</i> =5), 40-45 (<i>n</i> =2)
Reasons for IOL	Post-dates pregnancy (<i>n</i> =15) pre-labour rupture of membranes (<i>n</i> =2)

	pre-eclampsia (<i>n</i> =1) reduced fetal movements (<i>n</i> =1) gestational diabetes (<i>n</i> =1, aged over 40 (<i>n</i> =1)
Self-declared ethnicity	White British (<i>n</i> =16) Asian British (<i>n</i> =1) White non-British (<i>n</i> =4)
Occupation	Managerial/professional (<i>n</i> = 15) Clerical, retail or service (<i>N</i> =5) Not in employment (<i>n</i> =1)
Highest level of education	First degree or higher (<i>n</i> =15) Other post-A' level qualification (<i>n</i> =2) A' levels or equivalent (<i>n</i> =2) GCSE or equivalent (<i>n</i> =2)

95

96

97 A total of 33 women consented to be contacted, however twelve were lost to follow-
98 up, as they either could not be reached or declined to participate. Except for one
99 participant, who opted to be interviewed by telephone, all women were visited in their
100 homes by the first investigator, where the purpose of the study was verbally
101 reiterated, with reference to the participant information leaflet. Written consent was
102 obtained prior to commencing interviews. Confidentiality and anonymity in all stored
103 data and publications was assured. Interviews lasted 30-90 minutes and were audio-
104 recorded.

105 A field diary was used to facilitate reflexivity, by recording impressions and feelings
106 after each interview and reflecting on how the researcher's position as a
107 midwife/teacher/mother might influence data interpretation. Transcripts of audio-
108 recordings were re-read three times, whilst listening to the recordings, to check for
109 accuracy of transcription. Data were initially organised using *a priori* categories
110 formulated from the interview questions, with new categories added as they
111 emerged. The software package NVivo10© was used to create a hierarchical
112 structure of categories and sub-categories, which were then re-grouped into themes,
113 using an iterative process until all identifiable themes were exhausted (Barbour,
114 2008; Gibson & Brown, 2009). A form of framework analysis was also employed, in
115 which numerical instances of particular aspects of data were counted, helping to
116 identify the most frequently reported events, feelings or perceptions. All data were
117 anonymised, in accordance with the Data Protection Act (1998). In this paper all
118 quotations are suffixed by pseudonyms and the reason for induction.

119 **Findings**

120 Key themes emerging from the findings of this study relate to the acquisition of
121 information about labour induction, how women perceived choice and how they
122 made the decision to accept induction

123 **Sources of information on induction**

124 Family and friends were the most common sources of information, cited by two thirds
125 of participants. Impressions of induction were varied and sometimes contradictory.
126 Increased pain in labour was most frequently mentioned, but there was little
127 consensus on other aspects; for example, four women had heard that the onset of
128 labour would be quicker than natural labour, whilst five believed it would take longer.

129

130 *I just knew [...] from having spoken to other Mums and Dads that it would*
131 *artificially bring on the contractions...the one thing I did know was that it would*
132 *all mean it would happen a lot quicker ... and therefore it might be a good deal*
133 *more painful... (Clare: maternal age)*

134 *My mother had been induced.... I didn't really know what it was other than it*
135 *was meant to be more painful than a natural birth and that they gave you*
136 *something to make the baby come (Megan: pre-labour rupture of membranes)*

137

138 Fourteen participants had attended free antenatal classes led by midwives from the
139 local hospital, whilst seven had attended fee-paying classes, chiefly those organised
140 by the National Childbirth Trust (NCT) (n=21), a national parent's charity. Some
141 women had attended more than one type of class, but it was unlikely that any two
142 women had attended the same class simultaneously. Several women were not sure
143 whether their classes had covered induction and those who recalled information
144 described it as not very memorable.

145 *I don't remember a lot of detail though...nothing that really sticks in my mind...*
146 *(Donna: midwife-led classes. Post-dates pregnancy)*

147 *I don't think they did [mention induction] and if they did, I don't remember it*
148 *...it wasn't memorable. (Rose: midwife-led classes. Post-dates pregnancy)*

149 There was no suggestion that information had not been comprehensible to any
150 participant, however, some women reported that they had paid little attention, as

151 they could not foresee induction happening to them. Midwife-led classes attracted
152 less criticism than those run by the NCT:

153 *NCT's very much 'everyone has a perfect birth' and that's it... I mean, nobody*
154 *had said that ... inducing you actually makes the contractions more painful.*
155 *(Megan: NCT classes. Pre-labour rupture of membranes)*

156 *In NCT...we spent half an hour drawing pictures of what we thought would*
157 *help induce labour, so pineapple and raspberry leaf tea... Drawing pictures!*
158 *We're all in our 30s, all professionals! [...] so, I hadn't paid much attention, or*
159 *the information wasn't there to be paid attention to. (Jasmine: NCT classes.*
160 *Pre-labour rupture of membranes)*

161

162 The maternity unit produced an information leaflet on induction, to be given out when
163 induction was booked. Only eleven women reported reading the leaflet, whilst two
164 stated that they had received it but not read it. It was not clear whether the remaining
165 women had received a leaflet or not, but none reported having read it.

166 *[...] ...I've got so many leaflets I don't know what's what anymore! I don't*
167 *remember reading one, but they might well have done, and I've missed it...*
168 *(Olivia: post-dates pregnancy)*

169 Electronic media were mentioned by just seven women. Two women found helpful
170 'Apps', whereas those who searched the Internet often had trouble finding credible
171 websites and relating the information to their own situation:

172 *.....and then, obviously, you look on the Internet and there's so many... lots of*
173 *horror stories ...and other people were saying how it wasn't that bad...but it*

174 *didn't really help me, because it was going to be my experience anyway!*

175 *(Donna: gestational diabetes)*

176 Several women gleaned information from various sources:

177 *...a little bit from Google, a little bit from my sister [...] because my midwife*

178 *didn't explain a lot to me, [...] Yeah... from like friends and family. (Tanya:*

179 *post-dates pregnancy)*

180 As in Tanya's case, information from midwives in the antenatal clinic was often

181 perfunctory or limited to a leaflet, as midwives gave the appearance of being too

182 busy to offer much explanation:

183 *To be honest...I think she was quite busy, she always...just seemed a bit*

184 *rushed, so we didn't really get to talk a lot but...yeah, I didn't really know*

185 *anything! (Olivia: post-dates pregnancy)*

186 *I think she assumed that I knew about it and I sort of didn't really get asked if I*

187 *knew about it but I... it was all quite a quick appointment, I think they had*

188 *others waiting. (Sarah: post-dates pregnancy)*

189 Few women sought further information from midwives, as they perceived no need for

190 this at the time induction was first offered. With hindsight, however, many stated that

191 they would have preferred to have known more, particularly in relation to the possible

192 duration and procedures.

193 **Involvement in decision-making**

194 Half of the women stated that they had been involved in the decision to induce

195 labour, however, this tended to be framed as little more than agreeing to a

196 predetermined plan:

197 *I was kind of part of the decision, I was there when she made the phone call*
198 *to the hospital but it, other than that it was ‘oh, if you haven’t gone into labour*
199 *by this date then this is what’s gonna happen’ and that was, I was like ‘oh,*
200 *OK. (Gemma: post-dates pregnancy)*

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

204 Where induction was presented as an option, there appeared to be a bias towards
205 compliance:

206 *...it was presented as a choice, but they were definitely encouraging me to*
207 *strongly consider it rather than waiting. (Clare: maternal age)*

208 Nina, who had been planning a home birth, was highly resistant to the offer of
209 induction for post-dates pregnancy and opted to defer the procedure, but found the
210 stress of daily fetal monitoring overwhelming and eventually capitulated:

211 *[...] they did say I could push my induction date back, but because I kept*
212 *going in every day and all the stress [...] when it came to it I was like “do you*
213 *know what? Let’s just do it, I can’t deal with this stress any more” [...] (Nina:*
214 *post-dates pregnancy).*

215 The impression from most women was that regardless of reason, induction was often
216 presented as routine, with little or no opportunity for discussion and with compliance
217 assumed.

218 **Risk awareness**

219 Many women alluded to the powerful influence that any mention of risk had on their
220 decision to accept induction. Where medical conditions existed, women were
221 generally clear about the reason for induction; conversely, in cases of post-dates
222 pregnancy, perception of risk was often non-specific:

223 *Um...no, basically it was...being induced really, because obviously I was that*
224 *far overdue...they needed to get (baby) out I think (Isobel: post-dates*
225 *pregnancy)*

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

230 Trust in professional opinion appeared very strong and risk was generally seen only
231 in terms of dangers to the fetus of prolonged pregnancy, rather than risks to both the
232 woman and fetus/neonate from medical interventions.

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

236 *well, you know, if medical professionals advise you that that's the best thing*
237 *and the least risky thing, then you know you'd be very brave to do something*
238 *different really?(Emily: post-dates pregnancy)*

239 In all cases, concern for the unborn baby overrode women's prior aspirations for a
240 natural birth experience, a phenomenon noted in earlier studies (Heimstad et al.,
241 2007; Moore et al., 2014; Murtagh & Folan, 2014; Roberts & Young, 1991).

242 However, there was no apparent awareness of the statistical probability of harm.

243 **Influence of partners**

244 Partners were a significant influence on some women's decision to accept induction.

245 Some reportedly viewed induction simply as a logical choice for the sake of safety
246 and expediency, whilst others were impatient.

247 *...and when I spoke to [partner], he was the one to sort of realise I needed a*
248 *bit of a prod and, you know [...] they're saying to you baby is ready...so we*
249 *need to do it [...] (Jasmine: pre-labour rupture of membranes)*

250 *...I think my partner was more interested in it than me! I think he thought ...*
251 *can we just like book it now? ... (Beth: post-dates pregnancy)*

252 The role of partners in the decision to accept induction has not been previously
253 explored and is worthy of further study.

254 **Discussion**

255 The NICE guideline and quality standards emphasize the need for a thorough
256 explanation of the reasons for induction, the process, the relative risks and
257 alternative options (National Institute for Health and Care Excellence, 2014; National
258 Institute for Health and Clinical Excellence, 2008). Evidence from this study indicates

259 that women received very limited information during pregnancy and around the time
260 that induction was booked, indeed many could recall little or nothing that was
261 meaningful to them beyond anecdotes from friends and family. This contrasts with
262 other UK studies which cite clinicians as the main information providers (Gammie &
263 Key, 2014; Shetty et al., 2005).

264 Only half of participants had reportedly read the Trust's information leaflet on
265 induction. This lack of engagement may reflect information overload, which may
266 also explain the apparent reluctance to seek information via the internet. However, it
267 is possible that having accepted induction as inevitable, women felt no need to
268 enquire further for fear of fuelling anxiety, a phenomenon noted in earlier studies
269 (Hallgren, Kihlgren, Norberg, & Forslin, 1995; Levy, 1999). Moreover, it has been
270 demonstrated that the high level of trust afforded to clinicians leads many women to
271 assume that whatever is offered must be in their best interests (Edwards, 2008;
272 Jomeen, 2007; M. Kirkham, 2004a; Sakala, 2006). This may go some way towards
273 explaining the apparent lack of enquiry.

274

275 The connection between knowledge and power is widely documented and health
276 professionals have power to control the release of information (Bradbury-Jones,
277 Sambrook, & Irvine, 2008; Fahy, 2002; Johanson, Burr, & Leighton, 2000). It has
278 been argued that women without previous childbirth experience, are unlikely to
279 enquire about options which are not brought to their attention by clinical staff and are
280 thus especially vulnerable to coercion (DeVries, Salvesen, Wieggers, & Williams,
281 2001; Jomeen, 2007; Kirkham & Stapleton, 2004; Newburn, 2003). Withholding
282 information that may create dilemmas for women may be done for benevolent

283 reasons, such as to avoid creating anxiety (Levy, 2004). In this study, however, by
284 failing to share knowledge about other options or to discuss the finer details of
285 induction, it appears that midwives were steering women towards induction and
286 effectively suppressing autonomous choice.

287 It has been argued that too much information and responsibility for decision-making
288 can have effects similar to those of insufficient choice, leading to a sense of anxiety
289 and loss of control (Green, Coupland, & Kitzinger, 1998; Weaver, 1998). There were
290 instances in this study of women choosing not to seek information or opting to
291 delegate decision-making to clinicians (e.g. Rose). This raises questions about the
292 value that individual women place on information and decision-making and whether
293 they would have welcomed more information had it been offered.

294

295 Studies into the provision of childbirth information have highlighted the importance of
296 appropriate timing of information-giving (Cooper & Warland, 2011; Maher, 2008;
297 Stapleton, Kirkham, Curtis, & Thomas, 2002a). Women's recall of detail about
298 induction from antenatal classes suggests that they were unable to retain or
299 assimilate that which did not seem relevant to them. In some cases, this may have
300 been attributable to the presentation style of the class leader, however, by necessity,
301 information given in antenatal classes is generalised and there may not be scope to
302 address individual needs. Moreover, women typically attend classes early in the third
303 trimester of pregnancy, well before the question of induction arises. This highlights a
304 need for individualised and appropriately timed information in late pregnancy.

305 Only four women questioned the need for induction, the majority agreed to the
306 process without any discussion with health professionals, contrary to the

307 recommendations of NICE (2008., 2014). Fear of harm to the fetus was cited as the
308 chief influence. However, there was little evidence of risk evaluation having taken
309 place, particularly where induction was offered for uncomplicated, post-dates
310 pregnancy. Women need to be aware of the relatively low probability of mortality
311 resulting from prolonged pregnancy compared to the much higher probability of
312 lower levels of harm resulting from interventions following induction.

313 Poor understanding of probability is thought to be common among health
314 professionals (Cheyne et al., 2012; Furedi, 2006; Gigerenzer & Muir-Gray, 2011).
315 Midwives need a deeper understanding of risk and probability and the ability to
316 meaningfully convey this to women (Cheyne et al., 2012; Skyrme, 2014). Unless
317 both sides of a risk argument are presented, any decisions made cannot be said to
318 have been truly informed. Furthermore, midwives need to feel empowered to offer a
319 balanced discussion of risk, safe in the knowledge that they will not be penalised if
320 women choose not to comply with the expected norm (Skyrme, 2014).

321 It is easy to attribute the lack of information and discussion to shortcomings in
322 midwifery practice. However, in common with many UK maternity units, the system
323 of care was based around short, task-oriented appointments, which compels
324 midwives to control the agenda and limit discussion time to ensure that appointments
325 do not overrun. This leads to a reactive rather than proactive approach to discussion
326 (Kirkham & Stapleton, 2004; Levy, 2004). It was noted that midwives often appeared
327 busy and had others waiting, which may have inhibited women from asking
328 questions.

329

330 **Limitations**

331 This study was conducted in a single NHS Trust. The sample was self-selecting and
332 women from higher socio-economic groups were over-represented: a factor common
333 to studies of this nature (Levine, 2008). For pragmatic and ethical reasons, women
334 under eighteen, those not fluent in English and those deemed vulnerable were
335 excluded from the sample. There is a need for further studies to address the
336 experiences of such women.

337 **Conclusion and implications for clinical practice**

338 Midwives need to acknowledge that induction is often an unexpected disruption to
339 women's expected trajectory of labour and birth. Providing information and
340 preparation for what to expect during induction is of key importance in enabling
341 women to make an informed choice about induction, particularly where the risks and
342 benefits are not easily quantifiable. Findings of this study suggest that a new
343 approach is needed to the management of uncomplicated, post-dates pregnancy.
344 Rather than steering women towards routine acceptance of induction, women should
345 be given individualised information, taking account not only of their clinical status, but
346 also of their social and cultural background and their desire for choice and
347 information. This implies that providers of maternity care will need to consider more
348 flexible ways of working, allowing more contact time for women and midwives to
349 discuss options in an unhurried and balanced manner. Additional measures could be
350 considered, such as the use of decision aids, on-line resources or pre-induction
351 classes. This may require the recruitment of more midwives or the adoption of
352 alternative patterns of care provision, such as case-holding. Each will have budget
353 implications for maternity units.

354 Midwives and doctors need to be able to engage with women in a balanced
355 discussion of the relative risks of induction and expectant management. This implies
356 a need for Higher Education Institutions to emphasise the understanding and
357 communication of risk and probability as part of their undergraduate curricula.

358

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363

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