Informed consent and induction of labour at term gestation: process and implications

by

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Abstract

Informed consent and induction of labour at term: process and implications

Induction of labour is the most common intervention in maternity care. Induction of labour rates accounted for 20.4% of births in England in 2007/08, 29.4% in 2016/17, 31.6% in 2017/18, and 34% in 2022/23. While induction is sometimes indicated for clinical reasons, there is also concern that the rising rates do not always reflect clinical need, and it is not clear what health professionals and service users views and experiences are. Whilst there are some studies in this area, they tend to examine the views of service users only, and many studies are focused on induction for simple post maturity. In contrast, this study examines the issue of induction of labour in one NHS Trust (where the rate of induction at the time of the study was almost 50%) from the point of view of women with and without medical complications and the views of both midwives and obstetricians.

It is important to note that the interest of this study focuses on how informed consent for induction of labour is used in the United Kingdom. Different legal structures mean that this might not be the same in other countries. In the United Kingdom for example, the fetus does not have a legal status until it is born but this is not the case in other countries.

Following a systematic review of the current literature in this field, this study used questionnaires, interviews, and a discussion group to explore the experiences, views, and beliefs of maternity service users about how they gain information regarding induction of labour and how it affects their overall birth experience, as well as examining the views, beliefs and experiences of midwives and obstetricians.

Questionnaires were distributed to women being admitted to the antenatal ward for induction of labour in one NHS Trust over a six-week period with 98 women undertaking the questionnaire. Four semi-structured interviews were undertaken with postnatal women who had had their labour induced to discuss their birth experiences, with one written account also being received. Five semi-structured interviews were undertaken with midwives and obstetricians for their views and beliefs around informed consent and what factors impact upon this process when

discussing induction of labour with women. A discussion group with midwifery birth suite co-ordinators and two ward managers (five staff members) was then undertaken to explore their views and experiences of looking after women having their labour induced and the impact upon women, the staff looking after them as well as the maternity unit environment in terms of being equipped from a resource perspective.

The study revealed that women were being induced for a variety of different reasons. These were reflective of the rise in diabetes and other medical complexities as well as the option for maternal request in the absence of any other rationale. In contrast to many other studies in this area, most of those responding to the questionnaire and taking part in the qualitative data collection, reported being happy to be offered induction. This may be because 85.2% of respondents (n=86) and all the service user interviewees were being induced for medical complications, rather than for uncomplicated pregnancies that proceeded beyond 41 week's gestation. The questionnaire and interview findings highlighted that women use a variety of sources to obtain additional information including the induction of labour information leaflet, the internet, social media, partners, friends, and family. From a birth experience viewpoint, the interview findings highlighted that women's retrospective views ranged between extremely positive to extremely negative. Although physical events involved with the induction process had a significant impact on women's perceptions of induction of labour, relationships with health professionals were also an important factor.

The study revealed the individual nature of each woman's account of her experiences, and that overall perceptions of induction were affected by multiple factors, including women's individual personalities as well as their expectations for induction. Despite women feeling overall well informed, the questionnaires and interview findings showed there were some gaps in women's knowledge about various aspects of the induction of labour processes. The disparity between expectations of induction and reality highlighted that some of the women were not fully prepared for the duration, intensity, how they would experience induction and the potential implications of an induced labour.

From the interviews with health professionals, findings highlighted how protective steering may impact on obtaining informed consent, the nature of informed consent in current practice and how the health professional as ‘second victim’ may impact upon the informed consent process. Suggestions by health professionals for improvements to assist with informed consent highlighted the need for more information on various aspects of the induction of labour processes during the antenatal period when discussing induction. These included statistics associated with risk and also accessibility of information and guidance to share with women, particularly in the community setting. Continuity of carer, improved hospital resources to meet demand, accessible information for more marginalised women and for staff in all settings, antenatal education about induction, birth choices/pre induction of labour clinics, staff education, and induction consent forms detailing risks and benefits were all noted by health professionals as having the potential to improve informed consent. Suggestions such as innovations around outpatient induction and balloon induction of labour were proposed. These have been discussed to mitigate some of the disconnect between expectation and experience. However, there are gaps in the scientific evidence about the acceptability, equity, feasibility, and efficacy of these approaches.

Overall, the study highlighted the scope available for improvements to the informed consent provision for induction of labour for women being offered induction for medical complications, to take account of how it might be experienced and how long it may take, and to acknowledge the environment in which it takes place, including how staff experience the rising rates of labour induction on their workload and capacity to provide optimal care.

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Glossary

Assisted birth/instrumental birth	An assisted birth/instrumental birth is when forceps or a ventouse suction cup are used to help birth a baby.
Antenatal	Before birth.
Badgernet	An electronic maternity notes system that replaces handheld paper notes that also includes an online portal and an app whereby women can access their maternity records via the internet through their PC, tablet device or mobile phone.
Caesarean section	A caesarean section is a surgical operation for birthing a baby by abdominal surgery.
Cardiotocography (CTG)	A method of electronically monitoring fetal heart rate and uterine contractions to assess fetal wellbeing.
Cervix	The neck of the uterus where it opens into the vagina.
Cholestasis	A condition which impairs the flow of bile from the liver to the small intestine by either slowing or stopping the flow.
Continuity of carer	Continuity of carer is a model of midwifery care that provides a named midwife, with the support of a small team, who will work together to provide all of a woman’s care during your pregnancy, birth and after the birth of the baby.

Disseminated intravascular coagulation	A serious disorder occurring in response to an illness/disease that results in dysregulated blood clotting.
Doppler	Doppler ultrasound in pregnancy is used to study blood circulation in the fetus, uterus and placenta. Doppler ultrasound can diagnose restricted blood flow, blood clots and fetal health.
Dural puncture	Occurs when a hole is made in the fluid filled protective membrane (the “dura”) which surrounds the brain and spinal cord. Leakage of small volumes of fluid through this hole may be sufficient to drop the pressure of the spinal fluid, this can cause a severe headache and other symptoms.
Elective	A clinical procedure that is planned as opposed to being an emergency.
Electronic fetal monitoring	See cardiotocography.
Epidural	A form of analgesia administered via a catheter into the epidural space around the lower spinal cord.
Expectant management	The process of allowing pregnancy to continue with monitoring but excluding medical intervention.
Expected date of delivery	The end of the 40th week of pregnancy.
Eclampsia	A rare but serious complication of pre-eclampsia causing seizures during

	pregnancy that can be fatal for the mother and for the baby.
Fetal monitoring	The assessment of fetal wellbeing by intermittent or continuous auscultation of the heart.
Gestational diabetes	High blood sugar (glucose) that develops during pregnancy and usually disappears after giving birth.
Group B streptococcal	Group B streptococcal infection is the infectious disease caused by the bacterium Streptococcus agalactiae and can cause serious illness and sometimes death.
Hellp	A syndrome that is a rare pregnancy complication causing serious blood and liver problems.
Hyperstimulation	A potential complication of labour induction. The contraction frequency numbering more than five in a ten minute time frame.
Hypertension	Abnormally raised blood pressure.
Induction of labour	The artificial initiation of labour.
Intrapartum	During labour.
Intrauterine growth restriction	When the fetal weight is estimated to be below the 10th centile for its gestational age
In vitro fertilisation (IVF)	A process where an egg is combined with sperm in vitro fertilisation.
Low pregnancy associated	

plasma protein	PAPP-A is a hormone that is made by the placenta. A low PAPP-A indicates poor early placentation resulting in complications such are fetal growth restriction, fetal demise, preterm birth and pre-eclampsia in the third trimester.
Macrosomia	When an infant's estimated weight is higher than 90% of the average weight of babies in the same gestation age rage, they are considered large for gestational age.
Membrane sweeping	An intervention in which a finger is inserted through the cervix and then rotated to separate the membranes around the fetus from the lower uterine segment. This is to release prostaglandins to stimulate the onset of labour.
Maternity voices partnership (MNVP)	A Maternity and Neonatal Voices Partnership is an NHS working group of women and their families as well as commissioners and maternity service staff who work together to review and develop maternity services locally.
Multiparous	A woman who has given birth to one or more babies.
Nulliparous	Nulliparous describes a female who has never given birth to a live baby.
Occipito posterior	A fetal presentation in which the back of the head (the occiput) is in line with the mother's sacrum.
Outpatient induction of labour	Outpatient induction is the process of induction that starts as an inpatient or

	outpatient procedure for women who are then discharged either to home or to a setting where they do not have immediate access to the hospital, such as an outreach antenatal clinic or a birthing centre to await labour over a 24 hour period.
Oxytocin	As a medication it is used to cause contraction of the uterus to start labour, increase the speed of labour and to stop bleeding following birth.
Parity	Parity is the number of times a woman has given birth to a live neonate (any gestation) at 24 weeks or more, regardless of whether the child was viable or non-viable (i.e. stillbirth).
Perinatal	The period of time of becoming pregnant up until one year after birth.
Pessary	A vaginal suppository containing a therapeutic drug.
Polyhydramnios	Polyhydramnios is defined as an increase in the amniotic fluid in pregnancy and is associated with increased maternal and neonatal morbidity and mortality.
Post-dates pregnancy	A pregnancy that goes beyond 42 completed weeks of pregnancy.
Postpartum haemorrhage	Postpartum haemorrhage (PPH) is severe bleeding that occurs after giving birth and is a serious condition that usually occurs within 24hours of childbirth, but it can happen up to 12 weeks postnatally.

Post traumatic stress disorder	Post traumatic stress disorder (PTSD) is a mental health condition caused by very stressful, frightening, or distressing events.
Pre-eclampsia	A condition usually during the second half of pregnancy or soon after delivery causing high blood pressure and protein in the urine which can lead to serious complications.
Pre labour rupture of membranes	Spontaneous rupture of fetal membranes before the onset of labour.
Primigravid	A woman pregnant for the first time.
Propess	Propess contains the active substance dinoprostone 10mg and is used to help start the birth process. The dinoprostone opens the part of the birth canal known as the cervix.
Prostin	Prostin is a prostaglandin, which is a hormone-like substance released by the body's tissues. In a pregnant woman, prostin E2 is used to relax the muscles of the cervix in preparation for inducing labour at the end of pregnancy.
Rupture of membranes	The breaking of the membranes around the fetus.
Spontaneous labour	Labour that commences without intervention.
Syntocinon	Syntocinon contains the active ingredient oxytocin. Syntocinon is used to induce labour. It can also be used during and

	immediately after birth to help the birth and to prevent or treat excessive bleeding.
Tachysystole	Uterine tachysystole is a condition of excessively frequent uterine contractions during pregnancy and can affect the fetal heart rate and cause hypoxia and acidosis which are serious risk
Term	The time between 37 and 42 completed weeks of pregnancy.
Uterine rupture	Is a rare and life threatening condition involving a complete division of all three layers of the uterus (the endometrium, the myometrium and perimetrium).

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CHAPTER 1
Introduction and background

This introductory chapter aims to provide contextual information for the research study. The context will be provided utilising evidence to discuss an overview of induction of labour and informed consent and why it is important within maternity care and to induction of labour. This research project utilises a triangulated approach to examine the views, beliefs and experiences of maternity service users and midwives and obstetricians in relation to induction of labour and informed consent. The aims and the objectives of the research study and the research questions will be discussed within this chapter. Finally, to conclude chapter one, an overview of the structure of the thesis is detailed.

Induction of labour

Induction of labour rates are rising, with NHS maternity statistics (2020-21) indicating an increase of induction rates from 21% in 2010-2011 to 30.6% in 2020 (NHS Digital, 2020). In some Trusts the rate is around 50% (Harkness, Yuill, Cheyne, et al., 2021). At the Trust where the research study took place, the induction of labour rate in December 2022 was reported as almost 50%, which equated to 243 women having their labour induced during that month.

Induction of labour is the most common intervention worldwide in modern obstetrics (Lundh, Ovrum, and Dahl, 2023). Induction of labour is indicated to improve outcomes when the continuation of the pregnancy is associated with maternal or fetal risks and may be considered if there is no contraindication to vaginal birth (NHS, 2023).

Induction of labour may include ‘membrane sweeping’ which involves an internal examination to separate the membranes from the cervix (NICE, 2021) and this may be followed by pharmacological methods (including progesterone or oxytocin derivatives), or mechanical methods, such as artificial rupture of the fetal membranes (NICE, 2021).

There are different and specific circumstances whereby discussions about induction of labour may be advised including pregnancy lasting longer than 41 weeks, preterm pre labour rupture of membranes, pre labour rupture of membranes at term gestation, previous caesarean section, and fetal growth restriction (NICE, 2021). Suspected fetal macrosomia is another rationale for induction of labour due to its association with shoulder dystocia and therefore an early induction may be advised if a baby appears to be large.

Table one shows the risks associated with continuing a pregnancy in certain circumstances:

Table 1

Reasons for induction of labour (NICE 2021)

Condition	**Risk**	**Prevalence (Induction of labour versus expectant management)**
Prolonged pregnancy lasting longer than 41 weeks	Neonatal morbidity and mortality	NICE (2021) states that there was not enough evidence, so the committee made a recommendation for research to further explore the optimal timing for induction NICE (2021) references the MBRRACE-UK (2020) report that highlights that babies born to certain groups of women may be at higher risk of still birth. The committee made a recommendation for research to identify the

		optimal timing for induction of labour
Preterm pre labour rupture of membranes	Risk of serious neonatal infection	2% versus 15%
Pre labour rupture of membranes at term gestation	Risk of serious neonatal infection	1% (compared to 0.5% for women with intact membranes) There are no statistics within the evidence table (NICE, 2021) for induction of labour versus expectant management.
Previous caesarean section	Uterine rupture	Insufficient evidence
Fetal growth restriction	Neonatal morbidity	50% versus 35%

Improvements to outcome

The rationale usually provided for the rise in induction rates is that induction is associated with improved maternal and neonatal outcomes (Middleton, Shepherd, and Crowther, 2018). Much of the increase in statistics may be attributed to evolving national agendas. The National Maternity Review (2015) set out a range of initiatives to improve outcomes for women and babies by halving the 2010 rates of stillbirths, neonatal deaths, maternal deaths, and brain injuries in babies that occur during or soon after birth by 2030 with an expected reduction of 20% by 2020. In 2017, the Government brought forward this ambition to 2025 and extended it to include a reduction in the national rate of pre-term births from eight percent to six percent the same year. Other reasons for the rise in rates of induction of labour may include increasing maternal age, obesity, and medical conditions as well as improved fetal monitoring and management practices (Adler, Rahkonen and Kruit, 2020). With the rising rates of induction, outcomes had generally improved up to 2022, although improvements may be due to a range of factors. Recent data suggest that the improvements in stillbirth have stalled, although maternal mortality has

increased, with some of these adverse effects being independent of the effect of the Covid-19 pandemic (House of Commons, 2024).

The neonatal mortality rate ambition in England is 1.0 deaths per 1 000 live births, whereby a neonatal death is classified as the death of an infant aged under 28 days. Achieving the ambition in 2021 would have required at least 220 neonatal deaths of babies born at 24 weeks or over, so that the total did not exceed 592 (The Office for National Statistics, 2023). The still birth ambition in England is 2.6 still births per 1000 births. In 2021, the rate was 4.1 per 1000 births. Achieving the ambition in 2021 would have required at least 896 fewer still births so that the total did not exceed 1 556 (Office for National Statistics, 2023). Overall, the most recent statistics indicate there were 11.66 per 100,000 maternal deaths which is an increase from 10.9 in 2018-2020; this would be 10.06 per 100,000 if excluding covid 19 related deaths and with the majority occurring post birth (MBRRACE, 2023). However, even excluding Covid-19, the mortality rates for women who died during or soon after pregnancy has increased to levels not seen since 2003-2005 (University of Oxford, 2024).

The AFFIRM trial undertaken in the United Kingdom between 2014 and 2016 involved a care package to recognise reduced fetal movements, and planned induction where this was identified (Norman et al., 2018). In the event, there was an increase in induction of labour rates and caesarean section rates; however, there was no difference in perinatal mortality.

There has been debate about whether improved maternal and neonatal outcomes are due to causation, i.e., rising induction rates reduces adverse outcomes, or association i.e., that the two happen to co-occur, without one necessarily influencing the other. The ARRIVE trial, which was a large, randomised study taking place across 41 hospital sites in the USA, compared induction versus expectant management for healthy low risk women with first pregnancies undertaken during the 39th week of pregnancy. The research aimed to explore whether induction of labour at 39 weeks gestation would result in a lower rate of neonatal morbidity and mortality compared to waiting until 40 weeks and five days for elective induction of labour (Einerson and Grobman, 2018). The trial showed induction of labour at 39 weeks in

low-risk nulliparous women did not result in a lower frequency of adverse perinatal outcome. However, the findings did report a decrease in the rate of caesarean sections from 22% to 19%, if care providers follow the same induction practices as were utilised in the study (Einerson and Grobman, 2018).

Risks of induction of labour to consider

As part of a balanced discussion of the induction of labour offer, the risks of induction of labour need to be shared with pregnant women. Aside from missing the hormonal benefits of spontaneous labour which include regulation of labour and birth and bonding (Amis, 2014); risks of induction of labour include failure to get labour started, uterine hyperstimulation, uterine rupture, cord prolapse, abnormal fetal heart rate pattern, infection, excessive bleeding post birth and still birth (Boluvain et al., 2001; NICE, 2021). A search of the evidence tables within the NICE guidance (2021) highlighted that it was difficult to obtain the prevalence statistics for each individual risk associated with induction of labour. However, some statistics are available, NICE (2021) highlights that the prevalence for uterine hyperstimulation associated with induction of labour is 5.8% and the prevalence of abnormal fetal heart rate pattern is 31.5% (NICE, 2021). The lack of specific statistics is likely due to the multitude of other variables and factors involved with induction of labour that may influence these risks. This highlights a potential barrier for health professionals when having discussions to convey statistics and risks and benefits to women.

The average length of labour following induction is longer than spontaneous labour and there is evidence that women find it more painful (Ostborg, Romundstad and Eggebo, 2017). Additionally, further interventions may be required if labour does not get started which increases the likelihood that women will need epidural analgesia for pain relief (Jacobsen et al.,2018; Rydahl, Eriksen and Juhl, 2019). Randomised controlled trials have associated induction of labour in healthy women and babies with a lower risk of surgical births (Einerson and Grobman, 2018). However, this has been challenged by other recent studies such as Ekeus and Lindgren (2016) and Nethery et al. (2023).

Term gestation

Globally, there is variation in the definition of preterm or term pregnancy, though most authorities agree that term birth is between 36+6 or 37+0 weeks and 41+6/42+0 weeks gestation (Europeristat, 2020; World Health Organsiation, 2022). There are increasing sub-divisions of this classification, with both clinical practice and research recognising early and late preterm, and early term divisions. The latter of which is generally measured 37+0 to 38+0 weeks of gestation (Europeristat, 2020). However, these definitions are based on standardised populations. Women's menstrual cycles vary in length, although gestational age is now usually confirmed by ultrasound scan. For optimal gestational accuracy and pregnancy planning in the United Kingdom, the NICE guidance for antenatal care recommends an ultrasound scan between 11+2 weeks and 14+1 weeks gestation (NICE, 2021). Guidance in the United Kingdom does not reference the accuracy of the dating scan for gestational age, although does reference within the information available that screening tests are not perfect (NHS England, 2025). Additionally, the physiological length of pregnancy varies accordingly between individuals. Overall, this means that accurate assessment of when a particular woman or fetus might be at risk of prolonged pregnancy is very hard to determine accurately.

In the United Kingdom, the definition of a term pregnancy used by NICE (2023) in its Intrapartum guideline is between 37 and 42 weeks of pregnancy ('term'). Within this gestational age range, NHS England (2022) have identified that over 20% of admissions to neonatal units of babies born at or after 37 weeks are avoidable. Therefore, there is currently a preventative national focus on reducing admissions at these gestations, particularly with respect to respiratory conditions, hypoglycaemia, jaundice and asphyxia (NHS England, 2022). The aim of this focus is also to assist with improvements to maternal mental health, breastfeeding and the long term morbidity of women and their babies as well as the operational and resourcing benefits that arise from reducing admissions and unnecessarily separating women and their babies (NHS England, 2022).

However, the reasons for such admissions are complex, since rates of adverse neonatal outcomes between 37 to 42 weeks gestation, vary widely across the

studies that have examined this factor (MacKay et al., 2010; Boyle et al., 2012; Sengupta et al., 2013; Hua et al., 2023; Carlhall et al., 2024) (Please also see page 28 ‘medically indicated and elective induction of labour,’). Given the large gestational range of five weeks for a ‘term’ pregnancy and the potential for neonatal morbidity at the earlier stages of this time frame, decisions about when to end an otherwise healthy pregnancy are difficult to tailor to individual women, especially when also considering their values, expectations, hopes and fears for their pregnancy, birth, and baby. Aligned with the guidance of NICE (2021), discussions about induction of labour for maternal request alone must involve informed consent, taking into account the woman’s circumstances and preferences. The relatively fluid notion of ‘term’ should be part of these discussions, especially when the decision is being made solely upon gestational age (Reddy et al., 2011;Tita et al., 2018; Bengtsson et al., 2023).

Beyond maternal choice, NICE (2021) recommends that women who have a pregnancy lasting longer than 41 weeks should be offered induction of labour even if there are no other complications. This is a change from earlier NICE intrapartum guidelines, when the recommendation was for an offer of induction at 42 weeks gestation. The suggested information for health professionals to share with women is that labour usually starts naturally before 42+0 weeks, but that evidence illustrates there may be risks associated with a pregnancy beyond 41+0 weeks, including the increased likelihood of caesarean section, an increased likelihood of the baby needing admission to a neonatal intensive care unit and an increased likelihood of stillbirth and neonatal death (NICE, 2021). The guideline goes on to recommend discussing with women that induction of labour from 41+0 weeks may reduce these risks but that women will need to consider the impact of induction on their birth experience when making the decision. It is also noted that for every 1000 low risk women who have their labour induced at 41 weeks gestation, two less stillbirths would occur (NICE, 2021). The potential impacts of having an induction of labour include the possible limitations on choice of place of birth, use of the birthing pool, an increased risk of an assisted vaginal birth, hyperstimulation caused by pharmacological methods of induction of labour, increased intensity of pain aligned with the pharmacological methods and a longer hospital stay (NICE, 2021).

This guidance is balanced, and informed by the current evidence base. However, it does not take into account the external validity of some of the included studies (that were not undertaken with a UK population) nor does it consider the inaccuracies in assessing gestational age by ultrasound, without taking into account the menstrual cycle of the individual. The fact that 998 women and their fetuses who are otherwise healthy will be induced to reduce stillbirth by two, implies that the specificity and sensitivity of gestational age is very poor for the outcome of stillbirth.

The application of ‘term’ to a wide gestational age range has implications for maternal and neonatal morbidity and mortality. When induction for simple post maturity is offered at earlier and earlier gestations, based on single studies that may not have validity in a UK setting, there may be important public health issues that are not currently being examined, especially in terms of longer term impacts on the neonate and the child (Reddy et al., 2011;Tita et al., 2018; Bengtsson et al., 2023).

Medically indicated and elective induction of labour

Inductions are considered medically indicated by health professionals when there are medical problems or pregnancy complications that make it less safe, statistically, to continue the pregnancy in terms of mortality or severe morbidity (Hastings-Tolsma and Goodman, 2012). Labour inductions that do not have a clear medical reason or indication for taking place are usually termed ‘elective’ inductions (Hastings-Tolsma and Goodman 2012; Dogl et al., 2018). In some cases, the reasons for elective induction of labour may be considered ambiguous. For example, maternal request may occur for social reasons, for example childcare problems in difficult family circumstances, whereby an induction of labour date offers some degree of certainty for childcare organisation which spontaneous labour does not enable as easily (Dogl, Romundstad and Berntzen, 2018). Or other non-medical reasons like the woman feeling so uncomfortable towards the end of her pregnancy that the thought of continuing her pregnancy any longer is distressing (Dogl, Romundstad and Berntsen, 2018). For maternal request, The National Institute for Clinical Excellence (NICE, 2021) recommends consideration in line with discussing the benefits and risks with the women, whilst also considering individual circumstances and preferences. However, according to Coulm et al., (2015), parity and organisational

factors influence the decision around elective inductions, and it is difficult to determine the specifics associated with this.

In terms of early elective birth, it is important to note that ‘term’ is classed as between 37- and 42-weeks’ gestation (Yuill et al., 2023). Previous research identified that admission to a neonatal unit was increased in association with elective induction of labour for all gestations before 41 weeks (for example, at 40 weeks gestation 8% in the elective group compared with 7.3% in the expectant management group) (Stock et al., 2012). Indeed, with more recent research, there is emerging evidence that birth between 37- and 38-weeks’ gestation (early term) may be linked to a range of adverse outcomes (MacKay et al., 2010; Boyle et al., 2012; Coathup et al., 2020). There may be cognitive benefits for babies when the pregnancy continues to 40-41 weeks (Murray et al., 2017). A study of Scottish schoolchildren found that the need for special education was highest among children born before 37 weeks (preterm babies) and then there was a continuous decrease in the need for special education until a low point at 41 weeks after which the risk rose quickly again (MacKay et al., 2010). It is therefore important for women to be aware of the research evidence showing poorer health outcomes for those who wait for labour after 41 weeks of pregnancy for post-dates instead of being induced at 41 weeks of pregnancy (Wise, 2019; Lindquist et al.,2021).

Informed consent

Informed consent is both a legal and ethical requirement for health professionals, originating from the patients right to direct what happens to their body (Supreme Court, 2015). Treatment cannot be given without consent unless care and treatment are needed in an emergency whereby it is not possible to gain consent due to the nature of the situation (Supreme Court, 2015). For informed consent to take place, a person must have enough information and understand it before making decisions and accepting risk (General Medical Council, 2022).

Within the sphere of health care, the information required to achieve informed consent includes a discussion around the risks and benefits of treatments, including any alternative options, the patient’s role in the treatment and the patients right to

refuse treatment (Royal College of Midwives, 2015). Overall, for a patient to give consent that is valid, there are three elements to be considered for gaining informed consent and these are disclosure, capacity, and voluntariness. In health care settings, disclosure refers to the health professional giving the patient the necessary information to enable them to make an autonomous decision and to ensure that they have understood the information that has been given to them (General Medical Council, 2022). Capacity pertains to the patients ability to understand the information that has been provided to form a reasonable judgement based on the potential consequences of said decision (Nursing and Midwifery Council, 2015). Voluntariness refers to the patients right to utilise their decision making without any external influences such as coercion or manipulation that may have an impact on their ability to make a decision (Supreme Court, 2015).

Within healthcare, informed consent discussions should be documented including the nature of the procedure, the risks and benefits of the procedure, reasonable alternatives and the risks and benefits of the same and the assessment of the patients understanding of all of the required elements (Royal College of Midwives, 2022).

From a legal perspective, the failure to provide appropriate information may also leave health professionals open to claims of negligence if the patient suffers harm as a result of the treatment. Furthermore, giving misleading information about someone's condition or the treatment that is being discussed, or not giving them the relevant information, may mean that consent is not valid. It is against the law to give medical treatment unless it has been agreed to by the patient (Supreme Court, 2015). Indeed, health professionals who do not respect the principals of informed consent may be liable both to legal action by the patient and also to action by their professional body (Supreme Court, 2015). Furthermore, employing bodies may also be liable for the actions of their staff (Supreme Court, 2015).

Within maternity care, it is important to emphasise that a woman who has been assessed to have mental capacity can decline treatment options that are offered to them during pregnancy and labour. In terms of induction of labour and informed consent, a women can change their mind and decline the induction at any time, including on the day of the procedure.

The legalities and principles around informed consent are discussed in more detail in the subsequent sections of this chapter.

The NHS history: informed consent

When the NHS was launched in 1948, maternity services were initially based upon a so-called ‘medical’ model of care that was managed by doctors, with midwives providing support (Lupton, 1994; Martin, 2001). The medical model assumes that pregnancy and birth are pathological conditions that need to be medically managed to avoid problems (Rothman, 1991). In the United Kingdom, by the end of the 20th century, birth within the hospital as opposed to at home had become the usual practice (Kitzinger, 1988). Oakley (1993) describes how there was opposition to the increasing levels of clinical intervention in labour and birth and this began in the 1950s, reaching a peak in the 1970s between feminist writers and middle class women (Cartwright, 1979; Langan, 1998; Kirkham, 2004a). The opposition to the medical model included groups such as the National Childbirth Trust and this then led to the Winterton report (House of Commons Health Committee, 1992). The Winterton report concluded that maternity care should not follow medical risk-based models but should be focused on what women would like from pregnancy and childbirth (Walton and Hamilton, 1995). The Changing Childbirth report (Department of Health, 1993) followed on from the Winterton report, whereby the focus was upon choice for women as well as the benefits offered by continuity of care (Sandall, 1995; Walton and Hamilton, 1995; Kirkham 2004a).

The Changing Childbirth report brought notions of informed choice into maternity policy in the United Kingdom (Department of Health, 1993). Several further policies followed on from this, including those from the Department of Health, (2004b; 2007b; 2008) as well as the Royal College of Obstetrics and Gynaecology (2008). In 2008, the NICE guideline for induction of labour described the need for woman centred care during induction of labour. The guidance highlighted that women should be provided with the opportunity to make informed decisions about their care options, in liaison with health professionals (NICE, 2008). This continues to be reinforced in the updated NICE guidelines on induction of labour (NICE, 2021).

Informed consent and shared decision making

Within the health setting, informed decision making is defined as a process whereby health professionals and individuals work together to select tests, management and interventions based on evidence and the individuals' informed preferences (Goldberg, 2009; GMC, 2020). Informed consent is a crucial element of care provision with adequate information regarding the risks, benefits, and alternatives of a care treatment being necessary for true informed decision making, particularly with evidence regarding risks related to interventions (Goldberg, 2009). Furthermore, informed consent assists with strengthening the relationship between health professionals and women and may address any anxieties many women face as they approach birth (Rothnie, 2019).

Shared decision making in maternity care is defined as an enquiry by the health professional and the woman aimed at deciding upon a course of care or not, which takes the form of a discussion(s) within which the health professional fulfils their duty of care to the woman's knowledge by sharing their complete evidence-based knowledge and expertise, including any risks and benefits (Begley et al., 2023). Ultimately, health professionals have a duty of care to ensure shared decision making is fulfilled when relevant knowledge is discussed, and when personal beliefs and biases that may impinge on decision making are disclosed (Begley et al., 2023). Furthermore, shared decision making ensures that individuals are supported to make decisions that are right for them. This forms a key component of universal personalised care bringing together the health professionals' expertise including treatment choices, evidence, risks, and benefits and additionally the patients' personal circumstances, values, goals, beliefs, and preferences (NHS England, 2023). However, it must be considered that informed consent and shared decision making may not be considered as one and the same. It could be argued that the term 'informed consent' should be used as opposed to 'shared decision making' as it is the woman's choice alone that counts and not a shared decision with health providers. Moreover, the law states that health professionals do not have the right to overrule the woman with the exception of the rare occasion when a woman is not competent to make a decision (see Montgomery vs Lanarkshire, page 31, discussed in the section below).

Overall, information is a key component in promoting woman centred care, with access to credible information being crucial to a woman's experience and wellbeing during pregnancy and childbirth (Vogels-Broeke et al., 2022; Lundh, Ovrum and Dahl, 2023). Furthermore, patient access to evidence-based information is imperative under the scope of informed consent and is central to its legal and ethical sanction (Goldberg, 2009). Information provision must be appropriate to the specific clinical situation to enable women to make an informed decision about their preferences and needs for care at each stage of their maternity experience (RCM, 2022). Informed consent forms part of national legislation in most industrialised countries and is the key principle of the Nuremberg code, concluded by judges at the end of the Nuremberg trials in 1945 and the subsequent Declaration of Helsinki drawn up by the World Medical Association and updated at intervals ever since (World Medical Association, 2014).

Montgomery vs. Lanarkshire

Notably, a landmark shift towards a more collaborative approach to decision making in the United Kingdom was ruled following The Montgomery vs Lanarkshire case (Supreme Court, 2015). The Montgomery case provided the highest level of legal support for work around patient safety, information and risk assessment in decision making (Supreme Court, 2015). This ruling involves first finding out what is 'material' to each individual patient (or, in the case of maternity care, childbearing women) and then ensuring that the information given is tailored to the issues that matter to her, and is adequate in that regard, being judged from the perspective of a reasonable person in that service user's position (General Medical Council, 2020). Prior to this, a doctor's duty to warn patients of the risks was based on whether they acted in line with a responsible body of medical opinion and this was known as the Bolam test (General Medical Council, 2020). In contrast, health care providers must now ensure provision of information about the risks that might matter to each specific woman, including any alternative treatments that may be available (The General Medical Council, 2020).

Since the Montgomery vs Lanarkshire case, the recommendations of national agendas have continued to emphasise the requirement for the assurances that informed consent is obtained for all procedures and treatments throughout a

woman's pregnancy journey. This includes the National Maternity Review which stipulated increased choice and personalisation as a recommendation (The National Maternity Review, 2015). The findings of a report of an investigation at the Shrewsbury and Telford NHS Trust maternity services, highlighted within its immediate and essential actions, the requirement nationally for all Trusts to ensure informed consent provision for women within maternity services (Ockenden, 2020). The Core Competency Framework also incorporates this and there is guidance available for personalised care and support planning within the NHS (NHS England, 2021).

Current guidance on informed consent

The NICE guideline for improving the experience of care for patients in the NHS (2021) covers the components of a good patient experience, aiming to make sure that all service users utilising NHS services have the best possible experience of care. This guidance is centred on knowing the patient as an individual, the essential requirements of care, tailoring healthcare services for each patient, continuity of care and relationships and enabling patients to actively participate in their care. Indeed, for maternity services, it is a woman's right to be involved in making decisions about the care she receives.

In terms of induction of labour, the NICE guidelines (2021) were written by women who have had their labour induced and by the health professionals that look after maternity service users and their families. The guidelines state that women should be given clear information, the opportunity to talk through options and that women's views and concerns should be listened to carefully. The information giving should include an explanation of how labour will be induced and discussions with women about which options may not be right for them. The discussions about induction of labour should include talking through any questions women may have, how induction of labour will affect a woman and her baby and what will happen if a woman decides not to have her labour induced. To ensure informed consent, discussions need to entail the different choices available are discussed with women and that care options and potential treatment are explored in detail along with the risks and benefits (NICE, 2022).

In support of informed decision making, NHS England and NHS Improvement (2021) highlight the need for personalised care to improve women's experiences and outcomes, empowering women to take control of their health and enabling health professionals to understand each woman's physical and mental health, therefore building a relationship of trust between the woman and the health professional. To achieve personalised care, NHS England, and NHS Improvement (2021) stipulate that preference of mode of birth must be discussed in early pregnancy accounting for individual circumstances. This must then be reconfirmed via antenatal visits towards the end of pregnancy as this may have changed. In terms of induction, it is stipulated that it must be explained to women that induction of labour is a medical intervention, that it will affect birth options and that induction of labour may not always be successful. Location, method of induction, pain relief, risks and benefits and alternative options must also be discussed (NHS England, 2021; NHS Improvement, 2021). Indeed, women need time to discuss, to look at information and to ask questions along with the opportunity to proceed, delay, decline or stop the induction of labour process, with contingency plans agreed along with evidence-based information and respect for women's decision making. Moreover, informed choice is central to personalised care with the requirement for women to understand their options. In addition to the benefits of trust, personalised care is known to have a positive impact on health inequalities, taking account of the wider context of people's lives and is most effective whereby there is continuity of carer. Culturally appropriate treatment and care and the information women are given about it is crucial and furthermore, information should be accessible to women, their partners, and families, considering any additional needs such as physical or cognitive disabilities and inability to speak or read English (Latif, 2020).

The General Medical Council and the Nursing and Midwifery Council

The General Medical Council (2020) stipulates the seven principles of informed decision making and consent to provide assurances that a patient's consent or other valid authority is confirmed before the provision of any treatment. For midwives, the NMC code which sets out standards for midwifery practice stipulates that midwives must always act in the best interests of people, inclusive of ensuring gaining properly informed consent and documenting it before carrying out an action. Furthermore, it

is essential to balance the need to act in the best interest of people at all times with the requirement to respect a person's right to accept or refuse treatment and additionally to keep to all relevant laws about mental capacity and to tell colleagues or a manager whereby there is a conscientious objection to a particular treatment to enable a suitably qualified colleague to take over (NMC, 2015).

Individual approaches to care provision must align with the Nursing and Midwifery Council's code and be specific to the clinical decision to enable women to make an autonomous choice to decline or to consent to care, which also includes the ability to change their decision (RCM, 2022). Furthermore, from an informed consent perspective, guidance from line manager, members of the multidisciplinary team or specialist midwifery services should be accessed when a woman's needs are outside the scope of a midwife's practice (RCM, 2022). Indeed, by promoting women's opportunity for active participation in health care issues and taking the time needed to recognise the woman's needs, midwives are working in compliance with the requirements for professional standards and best practice in women centred midwifery care (Lundh, Ovrum and Dahl, 2023). Ultimately, the notion of informed consent involves health professionals and patients working together to achieve women centred care as part of a dynamic process (Begley et al., 2019).

Informed consent and how it operates within NHS Trusts

Within the Trust where the research study was held, there is clear policy in place that sets out the standards and procedures for ensuring that health professionals are able to comply with the guidance for informed consent stipulated by the Department of Health. The policy describes all aspects of the consent taking procedure including that it must be voluntary, informed and the person must have the capacity to give consent. The policy encourages the health professional to discuss the benefits, risks, alternatives, and the outcome of the option of doing nothing. The policy sets out what to do in terms of informed consent if a person is lacking capacity, the process for decision making for children and young people, advance decisions and power of attorney, documentation, consent forms, the health professionals responsibility for seeking consent, emergency surgery, anaesthesia and consent, tissue as well as clinical photography and conventional or digital video recordings.

The Trust also refers staff to 'Choosing Wisely UK' which is a global initiative aimed at improving and optimising conversations between patients and health professionals (https://www.aomrc.org.uk/projects-and-programmes/choosing-wisely/).

However, despite all these policies and procedures, and in common with anecdotal practice in maternity care across the country, this research study suggests that informed consent is inconsistently implemented, with variations occurring for a plethora of reasons, as discussed throughout the chapters of the thesis.

Barriers to informed consent

In terms of information giving, studies have highlighted the importance of appropriate timing (Jay, 2018)**.** Adequate information helps to decrease stress and anxiety and support self-esteem and control (Vogels-Broeke et al., 2022). Stapleton, Kirkham, and Thomas (2002) describe the way in which information is presented as being a potential barrier influencing decision making, including passive dissemination of information, and choices that are offered but not then supported by health professionals.

Interestingly, whilst most women may have trust in health professionals in making the right decisions, they may not always feel their own level of engagement in the process is enough (Coates et al., 2019). Indeed, a significant proportion of women are reported to be lacking in information relating to labour induction, including alternatives, choice, reason for induction of labour, methods, process, risk factors and potential complications (Coates et al., 2021; Yuill et al. 2022; Harkness et al. 2023; Lundh, Ovrum and Dahl, 2023). Stapleton, Kirkham, and Thomas. (2002) carried out a study whereby it was observed that women infrequently asked questions or made requests for alternative options. According to Stapleton, Kirkham, and Thomas (2002), Begley et al., (2023) and Lundh, Ovrum and Dahl, (2023), some of the barriers to communication for health professionals may include lack of resources and time for discussion, restrictions of guidelines and policies, lack of confidence and skills and making decisions based on personal biases. Furthermore, there is evidence health professionals feel responsible for anything that goes wrong, with a widespread fear of litigation, thus leading many health professionals to lean toward the promotion of technological interventions which in turn results in defensive practice (Stapleton, Kirkham, and Thomas, 2002).

It is known health professionals may feel pressured by time constraints, with midwives in particular being concerned regarding time allocation for discussions whereby informed consent is required (Stapleton, Kirkham, and Thomas, 2002). Research by Stapleton, Kirkham, and Thomas. (2002) found that women accommodated health professionals by limiting their questions and complying with expected norms in their discussions with health professionals, who they perceived as being busy with little time (Stapleton, Kirkham, and Thomas, 2002). Such situations may in turn result in informed compliance as opposed to informed consent (Stapleton, Kirkham, and Thomas, 2002). Additionally, it has been argued that too much information and responsibility for decision making can have effects like those of not enough choice, leading to a sense of anxiety and loss of control (so called 'decision fatigue') (Jay, 2018; Vogels-Broeke et al., 2022).

Women's experiences

As previously touched upon, childbirth is influenced by a variety of health, social and care factors with a plethora of studies available on the effects of pregnancy and labour on postnatal physical as well as mental health (Schetter & Tanner, 2008; Adler, Rahkonen and Kruit, 2020; Cantwell, 2021). However, despite induction of labour being one of the most common interventions in maternity care, research on women's experiences with induction of labour is limited for both planned and unexpected induction (Backmann, Schwarz and Zenamaier, 2017; Adler, Rahkonen and Kruit, 2020; Blanc-Petitjean and Dupont, 2021; Nilver et al., 2022; Lundh, Ovrum and Dahl, 2023). The evidence that does exist indicates that women undergoing induction of labour are less likely to be satisfied with their care and childbirth experience compared to women with a spontaneous onset of labour.

Women may be concerned about the impact of induction of labour on themselves or the baby and more often express anxiety, neglect, insufficient pain relief, birth plans not being followed and disappointment if their labour induction is unsuccessful (Cheung, Wan-Yim, and Chan, 2007). For some women, induction of labour is a high-risk event viewed as a way of forcing something that their body was not ready for (Lundh, Ovrum and Dahl, 2023). Indeed, induction of labour may be a challenging experience and some women may have additional anxieties. There is a recognition of the relationship between increased maternal anxiety and adverse

physiological and psychological effects which has led to growing interest in the identification and targeted treatment of at-risk women (Tan, 2019).

Overall, despite legislation, guidance, and policies, it is unclear whether informed consent takes place consistently in routine care (Gammie, 2014 and Coates, 2020, Yuill et al., 2023). It is evident, there are a plethora of reasons associated with this. This may be understood in terms of a gap between women's needs and the reality of their experiences around information, decision making, support and the environment (Coates, 2019). Recent research identified a 'double discourse' revealing a difference between what is expected to be said and what is actually said (Yuill et al. 2023). Indeed, debate continues as to whether advocacy of informed consent in maternity care is more rhetoric than reality with the sphere and authenticity of informed consent appearing to be limited (Skyrme, 2014). Additionally, there is extremely limited research regarding the experiences of health professionals involved with the process of induction of labour (Coates, 2021). Furthermore, due to the various debates in this field, there is some tension in the literature regarding when induction of labour is warranted and when not, with variability noted between guidelines and practice (Coates, 2020).

Middleton (2020), Coates (2020) and Erksine (2019) emphasise the role of education and information provision for women and health professionals in assisting with informed choice. Decision aids, antenatal classes, tailored counselling, communication training for health professionals to improve the quality of information available to women to enhance informed decision making are all recommended (Coates, 2019). Furthermore, compassionate support from partners and health professionals is also paramount to the process around all these factors and may benefit women by facilitating a sense of ownership or control of labour (Coates, 2019). Sometimes there are situations whereby risk of intervention versus no intervention for a woman and her baby are unclear and, in such circumstances, unbiased information and support for decision making may be beneficial when obtaining informed consent as key factors in reducing early elective births (Bonsack, 2019). Bonsack (2019) adds to this by discussing the potential implications that this can have on women and their families as well as the associated cost with induction of labour and the impact this can have on maternity services.

In addition to the clinical and psychological issues that might influence the experience of induction of labour, organisational constraints are also relevant to informed decision making. Recent studies have indicated that the steep rise in induction of labour has led to backlogs, with women who are admitted for induction and who have been told their baby is at risk, now waiting, sometimes days for the procedure to take place (Rothnie, 2019). This may lead to women's experience of childbirth being significantly affected by resource problems and makes it difficult to differentiate poor experience of induction of labour from poor experience of childbirth due to a lack of staff and the inadequate care that may then be associated with this (Harkness et al., 2023).

As highlighted, the decision for induction of labour is not one that should be taken lightly, with appropriate counselling of the woman about the indications, risks, benefits, and alternatives to induction of labour taking place to ensure the woman can make a decision that works for her (McCarthy 2011, Tan 2019). Finally, the thorough documentation of the provision of information is essential to ensure that decision making is clear for women and for health professionals (McCarthy, 2011).

In summary, making informed choices during childbirth can be complex and multifactorial and achieving informed consent may not always be realised (Goldber, 2009; Begley et al., 2019). Induction of labour is an intervention with the potential to negatively impact on and disrupt a woman's birth experience (Jay 2018, Lundh, Ovrum and Dahl, 2023). A poor childbirth experience plays a role in well-being after birth, future family planning, and subsequent pregnancies and births and may impact on women and their health in the short term as well as long term (Adler, Rahkonen and Kruit, 2020; Lundh, Ovrum and Dahl, 2023). Thus, considering the increasing rates of induction of labour, optimising the maternal childbirth experience in induced labour is crucial (Adler, Rahkonen and Kruit, 2020).

Indeed, the importance of informed decision making cannot be underestimated (Goldberg, 2009). Ultimately, the timing, quality and quantity of information provided is absolutely crucial for effectiveness in assisting women with reassurance and predictability, even in challenging situations (Lundh, Ovrum and Dahl, 2023). To be

effective, the process of informed decision making needs to start in the antenatal period, as part of developing a trusting relationship between health professionals and women, and to continue throughout pregnancy (Begley et al., 2023). The notion of informed choice carries great potential to resolve many of the issues faced by maternity services and a partnership between midwives and/or obstetricians with women in decision making and would hugely reduce the burden of responsibility presently experienced by health professionals (Stapleton, Kirkham, and Thomas, 2002). Therefore, the provision of information and preparation of women for what to expect during induction of labour is key to informed choice, particularly where the risks and benefits are not easily quantifiable (Jay, 2018). Indeed, midwives and obstetricians need to be able to engage with women in a balanced discussion of the relative risks of induction and that of expectant management (Jay, 2018). Women should be given individualised information, considering of their clinical status, social and cultural background, and their desire for choice information (Jay 2018; Lundh, Ovrum and Dahl, 2023). Therefore, and in view of pregnancy and childbirth having the potential to influence future health and family planning, further studies on factors and interventions affecting the maternal childbirth experience are required (Adler, Rahkonen and Kruit, 2020).

Research study aims and objectives:

To enhance and add to the current knowledge in the area of induction of labour and informed consent, this research study utilises a triangulated approach to explore women's and health professional's experiences, views, and beliefs, focusing upon induction of labour in relation to informed consent, for women with medical indications for induction, as well as those who are induced for maternal request, and for post maturity.

Aims:

The overall aim of the research is to gain understanding of the nature and experiences of informed consent and information sharing in the context of induction of labour for women with term pregnancies, for maternity service users as well as for midwives and obstetricians. It is important to note that the interest of this study focuses on how informed consent for induction of labour is used in the United Kingdom. Different legal structures mean that this might not be the same elsewhere.

In the United Kingdom for example, the fetus does not have a legal status until it is born but this is not the case in other countries.

The structure of my research study is then broken down into three phases:

Phase 1: A systematic review of the literature.

Phase 2: Online questionnaire for antenatal maternity service users who are having discussions around induction of labour.

Phase 3: Semi-structured interviews with postnatal maternity service users and semi-structured interviews with midwives and obstetricians as well as a discussion group with midwifery leaders.

The research question for the three phases of the research were specified as follows:

Phase 1 research question:
"How are the principles of informed consent applied when induction of labour is discussed with women with pregnancies that have reached term gestation and *"what are the experiences and implications for women and midwives and obstetricians?"*

Phase 1: A systematic literature review to explore the research evidence regarding how informed consent is applied when induction of labour is discussed with women with a full-term pregnancy and what the experiences are for women, midwives, and obstetricians within the maternity unit.

Phase 2 research question:
"How do women experience informed consent discussions when they are offered induction of labour at or beyond 37 week's gestation of pregnancy"?

Phase 2: An online questionnaire for women with pregnancies that have reached term gestation who have had discussions with a midwife and/or obstetrician regarding induction of labour.

Phase 3) A) research question:

"What do postnatal service users say about communication with health professionals regarding induction of labour"?

Phase 3) A): Interviews with women who had their labour induced who are now in the postnatal period to discuss their experiences of the decision-making process for induction of labour and their experiences around induction of labour.

Phase 3) B) research question:

"What are midwives and obstetricians' views and experiences of communication with maternity service users regarding induction of labour beyond term gestation?"

Phase 3) B): Interviews with midwives and obstetricians regarding their experiences of conversations with women around the decision-making process for induction of labour.

Phase 3) C) research question:

"What are midwives views on the impact of induction of labour on maternity service users birth experiences and the wider experiences for staff in the birth suite environment?"

Phase 3) C): A discussion group with midwives regarding their experiences, views, and beliefs around the induction of labour process.

Objectives:

1.To explore women's experiences of informed consent and induction of labour and how it impacts on women's overall birth experience.

2.To explore midwives and obstetricians' experiences, views, and beliefs of women's informed choice and consent for induction of labour and how it impacts a woman's overall birth experience.

3.To generate new knowledge to facilitate a greater understanding of informed consent regarding induction of labour.

4.To identify any barriers and constraints regarding informed consent.

5.To identify enabling factors regarding informed consent.

6.To identify key recommendations to inform any potential quality improvement initiatives for the process of informed consent for labour induction between midwives, obstetricians, and women.

Thesis structure

The thesis contains eight chapters, and these are summarised as follows:

Chapter 1: This chapter contains the introduction to the thesis and provides the context to the research project, including an overview of induction of labour and informed consent and its importance and relevance for maternity services. Further to this, the chapter sets out the aims and the objectives of the research study along with the research questions to be answered.

Chapter 2: This chapter contains the methodology for the three research phases of the thesis. It includes an exploration of the philosophical stance which assisted with the formation of my methodological approach and research questions for the study. The process of and aspects involved with ethical approval, data collection, analysis and interpretation and application of academic rigor are all detailed within this chapter. Also included is an exploration of reflexivity and the ethical challenges encountered during the research and the data collection process whilst holding a dual role as a Midwife Matron and as a Professional Doctorate student and the potential impact upon the participant/researcher relationship.

Chapter 3: This presents the findings of the systematic review of the literature (Phase one of the research study).

Chapter 4: This presents the findings of the online questionnaires undertaken with maternity service users (phase two of the research study).

Chapter 5: This presents the findings of interviews with postnatal maternity service users (part of phase three of the research study).

Chapter 6: This presents the findings of the interviews with midwives and obstetricians as well as the discussion group with the midwifery leaders (part of phase three of the research study).

Chapter 7: This chapter presents the general discussion of the findings of the research study including the identified strengths and limitations.

Chapter 8: This is the concluding chapter and provides an overview of the research study's original contribution in relation to my philosophical stance. Additionally, a wider discussion of the constraints, protective and enabling factors to informed consent for labour induction is presented within this chapter. The chapter also contains suggestions for further research.

Chapter 1: summary

This chapter provides a brief overview of induction of labour and informed consent. An overview of how the findings and analysis address the aims and objectives of the research study along with the research questions is also provided. To provide the context, my philosophical stance upon which the research study is based is discussed in chapter 2 along with my personal reflections.

CHAPTER 2

Methodology

Introduction

This chapter discusses how the research study was designed. This includes an exploration of the philosophical stance which helped with deciding upon my methodological approach and my research questions. The processes involved with ethical approval, data collection, analysis and academic rigor are all detailed within this chapter. Also included is an exploration of my reflexivity and the ethical challenges encountered during the research study whilst maintaining a dual role as a Midwife Matron and as a Professional Doctorate student, and the potential impact that this may have upon the participants and the researcher relationship.

The researcher's ontological and epistemological viewpoint along with the questions identified for any research project assist with both the design as well as the direction of any research (Mason, 2017). My interpretive ontological view is that reality does exist but that it may be interpreted in differing ways and my epistemological view is that some aspects of reality can be measured objectively, but that others can only be interpreted subjectively (Crotty, 1998). Therefore my chosen philosophical stance for the research study was pragmatism. I identified that a mixed method approach utilising qualitative and quantitative methods would optimise access to meaningful data for the questions that I was interested in exploring for my research study.

Philosophical stance

The philosophical stance adopted for research must be in keeping with the researcher's understanding and ideas of the nature of the world ('ontology') and how to understand it ('epistemology') (Savin-Baden and Howell-Major, 2013; Mason 2017). Thus, identifying the philosophical stance that the researcher plans to use is the initial task in the design of a research project once the research topic area has been chosen, and before creating the research questions that lead to the methods for data collection and the frameworks for analysis (Savin-Baden and Howell, 2013; Mason, 2017). The philosophical stance then enables the data collection methods to follow in a logical order.

The chosen philosophical perspective for my research study is pragmatism and this is based on the philosophical tradition founded in the United States around 1870 by Charles Sanders Peirce, William James, and John Dewey (Cherryholmes, 1992). Pragmatism is a philosophical tradition that considers words and thoughts as tools and instruments for prediction, problem solving and action. It rejects the idea that the function of thought is to describe, represent or mirror reality. Pragmatism provides a philosophical approach that draws upon both qualitative and quantitative research methods and is therefore ideal for mixed methods research (Cherryholmes, 1992). Pragmatism enables an approach that is pluralistic and is used to gain knowledge through various methods, views, and assumptions, as well as several types of data collection and analysis (Morgan, 2007). Crotty (1998) describes the pragmatic perspective as enabling an approach that is action based and focuses on problem solving to enable new knowledge and ideas to enhance services.

Qualitative research is described as a way of examining behaviours, perspectives, and experiences and enables an exploration of how people think, learn, and develop their understanding (Brinkmann and Kvale, 2014). Qualitative research takes a subjective approach, that reality is only understood through the subjective impressions of human beings (Savin-Baden and Howell-Major, 2013). Barbour (2013) states that qualitative methods can and should provide explanations which go beyond the descriptions of lived experiences. This is in contrast to quantitative research, which follows ontological and epistemological traditions that identify reality as an objective phenomenon that exists independently of human beings, and that, if we had the right tools, can be completely measured, counted, and explained (Savin-Baden and Howell-Major, 2013). Although qualitative research and quantitative research come from different philosophical stances, they are both brought together in pragmatism (Onwuegbuzie and Leech, 2005).

For my research study, I aim to look at what is fact, for example, the incidence of induction of labour, and about how those facts are interpreted, through the relevant views and experiences. Therefore, pragmatism is ideal as it addresses both of these perspectives in terms of qualitative research (subjective epistemology) and quantitative research (objective epistemology). From the perspective of a conceptual

framework, I came to the data without this as my plan was to discover what emerged from my data collection with minimal preconceptions.

Research questions

The overall study question and the sub-questions are detailed in Chapter 1 (background and introduction). This chapter discusses how the sub questions were looked at methodologically. The questions were developed following extensive reading of existing studies relating to decision making for induction of labour, and by reading the general literature around induction of labour and informed consent. This also included refreshing my knowledge of local and national policies and guidelines on induction of labour. Based on my philosophical stance, I decided to collect data to explore the experiences, views and beliefs of maternity service users, midwives, and obstetricians in relation to induction of labour and informed decision making. To answer the research questions that I had planned for, I designed a three phased approach. This consisted of a systematic literature review, followed by a questionnaire for antenatal maternity service users and then one-to-one interviews with postnatal service users, as well as midwives and obstetricians and a discussion group with midwives. I identified initial research questions in the first stages of my planning which was also based on my own experience and knowledge as a practicing midwife and this was done in conjunction with my supervisory team. A further crucial consideration was how the data that I collected would fit with all three phases of my research.

Qualitative data can offer a wealth of understanding and depth (Skinner, Tagg, and Holloway, 2000) which for the purpose of my research complements the quantitative approach of collecting numerical data (Cresswell, 1994). Teddlie and Abbas (2009) describe a mixed methods research approach as addressing a range of confirmatory and exploratory questions at the same time with both the qualitative and quantitative approaches, thus ensuring the provision of the opportunity for a much larger selection of a variety of views. Indeed, it is imperative that all researchers include strategies that enhance the credibility of a study during both the design and the implementation of their research (Noble and Smith, 2015). Therefore, I opted for a triangulated approach to enhance the credibility of my research study through the optimisation of a variety of sources of data collection.

Ethical approval

The ethical principles of autonomy, beneficence, non-maleficence, and justice, challenge all researchers to think about the harm to the person(s) involved in their research and to ensure they do all in their power to minimise any risks (Ledward, 2011). Therefore, after I had started the initial planning stages, the next step was to obtain ethical approval for my research study. I prepared more than twenty papers for submission for ethical approval for the three phases of my research. This included all the participant information sheets (appendix 1, 2, 4 and 5), the consent sheets (appendix 3 and 6), along with the questions for the questionnaire with maternity service users (see appendix 8), the questions for the interviews with maternity service users (see appendix 9), the questions for the interviews with health professionals (see appendix 10) and the questions for the midwifery discussion group (see appendix 11).

As part of the process, the ethical approval documentation was reviewed by the University of Central Lancashire (UCLAN) integrated research application system sponsor. Following this review, the documentation was submitted to the Health Research Authority in October 2021 (IRAS reference 296491). However, I experienced some administrative issues with the IRAS application process which subsequently led to a delay of three months to the final ethical approval being received. Just two minor amendments were required to the documentation, and these were then incorporated into the final versions of the documentation.

The application for ethical approval was granted by the Research Ethics Committee (REC), the Health Research Authority (HRA) and UCLAN ethics on the 4th of January 2022 (reference 21/LO/0792). I then logged my study with the Research and Development department at the Trust where the data collection for the research was taking place (reference Dev006).

Managing dual roles - reflexivity

As part of the planning for my research and data collection, there were various aspects that were important to consider to ensure the rigor, validity, credibility, and trustworthiness of my study. Indeed, the researcher's background has an impact on

what they choose to investigate and this includes the angle, the methods, as well as the interpretation of the findings (Malterud, 2001). Two of the aspects for my consideration included reflexivity and additionally, how I would manage my dual role as midwife matron and as a professional doctorate research student.

Reflexivity is described as a set of continuous, collaborative, and multifaceted practices through which researchers self-consciously critique, appraise, and evaluate how their subjectivity and their context influence the process of the research (Olmos-Vega et al., 2022). Indeed, how the researcher situates themselves in relation to the focus of the study and the potential participants of the study is the start of the process of reflexivity and is crucial to ensure qualitative research that is rigorous (Kingdon, 2005).

The importance of midwifery research to practice cannot be overstated (Ledward, 2011). The benefits of being in a dual role when conducting research include increased clinical relevance of the research questions, ease of gaining access to the clinical setting to conduct the research, bringing clinical expertise and insider perspectives to the research, having researchers who are trusted by participants which in turn may encourage participation and finally, having researchers who are keen to disseminate findings (Jean et al., 2016). However, the dual role of being a health professional and a researcher can also create challenges from an ethical and methodological perspective due to the expectations that participants may have, orientation, and the competing obligations of the researcher (Jean et al., 2016).

Therefore, to try and counteract some of the challenges associated with being in a dual role as midwife matron and as professional doctorate research student and as part of a strategy to maintain reflection, reflexivity, and to counter any research bias, it has been crucial for me to use a reflective notebook from the onset of my research study. According to Savin-Baden and Howell-Major (2013), reflexivity enables the researcher to acknowledge that they are both integral as well as being integrated into the research and therefore cannot remain outside the subject. Furthermore, reflexivity enables the researcher to embrace and to value their subjectivity (Olmos-Vega et al., 2022). Therefore, reflexivity in the context of my research study has involved an analytical scrutiny of myself as a researcher and how my position in

relation to the subject and the participants may influence the data collected and also my understanding of the data. A further consideration as part of the reflexivity process was the perception that the participants may have of me. The use of a reflective notebook therefore enabled me to record my feelings, planning and decisions, in addition to my progress with the study. In turn, this assisted with the maintenance of academic rigor as well as professional accountability in relation to my dual role as a midwife matron and as a student researcher.

From a reflexivity perspective, my knowledge, and my involvement with induction of labour came from a variety of sources pertaining to my midwifery education and my midwifery career, working in various positions throughout the maternity unit over the years. I gained my place as a student midwife in 2002 and during this time and when I began my midwifery career it was apparent to me that in many cases, although the process for induction of labour varied, it was frequently a lengthy process often leading to further medical interventions. As a clinical midwife based on the central birth suite for over 7 years, I cared for many women who were having their labour induced for a variety of reasons. During the last ten years as a midwifery manager, matron, and more latterly as consultant midwife, I have noted the direct impact on staffing, time and resources and the strain that the volume of induction of labour can place on maternity services from admission to antenatal ward, to intrapartum care, to postnatal care and to care in the community following discharge. This is due to induced births frequently leading to higher rates of medical intervention and women requiring greater levels of care. The additional care and interventions can lead to trauma for women and their families. Whilst many inductions are necessary to improve outcome, I had noted that on a regular basis women were having their labour induced for social reasons and non-medical reasons such as school holiday dates. Other indications for induction of labour had included carpal tunnel syndrome, anxiety, and non-familial previous stillbirth. Based in the antenatal ward setting, I had noted that queries from women and their partners regarding all aspects of induction of labour including the length of the process are not uncommon occurrences following admission for induction. Overall, it has become apparent to me over the years that there is frequently a disparity between women's expectations of induction of labour and their actual experience. Furthermore, in my post as matron and more latterly as consultant midwife, managing complaints and holding

debriefs linking into expectations for the induction of labour process led me to think about whether women are making truly informed choices regarding having their labour induced. Therefore, my personal experiences and reflections during this time are what sparked my interest to undertake this research study.

Study setting

The data collection for my research study was based on one site. The sociodemographic of the area is diverse and this was mirrored in the survey responses (see Chapter 5, Findings).

In terms of demographics of the area, the English indices of deprivation (Ministry of Housing, Communities, and Local Government, 2019) indicates that the area that the Trust where my research project was undertaken is within the most deprived 10% of the lower tier local authorities in England.

Like all Trusts throughout the UK, induction of labour is a routine occurrence with induction guidelines in keeping with other maternity units throughout the country.

At the Trust where the research study took place, in terms of patient experience, it is pertinent to note that the Care Quality Commission survey (2023) highlighted that 96% of women who responded to the maternity survey said they had ‘confidence and trust’ in the staff caring for them during labour and birth.

Research methods

The overarching study question and the sub-questions are detailed in Chapter 1 (background and introduction).

Phase 1 – systematic review

To assist with the flow of the chapter, the methods for the systematic literature review can be found in Chapter 4, Systematic literature review, page 75.

Phase 2 – Questionnaire for antenatal maternity service users

Table 2

Questionnaire for maternity service users:	
Inclusion criteria:	**Exclusion criteria:**
Women over 18 years of age at the time of consenting to the study	Maternity service users with a limited understanding of the English language
Women able to speak, understand and read English	
Women accessing discussions about labour induction for a term pregnancy	
Women accessing care at the Trust where the research study was taking place	

Recruitment and sampling:

For this aspect of my research, I developed an English language online questionnaire utilising Qualtrics web-based software. It was designed to be completed by maternity service users with term pregnancies who had been offered induction of labour. The objective of the questionnaire was to enable the exploration of women's specific views, beliefs, and experiences in relation to the research question. The information obtained from the systematic literature review (phase 1) assisted me with my thoughts and planning to inform the questions for the questionnaire. The questions were based around the indication for induction of labour, where the decision was made, how the decision was made, if the woman felt fully informed about the process and the rationale, input of the birth/support partner with the decision-making process, how the woman reached her decision, who helped her make the decision, and if she received any decision aids such as leaflets, or any further information.

As part of the planning phase, projected recruitment numbers for the questionnaire were in line with the birth rates at the Trust where the research took place. In 2019, 5662 women who were booked at the Trust reached 37 week's gestation with 1643 women reaching between 37- and 39-weeks' gestation (29%) and 4019 women

reaching 39 weeks or beyond (70%). Assuming an uptake of 50% of those eligible for the survey, I anticipated that it may be possible to recruit 471 women over a time scale of eight weeks. Data from the Trust in 2019 shows 6405 of the women booked in maternity services understood English which is almost 100% of women using the service. However, there are issues with both data input and data collection and reporting, therefore accuracy of this figure cannot be deemed as wholly reliable. Purposive sampling was used whereby all women admitted to the antenatal ward for induction of labour were included. Potential participants were maternity service users on the antenatal ward who had had conversations with either midwives and/or obstetricians regarding having their labour induced. However, there were limitations to this which are discussed further in Chapter 6, some examples of which include non-English speaking women, women who it was not appropriate to approach i.e., they were in pain and finally, midwives on duty not handing out the questionnaire.

I created an information sheet for maternity service users, detailing the specifics of the questionnaire. This contained a quick response (QR) code linking to the online questionnaire to enable women to answer a series of questions about how they felt about discussions with midwives and/or obstetricians regarding induction of labour (appendix 1). The participant information sheet was distributed by the lead midwife for the antenatal ward to women who had reached term gestation if induction of labour had been discussed with them by a midwife and/or an obstetrician. I also distributed participant information sheets. In liaison with the lead midwife for antenatal ward, I checked on a regular basis that all the eligible women attending had received a participant information sheet.

The questionnaire contained a mixture of open and closed questions to enable collection of information to describe, compare and explain views, beliefs, and experiences. The questionnaire platform enabled service users to change their answers as they went through the survey, and/or not to submit their responses if they decided not to finish the questionnaire part way through. The last section gave participants the opportunity to leave their email address to be involved in on-line interviews in phase three of the study.

As part of my planning, it was imperative to balance the needs of valid and reliable research with any ethical concerns. Ideally given the demographics of the Trust where the research took place and given the disparities in outcome between Asian and Black women and White women, the questionnaire would have been translated into different languages. However, due to the limitations of funding for my study and the limited resources available to me within the given time frame, unfortunately this was not a feasible option. This thought process included discussions with my academic supervisors and was considered in line with the need for ethical consciousness at all stages of the research process (Sherlock and Thyne, 2020).

Questionnaire analysis

The quantitative responses to the questionnaire were analysed with SPSS statistics. SPSS statistics is a statistical software suite for data management and analysis which is simple to use (Gogoi, 2020). Spss is thought to be a much more efficient instrument than other available spreadsheets (Rahman and Muktadir, 2021) and is one of the most widely used statistical software packages in health research (Muacevic and Adler, 2021). The findings of the data obtained from the questionnaire are reported in a variety of ways within the tables (Questionnaire findings, Chapter 4).

Phase 3 – Interviews with midwives, obstetricians, and postnatal maternity service users

Table 3

Interviews with postnatal maternity service users	
Inclusion criteria	**Exclusion criteria**
Women whose labour was induced at or close to term	Maternity service users with a limited understanding of the English language
Women over 18 years of age at the start of the study	
Women able to speak, understand and read English	

Women with a term pregnancy accessing discussions about labour induction	
Women accessing care at the Trust where the research study is taking place	

Table 4

Interviews with midwives and obstetricians	
Inclusion criteria	**Exclusion criteria**
Midwives and obstetricians who have discussions with maternity service users about induction of labour as part of their job role	Midwives and obstetricians who do not have discussions with maternity service users about induction of labour as part of their job role.

Table 5

Midwifery discussion group	
Inclusion criteria	**Exclusion criteria**
Midwifery leaders who co-ordinate activity throughout the maternity unit	

Recruitment and sampling

The recruitment of the postnatal maternity service users to the interviews was via the phase two questionnaires. Within the concluding section of the questionnaire, maternity service users were asked to leave their email addresses if they would like to take part in further research.

Additionally, phase three of my research study also involved interviews and a discussion group with midwives and obstetricians. For the interviews, I used purposive sampling to approach and invite individuals whose job role specifically entailed them having discussions with women regarding induction of labour. The project plan was for a small sample of five health professionals who were especially experienced in the area, to enable me to gain in-depth insights into the topic area.

My research proposal and ethical approval were designed to this end. The recruitment took place via email and verbal conversations to describe the purpose of the research utilising the participant information sheets.

I also held a discussion group with five midwifery leaders who I invited to take part due to their involvement with co-ordinating workload, including induction of labour, throughout the maternity unit. The midwifery leaders were selected for the discussion group via purposive sampling due to being the lead midwife for their respective area of the maternity unit, for example, antenatal ward, birth suite and postnatal ward. This enabled the viewpoints, beliefs and experiences of the midwifery leads for each different area that admits women having labour induced throughout women's induction and labour journey to ensure a representation of the views of operations and resources within all areas of a maternity unit.

Purposive sampling methods are common within both qualitative and mixed methods research. However, they may create limitations in terms of the reliance upon the researcher's judgement when identifying the individuals to take part to achieve the objectives of the study.

In the case of this study, Consultants as opposed to middle grade obstetricians were included in my study. Middle grade obstetricians may have brought a different perspective, in terms of views, experiences and beliefs so this would be a consideration for future research.

Participant information sheets were designed as part of the ethical approval process to ensure that participants were fully informed of what was involved with the interviews and discussion group before taking part (appendices 2, 4 and 6). A consent form was created, and this included the opportunity for participants to withdraw up until a month after taking part should they wish to do so (see appendices 3,5 and 7).

The number of interviews with the postnatal maternity service users was not pre-determined. It was planned that final numbers would be concluded when a saturation of themes was reached via the ongoing analysis of the interviews. However, due to a

lower than anticipated response rate to the postnatal maternity service user interviews, my focus needed to adapt and rather than aiming for maximum variability, it became evident that I would need to work with a small sample size for this aspect of my research. For the interviews with health professionals, for a reasonable and achievable sample size given the small scale of this research study, it was planned that two consultant obstetricians and three midwives would be interviewed and that a discussion group would be held with all the midwifery leaders who co-ordinate the activity throughout the maternity unit. The interviews were based on a sample of the multi-disciplinary team who hold conversations with women on a regular basis about induction of labour decisions.

Data collection methods

The interviews were all held via Microsoft Teams and took place at mutually convenient times over a period of five months between March and August 2022 with interviews lasting between 15 and 60 minutes.

Confidentiality, consent, and data protection

To protect participants and maintain public confidence in research, it is crucial that all research is conducted lawfully, with honesty and integrity and in accordance with good practice (General Medical Council, 2024). As evidenced within my ethical approval, all the measures taken for confidentiality, consent and data protection for the research study were in line with the data protection policy (UCLAN, 2020) and the IT security policy (UCLAN, 2016-2017) which in turn were compliant with the general data protection regulation (GDPR) and the data protection act (2018). Furthermore, the measures taken were in line with the Midwives' professional code of conduct (Nursing and Midwifery Council, 2018).

For the phase two questionnaires, the participant information sheet was handed out to maternity service users just prior to them completing the questionnaire. The participant information sheet contained a quick response (QR) code linking to the online questionnaire on Qualtrics. The consent section was contained at the beginning of the questionnaire and participants could not progress with the questionnaire without providing their consent.

For the phase 3 interviews, potential participants were sent the participant information sheets and consent sheets via email prior to the interviews taking place. The participant information sheets were also discussed by me verbally with maternity service users, midwives, and obstetricians as part of the consent taking procedure prior to the interviews. Participants were assured within the participant information sheets of the safe and confidential storage of data. As part of the consent taking procedure for the questionnaires and for the interviews, participants were assured that their names would be replaced by pseudonyms to ensure that the risk of identifying individuals was minimal. It was explained to participants that quotations might appear in published reports, be used for teaching purposes and to potentially inform a toolkit for future maternity care provision. As part of the consent taking procedure and the information sheets, participants were informed that their information would not be disclosed to any third party without their consent, unless there were significant concerns about the woman or for someone else's safety. The participant information sheets, and the consent sheet contained information regarding the rights of individuals to participate or to withdraw from the study.

The consent taking for the interviews and for the discussion group was recorded face to face with the participants on Microsoft Teams. The consent recordings were undertaken separately to the interviews, and this was done immediately prior to the interview recordings. After I had completed the consent recordings and the interviews on Microsoft Teams, I immediately downloaded the recordings and then uploaded them to the relevant folders on UCLAN's secure one drive to ensure confidentiality.

Ethical considerations

Within the participant information sheets for the questionnaires, the interview and the discussion group, the following information was included:

"There may not be any direct benefits to you of taking part. We hope that you may find it useful to think about your experiences, and the information you give us will help us inform maternity care provision for current and future practice."

Within the research study, the participant's well-being was supported by the information sheets (see appendices 2,4 and 6) which described the specifics regarding the method of data collection and how the data would be used. It clearly stated the right for participants to decline to take part in the study or to withdraw from the study within a given time. The sheets also assured anonymity and confidentiality within any written work and gave details of the methods for storage and destruction of the data. My contact details were included on the information sheets and maternity service users, midwives and obstetricians were encouraged to get in touch if they required more information later. In relation to risks, my planning included the potential for participants to become distressed due to the sensitive nature of the research area. Therefore, signposting was made available within the participant information sheets. This included the Trust's wellbeing mechanisms and occupational health for staff as well as counselling services and national support groups for maternity service users. This is all in keeping with the participants' wellbeing which is one of the main priorities of a researcher (Ledward, 2011).

Phase 3

Interview timings

From a review of the relevant research, there appeared to be no consensus on the ideal time to interview women after they have experienced labour induction. Dunning, Harris and Sandall (2016) concluded that for labour and birth experiences in general, the best time to talk to women so that they remember the details, is after the so called 'halo effect': i.e., between six and 18 months after giving birth. Dunning, Harris and Sandall (2016), concluded that interviewing women prior to six weeks post birth may interrupt the initial parenting experience and does not enable women enough time to fully process their birth experiences. Waldenstrom (2003) and Waldenstrom and Schytt (2008) found there to be significant variation in recollection, whilst Simpkin (1991) found that memories still remained vivid for women when interviewing them between 15- and 20-years post birth. Rijnders et al., (2008) found women became more critical about their experiences three years post birth.

My research study was designed to be effective upon the service provision of current maternity care and I therefore needed evidence of recent rather than older experiences. Therefore, I decided to interview postnatal women as soon as feasible

following the completion of the phase two questionnaire. This is on the basis that the best time for interviewing women post birth should be decided upon aligned with the aims of the study (Hodnett, 2002). I was also aware that by the time phase two was completed, the maternity service users would have been discharged from midwifery care and that this timing would also help with the research in terms of reducing the risk of any confusion that may have arisen from my dual role as midwife matron and as professional doctorate research student. Additionally, I also felt that this would ensure that pregnancy and birth experiences would still be clear and that women would have had some opportunity to settle in at home with their babies to help give the time required to partake in an interview.

Interview setting

Discussions of qualitative research interviews have focused on the optimal researcher and participant style of interactions with interviewers framed as being the instruments that are pivotal to this process (Knapik, 2006). There are debates over the quality of data collected via different methods and some researchers would argue that face to face in-person rather than telephone or on-line interviews allow the researcher to develop a better rapport and to notice any social cues (Opdenakker, 2006). Indeed, historically, qualitative interviews have been conducted in person. However, due to the ongoing Covid 19 pandemic, interviews have increasingly been held by a variety of different methods which also has the benefit of enabling a greater degree of flexibility (Azad et al., 2021). Being able to talk to researchers online may also be better for women who have recently given birth, as they do not have to leave their home and their young baby.

All interviews for my data collection were conducted on Microsoft Teams due to the Covid 19 pandemic and in line with the ethical approval for the study. For the participants within this study, interviewing via Microsoft Teams held an advantage as participants were all able to fit the interview within their daily routine. This was pertinent for maternity service users, obstetricians, and midwives alike, enabling the participants to be interviewed at a time chosen by themselves so that they had the availability needed for the interview. However, this method may have limited participation for service users who do not have easy access to the required technology to partake, or who are living in unsafe home circumstances.

Interview technique

As part of my research planning, I looked at different interview techniques and styles to decide which approach would be preferable for my data collection. The intention of an unstructured interview is to expose the research to unanticipated themes and to help the researcher develop a better understanding of the interviewee's social reality from the interviewee's perspective (Zhang and Wildemoth, 2017). Therefore, I decided against an unstructured approach as I felt this would be too broad for the purposes of my research. Mason (2017) describes a fixed closed question approach to interviewing as ensuring consistency. However, I also decided against this approach as it inhibits probing, and the potential for the participants to raise issues that matter to them. I planned a semi-structured approach of open-ended questions. I chose this approach as it enables the interviewee to control the direction, content, as well as the pace of the interview (Riessman, 2008).

The interview questions were informed from the findings of the phase one systematic literature review and from the phase two questionnaire with antenatal maternity service users. All interviewees were asked a similar opening question to set the scene for the interview and thereafter, a schedule of topics followed. Following initial introduction, checking whether the participants had any questions and following gaining consent; the opening question for the interviews with midwives and obstetricians and for the midwifery focus group was:

"Can you tell me generally about your feelings with regards to induction of labour"?

And the opening question for the interviews with the postnatal maternity service users was:

"Can you tell me about the discussion you had about having your labour induced"?

The researcher is described as being an active agent during the interview with the participant (Riessman, 2008). Rapley (2018) recommend the use of verbal prompts and then affirming the verbal responses received to encourage the participant to

continue to speak about their experiences. Dejonckheere and Vaughn (2019) note the importance of being sensitive to the vocabulary used with participants, and this is noted to be particularly pertinent in health-related research. Barbour (2008) recommends revisiting key points from the interview and reflecting them back to the participant to assist with clarity. During the interviews I undertook, following these approaches and where I felt it was necessary, I repeated or re-phrased questions to help with the participants understanding of what was being asked. In addition to providing clarity for the participant, the repeating and rephrasing of questions also enabled me to gain further information from the participants. Utilising all these techniques enabled questions to be more specific to the responses being received (Dejonckheere and Vaughn, 2019).

Interview field notes

As already discussed, the literature on qualitative research highlights the need for researchers to consider their influence on the study and to recognise the potential impact of their personal experience, knowledge, and beliefs on the interpretation of the data and to develop further understanding of the situation (Savin-Baden and Howell-Major, 2013; Mason, 2017). Field notes are largely recommended in qualitative research as a means of documenting the required information (Phillippi and Lauderdale, 2018). Most qualitative research methods encourage researchers to take field notes to enhance data and provide rich context for analysis (Phillippi and Lauderdale, 2018). Phillippi & Lauderdale (2018) identify interview setting, participants, critical reflection, and the integration of field notes with the study data as the key components of taking such notes.

Therefore, I made notes throughout all the interviews, to gather information of any events that may need follow up and to assist with any future data collection for the research study. Writing field notes enabled me to log events which could not be identified via the interview transcriptions including non-verbal ques. For example, the presence of other people in the room and reasons for any breaks in the recording, including tending to baby, poor signal etcetera. Additionally, after each of the interviews, I wrote about the interview experience including my own reflections and feelings and this helped me to think about any questions which I may need to explore further. Reflection also enabled me to think about how my interactions with

the participants during the interviews and the discussion group may have affected what they may choose to discuss (Mason, 2017). I then referred to both my field notes and my reflective journal during my analysis to think about these in alignment with my emerging data.

Within my notes, I documented that some interviews flowed better than others, with some lasting longer and this is something that I also discussed with my supervisory team. Other examples within my field notes included that on one occasion, during an interview with a postnatal service user (‘Sarah,’) another family member was in the same room tending to the baby during the interview. I felt this may have potentially subconsciously and indirectly influenced what the woman was saying in response to the questions being asked and may have had an indirect inhibitory effect on the interview. It was necessary for the partner to be present to tend to the baby as most women who were interviewed were caring for their babies during the interviews. This in turn may have been a distraction and impacted upon the woman’s ability to focus on the interview. One maternity service user (‘Lara’) did not turn her camera on for the interview. This was her choice and the reasons for this were not apparent. This situation was therefore not dissimilar to a telephone interview and the advantages of interviewing in this manner may have a positive effect on self-disclosure and emotional display (Azad et al., 2021). In terms of technical problems with the interviews being held on Microsoft Teams, the only minor issue that occurred was during one of the staff interviews whereby signal affected the quality. This was resolved by the midwife logging off and then logging back on again and the interview was recorded in two parts. However, this did not impact upon the quality of the data collection.

Potential participants – issues identified

For phase 2 of the research, the Antenatal Ward Manager was pivotal in identifying potential participants for the questionnaires with maternity service users.
My dual role as a researcher whilst working within the Trust and based on the antenatal ward, meant that I was privileged in having a position of accessibility within the maternity unit for opportunities of speaking to women and to midwives and obstetricians.

For phase 3, there were no issues with identifying potential participants for the interviews with midwives and obstetricians and for the midwifery discussion group. There were, however, issues with identifying potential participants for the interviews with postnatal service users. The postnatal service users were identified from having completed the Phase 2 questionnaires. Maternity service users who were happy to take part in further research had recorded their email addresses within the questionnaire information. There were 98 responses to the questionnaire with a total of 44 women leaving their email addresses to be contacted for further research.

Following the completion of the questionnaires, I contacted the women via the email addresses provided. Each woman was contacted a total of three times via email. I received just five responses for interviews, with one woman withdrawing immediately prior to the interview taking place due to mental health concerns. Therefore, I interviewed a total of four postnatal service users about their experiences of induction of labour. Due to the lower than anticipated response rate, I sought an amendment to my ethical approval which was approved in August 2022. I concluded that women may be too busy with their new babies to spare the time for the interview. Therefore, the amendment was to enable me to email potential participants for a fourth time for them to provide written or audio accounts as opposed to partaking in an interview. I felt that this may be preferable for women rather than taking part in a recorded interview on Microsoft Teams. Following the amendment to my ethical approval, just two further accounts were received. I was unable to use one of these accounts as not enough information was received as the service user did not provide consent or respond to a request for further information. Upon reflection, it wasn't clear to women from the questionnaire what the further research would entail. Additionally, as women had left their email addresses via the phase 2 questionnaire, I had not met or spoken to the women and therefore had not had the opportunity to meet or build a rapport with the women. Some of the women that I interviewed reported that my emails had gone into their 'junk' boxes. This increased the likelihood of the emails not being seen by women.

Building a rapport with participants – the researcher and participant relationship

The qualitative interview has proven invaluable in investigating people's beliefs, attitudes, and perspectives on a variety of issues and is widely used in gaining stories of personal experience and to explore the meanings of the same (Prior, 2017). However, qualitative research poses ethical issues and challenges that are unique to the study of human beings (Eide and Kahn, 2008). Indeed, there is an unsolvable dilemma implicit with research that involves interviews whereby aiming at rich descriptions relies upon disclosure of sensitive topics from the participant while at the same time ensuring that no harm is caused (Raheim et al., 2016). Therefore, research ethics may sometimes clash with the researcher's code of professional practice, which in turn may lead to an ethical dilemma (Rogers, 2008).

Interviewees describe their experiences and decide upon the way in which they choose to tell these, whilst researchers contribute their theoretical as well as their professional and clinical experience and the intention to understand the experiences described by participants (Karneli-Miller, Strier and Pessach, 2009). Additionally, there is substantial evidence to indicate that the behaviour of the interviewer may influence the accuracy of answers given by participants (Bell, Eldin and Gordon, 2016).Therefore, to counteract such issues, the interviewer must use their skills to obtain an accurate and effective interview (Anyan, 2013).

One of the themes for interviews that needs consideration relates to the researcher as well as the participant vulnerability, with Raheim et al. (2016) suggesting researcher vulnerability as being part of the dual role of the researcher, in addition to the potential for participant vulnerability. In developing the interpersonal relationship that is critical to qualitative research, the researcher and the participant engage in a process that often brings out experiences that are remembered and recounted in ways that would not otherwise occur (Eide and Kahn, 2008). Indeed, qualitative interviewing is based upon an emotionalist approach which has the potential to be upsetting when discussing experiences (Rees, 2011). Raheim et al. (2016) describes the interviewer's competence and the participants behaviour as being examples of power manifestations within the qualitative interview.

When considering the dual role status, it is thought that this may create trust and shared understanding between the researcher and the participants (Rees, 2011). Conversely, the dual researcher may be criticised for lack of objectivity (Anderson, 2011). From the perspective of midwives interviewing maternity service users, Kingdon (2005) discusses the potential of a gratitude bias to midwives from women who have had a positive pregnancy experience whilst also identifying the potential issue of the midwife sharing midwifery knowledge to participants that is not aligned with their role as the researcher. As already discussed, to combat this, the practice of the continuous reflexive awareness of the researcher is paramount when considering the dual role (Raheim et al., 2016).

In addition to this, numerous studies have shown that the health professional/researcher may have a lack of control over how participants initially regard their role and that they may be viewed primarily as providing information regarding health care (Easter et al., 2006; McCourt, 2006). Whilst ethical guidelines expect researchers to make clear distinctions between their professional and their research roles, participants may not necessarily understand this distinction (Ryan et al., 2011). The initial aim of engaging in qualitative research is to investigate individuals' experiences of specific phenomena, not to provide a therapy service to those who opt to participate. However, in reality, it is recognized that the researcher and participant relationship may result in benefits of a therapeutic nature (Eide and Kahn, 2008). Furthermore, in terms of interviewing maternity service users, Oakley (1993) described how feminist studies of women interviewing other women found that it inspires openness and trust (Oakley, 1993).

The subjective experience of giving birth may vary depending on psychological, medical, situational, relational, and other individual characteristics (Junge-Hoffmeister et al., 2022). Childbirth has the potential to have an impact on postpartum maternal mental health and family relationships, such as mother–infant bonding (Junge-Hoffmeister et al., 2022). The focus of pregnancy and childbirth tends to be upon the health of the mother and baby and therefore, the maternal psychological reaction may be easily neglected, especially if everything went seemingly well (Junge-Hoffmeister et al., 2022). Indeed, during the interview

process, I experienced emotions related to women's accounts of how they felt about their experiences. Henn, Weinstein, and Foard, (2006) and Kingdon (2005) state that this cannot be avoided. For example, Lara's story (chapter 5, findings) which included a dural tap following an epidural in labour and the experience that ensued sounded like an extremely difficult period of time for Lara. However, whilst this had not been great for Lara at the time, she was adamant that she would be open to induction of labour and an associated epidural for any future pregnancies. This example highlights the subjectivity involved with pregnancy and labour and the need for me to recognise and then to close off my feelings about the stories that I had been listening to.

Bearing all the barriers and challenges in mind, it is crucial to acknowledge that the ability to establish a rapport is one of the most important skills for interviewing (Bell et al., 2016). The researcher's and participants roles develop during the research process and are not fixed (Raheim et al., 2016). Therefore, the most important steps that researchers must take in the field are those related to rapport development with their participants. Indeed, both new and experienced researchers work through the challenges of both establishing and then maintaining such relationships (Pitts and Miller-Day, 2007). 'Being with' which refers to being authentically present with others to convey their experiences is an element that is crucial to the interview process (Eide and Kahn, 2008). In terms of rapport, when people talk about personal experiences of any great emotional intensity, there is an expectation that their recipients show not only their understanding of the content of the talk but also their understanding of the participants stance by showing understanding and empathy with the participant (Prior, 2017).

Despite the challenges discussed in relation to the dual role, Easter et al. (2006) concludes that the dual roles are compatible as evidenced by the codes of ethics that are mandated in both health research and healthcare. As already discussed, and as part of my acknowledgement of my dual role as a midwife and as a professional doctorate student researcher and to minimise any influence of the research data, I have continued to write a reflexive journal throughout the duration of my studies. In terms of interviewing the participants for the study, it has been essential to start the process of building a good relationship with participants from

the initial point of contact. At the onset of the interviews, it was crucial to have a general chat with participants, with interviews being undertaken in an informal manner. My reflexive journal assisted me with my thoughts and planning about the researcher and participant relationship. From my perspective, a good rapport was achieved with all participants, as evidenced by the depth of information I was given. It is not possible, however, to judge how the respondents felt about this.

Additional to my reflexive journal and in keeping with the mandated codes of ethics and to counteract any potential issues with the interview elements of my research, I explained my dual role as a midwife and as a researcher fully with the participants and I explained and reiterated that the interviews were being undertaken in my capacity as researcher and not as a midwife. For the interviews with the postnatal maternity service users, to try to minimise a participant power imbalance, I ensured that I didn't adopt either a counselling position or a health education position. I remained aware that women were vulnerable as new mothers. I offered to signpost four of the women I had contact with for a debrief about their pregnancy and birth experiences. This was for two of the women I interviewed and for the two women who provided written narratives who appeared to have elements of their care that they did not understand or were unhappy with, and, for a woman who was going to participate in an interview but withdrew just beforehand. Indeed, the ethic of caring would stipulate that the researcher should ensure that alternative forms of support for participants should be obtained if needed (Eide and Kahn, 2008).

Aligned with the safeguarding aspects of my NMC registration, within the 'how will my data be used' section of the participant information sheets (see appendix 1, 2 and 3), for service users and for midwives and obstetricians, in terms of confidentiality, there was a statement which read:

'There are however limits to confidentiality such as the following:

We will speak to your maternity care team if there are significant concerns about you (including if you experience any significant distress while taking part) or if there are concerns for someone else's safety. We will take all possible steps to discuss this

with you first and plan together about what to do, but ultimately, we have a duty of care to inform your teams of these concerns.'

This was explained to potential participants as part of the consent taking procedure and again at the onset of the interviews.

If I had become aware of any serious safeguarding issues arising from the research, my plan was to inform and liaise with the named midwife for safeguarding and dependent upon the specifics of the situation liaison may also have been required with human resources (HR) and the relevant manger(s) in the first instance to seek further advice and make the appropriate plan(s) aligned with Trust policies.

The experienced qualitative researcher will recognise that very often, the essence of the issues being discussed may become apparent after the interview recording is finished (Eide and Kahn, 2008). The recording may be a reminder for the participant of the research situation, and once the interview has been discontinued, a greater level of conversation may occur (Eide and Kahn, 2008). From a reflexive viewpoint, I did note that this happened with an interview with one of the midwives. The interview itself was fairly short and the midwife then revealed far more information after the recording had taken place and it was likely that she felt more comfortable when the recording had ended. This also happened with the maternity service user who submitted a written narrative; she did not want to be interviewed. However, when recording consent, she gave additional information as part of an impromptu and informal chat that unfortunately could not be utilised in the write up as she had only consented to the written narrative.

Transcription

Transcription is a practice that is central to qualitative research (Davidson, 2009). However, according to Davidson (2009), description of transcription methods is often overlooked in reports of such studies. Transcription decisions impact on the ensuing analysis and interpretation of the data. There is, therefore, a need for researchers to be clear about transcription (Riessman, 2008). Davidson (2009) highlights the requirement to look at how transcription is defined and understood, how it is conducted and how it is reported in research studies. Ochs (1979) put forward the notion that transcription is not merely a technical task, but that it is made up of

theoretical commitments and research positioning and is therefore a crucial element to report upon.

For the transcriptions of my interviews, I had originally planned to utilise SONIX, a software tool that rapidly transforms speech into written text. However, following discussions with my academic supervisors and due to issues with the available Sonix licensing agreement, I decided that the most timely and effective approach was for me to record all the interviews via Microsoft Teams and to utilise the live transcription function. When transcribing the interviews, I was mindful that the transcribing process involves judgements and decisions that require transparency, i.e., the level of detail to transcribe, whether to transcribe verbatim as opposed to correcting grammar and speech, and whether to represent the non-verbal data (Davidson, 2009). Transcription can be difficult to interpret as the verbal speech is often broken by pauses, stutters, hesitation, slang, accents, diction, involuntary vocalisations, response tokens, non-verbal vocalisations, grammar, and going off topic to a shift of subject matter (Silva and Steinbruch, 2019). Therefore, as suggested within the research evidence, it was imperative that I incorporated reflection of the transcriptions into my research design by thinking about my transcriptions and any influence this may have on the data (Davidson, 2009). I did this through the utilisation of my field notes and of my reflective journal to attempt to avoid any potential issues.

Data immersion, interpretation, and analysis – interviews

Data analysis is described by Thorne (2000) as one of the most complex and difficult of all the phases of a qualitative project. Therefore, a thorough and rigorous approach to analysing qualitative data is essential to obtain important insights into the intricacies involved (Coates, 2021). A constant interaction with the data is essential for insightful interactions (Maher et al., 2018). Indeed, it is essential for the researcher to immerse themselves in the data and explore all nuances which in turn enables data to be viewed from a variety of perspectives to support the analytical thought process required for understanding and for new theory generation (Maher et al., 2018).

For the postnatal maternity service users, I had hoped that the sample size for the interviews would be approximately twenty or until a saturation of themes was achieved. However, due to a low response rate, just four interviews were undertaken, and one written summary received.

Thematic analysis (Staff interviews)

Thematic analysis is widely used among qualitative researchers as it can be applied to various methodologies and can be used flexibly (Savin-Baden and Howell-Major, 2013; Braun and Clarke, 2021). Thematic analysis ensures a solid approach to looking at views, opinions, knowledge, experiences, and values gathered from the qualitative data (Braun and Clarke, 2021). Through the provision of its theoretical freedom, thematic analysis enables a flexible approach that may be modified whilst giving a detailed and rich, complex analysis of the data collection (Braun and Clarke, 2021). Thematic analysis involves a six-phase process to identify the themes from the data collected through the categorising of gathered data, coding, generation of themes, reviewing themes and defining and naming themes (Savin-Baden and Howell-Major, 2013; Braun and Clarke, 2021). I therefore considered this approach to analysis to fit with my own approach for the interviews with the midwives and obstetricians and for the midwifery discussion group.

Following discussion with my supervisors and the utilisation of the University information for recording on Microsoft Teams, I recorded the interviews and I used the transcript function. I then transferred and saved the transcripts into word documents on the university's secured one drive for each of the interviews and for the discussion group. The recordings enabled word for word transcription and I utilised the University's 'How to auto transcribe and correct interviews' to guide me with this process in conjunction with the advice of my supervisor. I utilised deductive and inductive coding as this is thought to increase the rigor of the analysis process (Braun and Clarke, 2021). Through re listening to each of the interview recordings and by re reading the transcripts on multiple occasions, I was able to identify the obvious themes as a starting point for the ensuing data analysis. For the interview transcripts, the process I utilised included manually highlighting statements within the interviews on paper copies that were particularly pertinent. These were steps 1 and 2 of the thematic analysis process and enabled me to familiarise myself with the data

to identify initial themes. This also assisted me with choosing quotes to utilise to represent different points of view as well as patterns aligned with the objectives of my research and facilitated a focused analysis. Indeed, pertinent quotes bring the context and the narrative of the interviews alive (Eldh et al., 2020; Lingard, 2019).

Following this and for step 3 (coding) of my data and aligned with the questions on my interview schedules, I then started to categorise the data collected in relation to what I had highlighted manually on the paper copies of the transcripts. As I worked through the data and revisited the data, new categories as well as subcategories began to become apparent, and I continued with this process until there were no further categories to be found. I also identified keywords within the transcripts. Keywords are a crucial part of coding as they form the basis of the analysis and assist with converting the data into insightful sections (Braun and Clarke, 2021). I continued to use a manual process throughout my analysis utilising paper copies.

Working manually between steps 4 (reviewing) and 5 (defining) the themes and sub themes, I then either merged or rejected these to ensure that the data was represented by the analytical findings. During the analysis process, it was necessary for me to work with the entirety of the data collected whilst also looking at the individual data and to refer back to my philosophical stance to ensure that I was looking for any themes that may not be as obvious within the transcriptions and also to enhance rigor and reduce the chance of only finding themes that fit with my own interpretation of the data (Silverman, 2021).

For maternity service users taking part in both the questionnaire and the interview, the data were linked for comparisons between information sharing at the time of the discussion regarding induction of labour and women's experiences and views postnatally. This involved me revisiting the responses that had been submitted on Qualtrics and the women were identifiable by virtue of including their email addresses within the questionnaire responses. Within the questionnaire, the email addresses had been submitted by women who were considering taking part in further research. Writing up (step 6) was completed in relation to the whole research study (see the Findings chapters).

Case studies analysis (Service user interviews)

Due to the lower than anticipated response rate for the interviews with the postnatal maternity service users and following a discussion with my supervisors, I utilised an individual ('biographical') case study approach (Yin, 2018) to analyse the interviews with the postnatal maternity service users rather than using thematic analysis. A case study is a research approach that is used to generate an in-depth, multi-faceted understanding of a complex issue in its real-life context and is an established research design that is used extensively in a wide variety of disciplines, particularly in the social sciences (Yin, 2018; Rashid, Rashid, and Waseem, 2019). The case study approach is particularly useful when there is a need to obtain an in-depth understanding of an issue, event, or phenomenon of interest, in its real-life context and lends itself well to capturing information on more explanatory '*how*', *'what'* and '*why*' questions (Crowe et al., 2011). The collective case study involves studying multiple cases simultaneously or sequentially to generate a still broader appreciation of a particular issue (Crowe et al., 2011). Generally, case studies cross a whole site or organisation. However, single biographical case studies are also done (Yin, 2018). Given the small numbers of women in the study, and both the variations and similarities in their induction stories, I decided that this approach to analysis would be ideally suited to the interviews with the postnatal maternity service users.

I approached each of the interviews with the postnatal maternity services users as an individual case study whereby one participant's data did not depend on that of another participant. In addition to the interview recordings, the one written case study that was received was read with my interpretations and pertinent areas highlighted accordingly. This process included me noting any follow up questions that became apparent from reading the case studies.

Finally and to assist with the mobilisation of data and knowledge and to identify the themes from the five individual case studies, cross-case analysis was then undertaken for an in-depth exploration of the similarities and differences between the cases to support with empirical generalisability and theoretical predictions (Yin, 2018).

Participant involvement

Prior to submission for ethical approval, I wanted to ensure that I had an overall sound approach to the questions that I had devised for the questionnaire and the interview questions for maternity service users (phase 2). Therefore, I asked service user members of the Maternity and Neonatal Voices Partnership (MNVP), to review the questionnaire. The questionnaire was also reviewed by a consultant obstetrician as well as a midwife. This enabled the opportunity for any amendments or additions to the questions being asked which I then incorporated into the final version of the questionnaire.

Rigour, dependability, trustworthiness, and transferability

According to Nowell et al. (2017), for research to be trustworthy, qualitative researchers must evidence that both data collection and analysis has been conducted in a precise, consistent, and exhaustive manner through recording, systemising, and disclosing methods of analysis with sufficient detail for the reader to determine whether the process is credible. Credibility is the element that enables others to recognise the experiences contained within the study through the interpretation of participants experiences and validity and embodies the credibility of findings as well as the value of the research (Thomas and Magilvy, 2011). Rigor is defined as the quality or state of being exact, careful, or with strict precision or the quality of being thorough and accurate (Cypress, 2017). Rigor in qualitative analysis is an interpretivist concept and belongs to the process and its trustworthiness (Maher et al., 2018). Savin-Baden & Howell-Major (2013) suggest the use of multiple data sources to counteract any issues, whilst Henn, Weinstein, and Foard (2006) suggest the use of a reflective journal, both of which were undertaken during the course of my research study.

Validity and generalisability

Validity and generalisability are quantitative, positivist concepts (Leung, 2015) and were therefore considered for the phase 2 questionnaire of my research study. Validity refers to the appropriateness of the tools, process, and data, whilst generalisability is defined as the degree to which the findings can be generalised from the study sample to the entire population (Leung, 2015). A pragmatic approach to assessing generalisability for qualitative studies is to adopt the same criteria for

validity which includes the systematic sampling, triangulation and constant comparison, audit and documentation, and multi-dimensional theory (Leung, 2015).

Summary of chapter 3

Within this chapter, I have discussed the rationale for my research study design and for my methodological approach. This includes the aims of the research study and the research questions along with an examination of the philosophical stance utilised. The strategies I used to collect data are discussed, including the rigorous methods used for management of the data as well as the analysis and the interpretation of the data. I have described my reasoning for all aspects of the methodology, and I have discussed the ethical issues encountered along with a discussion about reflexivity and an exploration of the challenges experienced during the collection of the data. I have also discussed the potential challenges of undertaking research whilst holding a dual role as a midwife matron and as a professional doctorate student and the potential influence and impact this may have upon the participant/researcher relationship.

The next four chapters discuss the findings of my research. The four chapters are in a consecutive order, beginning with the methods for and the findings of the systematic literature review (Chapter 3), the findings of the questionnaire for women having discussions with midwives and/or obstetricians in relation to informed consent (Chapter 4), followed by the induction of labour experience for postnatal women (Chapter 5) and finally the thoughts, views and experiences of midwives and obstetricians regarding the induction of labour experience (Chapter 6). Chapter 7 discusses the themes identified from the findings of this study. Chapter 8 discusses a summary of the key findings, suggestions for practice and policy change and suggestions for future research.

CHAPTER 3

Systematic literature review

Background and rationale for review

As discussed in Chapter 1 and throughout my thesis, induction of labour is one of the most common interventions in pregnancy with a high proportion of those being for postdates pregnancy (Coates, 2020). Whilst induction of labour may be indicated for clinical reasons and to improve maternal and neonatal outcomes, there is a concern that the rising rates of induction do not always reflect the clinical need. Women's experiences of induction of labour can be shaped by factors including method of induction, setting, the information and support received from health providers, family, and friends as well as women's perceptions of risk, control, and choice (Coates, 2020). For women to make an informed choice regarding induction of labour, it is crucial for discussions to be facilitated using current, high-quality evidence (RCM, 2019). However, whilst informed consent is a legality and is also embedded within national agendas in the United Kingdom, as discussed in Chapter 1 (Introduction) and throughout my thesis; the available research indicates that there is concern that informed consent is inconsistently implemented. In turn, this may lead women to undergoing interventions that they may have chosen not to if true informed consent had been achieved.

To establish the evidence base and identify gaps in the literature for this area prior to running an empirical study, I undertook a systematic review of the literature. The systematic review formed part of the triangulated approach I wanted to take for my research project. The aim of the systematic literature review was to provide a thorough overview of the available literature on the topic of women's experiences and in turn to inform the planning for phases two and three of my research.

Phase 1 research question

The research question for this phase of the study was:

"How are the principles of informed consent applied when induction of labour is discussed with women with a full-term pregnancy and what are the experiences and implications for women?"

The review was designed to address the phase 1 objective of how the research evidence regarding informed consent is applied when induction of labour is discussed with women with a full-term pregnancy and what the experiences are for women. Thus, linking back to the overall study aim and objective of the process and implications of informed consent and induction of labour at term gestation.

Method

Search strategy

I began by conducting a literature search with the support of the clinical librarian at the Trust where I am employed. We searched with various strategies and in multiple search engines. The initial search consisted of six strings, but this failed to limit the results. I therefore refined the search to four strings to obtain the necessary results.

The search of the literature was conducted utilising the electronic databases of Cinahl (EBSCO), Medline (EBSCO) and Embase (OVID).

Additional resources were then obtained utilising the key words from the literature obtained in the first search.

Finally, the reference lists of all the included studies from those that met the criteria were searched to locate any relevant studies that had been missed by the initial searches.

Search terms

Specific terms relating to post term pregnancy, induction of labour, informed consent and the experiences of women were used to search the databases. The population, intervention, and outcomes (PIO) were identified as:

Population: Women with a post term pregnancy

Intervention: Induction of labour

Outcomes of interest: The experiences of women – with informed consent

Based on the Population and Outcomes of interest (PIO) and the initial scoping search, four search strings were used to look at the concepts that were being considered in relation to informed consent and induction of labour with a full term or post term pregnancy. These were:

Table 6:

Population	Intervention	Outcome
String 1: 37 weeks, 38 weeks, 39 weeks, 40 weeks, 41 weeks, 42 weeks, beyond term, full-term, full-term pregnancy, later term pregnancy, late term pregnancy, overdue, post maturity, postdate pregnancy, post term pregnancy, post term, prolonged pregnancies, prolonged pregnancy, term pregnancy, third trimester **String 2:** artificially induced, induced labor, induced labour, induction of labor, induction of labour, labor induction, labour induction, IOL	**String 3:** Brochure, care options, clinical education, clinical information, communicate, communication, consumer focused, counselling, decision aid, decision making, decisional support, discussions, education, health education, healthcare education, information informed,informed choice, informed consent, informed decision leaflets, patient centered, patient centred, patient experience, patient information,patient involvement, policy of choice, professional education, qualitative evidence qualitative studies, questionnaire, recommendation, shared decision making, support survey, women-centred care	**String 4:** attitude, attitudes, beliefs, choice, expectations, experience, experienced, feeling, included/inclusive, interview, interviewed, involved, involvement, issues, knowledge, listening, maternal perception, maternal preference, maternity education, opinion, ownership, participation, perceptions, personal choice, personal values, perspectives, preferences, satisfaction, training, value, want, women's experience, women's perception, women's preference, women's views, women's voices.

Each word in the string was separated by ‘OR’, and the strings were all combined with ‘AND.’ Citation tracking was then undertaken to check for further articles from the reference lists of key articles.

Table 7: Inclusion and exclusion criteria

Inclusion criteria	Exclusion criteria
Studies that include the views, beliefs, and experiences of maternity service users	
Studies focused on discussions around induction of labour when pregnancy is at or near term	
Studies in higher income countries to enable comparisons to the UK. The DAC list of ODA (official development assistance) recipients was utilised to identify upper and middle-income countries and territories	Studies in lower income countries were not included as these may not be considered to be comparable to health care within the United Kingdom
Studies in any language (Google translate was used for any articles that were not in the English language to check the abstracts for relevance)	
Qualitative studies, mixed methods studies that reported some qualitative data relating to the outcomes of interest and questionnaire studies with qualitatitive data	Articles were excluded if they were only published in abstract form as were studies with no qualitative component
Studies published on or after 2000 to look at more recent research in line with the increasing rates of induction of labour	Studies published before the year 2000

Data screening and selection of studies

Following an initial broad search, titles and abstracts were reviewed. Following this, 36 studies were identified as potentially being relevant to my review. Manual searching of the reference lists and citation tracking of included papers was conducted to identify any further potentially relevant studies. All qualitative studies that met the inclusion criteria were included regardless of epistemological underpinnings as is common in the synthesis of health research. The data screening and selection of studies is detailed in a PRISMA diagram (figure 1).

Critical appraisal and data extraction:

The quality of the included studies was appraised, with each study being assessed independently. The characteristics of the studies were logged onto a word document, and this included author details, study type, participant numbers, design methods, interventions, population, inclusion, time point, data collection methods and quality/limitations of the review (see table 8).

Data analysis and synthesis:

Following on from critical appraisal and data extraction, thematic synthesis was utilised which involved extracting quotes, themes, and metaphors from the studies included (Thomas and Harden, 2008). This principle was used to synthesise the qualitative data, enabling collation and comparison of the evidence across the studies whilst preserving the meaning as interpreted by the original authors. First order constructs (initial codes) were constructed from the index paper and abstract of each study, and these were then refined and combined into emerging themes. The emerging themes were decided by comparing studies that had already been analysed with the study that was currently being analysed and looking at any differences. The themes that emerged form part of the review findings and were grouped into final themes. Second order constructs comprised interpretations, themes or statements developed by the primary studies' authors in response to the first order constructs. Common and contradictory themes were explored across the studies. Using an inductive approach, third order constructs were then developed after combining and exploring first and second order constructs to elicit an explanatory framework for the reported findings.

Results

Study participants, design, and quality

The characteristics of studies are contained within Table 8. Titles and abstracts were reviewed by myself with a subset of records reviewed by my two supervisors (10%). Following further review and utilising the inclusion and exclusion criteria, there were eight eligible studies, comprising of a total of 2852 participants and these were quantitative and qualitative studies with methods including semi-structured interviews, focus groups, surveys, and questionnaires and hypothetical scenarios. Each study was conducted in a single country, including the UK (3) Australia (3) United States (1) Germany (1) and Denmark (1). Participants included women whereby the plan had been to have their labour induced for post term pregnancy. Common limitations in the studies included lack of information with regard to whether any of the methods needed to be modified during the course of the research, whether any events needed to be responded to during the studies and whether this led to any consideration of the implications of changes to the research design, to what extent contradictory information is taken into account, whether the researcher critically examined their own role, potential bias and influence during the analysis and selection of data for presentation, discussions re the credibility of findings (for example triangulation, respondent validation). Other limitations included lack of in-depth information regarding the analysis process, discussions of issues raised by the studies, for example informed consent or confidentiality and finally, the effects of the study on the participants during and after the study, adequate discussions around recruitment (for example, why some people chose not to take part), adequate discussion of the evidence for and against the researcher's arguments.

Table 8: Characteristics of included studies

First author, year, and country	Study type	Participants	Time point	Data collection methods	Aim of study	Quality/limitations
Gatward, 2009, Australia	Qualitative interviews	23 primigravid women	Interview at the time of being booked for induction labour. Repeat interview for those women who didn't labour spontaneously 30 min to 2hr following insertion of the first prostaglandin	Tape recorded interviews using an interview guide with focused questions	To explore the women's experiences of being booked for induction	No discussion regarding if there were any women who chose not to take part There was no information regarding consideration of the relationship between the researcher and the participant No information included regarding the researchers own role No information included in any changes to the research design
Murtagh, 2014, Ireland, United Kingdom	Qualitative study	9 primigravid women (having their labour induced for post-dates pregnancy)	Post induction of labour	Semi-structured interviews	To investigate women's experiences of induction of labour (IOL) and how it impacts on their experience of childbirth	Limited information regarding how participants were selected Limited discussion around recruitment

						Limited information regarding the relationship between the researcher and participants, reflexivity No information regarding if there were any events to respond to during the study No information regarding if there was any contradictory data that needed to be accounted for
Stevens, 2012, Australia	Qualitative Interviews based on hypothetical scenarios	595 women	Women were contacted from a database of women who had consented to be contacted for future research about maternity care and were not currently pregnant	Hypothetical scenarios in which an obstetrician discussed induction of labour with a pregnant woman	To investigate the effect of specific variations in health caregiver communication on women's preferences for induction of labour for prolonged pregnancy	No information about the consideration of the relationship between the researcher and the participant
Gammie, 2012, Scotland, United Kingdom	Qualitative interviews	7 primigravid women	Low risk primigravid women having their labour induced for post maturity	Semi-structured qualitative interviews	To explore women's experiences of induction of labour	Limited explanation regarding a statement for the aims of the research and the research design

						Limited information regarding the recruitment strategy Limited information regarding data collection No information regarding the researcher and participant relationship Limited information regarding the rigour of the data analysis
Roberts, 2019 England, United Kingdom	Qualitative study	26 women	Data was collected over a 2-month period of time for women living in the UK who had given birth in the previous 12 months at 41 week's gestation or beyond. Women may have had their labour induced for post term pregnancy or may have gone into	Semi-structured interviews of 15 of the women Online focus group for 11 of the women	To explore policies of choice and agency in maternity care as well as exploring support for women with post-date pregnancies	No statement of aims Limited information about the researcher/participant relationship Limited information regarding rigour of the data

			labour spontaneously.			
Lou, 2019, Denmark	Qualitative interviews	23 women	Women who had their labour induced for post-date pregnancies, 4-8 week's after giving birth	Qualitative interviews	To explore how women with uncomplicated pregnancies experienced late term induction of labour	
Declerq, 2020 United States	Qualitative survey	2119 women	Women planning to have a vaginal birth in 2016	Survey	To examine experiences of women who had their labour induced	Limited information regarding the researcher/participant relationship Limited information regarding generalisability and identification of further research
Cooper, 2010, Australia	Quantitative Quasi experimental trial	50 women	Women currently undergoing antenatal care at a small maternity hospital	A Quasi experimental trial with 25 women selected to the control group and 25 selected to the intervention group	To gain a better understanding of women's baseline knowledge of induction of labour (IOL) and determine whether giving written information at the time of the IOL, results in significant differences in knowledge and understanding of the process	Limited information regarding the researcher/participant relationship

Themes identified

Two overall themes which interlink directly were identified and these were: 1) ***A sense of 'time being up'*** *and,* 2) ***Informed consent and women's information needs.*** Within the two overall themes, subthemes were identified including a sense of time being up, additional information, timing of information, women's expectations, women's experience of informed consent and hospital policies. The overarching themes overlap and interlink with one another which highlights the multidimensional aspects involved with informed consent, views, and experiences. The quotes within the themes and findings are from the texts and participants of the original studies that have been reviewed. A synopsis of the themes and the subthemes that were identified are provided in tables 9 and 10 below.

Table 9: Theme and subtheme identified

Theme	**Subtheme**	**Studies**
A sense of 'time being up'	Impact of a 'shift in expectation'	Gammie, N. and Key, S. (2014) Time's up! Women's experience of induction of labour. *The Practising Midwife.* 17 (4) pp. 15-18. Gatward, H., Simpson, M., Woodhart, L., and Stainton, M. (2009) Lou, S. Carstensen, K. Hvidman, L, Fritzner Jenson, T. Neumann, L. Habben, J.G. and Uldbjerg, N. (2020) Murtagh, M. and Folan, M. (2014)

Table 10: Theme and subtheme identified

Theme	**Subtheme**	**Studies**
Informed consent and women's	Additional information	Gammie, N. and Key, S. (2014)

information needs	Timing of information and detail of information Women's expectations Women's experience of informed consent discussions Hospital policies	Gatward, H., Simpson, M., Woodhart, L., and Stainton, M. (2007) Jenson, T. et al., (2020) Lou, S. Carstensen, K. Hvidman, L, Fritzner Jenson, T. Neumann, L. Habben, J.G. and Uldbjerg, N. (2020) Murtagh, M. and Folan, M. (2014) Stevens, G. and Miller, Y.D. (2012)

A sense of 'time being up'

In terms of the theme of a sense of 'time being up,' pending induction may be unexpected for many women, although not all. When there needs to be a decision made for labour to be induced, this theme highlights the need for a shift in expectation for many women's original plan for labour and birth, particularly for postdates induction. This theme evidenced that there are women with a preference to wait for induction of labour, women who are happy to be induced, women who feel resigned or a sense of passivity at the thought of induction of labour and women who do not mind so long as the result is a healthy baby. The reasons for women's differing views are multi factorial and will be discussed within this chapter and further within Chapter 7 (Discussion). Ultimately, a woman's experience of induction of labour will influence all aspects of her overall experience of birth (Murtagh and Folan, 2014).

Impact of a shift in expectation

Gammie and Key (2014), identified that all women interviewed shared a sense of their estimated date of birth as being the scheduled date when their baby was due to

arrive, and they were literally counting the days that their baby was ‘late’ with women describing time as ‘running out.’

“It just seems wrong without being wrong.”
(Gatward et al., 2009)

For some women, induction of labour can be viewed as a ‘loss of ideal’ due to labour not starting spontaneously and perhaps feeling that their body and the baby are not ready for birth, even though their ***‘time was up’*** in terms of the need or pressure to be induced (Gatward et al., 2009; Gammie and Key, 2014):

“I am a bit disappointed that I have to be induced. I would rather go into natural labour. I am just hoping something will happen otherwise. I will stay positive. Nevertheless, at the end of the day, I am going to have a baby and that is the main point and that’s how I am looking at it right now.”
(Gatward et al., 2009)

“I didn’t want to be induced, it felt forced and unnatural.”
(Gammie and Key 2014)

Such decisions can lead to a sense of disappointment amongst women who may view induction of labour as unnatural:

“I’ve not enjoyed that feeling (IOL date approaching); last night it was ‘that’s it’ there’s no going back now”
(Gammie and Key, 2014)

“I am having an induction as opposed to having a baby. “
(Gatward et al., 2009)

For others, this ***shift in expectation*** may lead to feelings of resignation and passivity as they accept the medical reasons for post term induction of labour (Gatward et al., 2009; Gammie and Key, 2014; Lou et al., 2020):

“I was tired of being pregnant at this point. I felt huge and I was tired of waiting. I was just exhausted, so I just wanted him [the baby] to come out.”
(Lou et al., 2020)

“I’m just relieved that something is going to happen to be honest because I have been waiting and waiting and it is time basically.”
(Gatward et al., 2009)

“I suppose I was kind of resigned to it.”

(Gammie and Key, 2014)

Conversely, the shift in expectation entails some women welcoming the end of their pregnancy (Gatward et al., 2009; Gammie and Key., 2014):

“It’s good to have a date to aim for.”

(Gammie and Key., 2014)

Gatward et al. (2009), Roberts and Walsh (2019) and Lou et al. (2019) found that some women had increased concern about the more frequent, but the less severe risks associated with induction of labour, or that they were still hoping for a spontaneous birth with the reasonable risks and expected benefits being subjective. The following quotations represent women viewing pregnancy and birth as a natural event as opposed to a medical event:

“My baby’s safety was always the priority but why if my baby was absolutely fine at 42 weeks’ would I try and force her out? It made no sense to me or my partner.”
(Roberts and Walsh, 2019)

“I still hope things will kick in and deliver naturally. Even in the last acupuncture session – I just had a very gruelling session with the homeopath and was feeling very vulnerable like what am I doing here - and then I went on to my acupuncture

and I had this really amazing really empowering acupuncture where I just felt so strong and I was ready."
(Gatward et al., 2009)

Some of the studies indicated that the range of emotions that can be experienced by women may be resolved by the birth of a healthy baby (Gatward et al,. 2009 and Murtagh and Folan, 2014):

"To be honest, at the end of the day I have a healthy baby…I don't really care about anything else including how I got there."
(Murtagh and Folan, 2014)

"I feel very emotional and teary and can't wait to meet the little fellow. As long as the baby is healthy and through it I will be fine."
(Gatward et al., 2009)

"It's time for baby to be born. I just want to meet baby now."
(Gammie and Key, 2014)

Women and health professionals must weigh up the value they place on the consequences of each possible outcome and their belief about how likely it is to occur. This in turn creates a holistic decision threshold for acting. In terms of the influence of the social context, women's decisions can be formed through information gathered from the media, the internet and from family and friends, all of which can influence and impact women's decision making processes alongside having conversations with health professionals regarding the decision making process (Gammie and Key, 2014).

Women's information requirements and informed consent discussions

This theme includes women's information requirements for decision making around induction of labour, aligned with the role of the health professionals holding discussions with women. The studies reviewed highlighted conflicting information and disparities from women's experiences with this process. The included studies

highlight that for many reasons, some women do not feel fully informed of the induction of labour process. This theme also highlights that women do not always feel that they experienced informed decision making. Health professionals' experiences of informed decision making for induction of labour are reported as part of my empirical research study (Phase 3, Chapter 6).

Additional information

In the included studies, women who were not aware of induction of labour before their pregnancy indicated that doctors, antenatal classes, other pregnant women, and books were the most common sources to address their information requirements (Cooper and Warland, 2011). Gammie and Key (2014) describe how women use multiple sources of information to meet their needs and view information leaflets as being helpful:

"…*the leaflet they gave you, I found that interesting and quite informative as well."*
(Gammie and Key, 2014)

Some women described looking at additional information to supplement the information that they had received from health professionals:

"I've got pregnancy books, and we looked in them."
(Gammie and Key, 2014)

Roberts and Walsh (2019) and Gammie and Key (2014) describe how the internet has become an important point of additional information. These studies also found that communication from friends and family can have an impact, with some women reporting receiving phone calls, messages, and social media posts for updates of the progress of pregnancy and birth. For some, this was intrusive as opposed to being helpful .

Timing of information and detail of information

Despite this, many women reported not being informed in any detail before their due date about the possibility of post term induction of labour. Stevens and Miller (2012) highlighted that most women were not aware of the level of information required to make an informed decision and that the order in which choices are presented, and non-neutral representation of options can make a difference to how women make decisions. For many women this was acceptable as they viewed other issues being of more importance earlier on in pregnancy (Stevens and Miller, 2012).

"I think that it's a good thing…not speaking a whole lot about induction during the pregnancy, because there are just so many other things that keep you occupied. You don't need information about induction on top of that."
(Lou et al., 2019)

Conversely, some women described how they would like to receive earlier information:

"I could have done with some discussion because things happened that I feel the leaflet did mention but needed more discussion…things like the pain and how bad it was…and you might not even be in labour."
(Murtagh and Folan, 2014)

The study of Lou et al., (2019) highlighted that whilst many women understood medical reasons for post term induction of labour, fewer women remembered about the risks being discussed with them, with some women verbalising that they wish they had had further time for decision making based on informed consent discussions. Stevens and Miller (2012) and Gatward et al., (2009) report that many women are unaware of the information they need to make an informed decision.

"I wish I had been given a little more time; you know. That someone had said, "you know what, this is not the only option. Go home and come back tomorrow." Or something…and have told that when you are induced sometimes this and that can happen."
(Lou et al. 2019)

Additionally, Declerq et al. (2020) identified that one third of women perceived that there had been discussion around inducing labour with no medical indication.

Women's expectations

Within the studies, women described how the reality of their experiences of induction of labour did not meet with their expectations.

"I sort of scrambled for info from the web and you read that it will be done and then done again in 6 hours if it doesn't work, and that wasn't actually what was done either, so it was just like we didn't have a clue."
(Murtagh and Folan, 2014)

"It wasn't clear to me at the time that they did the prostaglandin that I will be staying in hospital from that time on and I don't have any idea whether or not there is a fetal monitor on me or on the baby and how restricted I'll be."
(Gatward et al., 2009)

Studies highlighted hospital time scales as being an issue in terms of birth experience:

"I was told so many times it might take 2-3 days, then an hour later it was here…I was shocked for ages. I think women should be told it could go this way or that way or another way and that there was no way of predicting it…at least if you are familiar you can be at least a little better prepared for it I think."
(Murtagh and Folan, 2014)

"They (antenatal ward staff) came in and said your waters are broken; you're going down to Delivery Suite. And then the midwife literally picked my bags up. We didn't even get to finish our toast! It was obvious we were working to somebody else's timetable."
(Gatward et al., 2009)

Women's experiences of informed consent discussions

Many women reported trusting health professionals and what they had been told about the process and therefore the notion of challenging them was not brought forward, even though there was evidence in some of the papers that informed decision making was not always taking place:

"You know as far as I'm concerned, when the doctor says you should be induced then they know best…I would never go against that."
(Murtagh and Folan, 2014)

"Well, they make it sound like the best thing…I never even would think to question a doctor…I mean they are doctors…like it's their profession and I totally trust them to be telling me to do what is right for the baby.
(Murtagh and Folan, 2014)

In contrast, some women described experiencing induction of labour as an offer that was also a recommendation, with the feeling that they still had an option to say no to the process, therefore highlighting that for some women, informed discussions are taking place. This is highlighted in the following quotations from the papers reviewed for the systematic literature review:

"It was clear that it was something they [the midwives] recommended, but it was not a forced recommendation and they explained why they recommended it. So, everything was clear to me, and they didn't make induction feel like an obligation."
(Lou et al., 2019)

"I was pretty unprepared for the amount of pressure which would be placed on me once I had gone past my EDD (estimated due date). The pressure was pretty much instant."
(Roberts and Walsh, 2019)

Additionally, some women in the studies stated that they felt adequately prepared for induction of labour and had sufficient information. However, conversely, there are also study findings to suggest that women felt they had experienced induction of

labour as a non-choice, with pressure from health professionals to consent to the process, therefore illustrating a lack of informed decision-making taking place (Roberts and Walsh, 2019). The so-called 'risk discourse' in which the emphasis was put onto rare but serious risks to persuade women to make certain choices was evident in some of the studies:

"I actually told the midwife that I didn't really want to be induced. But she kinda ended up persuading me…Because, she said that they preferred all children to be born before 42 full weeks and that the odds would be better. But I was a bit surprised by that persuasion…because up until then I had felt really included and heard in all the decision regarding my pregnancy and birth."
(Lou et al., 2019)

"From forty plus five onwards every single member of staff insisted on reading me the riot act – how I was doubling or trebling the risk of stillbirth, that I should be induced, that I was taking a terrible risk, that there were going to document that I had been told etc etc."
(Roberts and Walsh, 2019)

Hospital policy

Additionally, from a hospital policy perspective, some findings highlighted the notion of women feeling that they needed to accommodate the induction of labour process due to the policies and guidelines of the hospital (Roberts and Walsh, 2019). This can prove particularly challenging for health professionals who are acting as the woman's advocate whilst managing risk policies and guidance (Roberts and Walsh, 2019). For example, policies recommending induction of labour for prolonged pregnancy are debated amongst professional groups because optimal timing of induction of labour in some situations remains uncertain, and this can cause difficulties when discussing it (Roberts and Walsh, 2019).

One study highlighted that informed consent was not always taking place for procedures being undertaken:

“Unfortunately, I had my ‘membranes stripped’ without being told why or given any information. It was only afterwards that he mentioned the name of what he had done (I looked it up) and that I could go into labour soon (which I did).”
(Stevens and Miller, 2012)

Lou et al. (2019) described how some women felt that they were part of a regimented process once induction of labour was underway:

“The midwife said, “Oh, it’s already in.” I guess it implies consent that I have checked into the hospital. For her, that prostaglandin has been so long out of the fridge, but you know, my child and my feelings about labour are more important and she could just take another one out.”
(Lou et al., 2019)

Ultimately, health professionals are required to provide women with sufficient and accurate information to enable women to have the freedom to make autonomous decisions regarding their care, with the principles of informed choice being the core aim of women centred care. However, this theme highlights the range of challenging issues with these processes and the multiple variables involved with achieving this outcome effectively.

Discussion

Induction of labour, like any intervention offered to pregnant women needs informed discussion and consent to be undertaken. However, an issue of concern that continues to be noted is, if and how informed decision making is taking place and how this aligns with women’s holistic care needs and birth philosophies (Yuill et al., 2022; Harkness et al., 2023). The information provision for induction of labour is crucial to mitigate against a negative birth experience, which can be associated with postpartum mental health problems (Lou et al. 2019). Therefore, women and their partners who are experiencing induction of labour need a sense of involvement and inclusion (Lou et al., 2019). However, this review indicates that information about the risks and benefits of induction of labour may be presented to women superficially by health professionals. This is in line with other studies about information and consent in maternity care specifically (Nicholls et al., 2021; Elf, Nicholls and

Lanceley, 2024) and within health care more generally (Lamont, Stewart and Chiarella, 2017). Furthermore, women's attitudes towards and experiences of induction of labour seem to vary considerably, some of which can be attributed to the social contexts and expectations of family, friends, and social media.

From an information giving perspective, it is evident that many women are not aware of the level of information that is needed to achieve an informed decision (Stevens and Miller, 2012). Various suggestions were identified by participants in the studies included in the review to support information giving, including women preferring to receive information earlier and to be given more time to consider their own feelings and values (Lou et al., 2019). Furthermore, some women would prefer a more thorough presentation of the alternatives and more time to think the situation over (Lou et al., 2019). Indeed, a woman may need time for preparation and a variety of sources of information in order to have the autonomy to opt for the less recommended path if they should choose to do so (Larner and Hooks, 2020; McAllister, S. and Litchfield, 2024). Women valued health professionals who gave detailed information and at the same time respected their choices (Chen et al., 2018; Bohren, Tuncalp, and Miller 2020).

Policies can sometimes be looked upon as implementing 'time standards' rather than considering embodied knowledge. For some women, whilst they acknowledge medical expertise, they would also like to consider their own expertise in relation to their bodies and their babies (Roberts and Walsh, 2019). However, many women do not feel that they are offered a choice, with induction of labour being the inevitable next step in their care (Lou et al., 2019). Some women describe declining the intervention but the need to be assertive, with the feeling that their embodied knowledge carries little weight with health professionals (Roberts and Walsh, 2019). Some women felt it inappropriate to challenge the practitioner as the professionals involved in their care (Lou et al., 2019). Indeed, for some women, the notion of challenging health professionals would not come into question as they trusted what they were being advised to do (Murtagh and Folan, 2014). Some women felt that they did not have the knowledge or the confidence to question the interventions that were being recommended by health professionals (Lou et al., 2019). Resistance to

medical advice does remain possible since women do make choices against medical recommendations especially when they report that their embodied knowledge is not always listened to by health professionals (Roberts and Walsh, 2019).

Whilst adequate information is essential, it is imperative that health professionals are aware of the other interacting factors that impact on informed decision making and informed consent. Indeed, there are a plethora of factors involved with informed decision making that impact upon the process in a variety of differing ways and these are discussed throughout all phases of my research. A thorough understanding of the variations that may impact upon discussions, aids health professionals with their communication when guiding women throughout induced labour and the birthing of a healthy baby (Gatward et al., 2009 and Murtagh and Folan, 2014). This includes structural factors, cultural factors, individual abilities, the relationship with the health professional including trust, as well as the capability to influence the decision-making process (Gatward et al., 2009 and Murtagh and Folan, 2014).

With all this in mind, health professionals need to understand the variety of possible situations that are, in legal terms, 'material' (The Supreme Court, 2015) to the women they talk to about induction of labour. They also need to be respectful and responsive to the way women react to these discussions, and to the decisions they make. It is essential that encouragement to ask questions and participation in the decision-making process is supported to facilitate inclusion and to validate women's opinions. In turn, this informs the holistic and individualised and personalised discussions that enable women and their partners to make a fully informed choice.

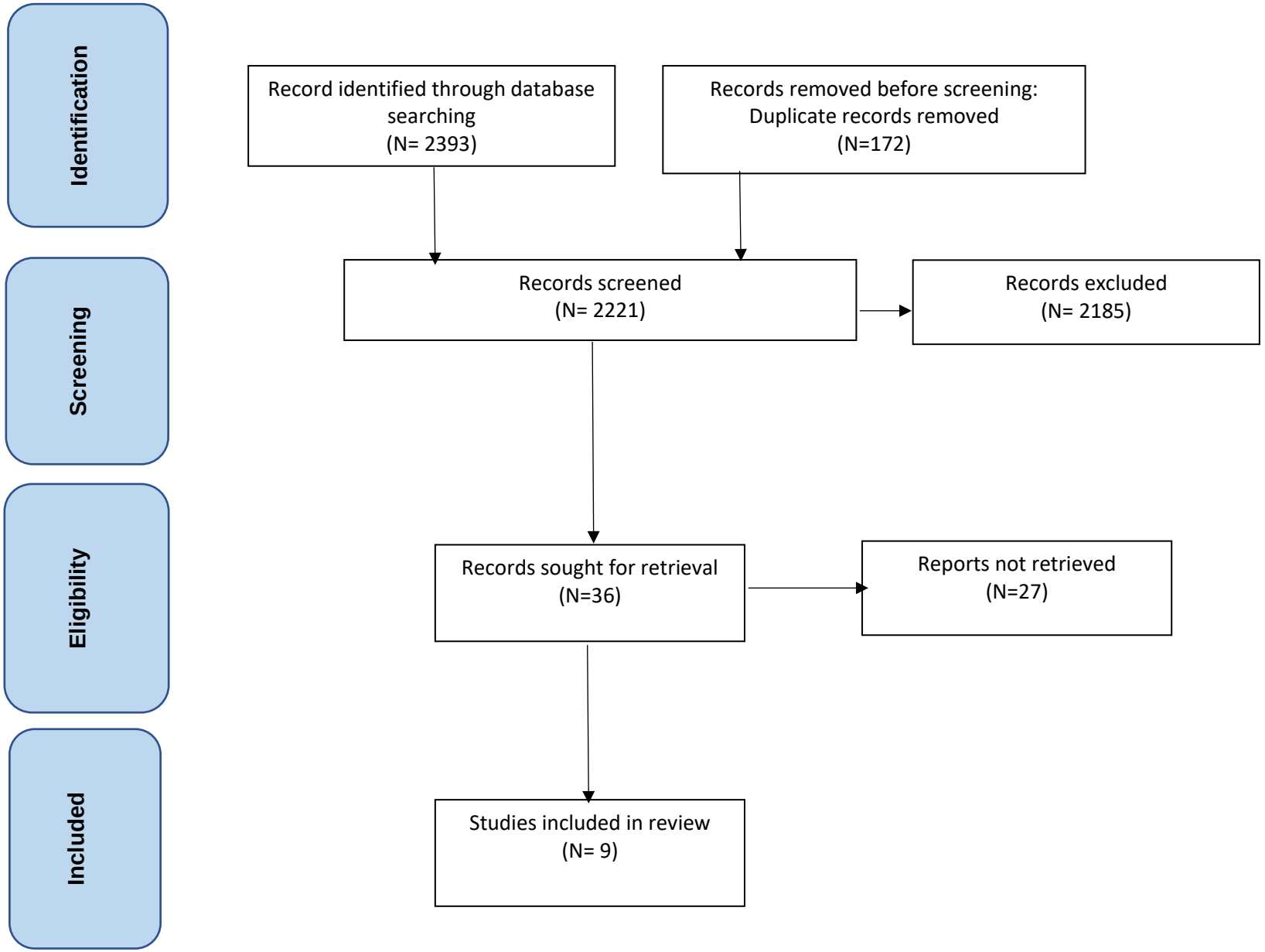
Summary

This review contributes to exploring women's experiences of induction of labour and informed consent with a term pregnancy. It is evident that there are many variables to look at when considering informed consent processes for induction of labour. In summary, the interconnected and overlapping themes identified and discussed within this systematic review of the literature are: 1) a sense of 'time being up' and, 2) Informed consent and women's information needs.

The systematic literature review highlights that women's feelings towards their experiences and their decision-making processes vary and this can be associated with the multiple inter weaving factors noted throughout this chapter. Discussed within the review is women's information requirements and if and how informed decision making takes place and the plethora of variations identified with this. Also discussed within the review are the additional sources of information that women utilise and how these all intertwine and impact upon decision making.

The findings of this review illuminate the need for further education for health professionals around the informed consent process to improve the quality of information given to women. Health professionals need to be able to understand and adapt the discussions by understanding the variation in responses to match communication with women. This includes consideration of how social contexts may impact upon informed decision making. Another finding of this review highlights that due to the barriers described, it is unreasonable to expect that all verbal information provided is retained and that health professionals alone are sufficient to educate women fully. In the case of induction of labour, the studies highlight that offering women written information at the time of the decision for induction of labour enhances women's knowledge and understanding of many aspects relating to the process, time frames involved to the birth of their baby, increased awareness of side effects and risks of the procedures involved as well as a greater understanding of the likelihood of common induction of labour related events occurring. The provision of high-quality information in the correct formats at the correct time along with respectful and comprehensive discussion about options may enable women a sense of control over the process through the confirmation of informed consent. This in turn also strengthens relationships of trust between women and health professionals and enables holistic, individualised care planning to take place effectively.

FIGURE 1: PRISMA DIAGRAM



CHAPTER 4

Questionnaire of antenatal maternity service users

Introduction

This chapter presents the results of the questionnaire of the antenatal service users who had partaken in discussions with health professionals regarding induction of labour. The details of the methods used can be found in Chapter 2, Methodology. The results are presented in tables along with the free text quotes that were collected as part of the responses.

The research question for this phase of the study was:

"How is informed consent discussed with women who are offered induction of labour at or beyond term gestation"?

This part of the study links to phase 2, whereby an online questionnaire was devised and undertaken for women with pregnancies that had reached term gestation who had had discussions with a midwife and/or obstetrician regarding induction of labour.

The questions were generated by the findings of the systematic literature review (Chapter 3). It was generated on Qualtrics (Qualtrics XM: The Leading Experience Management Software) and was accessed by women via a quick response (QR) code on the participant information sheet. It comprised sixteen questions regarding age, ethnicity, discussions around induction of labour, location of discussion(s), who discussion(s) were held with, clarity of information, involvement with decision making, timing of decision, types of information provided, opportunity for questions and exploration of options, understanding of information provided, information received including the induction of labour leaflet, other information sources accessed, any additional information received from anyone other than a health professional and usefulness of the same. The questionnaire ended with the opportunity for women to leave their email address if they were interested in taking part in further research for this project. A copy of the questionnaire questions can be found in appendix 8.

Response rate

In total, 102 respondents logged on via the quick response (QR) code to answer the questionnaire. Of the 102 women who accessed the questionnaire, 99 women consented to take part. 98 women started to complete the questionnaire which dropped to 96, 95 and 94 as the questionnaire progressed and as detailed within the chapter. As per ethical approval, one woman was not eligible to complete the questionnaire due to not receiving care at the Trust where the research project was taking place. It is unclear why the other two potential participants did not consent to take part.

Demographics

As part of the demographic data collection, participants were asked their age. The mean age of the respondents in the questionnaire was 29 years and four months, with the youngest respondent being 18 years old and the oldest respondent being 41 years old, thus providing information from a wide range of ages.

Table 11

Age of respondents		
Age (years)	**Number of women**	**%**
18-24	18	18%
25-29	37	38%
30-34	24	25%
35-39	17	17%
40-44	2	2%
Total	98	100%

As part of the demographic questions, participants were asked about their ethnic group. The Census (2021) identifies that there is a population of 443 017 people within the area of the Trust where the research project took place. Of that population, the statistics identify that 70% of people are white, 24% are Asian, less than one percent are black, less than one percent are Arabian, one percent are mixed multiple with the remainder being of another ethnic group. This is reflected with accuracy in the ethnic groups identified in the questionnaire with 68% of respondents identifying as White British, two percent identifying as white any other background, one percent identifying as white any other mixed background, two

percent identifying as Bangladeshi, one percent identifying as Asian any other background and 14% identifying as Pakistani and nine percent identifying as Indian, with some of the other ethnic groups making up the remainder of the responses. In terms of ethnicity, respondents may therefore be considered representative of the population in the area where my research study took place.

Table 12

Ethnicity of respondents		
Ethnicity	**Number of women**	**%**
White British	67	68%
White Irish	0	0%
White any other background	2	2%
White and black Caribbean	0	0%
White and black African	0	0%
White any other mixed background	1	1%
Indian	9	9%
Pakistani	14	14%
Bangladeshi	2	2%
Any other Asian background	1	1%
Caribbean	0	0%
African	0	0%
Any other black background	0	0%
Chinese	0	0%
Other ethnic category	2	2%
Total	98	100%

Reasons for induction of labour and location where the discussions took place

Participants were asked why they were having their labour induced. The results are depicted in the table below:

Table 13

Why did you have a discussion about having your labour induced?		
Reason for discussion	**Number of women**	**Percentage of women**
Overdue	11	11%
Preterm pre labour rupture of membranes	2	2%
At my request/I wanted to be induced	6	6%
My baby was small	20	20%
My baby was large	17	17%
Diabetes	21	21%
Other medical complications	37	38%
I've decided not to have my labour induced	1	1%

There were 115 responses received from the 98 respondents who completed the questionnaire which as expected, indicates that some women had more than one reason for having their labour induced. The majority of those responding to the questionnaire were having discussions about induction for medical need. There were 40 free text responses that included; five for reduced growth, six responses for reduced fetal movement, 4 responses for raised blood pressure, two responses for diabetes, a twin pregnancy, two responses for IVF pregnancies, one response for Group B streptoccocus, two responses for polyhydramnios and responses for low pregnancy associated plasma protein A (PAPP-A), 'baby's doppler high blood flow',

'bleeding regularly, 'anxiety' and 'post-traumatic stress disorder' and choleostasis. Further responses included *'other medical complications' and 'obstetric.'*

Very few were requesting induction, and only about 1:10 were being offered induction due to post maturity. This is therefore a different sample of women than those included in most research studies in this area, whereby low risk health women being offered induction for simple post maturity are the majority.

Women were also asked where discussion(s) about induction of labour decisions had taken place. It was possible to select more than one answer to this question, and from the 96 respondents there were 106 responses received which indicates that for some women, discussions had taken place in more than one location.

Table 14

Where did you have the discussion for your induction of labour?		
Location	**Number of women responding**	**%**
GP Surgery/Midwife appointment	15	16%
Antenatal Clinic	44	46%
Central Birth Suite	7	7%
Antenatal Ward	6	6%
Antenatal Triage	5	5%
Blackburn Birth Centre	5	5%
Burnley Birth Centre	12	13%
Not sure	12	13%

Additionally, 12 free text responses were received, and these included two respondents citing a '*growth scan appointment'* as the location for their discussion and one respondent citing the '*Specialist Perinatal Mental Health Midwife'*. Four respondents cited *'consultant',* with other responses including *'ultrasound'*, *'antenatal clinic',* and *'rainbow clinic'.* Two other responses cited the '*other hospital site away from the main maternity unit'* as the location; it's unclear but this is likely to reflect the discussion taking place at the Antenatal Clinic at the other site.

The data collected for this question links to the reasons the women gave for why their labour was induced and which area of maternity services women were accessing based on their antenatal care needs when discussions took place. For example, those with diabetes, large for gestational age babies and small for gestational age babies are likely to have had discussions within the Antenatal Clinic setting, whilst women with preterm pre labour rupture of membranes are likely to have had discussions on the Antenatal Triage or Birth Suite.

From a question regarding who discussion(s) had taken place with, there were 96 respondents to this question. As table 13 shows, only a small minority of women discussed induction of labour with their midwife alone, while nearly half only discussed this with their doctor. This raises questions about what kinds of situations would endanger discussions with only one involved professional, since for most women it is important that both professional groups involved in their care are aligned about the offer of induction of labour.

Table 15

Who did discussion(s) for induction of labour take place with?		
Who with?	**Number of women**	**Percentage of women**
Midwife	16	17%
Doctor	41	43%
Both	39	41%
Total	96	100%

The results from these questions evidence that midwives and obstetricians in all areas of the maternity unit are likely to hold conversations with women about induction of labour, thus emphasising the requirement for both these groups of the multi-disciplinary team to be involved with the processes for informed consent.

Women's involvement in the process of discussions

To explore and address the key points discussed and considered around informed consent, it was important to ask women as part of the questionnaire regarding whether they felt involved in the discussions about induction of labour, the types of information they received from midwives and/or obstetricians, the clarity and understanding of the information received, opportunity and time for questions and

discussion with midwives and/or obstetricians, and whether they received the induction of labour leaflet.

Women were asked how involved they felt in the decision-making process and the results are depicted in the table below:

Table 16

How involved were you in the process to decide whether to have your labour induced?		
Involvement	**Number of women**	**%**
I wanted my labour to be induced	25	26%
I was told that induction of labour was recommended, and I was agreeable to this	51	53%
I was told that induction of labour was needed but I needed reassurance	6	6%
I was told induction of labour was needed, I agreed but would have preferred to wait	5	5%
I wasn't involved in the decision-making process	7	7%
I asked for more time to make a decision	1	1%
I declined	1	1%
Total	96	100%

There was one free text response received with the respondent stating that '*a shared decision had been made'*, *'following discussion at an antenatal appointment due to*

having an in vitro fertilisation (IVF) pregnancy'. The data collected highlights that a high proportion of women (82%) were agreeable to plans. However, this did mean that about 1:5 respondents were either hesitant, or actively resistant to the idea of induction of labour, and it is concerning that seven respondents said they felt they had no involvement in the decision-making process.

Clarity of information provided

Women were asked about the clarity of the information that they received about induction of labour and the data collected is depicted in the table below:

Table 17

Was induction of labour explained to you clearly so that you could make a choice that was right for you and your baby?		
Involvement	**Number of women**	**%**
Definitely yes	64	67%
Probably yes	29	30%
Probably not	2	2%
Definitely not	1	1%
Total	96	100%

This indicates that the vast majority of respondents (96%) felt that information was definitely or probably clear. However, this is partly contradicted by the data in table 18, which indicates that only just over half of respondents fully understood the information they were given, raising some questions about the impact of this on informed consent.

Understanding the information received regarding induction of labour and time to ask questions and explore options

Table 18

To what extent did you understand the information you were given about induction of labour?		
Extent	**Number of women**	**%**
Fully understood	56	59%

Partially understood	35	37%
Didn't understand	4	4%
Total	95	100%

Indeed, the free text responses to the questions suggested that some women struggled to process all the information they were given:

"Just a lot to take in."

Or, that they were not given information at some stages in the process:

"Was induced with first after waters broke but didn't get information then too and didn't really know what was going on."

Crucially one of the free text responses indicated that one woman did not understand how long the process could take and this was also reflected elsewhere within the responses received:

"Understood some parts but was told it would take two hours not three days possibly."

One woman felt that obtaining information from additional sources had supported her with the information she needed to make a decision:

"I had done a lot of research of my own and completed antenatal education. I feel that I was able to challenge what was recommended and make the best-informed decision best for my circumstances, but others may not be as inquisitive/knowledgeable to challenge or ask the right questions. More information and other options should be more clearly encouraged.'

Women were asked whether they felt they'd had time to ask questions, discuss and explore options for induction of labour. The results are depicted in the table below:

Table 19

Were you given time to ask questions, discuss and explore your options for induction of labour?		
Time	**Number of women**	**Total %**
Definitely yes	66	69%

Probably yes	22	23%
Probably not	6	6%
Definitely not	1	1%
Total	95	100%

Again, although a majority felt they definitely had enough time, about 1:3 were more uncertain. Following on from this, it was important to find out what subjects women received information on. In the Trust where the research was undertaken, to support information giving, the maternity unit has an induction of labour information leaflet for women. Of the 98 women who responded to the questionnaire, 86 women reported receiving a copy (88%). The remaining 12 (12%) stated that they had not received a leaflet although it is unclear why. It is also unclear from the data collected for this research whether the leaflets were being used as a tool for discussion. The results are depicted in the tables below:

Table 20

Were you given information on the following subjects?		
Information	**Number of women**	**%**
Why induction of labour is recommended for you	72	76%
What to expect when you are being induced	75	79%
Setting for your induction of labour	44	46%
Timing for your induction of labour	37	39%
Pain relief	37	39%
Prevention and management of any complications	34	36%

There were 331 responses to the question asking what types of information women received, which as expected indicates that respondents received information on more than one of the subjects. Information for why discussions were being held about labour induction and what to expect were the top answers. However, despite the majority of women saying they were happy with the time they had and the information they got, less than 1:4 reported getting information on key subjects related to induction, suggesting that, in the antenatal period, women were not aware of important information they needed to have fully informed consent related to labour induction.

Five respondents left free text responses to indicate other sources of information, and these included, '*receiving the information leaflet provided to read at home'*, two respondents cited being given information on the '*possible risks'* that may occur. One respondent cited *'the midwife on the daily monitoring unit was very reassuring and gave me all the information I required'* with another stating *"I thought everything was great, staff at the hospital, service, care, information."*

Based on the questions around information received, clarity and understanding and whether women felt they had time to ask questions and to think, it was important to ask women as part of the questionnaire at what point they made the decision for labour induction.

Making the decision for induction of labour or not

Table 21

At what point did you make your decision to accept or decline induction of labour?		
Time of decision	**Number of women**	**%**
As soon as I could past my due date	6	6%
One week past my due date	3	3%
Two weeks past my due date	2	2%
Planned in advance	37	39%

When my pregnancy wasn't going as expected	15	16%
When my membranes ruptured but I hadn't gone into labour	2	2%
I wasn't given time to decide	3	3%
I don't remember	5	5%
Other	9	9%
Free text comments	14	15%
Total	96	100%

There were 14 free text responses included, with one respondent citing the decision being taken two weeks prior, one respondent citing that they had been told that they would need to be induced as soon as possible and were booked for the following morning rather than *'waiting to see if a sweep at 38 weeks worked over 48 hours.'* One respondent left a free text response to say they had taken the decision in '*diabetic clinic'*. Other reasons were for '*reduced movement'* and '*age',* '*planned in advance due to IVF'*, *'never felt comfortable going beyond 39 weeks due to previous stillbirth', 'when I got advised', 'when I was told my baby was big', '38 weeks to benefit my baby and me', 'soon as it was mentioned', '2 weeks to decide as I was 36 weeks', 'when I was told my placenta may stop working properly', 'during the consultation with doctor after scan', 'when we told about the condition.'*

From the data collected from these questions, overall, most women felt they had been involved in the decision-making process, that there was clarity and understanding about the information they had received and that there had been opportunity to ask questions, discuss and explore their options. For the question regarding types of information women had received, there were fewer answers for setting for induction of labour, timings, pain relief and prevention of management of any complications. This may suggest that whilst women felt they had clarity and understanding and had been involved, that there were important elements of information that were missing that they were unaware of. Therefore, this may

indicate the necessity for a more targeted and specific approach on the different aspects of information required to enable fully informed consent.

Other materials accessed

The results are depicted in the table below:

Table 22

What other materials did you access for information about induction of labour?		
Other materials accessed	**Number of women**	**%**
Books	4	4%
Internet	68	72%
Social media	10	11%
None	18	19%

There were 95 respondents to this question. Five respondents left free text responses with one respondent saying she had spoken to '*family and friends'*. Two respondents had accessed '*NCT classes'*, one had accessed an '*Antenatal course'*, one cited accessing '*leaflets'* and one confirmed *'decision with midwife.'* This illustrates the significant influence of the internet on where women access information from.

Additional advice from anyone other than a health care professional and usefulness of the information

Table 23 notes additional advice women had received from anyone else other than a health professional.

Table 23

Did you receive any additional advice from anyone else other than a healthcare professional when making your decision about induction of labour?		
Advice from others	**Number of women**	**%**
No	46	48%
Partner	21	22%
Friend	20	21%
Family member	29	31%

Doula	1	1%

There were 95 respondents to this question with 117 responses which suggests that some respondents used more than one source to seek additional information. From the responses obtained, it was evident that women utilise partners, family, and friends as additional sources of information. Additionally, other free text responses to the question were received as follows:

"My own previous experience."

"Was warned it will take more than two hours but did not prepare to be here for days. Need to rearrange childcare."

"Consultant forgot to add our induction of labour information to my book."

Some of the free text responses pertain to discussions earlier on in this chapter regarding women utilising their own previous experience to inform their current pregnancy, with others noting a lack of information in terms of length of time an induction of labour may take, and a lack of information provision.

Table 24

Was the additional information useful?		
Usefulness of information	**Number of women**	**%**
Extremely useful	20	21%
Very useful	33	35%
Moderately useful	22	23%
Slightly useful	11	12%
Not at all useful	8	9%
Total	94	100%

Therefore, over half of the respondents (58%) found the additional information to be extremely, very, or moderately useful. This implies that the information they received

from non-NHS sources did not meet all of their needs. Information received from other sources adds to the complications around the informed consent process as discussed throughout the thesis.

Summary

In summary, the results of the questionnaire indicated that women were being offered induction of labour for a variety of different reasons, with over half of the respondents having medical needs such as diabetes and other medical complexities. Very few indicated that they were choosing induction of labour without medical reasons. Overall, the questionnaire responses show that most respondents agreed with having their labour induced on the basis of the information they received. However, table 18 indicates that this information may not have in fact been comprehensive, suggesting that some pregnant women may have believed they were fully informed, without actually knowing some of the key facts.

It is important to note that those who had medical conditions such as diabetes would have known from an earlier gestation that their labour was likely to be induced, therefore potentially providing more opportunity to digest the information to enable informed decision making. The Trust where the data was collected has a diabetic continuity of carer team which likely aided the ability for informed consent to take place effectively. The questionnaire showed that women used a variety of sources to obtain additional information including the induction of labour information leaflet, the internet, social media, partners, friends, and family.

The key strength of this questionnaire is that the respondents appeared to be representative of the Trust population, and that they included the full range of women who might be offered, or request, labour induction. One key limitation is that it was not open to women who did not read English, which is important based on the known inequities in maternity care for those from Black and Asian backgrounds (Core20PLUS5, 2021; MBRRACE, 2023). Whilst free text was an option that was utilised within the questionnaire, a further limitation of a questionnaire is that it does not allow for deeper probing. For example, why women felt well informed when many actually did not receive some of the critical information required to make a fully informed decision. The postnatal interviews in the next phase of the study allowed for deeper exploration of these and of other issues.

CHAPTER 5

Interviews with postnatal maternity service users

Introduction

This chapter presents the findings of the interviews with postnatal maternity service users who had responded to the antenatal survey (phase 2). The aim of the interviews was to gain the views of women in relation to informed consent and how this shaped their experiences of induction of labour.

The research question for this phase of the study was:

"What do postnatal women say about communication with healthcare professionals in regard to induction of labour and the impact this had on their decision for birth and their subsequent birth experiences"?

The chapter opens with a section about the participants of the key areas of interest identified. As discussed on page 71, a case study approach was utilised built on the stories told by maternity service users. Some quotes have been truncated for precision and where words have been omitted this is written as: […]. Pseudonyms are used throughout the analysis to ensure anonymity. This includes anonymisation of the quotations used. As part of the cross case analysis, the chapter concludes with a discussion about the similarities and differences between the case studies and then a short summary of the findings of the interviews with the postnatal service users.

Participants

As discussed on page 71, a smaller sample than intended of four women whose labours were induced were interviewed postnatally via Microsoft Teams and one woman provided a written summary of her experiences of informed consent in relation to induction of labour. Table 25 provides the details of the demographics of the included participants.

Table 25

Name	Age group (years)	Ethnicity	Reason for induction of labour
Sarah	31	White British	Gestational diabetes
Rachel	37	White British	One episode of reduced fetal movements at greater than 39 weeks and maternal age
Saida	29	Indian	Epileptic and small baby
Lara	26	White British	Large baby
Saima	31	Any other Asian background	Raised blood pressure, one episode of reduced fetal movements and large baby

Case study 1

Sarah

Sarah explained that she had her labour induced for gestational diabetes and that this was her first baby.

Trust guidance stipulates that for gestational diabetes, a plan for birth should be discussed and documented in the woman's notes and if there are no other complications, elective induction of labour or caesarean section should be offered at 40+6 gestation. In the presence of complications, then the offer of induction of labour may be made sooner as was the case for Sarah.

Sarah discussed her experience following her diagnosis of gestational diabetes:

"…I had gestational diabetes so when I was diagnosed pretty soon after that I saw the xxxx team which was at xxxx just for women with the diabetes and pretty soon, probably about a week after I found out I had it, they said the chances are you'll need to be induced but it's a conversation to have much further down the line. My scans increased; I had growth scans every third week. And I met with the dietitian and each time they said you'll be, you'll be induced, you'll be induced, so I just sort of knew that it were gonna happen from probably about 24 weeks. It was written as part of my plan that that was what was going to happen" (Sarah)

Sarah talks about her plans, but the wording may suggest that these seem to be the plan of the health professionals and may reflect how clinical norms can subvert women's agency. What Sarah says does not appear to necessarily reflect an experience of an 'offer' of induction, accompanied with discussion or informed consent. Yuill et al. (2020) describes how women may be exposed to frameworks of choice defined by policy makers and health professionals, as opposed to women making their own choices. Sarah had very specific medical reasons and rationale for induction of labour discussions to take place for safety. However, the full risks and benefits would need to be discussed to enable the informed decision making process begin to take place.

To assist with her decision-making process, Sarah explained how she received a 'worst case' and 'best case scenario' about the process of induction of labour to enable her to prepare:

"…for my..pre induction meeting they'd said like worst case scenario three days with the pessaries and the gels, everything taking time and I was like ohh right, and they said we'd rather you have the full information." (Sarah)

Sarah went on to explain how she appreciated this approach as part of her preparation:

"Worst case scenario. Anything else is a bonus, but yeah…I want the best case, a worst case and then I can somehow judge anything better than that I'll be happy with, but.. I'm an advocate of having the worst-case scenario. Not that I'm pessimistic but just to know I like, I don't like being surprised. I don't like thinking, yeah but you said I'm giving up because I thought it was sooner. I'd rather expect the worst and then anything else is a benefit really." (Sarah)

During the course of the interview, Sarah disclosed that she suffered from anxiety. This fits with benefitting from receiving the 'worst case' and 'best case' scenario which interlink with the notion of catastrophising, whereby a person thinking of the worst-case scenario can then be prepared for any adverse outcome. It is thought that this way of thinking is reassuring for anxiety as it enhances a perception of control (Crawford, 2023).

Indeed, access to reliable information is imperative to women's experience and wellbeing during pregnancy and childbirth with professional sources of information being perceived as highly trustworthy and useful. However, in terms of seeking information, it is known that whilst women place value in their care provider, many women access information from other sources to fill any voids in their knowledge (Sanders et al., 2018). In terms of enhancing her knowledge, Sarah had accessed further information from a variety of sources. This included a book:

"I read a book on inductions called 'Why induction matters'". (Sarah)

Grimes et al., found that 17.2% of women had found books to be a useful source of information for pregnant women (Grimes, Forster, and Newton, 2014).

Grimes, Forster & Newton (2014) found that women use several different sources of information when given the option, with the majority preferring a variety of formats. In keeping with the 'worst case' and 'best case' approach that Sarah had described, she explained that she had googled a lot, particularly the experiences of other women rather than 'official' NHS information:

"I googled a lot… like…the facts I find quite scary. I found listening or reading as such other birth stories so things like Net mums, forums, reading other women's induction stories, I found it empowering. Whether they were a good story, whether they were a negative story, the more stories I could read, the better for me and just listening to the facts on like the NHS website, it didn't really do anything for me… and yeah, I've read all of them. Good, bad, everything…to hear all the real women's stories rather than just facts that are put by someone very clever." (Sarah)

The emphasis on *'stories rather than **just** facts'* is intriguing, in that it suggests that stories are more 'real' for decision making than factual information. In terms of advice from others, women find the range of information available online as largely

beneficial, with immediate access available from online networks (Sanders et al., 2018). Such sources can give some women entrance into a space, allowing for a different sense of privacy in which to explore options (Sanders and Crozier, 2018). However, the alternative side to this freedom is that women can encounter extremes of the birth spectrum, with stories offering alarming as well as reassuring narratives (Sanders and Crozier, 2018). Digital sources are one of the most commonly used information sources by some women, however they may be perceived by some as less trustworthy than professional sources (Vogels-Broeke et al., 2022). To negate this, Vogels-Broeke et al., (2022) suggest that health professionals should ask women what information sources they are using for their decision making and to recommend websites that are trustworthy and useful. However, the comment above from Sarah about the value of stories rather than facts may suggest that what health providers find as 'trustworthy and useful' is not the same for all women.

Sarah went on to describe how her partner had been pivotal in the decision-making process, reflecting that they played a significant influencing role:

"But because my partner was all for it, that helped me but if he'd have been against it as well, I'd certainly have been like what? What am I doing here? I'd have had to weigh it up a lot more, but…we both sang from the same hymn sheet as such, and we both agreed this was the best." (Sarah)

In contrast to the support from her partner, Sarah found advice from friends not to be so useful due to their differing experiences of induction of labour:

"The fact that the majority of my friends had a very strong opinion as mothers and they were against it, that ..was a struggle for me to come up against. …but they didn't have any knowledge of diabetes…your body knows best, and they were dead against it but I for some reason I wasn't against induction." (Sarah)

Dunn, Pirie and Hellerstedt (2003) acknowledge the important role that close female friends and relatives have for women in pregnancy. It is well-documented that women who benefit from the emotional support of their spouse, family, and social networks during pregnancy are less likely to be affected by psychological problems, such as distress, anxiety disorders and depression (Maharlouei, 2015). However, Sanders and Crozier (2018) report that if information received does not align with

women's perception of birth, then they feel strongly inclined to discard it and continue to seek that which is more congruent with their beliefs. This may go some way toward explaining why Sarah rejected the advice of her friends since it was evident that they had no awareness of gestational diabetes and medical complications.

From an information gathering perspective, Sarah explained that she had attended baby yoga and as well as enjoying the social aspects, had found this to be informative:

"…I went to I don't know if you'll know where xxxx, baby yoga and yes, I did that every week and she's quite knowledgeable. She was very pro birth centre and doing it naturally but that was somewhere I went and met other pregnant ladies at xxxx..." (Sarah)

Indeed, Spinelli et al. (2003) and Spiby et al. (2022) highlight the benefits of antenatal classes to enable women to access trustworthy information, to feel more confident and better prepared for labour and to understand about analgesia and interventions. Antenatal classes also enable women to be with other women at a similar stage of pregnancy which can help to normalise any anxieties being experienced (Spiby et al., 2022).

However, it is worth noting, that the data collection for this research study was during the Covid 19 pandemic with a variety of different restrictions in place at different times in terms of access to maternity services for women and their families. Therefore, access to formal antenatal education with health professionals was limited for women utilising services.

Sarah described the admission process for her induction of labour which was not dis similar to the women in the other case studies:

"*…so I was booked in for the Monday the 21st of March. They told me to ring up at 9:00 o'clock and check my bed was ready. So, I rang up at five to nine in the car. I didn't realise that I thought at this point you just say your beds ready on your way and they said yeah, you're booked in for 1:00pm and I was like one o'clock, I'm in the car now and they're like no one o'clock. So, I went to my boyfriend's work for the day, for the morning driving down with him." (Sarah)*

Upon admission to the antenatal ward and during her inpatient stay, Sarah described the staff as being lovely:

"…the staff were lovely. They were, they were just wonderful…just say thank you" (Sarah)

Indeed, despite the nature of their labours and any interventions experienced, all the women who were interviewed reported being extremely pleased with the health professionals who looked after them in the hospital setting, and this highlights the importance of being looked after by empathetic midwives. This may also be partially reflected by what Van Teijlingen et al. (2003) describe as a gratitude bias, whereby the birth of a healthy baby creates positive feelings from women toward the health professionals that care for them. Additionally, it has been suggested that women's memories of the childbirth experience are connected more to the emotional experiences than they are to the physical events of labour and birth (Jacoby and Cartwright, 1990; Heimstad et al., 2007; Murtagh and Folan, 2014).

Sarah went on to describe a sense of community within the four bedded hospital bay where she was in the early stages of her labour:

"I was so jealous but then I did skip ahead of somebody else and then they were saying oh my God you go in you and it was really lovely because actually they were quite happy for me and they were like if you go, my word you going to go meet your baby…Like I said I wish I'd actually exchanged numbers or whatever. You just don't think at the time, but it was really, really nice waving people off or thinking oh my word, I wish it was me but…I liked being that little community." (Sarah)

The sense of community was further emphasised by Sarah during the course of the interview, and this also gave opportunity for the women in the bay together to discuss their reasons for induction:

"… it all just kicked off as soon as the contractions came I didn't wanna know anybody but yeah we all opened our curtains when all the fellas had gone home, we were all on the [birthing] *balls. There were four of us in the room and we were all just chatting and moaning at the same time and contractions and pain. But it would be really nice to go, why you being induced? Why you being induced and learning that actually it's not just because for my story it was.. being diabetic but and I've never*

known anyone else being induced for any other reason. My sister was induced. She was diabetic, but actually another woman said, no, my baby's actually she's not grown in a couple of weeks so they're inducing me. Or my baby's grown too much, or I'm an older mum or this and that and I was like oh my word, there's loads of reasons why these things happen, and I didn't even know, and I was going through it myself." (Sarah)

Sarah's experience of the hospital setting differed from some of the more negative stories described in the case studies later in this chapter, providing a counterbalance requiring further exploration. Some of Sarah's feelings and experiences may be reflective of her early awareness that she knew she would opt for induction of labour due to her diabetes and other complications, therefore perhaps also meaning that she had more knowledge and understanding of the induction process.

Sarah did described a more negative experience for one of the other women in the bay:

"…there was a lady in the bed next to me…she went during the middle of the night when my contractions had started. She went up but the doctor came to check her, and she just cried every time the doctor came because…she'd had it…and still hadn't progressed and she didn't really speak much English, but she screamed, and it was the middle of the night. And that was the only thing that sleep was difficult because obviously you're all having like contractions at different times and…she wailed and cried and cried and cried. But after my contractions .. kicked in, I understood exactly why." (Sarah)

It is unclear from the narrative provided, but it may be possible that language barriers impacted on this woman's experience. Overall, women with language barriers describe difficulties accessing maternity services, a lack of choice of interpreter, suspicions concerning the confidentiality that interpreting services provide and how well interpreters liaise with health professionals (Rayment-Jones et al., 2021). This may all have impacted on this woman's experience and is an issue that warrants further research and exploration.

Sarah described her own labour experience:

"…Really nervous, I knew what was gonna happen, but I didn't know how it would feel. I didn't know how strong the contractions would be. I didn't know how long anything would last and so they'd given me a worst-case scenario. They inserted the pessary at 3:00 PM. Didn't feel anything until 8:00 PM, nothing. My partner went home and then about 9:00 o'clock I texted him saying it's happening, something's happening..." and my friend who is having twins, I found out that she was being scanned downstairs. So, I walked downstairs, and I was on the red chair rocking, having contractions... Um and then it was at 3:00 PM it yeah, they were meant to check the pessary at 3:00 PM. So, it went in at three and then they saw me walking at about midday and they said we think we should check you early and they said that it had overstimulated, so it had done its job. It had ripened my cervix and it had actually kickstarted more contractions than necessary so they pulled it out and said .. you won't need the gels, which was lovely because they told me that would be six hours each for three rounds of gels. So, they said we'll see if your contractions carry on with nothing in and then we'll check you at three, and they did. I went down to the birth suite at 4:00pm, so that was 25 hours after the pessary had been put in and they broke my waters. That was strange, weren't bad. It was strange feeling all the water…And then I woke up at, I woke up at 9:00 PM and decided to stop pressing the pain relief [for epidural analgesia] *and thought I can do a bit more now that I've had a rest. Erm and at 10:00 PM, I said I need to be checked and they said no, you don't. We'll check you at 2:00 AM and we expect at 2:00 AM to be eight centimetres and I… kept saying I need you to check me at 10:00 PM and need to check me and by half ten she said all right, we'll let the student check you if that's alright, of course, so xxxx the student checked me and she said to the midwife, I think you need to check so the midwife checked and then said to the student what do you think she is and she said ten centimetres. And the midwife said, yes, she is. And then she said that because I hadn't pressed the button, if I wanted to leave it a little while before pushing, I could. So, we left it till midnight so that most of the epidural had worn off. I was saying I wanted to get up and go and they're like you cannot stand up off an epidural. I could have stood up as I could wiggle my legs and everything and, they said we'll tell you when to push and they told me twice but then by the third time I said you don't, you don't need to tell me I can, I can tell it's coming, I can feel it and then uh, about ten minutes before it was over, I said I can't do this and I thought they're lying to me and they kept saying, she's coming round the bend. I can see her*

head and she keeps going back and I thought they're lying. And then my boyfriend said it. I could see her hair and he's lying as well. Two or three more pushes and 0103am she was born crying…" (Sarah)

This quote is interesting in that it illustrates that Sarah felt that she knew what was happening to her body but that the midwives were more inclined at first to go 'by the book' and to follow hospital guidelines and told her she could not be right in thinking that her labour was progressing quickly, when in fact Sarah was correct. It is unclear from the quote but the midwives may have been concerned with factors such as increasing the risk of infection with multiple internal examinations. Sarah's quote also illustrates that for some women, labour and birth after induction of labour can be swift and straightforward and this is also a crucial part of informed decision making discussions around induction of labour.

This section of Sarah's story does not include accounts of labour pain. It does mention pain relief, though ('*pressing the button'* for epidural analgesia). The issue of how painful labour can be is reflected in the majority of the case studies. In fact, in other sections of her story, Sarah describes her experience of labour pain:

"Midnight, I asked for some paracetamol, and they gave them to me. And then by the morning, it's certainly as the contractions are ramped up and they suggested I had a bath which was delightful. Whilst I was in the water, all the contractions went. It was lovely. As soon as I got out, well, the contractions didn't go, the pain went as soon as they got out. The pain was horrific again …" (Sarah)

Sarah goes onto describe the intensity as the contractions increased:

"Ohh, then, the contractions were horrific. They were horrific. It was horrible but I'm sure it's horrible for everybody. I had the gas and air... What do I have after the gas and air? Ohh they checked and unfortunately, I wasn't dilating enough so they said that I'd have to have the bag of oxytocin…or something. They said that and they already warned me at my pre-birth meetings that that would ramp up the contractions even more. They'd probably be back-to-back contractions and the pain would be a lot…" (Sarah)

Similarly to most of the women who were interviewed, Sarah opted for an epidural:

“So, at that point I said I want an epidural. And they said, do you want to see if you can get to 6 centimetres without the epidural? No, if I'm having it to me I just said, if I've decided on the epidural if I'm having it either way, it doesn't matter whether I'm 4 centimetres or 6 centimetres. Let's not… I'm having it, so let's just do it now. And I slept and it was lovely”. (Sarah)

The average length of labour following induction is longer than spontaneous labour and there is evidence that women find it more painful (Ostborg, Romundstad and Eggebo, 2017). Additionally, and in line with this, the literature, and the research highlight that the uptake of an epidural is far higher for women whose labours are induced; 47% compared to 19% of women with a spontaneous birth (CQC, 2020).

In summary, Sarah was happy with her overall birth experience:

“…I think it [planned induction] *made my birth experience better…I really do because I knew…when it was happening. I decided on the day with the nurse. You know, they originally said a date. I said that's not going to quite work with me. So, we negotiated a date together and I quite liked it. After I got my head around it, I liked it, that I knew when it was going to be, it wasn't spontaneous, I wasn't waiting around. I wasn't getting more and more and more anxious because I knew well, there's no point worrying because this is what it's gonna be. And it actually, I think it improved my birth story for the better…I would do it again.” (Sarah)*

Overall, Sarah described how she would like to see induction of labour being more normalised:

“…I just wish there were more, more normalised as such… [for] *people in the community that have got a health concern or if you’re of a certain age or if for whatever reason you're being induced then it becomes normal to you. It was my norm, I knew no different but when I told other people to them it was like I was speaking a foreign language. It was so bizarre that I would choose this… I think things are only normal that we see..don't you know that we're accustomed to quite a lot that we see a lot that that's around a lot and if you don't know anybody that's been induced, especially early because most people are when it gets late aren't they? But yeah, I don't know how it would go about but just normalising it because I think if you go back maybe 20 years, maybe even 10 years, caesareans had stigma against them that you’re too posh to push, it is the easy way out. And nowadays there's so*

much on social media, so many things are shared about the seven layers that people have to cut through and it's not the easy option and the recovery is harder. And now everyone respects caesarean choices but there's still not really anything out there about inductions and that's a lot of stories. A lot of women. That's their story and it was my story and it'll be my story again and I would like to see it more normalized. That it does take, you know, it's a decision that you have to weigh up when most women don't have to do that. You don't, you don't get that." (Sarah)

Sarah's birth reflects the thoughts of someone with very specific medical reasons to be induced both for herself and for her baby. There was also the additional benefit that, as someone who tended to be anxious with uncertainty, Sarah enjoyed the opportunity to be in control by organising her date for induction of labour to enable her planning. It is important to note that these circumstances are not always typical of other women being induced and women who are induced for different types of medical rationale and non-medical rationale may have very different opinions of their experiences and how they felt about them.

Case study 2

Rachel

Rachel told me that she had been offered induction of labour for one episode of reduced fetal movements after 39 week's gestation and for maternal age (37 years old).

At the Trust where the research study took place, reduced fetal movements can be a reason for offering labour induction, based on NICE guidelines (NICE, 2021). However, if a woman opts not to have her labour induced for reduced fetal movements, the care pathway recommends the offer of ultrasound assessment of fetal growth, unless it has been performed in the preceding two weeks. If the scan does not raise any concerns, twice weekly CTG's and weekly ultrasound for liquor volume and umbilical artery Doppler are offered with consideration of birth of the baby at any time in the presence of ongoing reduced fetal movements.

When considering maternal age alone, the Trust guidance states the option for induction of labour at 39-40 weeks should be discussed in antenatal clinic at or over

age 40. Therefore, whilst Rachel reported being told that her age (37 years) was one of the factors for the recommendation of induction, this should not have been a factor in discussions with her about her decisions on labour onset.

For Rachel, the ultimate decision for induction was based on the consideration of her safety and that of her baby based on the information that she received:

"…So, the discussions started because I had reduced fetal movements so … I was due on the Tuesday, went in on the Saturday, concerned about the reduced movement. Ended up going back for a scan and further monitoring at the beginning of the next week and then had a discussion with the doctors and the midwives in the monitoring unit at xxxx in relation to being induced that week and then went in for the induction on the Wednesday…due to the reduced fetal movement and also my age as well. So, I'm 37 so that was a concerning factor for myself and my husband after speaking to the midwives and the doctors and ….. and then that was basically it. So, we took a decision me and my partner to go ahead with the induction and just based on the risk factors that you know my age and things like that". (Rachel)

Rachel went on to describe that following discussion, the risks she had been told about of continuing her pregnancy cemented her decision making to have her labour induced:

"…I think um well to be honest it could have I could have come naturally over the erm you know, the course of that week. However, I didn't want to take that risk and with my age and with I know that still birth percentages are quite rare but you always do think oh God, if it is mine and I've carried it to term, you know you just I personally just couldn't take that risk and for the sake of being induced as awful as it was the first time I thought do you know what, as long as the babies here safe and that's all that kind of mattered and so it probably did affect it and did make it a little bit more dramatic but that was completely my decision to make and that was made very clear by the staff at xxxx and you know it is what it is and she's here safe so that's all that matters really" (Rachel)

Rachel felt that the information she got was clear, both through verbal communication with health professionals and via the induction of labour leaflet she received:

"Yeah, yeah it was definitely clear. The midwife discussed it with me then further the doctor came in. I think it was a doctor erm resident I don't know what you call them sorry and then we had a leaflet on it they gave us time to discuss it in private as well. Then came back answered more questions that we had…Umm and then actually did another sweep right before inducing and just to give us that push along I suppose prior to induction. So yeah, it was really clear. Really concise and they were all really supportive and depending on that there was no pressure in terms of 'you have to… have to be induced', it was more, 'it's your decision'. These are your options, and this is potentially what could happen, you know. And then we made the decision and went ahead with it the day after". (Rachel)

Rachel's decision-making is in keeping with the research evidence which illustrates that as medical complications rise, women feel more concerned with risk and become more reliant on medical opinion (Furedi, 2006; Rooks, 2006). However, Rachel's story raises the question about the accuracy of some of the information that she may have received on which that risk-aversion was based, especially in terms of her age.

Similar to the other interviewees, Rachel described her experience of being admitted to the antenatal ward on the day of her booked induction:

"So, I rang on the morning, so it was a Wednesday. I rang to get my slot to go in erm and they basically said I'll ring back in an hour because the doctors aren't here. So, I rang back and ended up going into xxxx at 2:00 o'clock and then ended up with a pessary in about half 4 and we then went for a coffee and my contractions actually started..."

Whilst Rachel felt she had been well informed; this was Rachel's second baby. For her first birth, Rachel's labour had been augmented due to spontaneous rupture of membranes. Having given birth before, she was expecting this second labour to be easier:

"…I thought second time was going to be a breeze, but it turned out it was a little bit more dramatic than the first..." (Rachel)

Rachel went on to discuss her labour:

"…[I] *told the midwives that I was in a little bit of pain so they said 'oh we'll run you a bath to help with the pain if you want' and I was like great yeah that's fantastic and as I was in the bathroom waters broke and she…pooed inside me so I had meconium again and so then I got out of the bath went back to the induction ward…At which time I did feel pressure to start pushing um…anyway, … I think about three hours later we decided that we were going to push. Began to push, push for about 40 minutes, and then realised that she was actually back-to-back, and she was never gonna come out without forceps or a C-section so erm ended up in theatre. Had a block to prepare for a C-section but then she ended up coming with forceps on the second go. So that was quite a dramatic story shortened down to be honest… Yeah, the pessary…to be honest the pain I thought I was being a bit of a wimp and then I was like no this pain seems different and it … I could understand it now it was kind of pushing down on my back and after birth I did have a little bit of back pain. So, I think that has had something to do with it as well. So yeah, I thought second time was going to be a breeze, but it turned out it was a little bit more dramatic than the first." (Rachel)*

Similar to most of the other interviewees, Rachel opted for an epidural:

"…had the Pessary removed and then they were, contractions were coming pretty fast by that point so then I was moved to the birthing suite at which point I asked for an epidural because I'd had an epidural before, and the pain was quite well I thought it was more this time. To be honest, I don't know whether I just blanked out the pain or what, um, so xxxx, the amazing midwife rang for the epidural and said it would be about an hour…ended up with an epidural about a few hours later." (Rachel)

In addition to the increased pain associated with induction of labour, Rachel had also described that she discovered the baby was in an occipito posterior position. This is a common malposition whereby baby's head faces downwards, but it faces the mother's front instead of her back, thus potentially resulting in longer labour, being more painful with an increased likelihood of caesarean section or instrumental birth (Phipps et al., 2015).

Rachel felt that overall, she had made an informed decision to be induced due to the risk of continuing the pregnancy and that the staff were *'incredible.'* Like the other women in the case studies, Rachel went on to emphasise the staff as being fantastic and amazing, reassuring and available to answer any questions. Rachel stated that the experience would have been horrific without the support of the health professionals.

"…the staff you know literally from checking me in to the discussions to actually going through labour to the afterbirth were just fantastic and really good…reassured us all the way, answered all the questions that we had and obviously we took different paths and you know, kind of didn't understand different things and everything was discussed and highlighted to us and made very clear and they were really supportive…the staff were just amazing…they were incredible…going through it without the staff support would be horrific…"(Rachel)

This highlights the importance of women and their families having good relationships with the health professionals caring for them. Indeed, the emotional experiences of birth may be perceived by women as being more important than the physical events (Thomson and Downe, 2008).

While the health professional support made the process positive for Rachel, questions still remain on the accuracy of some of the information on which she made her decision to be induced.

Case study 3
Saida

Saida was offered induction of labour due to epilepsy and the identification of reducing fetal growth. This was Saida's second baby, and she had also been induced for the same reasons with her first pregnancy.

Epilepsy is one of the most common neurological conditions in pregnancy, with a prevalence of 0.5–1%. The mortality rate is known to be increased ten-fold (1 in 1000) in women with epilepsy compared to those without the condition. Epilepsy is a key focus of the most recent report in Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries (MBRRACE, 2023) across the UK. The most recent report notes that the number of deaths from sudden unexpected death in epilepsy (SUDEP) has almost doubled in comparison to previous years. The report

authors suggest that this could be partly due to lack of preventative measures being discussed and medication reviews not taking place.

In the Trust where this research study took place, for epilepsy, the guideline stipulates that serial growth scans are recommended for detection of a small for gestational age fetus and to plan further management in women with epilepsy on anti-epileptic drugs. For the detection and management of fetal growth restriction, the Trust guidance recommends that if the estimated fetal weight is less than the 3rd centile, planned delivery should be offered after 37 weeks. If the estimated fetal weight is between the 3rd and 10th centile and other parameters are normal, planned delivery at 39 weeks is appropriate. If there are other concerning features, other than fetal size, birth should be considered prior to this, following discussion with an obstetric consultant.

Saida describes the discussion she had when making the decision for induction of labour:

"…this..was my second pregnancy um so was actually induced with my first one also um also was quite familiar with the induction process, um, it's very similar situation. So, I'm epileptic. So, I had frequent scans towards the end of my pregnancy. So that at the 36 weeks scan they said that the growth is stunted and so they decided that the best thing would be to induce. So, this happened the first time also and I think I was slightly reluctant because my induction process uh, continued over three days. It was quite long, and I think I was naive the first time to think from being induced and it's going to happen pretty much straight away. But umm, it was quite a long process erm but at the 30-week scan that the head of the baby was really low down and so they were quite optimistic to say that erm it's going to happen very quickly. So yeah, so was informed of the process. I did say that you know, I'm happy to go with what you think is best erm to the midwife at the time. Umm, and they said that we.. do, uh, think that the best thing to do is to induce, uh, this time. So, when I was given the information about the induction again but because I've gone through the whole process last time, I think I was very aware of .. all the different stages". (Saida)

Saida had very specific medical reasons to be induced both for the safety of herself and the safety of her baby. Some of Saida's thought making process was around

how long the induction process would take and similarly, to Rachel, Saida also felt that the process would be easier second time:

"…because your body's been through the process uh, probably just need a nudge to get it moving. And so here I was.. sure that it was gonna happen faster but it wasn't." (Saida)

Aside from her medical condition and in addition to considering length of the induction process, Saida explained that one of her reasons for consenting to be induced was that she wanted to be in the hospital environment rather than in the home environment when she went into labour in case labour was quicker second time round:

"…but partly because I think what I was slightly worried about this time…obviously because I was induced the first time, you're in the hospital when things are going to get moving and so I was a bit worried that if I'm at home this time then you know …what do I need to do or what… if it starts happening really fast whilst I'm at home? So, I think there's a bit of reassurance in going in for induction…and umm, like I said at that scan, they had convinced me that the best thing to do was to…be induced. And so, I went with that… with their recommendation." (Saida)

Saida felt that the information she received from health professionals about induction was clear and that she had made an informed decision:

"Yeah, it was because I was told the risks. Also, that it could go up to you know 'but you need a caesarean if it doesn't progress as.. it as it's meant to'. So yeah, I, I think it was and like I said, because I've been through it all the first time, I think I felt like I was informed of the whole process." (Saida)

Similarly to Sarah and Rachel, Saida had the full support of her partner:

"My husband again, he agreed that what whatever the um the doctors and midwives are saying that's probably the best umm, advice and so he was supportive that we, you know, opted for the induction.. to be induced. And I think, just generally, I think we kind of trust the doctors and midwives for their advice." (Saida)

Ultimately, Saida and her partner had a level of trust with the health professionals. As O'Hare and Fallon (2011) report, mutual trust is a critical element in considering options in maternity services.

Saida also obtained information from other sources, including reading a book and getting information from NHS websites:

"I was currently reading a book, so I read the chapter in relation to induced labour." (Saida)

Unlike Sarah, whilst Saida did utilise the internet, she read the official NHS information as opposed to the online stories of other women:

"…read online on the NHS website and…all the websites as well about the induction of labour." (Saida)

However, despite feeling informed of the process, there were significant elements of the induction of labour process that Saida wasn't aware of:

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

"…my mum was abroad, and I kept telling her, they say you should happen now and so she was getting stressed out also thinking why is nothing happening if they're saying you know that it's going to happen soon." (Saida)

Some of Saida's thought process was based on the assumption that her labour would be quicker for her second baby. Indeed, many women are not aware of the duration of induction; and this has been highlighted in various other studies (Gatward et al., 2009; Cooper and Warland, 2011; Yuill et al., 2022; Harkness et al., 2023). Furthermore, resulting expectations may also be exacerbated by pressure from family and friends who are anticipating the birth on the day of induction (Webb et al., 2021).

Saida went on to describe her labour:

“That was really quick the first time when my first pregnancy it was quite a mission for them to break the waters and the doctor this time managed it really quickly and again she was convinced that you know things were going to start moving very soon, so she explained I think it was about four hours, they'll let the contractions you know start and hopefully get stronger and then she mentioned the hormone drip and again, she said you probably won't need a if you need a dose, probably just be the lowest dose six mil and it should basically get moving and throughout the day then carried on from six ml and this was about two or three o'clock in the afternoon. It was increased eventually all the way up to 36 ml...” (Saida)

Saida’s experience went on to include the potential for a caesarean section due to concerns for the baby’s heart rate as well as a knot in the umbilical cord:

“So just literally on the border of having a caesarean and then just later on I was thinking as well that for all of that time, um, that the heart rate was uh being monitored and it was it was critically low. The one thing that I was trying to avoid was this caesarean. You know before the labour as well that's one thing that I was anxious about like I just didn't want to or want it to get to that stage but even I was thinking at that time why don't they just do it? If the heart rate is going down, why are they not just going for, they're gonna leave me for another two hours before they checked…and like I said, it got to that stage where they decided that you know it now it was necessary but like I said, the head the baby just started coming out and it was only after she was born that they realised there was a knot in the umbilical cord and it was a true knot. And so as the contractions were getting stronger and obviously the knot was restricting the oxygen to the baby and it was only after she was born that they realised that was what was happening…it's more exhausting just because at every stage, um, whoever was doing the examination, they were so convincing that it was you know, that was gonna happen, so like, I keep saying that it was more exhausting this time even though it went over three days because of that reason, yeah.” (Saida)

Saida felt that the pain she experienced as part of the induction process *‘wasn’t natural’* and she explained why she felt like this:

“I said I don't want the pain really … I just want things to move faster but yeah, the contractions were stronger, you know…whatever that they use, that was a bit messed up umm so they weren't actually able to measure the contractions and so even towards the end, when they increased the hormone drip at a very high… I'd say at 36 mil that wasn't natural pain, that was, um, pain beyond anything that I've ever because I kept refusing the pain relief throughout the day. And at that point then, I said, you know, you need to give me that pain relief…”

Saida explained how after declining an epidural from the onset of her labour, she discovered that when she was ready for further pain relief, she was told that this wasn’t possible due to her epilepsy:

“… the midwife she went to the doctor and then came back and said we can't actually give you that because of your epilepsy. So, they been offering that all day and then when I needed it or wanted it then that's the uh what I was told that because of the epilepsy I can't, can't have that…” (Saida)

Saida described how she felt she could not cope with the pain any longer but that she could not have any further pain relief at that time due to concerns for the baby’s heart rate. Baby was then suddenly born:

“… the other reason why they weren't giving pain relief is as the contractions are getting stronger and the heart rate of the baby was dropping quite a lot and so he said until that becomes under control we can't offer any pain relief like but like I said, that pain at that time was I couldn't control myself well when it got to that thirty six ml of the hormone drip like I said but natural pain I'm quite you know I can, I can take. I was dealing with it all throughout the day but that was just something else altogether. And then it was literally got to the point where the doctor came and said it's gone critically low the heart rate so and they were preparing for caesarean and not just at that point things got moving and literally the head sort of came out.” (Saida)

Saida noted that, in the end, her baby was not born particularly small. This led her to question the grounds on which the induction had been recommended at 37 weeks of pregnancy:

“…but if when they're saying that the growth.. had stopped but he was born 6lb 8 which was at 37 weeks was not you know it wasn't bad at all. My daughter she was

born 5lb 5 which is considered just slightly low weight but again for 37 weeks, I wouldn't say that was, you know, that.. low weight you know and so it makes me question well, what was it necessary at that time? If it being allowed to continue for another two weeks so you know, so maybe the body would be more prepared for the labour process. I don't know. That's what I question that it would it have made the difference being induced so early as opposed to allowing the pregnancy to progress in and allow things to happen more naturally. UM, yeah, so it's happened twice now and so I'm thinking if there is a third time and if I'm advised the same thing at 30 weeks, I'd probably say can we let it you know progress slightly further from another scan and then they think it's still low weight then probably be happier to be induced at that time…Yeah, I think the problem is I had a posterior cervix and that's why it was very, it took a very long time to sort of get to the point where I was able to give birth…"(Saida)

Despite these reservations, and the length of time of her induction process, the pain of labour and concerns for baby's wellbeing during labour, Saida she felt reasonably well informed about the induction process:

"…I think I was happy with it. I was given notes so the sheets that explain the stages that I was able to refer back to them later on. Also, um, and so I think that..was useful because obviously there are you know there is quite a bit .. of information on the induction process which like I said the first time around, I hadn't expected that to be so much. In my mind, it was just a case of you're induced and so labour and that would commence. So yeah, I was informed very well. Like I said, I was given those information sheets which were useful, something to look back to and I'm just very clear, clear, uh and aware of the process of stages um of induction." (Saida)

This is somewhat paradoxical, given Saida's reservations about the grounds for induction before her pregnancy reached term. It may suggest that receiving some information is valued by women, even if it does not meet all of their information needs. However, it could be argued that information that does not fully prepare women or enable them to make decisions that work for them, is still sufficient so long as women value it.

Case study 4

Lara

Lara explained that she had been offered induction of labour at 38+5 weeks gestation due to her fetus being bigger than expected for her weeks of pregnancy:

"…I had a growth scan, and they gave me the option of an induction and the benefits, obviously because he was so big…it was a doctor and there was a lady with her. So, I went in after the scan in the hospital…he definitely was on the larger side…"

The reason induction is offered for large for gestational age is because there is some evidence that there are higher risks for both mother and baby when the baby is estimated by ultrasound scan to weigh greater than 4.0kg or is above the 95th centile at or beyond 36 weeks gestation (NICE, 2021), though the accuracy of ultrasound scan measurements for large for gestational age babies is contested by some. The rationale for detection of large for gestational age is to try and reduce the occurrence of shoulder dystocia and other complications such as third-degree tear, prolonged labour, operative birth including caesarean section, perineal trauma, postpartum haemorrhage, and uterine rupture (NICE, 2021). The risks for the baby include shoulder dystocia, brachial plexus injury, bone fractures, hypoglycaemia, intra uterine death, fetal hypoxia, and admission to the neonatal intensive care unit (NICE, 2021).

However, despite guidance for the ideal approach to labour and birth for macrosomic or large for gestational age babies, the evidence on this is mixed. The probability of detecting a macrosomic fetus in an uncomplicated pregnancy is variable, ranging from fifteen to seventeen percent with sonographic estimates of birthweight, and from 40% to 50% with clinical estimates (Chauhan et al., 2005). Therefore, the diagnosis of fetal macrosomia in pregnancy remains a challenge as prenatal diagnostic methods based on clinical examination and ultrasound are imprecise for fetal weight estimations (Araujo,.et al., 2017). This means that due to the limitations with accuracy, large for gestational age is a particularly grey area when considering offering induction of labour. Research, guidelines, and clinical practice need to take these additional factors into account, to avoid the risk of over-diagnosing, causing

potential harm and reducing the capacity for personalisation of decision making based on the mother/fetus dynamic (Chandrasekaran, 2021). In addition to the size of the baby, the mother's pelvis, the position she is in, the degree to which her soft tissues stretch as the fetus descends and rotates are all factors that need to be considered (Desseauve et al., 2017). However, a high level of suspicion for macrosomia should be maintained whereby there are risk factors noted for women, such as a history of macrosomia, high BMI pre pregnancy, increased weight gain in pregnancy, multiparity, male fetus, being over 40 weeks gestation, maternal age, and other risk factors (Araujo et al.,2017).

Lara described how part of her decision-making process was to avoid the risks associated with having a large baby:

"…And obviously the other problems that can get stuck… kind of didn't really want any intervention like the forceps and things are really didn't want a caesarean either so yeah, the health benefits from it were probably the main reason and also the fact that I couldn't sleep well. It was just awful to be honest". (Lara)

This quote would suggest that Lara may not have been aware of the risks associated with having her labour induced, as she viewed the induction as being a '*health benefit'*. This may fit with the findings of Sakala (2006) and Jomeen (2007) who proposed that nulliparous women may assume that what is offered to them is the best option to take, with a lack of understanding or differentiation between individual and collective risk, which in turn then deters women from questioning any medical interventions. This may also be attributed to Lara's limited knowledge of the induction of labour process which became apparent as the interview progressed. Lara's thoughts may also fit with the findings of other studies, whereby the assumption that interventions would be more likely to improve the health of women and that of their baby were more important in the decision making process than any benefits that may result from spontaneous onset of labour (Roberts and Young 1991; Heimstad et al., 2007, Moore et al., 2014, Murtagh and Folan 2014).

For Lara, though having a large baby was only one part of the decision-making process. She also viewed induction as an end to an uncomfortable pregnancy, and as the opportunity to meet her baby:

"…I couldn't sleep because my hips were hurting a lot. I think it was the weight and the pressure…when I laid down it was really difficult to get to sleep and that's probably the main reason. Also, you kind of wanna meet him. So, I was like, well, just have him a bit sooner…"

Lara's comments may also be reflective of other studies which have shown that women's feelings about induction of labour change as their pregnancy advances, with women potentially becoming more receptive to the idea of induction of labour as pregnancy starts to feel uncomfortable (Roberts and Young 1991; Heimstad et al., 2007; Hildingsson, Karlstrom and Nystedt, 2011; Murtagh and Folan, 2014). There is also the potential for women to be happy for the health professional to recommend decisions for them as their pregnancy advances (Idris et al., 2012). However, wanting the health professional to make the decision may also cause potential issues when considering the informed consent process. In fact, according to Abhyankar and Williams (2012), there is generally a poor understanding of probability statistics amongst health professionals. This may not help when explaining and discussing 'grey areas' such as large for gestational age to women.

In terms of accessing any additional information other than from a health professional, Lara explained she had spoken to her clients (tattoo parlour) about being induced, and that they advised her not to do so:

"… I did speak to a lot of people…I'm a tattooist so I can speak to everyone who's had a baby about it and they're all telling me not to get induced but…I think it was just talking about it really." (Lara)

Lara didn't discuss accessing any other information and unlike Sarah, Lara described how she didn't use the internet:

"I don't think I went on Google because that's not the best thing." (Lara)

This is not typically in line with the research that as already discussed suggests that online sources are one of the most frequently used information touch points for

women in pregnancy. It's unclear why Lara did not access any further information; it may be that she felt happy with the information she had already received from health professionals. Indeed, when asked if she felt that the information for induction of labour had been discussed clearly, she felt that it had:

"Yeah, definitely by the doctor." (Lara)

Similarly to all the other interviewees, on admission to the antenatal ward for the induction process, Lara described the midwives positively:

"..the midwives are lovely."(Lara)

Lara went on to describe her experience of going into labour and how she soon experienced too many contractions:

"They gave me my pessary erm but I had a reaction and so I was having eight contractions in ten minutes…I was pacing up and down cos I couldn't sit down because I was in so much pain. I thought that was normal and I thought I was being a bit of a wimp..." (Lara)

Hyperstimulation can cause uterine tachysystole whereby the frequency of contractions is more than five in a ten-minute period of time or whereby contractions exceed more than two minutes in duration, which can result in fetal distress and fetal compromise (NICE, 2021).

Lara described how she had requested pain relief and similar to the other four women who went into labour, Lara requested an epidural due to the extreme pain she was experiencing:

"…she offered me some paracetamols. I said I think I need something a little bit stronger than that. So, she hooked me up to the machine that you know, checks his vitals and things and then she realised. So, they had to take it [the induction agent] *out and restart it again twelve hours later. And then I think about twelve hours after that I got put in the delivery suite…they put me on the drip and got my contractions up to four in ten minutes but they were extremely painful, I think because it happened so quick, I couldn't get used to the pain, so I had an epidural…" (Lara)*

Lara then described how she suffered a dural tap which is a recognised complication of having an epidural:

“So I had an epidural and that went wrong…it pierced my spinal cord, so I had to have a blood patch after…it was horrific…So, when I’d had him, I couldn't really stand up because my head was pounding, and my ears were ringing. So, I was kind of struggling to get about and they didn't realise what had happened until a few days later when I was home and that I was really ill. I could not stand up. I just thought every time you laid down, you're fine. But when you stand up, that's when it all kicks in. So, I had to go back and have the blood patch…Yeah, I think the anxiety from it, obviously because it's your spine is a bit, made me panic a little bit, but after I’d had the blood patch maybe a week later I was ok but I think it's just a bit scary that’s all…Just yes, no idea what… they just said the headaches were normal… the intensity of it. It wasn't, and even the anaesthetist said before I left all that's weird, but you can go home but it wasn't normal.” (Lara)

It is not clear that this side effect of having an epidural had been explained to Lara. She described how she was trying to enjoy her newborn baby, but the dural tap significantly impacted on her ability to breastfeed and to enjoy her baby:

“…on the first day, the midwife came in at 2:00 AM and said I'm really struggling to sit up, erm I need some help, she said, I'll just get a bottle then and then my breastfeeding just went downhill from there…”(Lara)

Additionally, Lara described that the dural tap remained unidentified initially:

“… they just kind of left me whilst I were really struggling. I couldn't eat or anything because I couldn't sit up. It was, I don't know… they were really, really, nice but in a way that didn't help me whatsoever…I did tell them that I didn’t feel well but I don't know if I explained enough how unwell I felt.” (Lara)

“…I wish that they kind of you know looked into it a little bit more before they sent me away because I couldn't feed him in the night…”(Lara)

The incidence of a post dural puncture headache is 0.5-1% and usually occurs between one- and two-days after an epidural is sited (Turnbull and Shepherd, 2003). As described by Lara, a post dural puncture headache can significantly impact on a

woman's ability to care for her baby. NICE guidance (2021) stipulates that when caring for a woman who has recently given birth, it is crucial to listen to the woman and to be responsive to her needs and preferences. However, Lara's perception was that she felt like, though the midwives were '*really really nice'* they did not really pay attention to what she actually needed.

There are a range of other reasons why this could be happening, including a loss of capacity for the health professional to be 'present' enough with a woman to notice and understand what she needs, beyond the actual words she uses (Kennedy et al., 2004; Pembroke and Pembroke, 2008). This may also be attributable to high workloads. Indeed, the Health and Social Care Committee's report on workforce burnout and resilience in the NHS describes chronic excessive workloads impacting on the ability of health professionals to provide high quality care (Health and Social Care Committee, 2021).

The current NICE guidance on intrapartum care (2021) also recognises and focuses on the role that partners play in a woman's pregnancy journey. Lara describes her partner not being present and again it is unclear why. However, it must be noted that Lara had her baby during the Covid 19 pandemic whereby there were staffing pressures and also limitations to partners visiting in hospital due to the infection risk.

Despite the problems she had encountered many of which, if not all were attributable to the induction of labour process, Lara confirmed that she would undergo the process once again:

"…I'd still do it again if I had another…I mean he was still fine. My birthing experience wasn't bad, it was just a couple of things that went wrong after I suppose…"(Lara)

At the end of the interview, Lara was asked if she had any final comments or suggestions for improvements:

"The only thing I didn't know before I went in is about the pessaries and the fact that it was 12 hours, I think it was twelve-hour 12 hour, another 12 hour and then

something else after. I had no clue about that. Yeah, I had no clue. I mean, I thought I should have researched it myself..." (Lara)

Lara's final comments of her knowledge of contractions and timings were suggestive of the fact that she wasn't fully aware of or understanding of the induction of labour process. Lara had felt that everything had been explained clearly to her, but based on her accounts, and as for other women whose stories are in this chapter, Lara did not have a full understanding of events. This is important, since women's overall perception of induction is often affected by the difference between their expectations and the reality they then experience (Nuutila et al. 1999; Shetty et al., 2005 Gatward et al., 2007; Cooper and Warland., 2011; Murtagh and Folan., 2014).

Case study 5
Saima

Saima, who agreed to induction of labour for raised blood pressure and an episode of reduced fetal movements, as well as a predicted large for dates baby, provided a written account of her experiences as opposed to an interview. This was Saima's first baby.

The conditions associated with raised blood pressure in pregnancy include chronic hypertension; gestational hypertension; pre-eclampsia; and eclampsia (the latter two often accompanied by gestational proteinuria). The management of raised blood pressure is very different depending on the degree of hypertension. The Trust where the research took place has a series of guidelines for health professionals to follow, depending on the differential diagnosis between these various conditions. The Trust guidance around reduced fetal movements is provided on page 126.

Information about the outcomes for large for dates babies is given on page 137. Pre-eclampsia is a recognised cause of mortality in the United Kingdom, affecting between two and five percent of pregnancies in the UK and left undiagnosed and unmonitored can lead to eclampsia, HELLP syndrome, disseminated intravascular coagulation disorder (DIC), stroke, and organ dysfunction including the liver, kidneys, brain, and lungs (NICE, 2019). For the baby, this can result in a greater risk

of intrauterine growth restriction, prematurity, and intrauterine death (NICE, 2019). 4% of the 241 women who died during or up to 6 weeks after pregnancy died from pre-eclampsia (9/241) (MBRRACE-UK, 2023). However, the large majority of women with hypertension in pregnancy do not experience these extreme consequences.

As this was a written account as opposed to an interview, it was difficult to ascertain the full specifics around the exact clinical indications that informed the discussions around induction of labour.

Originally, Saima had universal care needs and had planned a birth centre birth in line with this:

"... My initial plan was to have a natural birth at xxxx Birthing Centre." (Saima)

However, towards the end of pregnancy, Saima experienced raised blood pressure and was told that her baby was large for dates. This led to discussions about induction of labour. It had the effect of changing her plans for a birth centre birth, even though she believed that her raised blood pressure had been caused by long waiting times at her antenatal clinic appointments:

"…due to my raised blood pressure, I was encouraged and pushed towards having an induction. However, I found my blood pressure was only ever raised during my hospital appointment at xxxx and xxxx due to the waiting periods, the lack of information and in general the anxiety that in turn brought along. I fed back numerous times how helpful it would be for reception staff to advise and set the expectation of your waiting time if your scheduled appointment wasn't on time. This would have hugely reduced my need to be induced." (Saima)

It is not clear from her account who Saima contacted and whether anyone had given her any feedback about the waiting times. However, whatever the clinical specifics were, Saima felt that she had not been listened to.

She describes being told she would need to be induced which was during an admission for reduced fetal movements:

"…I went to xxxx on the 3rd of April with reduced movements and was monitored at that stage for a few hours. I was also given a sweep and advised of what was happening. I was always against the idea of an induction as I wanted my body to be prepared to give birth. However, based on professionals telling me my baby was head down, engaged and my cervix was opening slightly I should be booked in for an induction".

In the following quote, Saima describes that she was told that she would need to be induced that day but that she had refused:

"That day I left the hospital I was booked in for a blood pressure screening at xxxx and my induction for the Wednesday…I was told I would need to be induced that day as they suspected preeclampsia, however after 20 minutes my blood pressure had returned to normal, and I had already refused to be induced. I was sent home and asked to return the following day and they would ring me with a time slot to go in." (Saima)

Within the quotation above, Saima exercised agency, but from her wording this could be interpreted as Saima actively refusing the induction and that this was not on the basis of informed discussions of the offer of induction, along with possible alternatives, given that she says she states that she was 'told I would need to be induced' . This may fit with the notion of informed refusal, but informed refusal needs to take place in the presence of an informed discussion (Peterson, 2022) and it is not clear from the written account what the specifics of the clinical situation were and what the exact discussions were.

It is unclear from Saima's written account if pre-eclampsia was diagnosed following the triage admission.

Saima continued to be unhappy about the lack of informed choice surrounding her discussions for induction of labour. Saima felt that she had lacked any control or involvement throughout discussions:

"The advice from family and friends was to avoid an induction, however the pressure from medical staff makes you feel like you have to accept it. Had I not done research I was under the impression you had to follow the instructions from the hospital staff and were unable to decline." (Saima)

Saima's accounts suggest that either the clinical indications for induction of labour may not have been fully explained to her or that she had not fully understood some of the information provided. Beyond this, she believed that she could be made to undergo induction of labour against her will ('*you have to accept it'*). This is against the law of Montgomery and Lanarkshire (Supreme Court, 2015), where information provided for service users must take into account what is 'material' for them, and they must be able to make the final decision on what happens to their body. A feeling of loss of control and not being involved in care can in turn lead to a negative birth experience (Arney, 1982; Namey and Lyerly, 2010; O'Hare and Fallon, 2011 and Alruwali et al., 2023)**.** A deviation or change in a woman's birth plan that allows limited or no control is a difficult situation for women to experience and to comprehend (Cook and Loomis, 2012). As other researchers have noted, women require clear explanations, simple communication and involvement in decision making processes about their care which in turn optimises satisfaction, a feeling of empowerment and a reduction in stress (Alruwaili et al., 2023). The lack of clear information, the change of birth plan and Saima's understanding of the information provided may go some way toward understanding Saima's feelings about induction.

Saima describes how she agreed to the induction due to exhaustion:

"A lot of the time, I agreed to a natural/induction labour because I was too exhausted to keep going back and forth…"(Saima)

Saima's agreement to the process was assumed to be her consent, when, in fact, it was an expression of how far she felt that the insistence for induction broke her resolve for a birth centre birth. Despite this, she describes that initially, her experience of admission to the ward was '*pleasant'* and that the staff were '*lovely*'. However, she soon found the environment to be stressful due to other women also undergoing induction of labour within a confined vicinity:

"The ward itself was incredibly stressful, it was difficult to relax, to sleep or feel comfortable due to the pained noises and groans from those further into their induction and others like myself waiting for it to start." (Saima)

Saima then describes what she felt to have been disrespectful treatment of another woman:

"…the lady in the bed next to me was having her examination following the 24 hours post pessary. "Although it was a private examination with the curtains drawn, the sounds she made were horrifying. The screams, shouts, kicks, punches and swearing again increased mine and my partners anxiety and will in honesty haunt me for a while. She was given gas and air to complete the examination and for them to insert the first set of gel."(Saima)

The experience of still being 'haunted' implies secondary trauma for Saima, even before her labour started. She also reported that she felt that women were sent to the labour ward when they were not clinically ready to have their waters broken. Saima felt this put a clock on the time to delivery from being transferred and perceived this to be affirmed by her experiences on the postnatal ward:

"When on the section recovery ward, I recognised people/women from the induction ward that had resulted in emergency sections following their waters being broken at 2cm and again it cemented I had made the right decision in electing for a section." (Saima)

In her written narrative, Saima went on to describe her overall birth experience. Initially Saima felt fine with the process. However, when there was no progress with the induction process, Saima requested a caesarean section:

"…I wasn't happy about this at all. I informed her I had spoken to my partner, and we had discussed that I would like to elect for a Caesarean section…"(Saima)

She reported that she had also broached caesarean section previously, and that she felt she was not being listened to:

“I had discussed this in the past with my midwives and healthcare professionals and always been advised against it and pushed towards the natural/induction route. I was made to feel like my choice of request of a section wasn’t convenient as I was given the talk of my body being made to give birth and a very cheesy empowerment speech...” (Saima)

The health professionals involved may have been trying to avoid further intervention if at all possible and the subsequent impact on both the current pregnancy and any future pregnancies, but this is not how it was perceived by Saima who felt that she was not being listened to and not given a choice:

“…I was very adamant I wanted a section. So much so, I stated verbatim, “I have decided to stop the induction process and would like to elect for a section. I’m certain this is what I want and do not want to be talked out of it.” However, the attempt to talk me out of it was made. Being in a state of increased emotions already I found it to be inappropriate considering my clear wishes. The midwife then suggested I continue with the induction and be added to the list for a section. However, I declined quite forcefully her suggestion of putting the gel in anyway as my body was clearly not ready to give birth. At this point my induction stopped and I am so happy it did…” (Saima)

Saima describes feeling calm, comfortable, and relaxed once she knew that her request for a caesarean section was due to happen:

“…the following day, I filled out all the appropriate paperwork and was taken to have a section. I was calm, I was comfortable, and I was relaxed. My partner was with me, and it felt like when my daughter arrived and I could fully take in the entire process and moment…”(Saima)

Overall, Saima felt that she had not been listened to and that her wishes had not been respected. Indeed, many studies illustrate that a feeling of control is a major factor in a woman’s birth experience and subsequent wellbeing with women needing to feel respected and treated as an individual by health professionals and for health

professionals to be considerate (Green and Baston, 2003). Her strong desire not to be induced seems to have been even further reinforced by hearing what Saima perceived to be the traumatic experiences of others as she waited for her own induction of labour. Having originally wanted a birth centre birth, given the pressure not to wait for labour to start spontaneously, she felt vindicated by the decision to opt for a caesarean rather than to continue with the induction of labour by comments made by the obstetrician undertaking her operation:

"…when removing the baby, the surgeon advised that if I had gone through the induction process, I would have needed an emergency section as my daughter's head was never in an engaged position and she was further up my body than all the health professionals had predicted during scans and assessments..."(Saima)

This may have been an occasion when Saima felt that she had been listened to and that the surgeon had affirmed her thoughts about induction of labour.
It is likely that as Saima felt that she had not made an informed decision when her clinical situation changed and discussions began, then this significantly impacted on her subsequent experiences with the induction of labour process. Indeed, the Patient Experience Improvement Framework and NHS Outcomes Framework highlight that a good experience is a crucial part of excellent health care, with informed decision making forming a fundamental part of improving experiences (CQC, 2019).

Saima goes onto describe how one of the reasons that she was advised induction was due to large for gestational age but that her baby was not large:

"…I appreciate when feeling the stomach and groin pubic area it can be hard to predict the exact whereabouts of the baby, but the scans were quite clear, yet it was still incorrect. I was also told my daughter was too big and also why I would need to be induced however, she was delivered at 7lbs 10oz, eight days after her expected date..." (Saima)

As noted on page 137, the accuracy of ultrasound scans for estimation of fetal weight is contentious. Both of the women in this study who were told their baby was

either small or large for dates had babies that were in the average weight range for gestation.

Saima describes how the induction of labour process impacted on her birth experience in a negative manner:

"The induction process hugely impacted on my birth experience, I was unable to deliver as I had planned, naturally, at the birth centre and found it was a drastically painful experience, regardless of the exercises and research I had done regarding my anatomy, how the body works during labour and the breathing exercises. I read numerous books, the positive birth book and hypnobirthing. And although, the hypnobirthing wasn't something I was very responsive to, the information within the book about how a woman's body works during labour was very helpful." (Saima)

As part of her final comments for what could be improved upon, Saima confirmed and reiterated that she felt she had not been given information about all birth options, thus impacting on the informed decision-making process:

"I think for me, discussing the pros and cons of all birthing options would be helpful. I was told a section would take weeks and weeks to recover from and was dangerous and complicated. But my experience was far, far from that. My healing process was completed in two weeks. I continued to follow advice, but I managed well, even in a home with three floors that I walked up and down regularly. I think it's inappropriate and unfair to feel shamed into making such a big decision. I felt pressured into an induction and was told numerous inaccuracies regarding the size, position, and health of my baby...given the option again, I would opt from the very beginning for a section. It would have saved me lots of stress, anxiety, waiting for hours with no information, increased blood pressure and general fear of the birth process". (Saima)

Some have found that women's memories of their birth experiences are related more to feelings of empowerment, choice and control than to the specific details of the labour and birth process (Cook and Loomis, 2012). Indeed, Saima felt that she had no control over the decision making for induction of labour. From Saima's written narrative, she may have been experiencing birth trauma. Birth trauma stems from

being in a powerless, unbearable, and helpless situation and can disrupt memory processes whereby the person has been in an overwhelming and inescapable event (Thomson, 2019).

Similarities and differences of the case studies

From the interviews, I identified key areas of interest:

Table 26

Key areas of interest identified from the data
Reasons for induction of labour
Information from health professionals at the time of booking induction
Information from partner, family, and friends
Information from other sources
Hospital setting
Expectations for induction of labour
Planning for future births

N=4 women who were interviewed for my study and therefore the majority, confirmed that the risks of continuing the pregnancy against the potential for expectant management of the pregnancy had been discussed. At the time of having the induction of labour discussions, trust in professional opinion was strong for three of the five women and they opted for induction with the notion of this being in the best interests of their health and the health of their babies. Most women interviewed (four of the five) were happy to be guided by the protocol and by advice from health professionals during their induction. In contrast, Saima was deeply untrusting of professional advice throughout the process and felt she was not supported in her stated preference for caesarean section rather than for induction of labour. Rachel and Saida felt more equivocal by the end of their labour.

Women accessed information from a variety of sources other than health professionals, including books and the internet as well as partners and friends. One woman (Lara) specifically stated not using ‘google’ describing it as ‘*not the best*.’ Like lots of NHS Trusts, induction of labour at the Trust where the research study was undertaken starts on the antenatal ward until women are going into labour or are

ready for artificial rupture of the membranes, at which time, they are transferred to the birth suite setting. Of the interviewees, two of the women reported interruptions from other women who were also being induced in the four bedded bays within the antenatal ward setting. The experiences of two of the interviewees were in stark contrast. Saima described being haunted by the experiences of another woman in the bay. Conversely, Sarah, found being with other women in the bay made the experience of pain more bearable and she enjoyed being with women undergoing a similar experience. In part, this may have been due to their respective experiences with Saima feeling that she had not made an informed decision about her induction of labour, whereas, conversely, Sarah felt very well prepared for induction from an early stage due to her medical condition.

From an overall birth experience perspective, women's perception of the midwives caring for them formed a significant part of their experiences and as illustrated within the quotations, all five of the women were complimentary of the midwives caring for them to an extent even though in some cases they reported that health professionals didn't always hear what the women were trying to tell them.

The interview findings highlighted discrepancies between some women's (and their families) expected timeline of induction and the reality they experienced, thus proving to be a source of frustration (Saida and Lara). Additionally, all five women interviewed experienced unanticipated interventions once labour was underway. However, they did not necessarily attribute the unanticipated events to the induction of labour process. From an analgesia perspective, all of the women interviewed who went into labour following induction spoke of the intense pain that they experienced and all of the women either had an epidural or had requested an epidural.

Despite on the whole feeling well informed, there were some aspects of induction of labour that with hindsight, women would have preferred to have known more about in advance, as discussed throughout the chapter. One woman (Lara) felt more information was required regarding contractions and the potential risk of hyperstimulation. In conjunction with this, Lara cited the need for more specific information antenatally regarding the medication utilised to induce labour and how information about the timings and trajectory of these would improve the induction

experience. One woman (Saima) requested more information when discussing induction of labour with health professionals about all birthing options to enable informed decision making. The request for this information raised questions about whether informed decision-making is taking place, despite what the women believed. This reflects the findings in the survey that, despite most of the (pregnant) respondents saying they got the information they needed early in the questionnaire, when specific components of the induction process were presented to them later in the questionnaire, many reported not having this specific information.

The accounts from Sarah and Rachel indicated that their experience of induction had met their expectations. Sarah in particular had been well prepared for induction, with discussions from an early stage in her pregnancy due to gestational diabetes. For Lara, there were aspects of her care on both the antenatal and the postnatal ward that were negative and unexpected. However, despite Lara's feelings of a lack of information during the induction process, a dural tap and a feeling of limited help on the postnatal ward with breastfeeding, she concluded that she would be open to induction of labour for future pregnancies. Lara also shared the belief that her expectations had largely been met, despite the issues she described of her experiences of induction. Saida also confirmed that her experience of induction had met her expectation. These responses may be attributed to the fact that all these women were induced for medical reasons.

Conversely, Saima felt that she would not have opted for induction of labour from the offset, that informed choice had not been exercised, and that next time she would opt for an elective caesarean section. This is particularly striking since she had originally intended to labour in a birth centre. She had a very negative experience of labour induction, compounded by her feeling that health professionals were not responding to her decision for a caesarean section rather than induction. It is not clear what would have happened if Saima had gone into labour spontaneously. However, as many other studies have shown, women who have difficult birth experiences first time round often opt for specific choices for a second pregnancy, that reflect their desire not to be as out of control as they felt first time. For some, as for Saima, this is a decision for a planned caesarean section. For others, it might be to avoid intervention completely, through a home birth, or even free birthing (Lothian,

2014; Feeley and Thomson, 2016). In all of these cases, the choices are not necessarily the ones women would make if they had trust in the health care service. Such situations may be an important adverse consequence of feeling deprived of good quality information and truly informed choice.

Summary

This chapter has discussed the findings of my study relating to women's experiences during the lead up to induction of labour, the induction of labour process, and their birth experiences, including the immediate postnatal period. This has enabled an understanding of how women gained information and made decisions about induction of labour, their overall birth experiences and how this met with their expectations for labour and birth.

Finally, it is important to acknowledge the individual nature of each woman's account of her experiences and to recognise that overall perceptions of induction were affected by multiple factors, including individual clinical circumstances, individual personalities as well as individual expectations for induction. It is also crucial to note that all the women who were interviewed were induced for medical reasons (and differing medical reasons) and therefore, the findings can only be considered for women in a similar situation. It must be considered that their responses may be different to women who are offered induction of labour for 'post-dates' pregnancy or for other rationale. The findings from this chapter are discussed in further detail in chapter 7 (Discussion). Suggestions for improvements are also discussed in chapter 7.

CHAPTER 6

Findings

Interviews and discussion group with health professionals

Introduction

This chapter presents the findings of the interviews with midwives and obstetricians and the discussion group with midwifery leaders. Two consultant obstetricians and three midwives were interviewed. Additionally, I held a discussion group with five of the midwives who co-ordinate the activity throughout maternity services. These interviews and a discussion group formed phase 3 of the overall study, building on the systematic literature review (phase 1; chapter 3) and maternity service user survey (phase 2; chapter 4) and maternity service user interviews (phase 3; chapter 5).

The research question for the interviews with the midwives and obstetricians was:

"How is informed consent discussed with maternity service users who are offered induction of labour at or beyond term gestation"?

During the interviews, midwives and obstetricians were asked about: the discussions they have with women about induction, their feelings regarding induction, how they adapt to women's decision making processes, key tools that help when having discussions with women about induction, barriers that may hinder discussions, interpretation of the induction of labour guidance, thoughts on influences for women when making a decision to have their labour induced or not, thoughts on influences for midwives and obstetricians when having discussions, memorable experiences regarding discussions with women and their families, thoughts on informed consent and suggestions for how discussions with midwives and/or obstetricians could be improved. Please refer to appendix 10 for the specific interview schedule including examples of general prompts that were utilised.

The research question for the discussion group was:

"What are midwives views and experiences working in the birth settings including the antenatal and postnatal ward with women who have had their labours induced?"

During the discussion group, the midwifery leaders were asked about: experiences on the central birth suite, antenatal ward, and postnatal ward of caring for women who have had their labour induced, experiences of any impact that induction of labour has on the daily work in all the areas, any examples that they would like to discuss when thinking about the daily work in each of the areas, thoughts on the main influences for women when making decisions about induction, thoughts on the best ways to give women information about induction, what should be included in the information that women receive about induction, and any suggestions for key improvements. Please refer to appendix 11 for the specific interview schedule including examples of general prompts that were utilised.

Each area of interest that is discussed is supported by quotations from the health professionals. Some quotations have been truncated for precision and where words have been omitted this is written as: […]. Pseudonyms are used throughout the analysis to ensure anonymity, including the quotations. The chapter concludes with suggested improvements for informed consent, using quotations from the health professionals interviews, based on the findings of the analysis.

Table 27 – Overarching themes and subthemes:

Theme number	Theme	Subtheme
1	*The nature of and clinical influences on informed consent for labour induction*	The nature of informed consent
2	*Influences on women's choices and expectations*	Consumerism
		Previous experiences
		A risk society
		Social media
		Partners/family/friends
		Information overload
		Expectation versus reality
3	*The influence of and on the health professional*	Framing of risk discussions

		The health professional as the second victim
4	*The NHS organisation: settings and resources*	Grey areas in the guideline
		Organisational constraints (time, accessibility of information, hospital resources, iatrogenic effects of induction of labour)
		Organisational response to the birth partner
		Provision of continuity of carer
		Suggested service improvements

Theme one: The nature of and clinical influences on informed consent for induction of labour

The nature of informed consent

Rates of induction of labour have increased steadily over the last couple of decades in the UK. According to NHS Digital (2018), between 2007 and 2008, induction of labour rates accounted for 20.4% of births. This has increased to 29.4% between 2016 and 2017 and 31.6% between 2017 and 2018 (NHS digital, 2018). In 2023, induction of labour rates at the Trust where the research study took place were almost fifty percent. Within my research study, health professionals discussed a range of factors that might underlie the increasing numbers of induction of labour.

During the interviews, midwives and obstetricians mooted their thoughts on whether all inductions were necessary. In the following quotation, Midwife Sally questions whether there is enough discussion of the implications of induction of labour and whether the reasons for labour being induced are always valid:

"I feel that the induction rates are very high and getting higher and higher…which is worrying. I feel that we don't discuss enough around the implications of an induction of labour…and I think some of the reasons that we give for induction of labour are perhaps I don't know, debatable as whether there are valid reasons for doing such an intervention, really". (Midwife Sally - interview)

Relatedly, in the following quotation, Midwife Amy wonders if induction of labour is offered too readily in response to perceived expectations:

"I sometimes feel we offer it too readily to people or that there is an expectation from women that we should be offering it and it should be offered early. I think we probably do too many for non-clinical reasons.….it has its place I just don't know if we are utilising induction of labour properly sometimes if that makes sense." (Midwife Amy - interview)

Good outcomes for women with more complex pregnancies and labours often depend on tailored interventions (Better Births, 2016). There is a prevailing view that increasing maternal age and greater obesity rates have resulted in women needing a greater level of care. Other factors, such as the increasing success of assisted pregnancy for women with pre-existing medical complications, have also been implicated, as illustrated by the following quote:

"Look at your women that are coming through now that 10 years ago, 15 years ago wouldn't have got pregnant like the really poorly controlled diabetics. Or you know, your women with polycystic ovaries. And because of the advancements in preconceptual care and conception, we're seeing women that historically would never have had babies, would they? And that brings the added complications of them as well." (Midwife Julie – discussion group)

Complications of pregnancy include physical and mental conditions that affect the health of the pregnant or postnatal woman, their baby or both (CDC, 2023). One example includes a rise in body mass index in the pregnant population (Walker et al., 2014) which in turn may correlate with the rapid increase in the number of inductions for diabetes, since women with diabetes tend to be heavier.

Another example is women giving birth later in their reproductive life. This is reflected in the steady increase in the average age of first-time mothers from 27.2 years to

30.2 years (Better Births, 2016). Moreover, according to the Institute of Fiscal Studies (2021), women giving birth now are more likely to be older and have more complex health conditions than the previous decade. However, this was not evidenced within this research study. Being above the age of 40 means that women have a greater chance of developing a health condition and are more likely to need assistance with giving birth (NHS Digital, 2018) though there is some debate about whether this is partly because of the expectation of complications, rather than because there are always problems for women in this age bracket (Blickstein, 2003). It is the case that births to women aged 40 or over have increased over the last decade and numbers of women recorded as obese when they give birth or with other complex medical needs also rising (The Institute of Fiscal Studies, 2021).

Previously and historically, labour induction in low-risk nulliparous women has been discouraged due to the belief that this intervention increases the risk for caesarean birth without a clear benefit (Einerson and Grobman, 2020). Offering induction of labour before 40 weeks gestation for healthy women and babies has been a hotly debated topic for decades (Walker, Bugg and Macpherson, 2016; Einerson and Grobman, 2020). However, at present, recommendations in the UK are for induction of labour to be offered to women with uncomplicated pregnancies who go beyond 41 weeks, to avoid the risks associated with prolonged pregnancy, including the risk of still birth (NICE, 2021). Essentially, the idea of offering an earlier induction is to make birth safer for women and their babies. Recent research comparing induction times and outcomes evidenced higher infant mortality rates after 42 weeks gestation if a woman had not been induced and this was incorporated within the updated NICE guidance (NICE, 2021). Evidence does not support the widespread use of routine induction prior to post term 41+0-6 gestational weeks (Middleton, Shepherd and Crowther, 2020).

The following quote describes the challenges of holding off from offering induction of labour:

"…I really try and avoid inducing people before 39 weeks unless I have to…it's those really difficult conversations to have because you know in many ways you're like the gatekeeper aren't you…"(Consultant Ruth - interview)

The way that being the 'gate keeper' is described, suggests that the doctor may not be comfortable with that. However, the framing of the quotation appears to suggest a lack of agency/informed consent for the woman. The active participant is the doctor who is doing or not doing the inducing. Rather than framing the conversation for example as *'I feel uncomfortable about induction of labour before 39 weeks because….and when I talk to women I discuss with them before they make their decision…'*:

The following quote also highlights the challenges of early elective induction:

"… then there are some requests for example things like you know pelvic girdle pain where we get women who have you know pelvic girdle pain from really quite early on in pregnancy and they've been requesting early births from ..as early.. the early 30s really. And we're trying to sort of persuade them to try and prolong the pregnancy as long as possible. But as we start approaching, you know, 37/38 weeks, sometimes it's almost kinder than having women, sadly, and you know..in a lot of pain and essentially upset and in tears in the antenatal clinic, I think there has to be a pragmatic approach and I think as long as women understand the process, the length of process and the potential risks of the process and the making an informed choice…I think we probably should support that choice as long as…I wouldn't be recommending an induction for a lady before 37 weeks without a clinical indication but I think once you get sort of beyond as you're approaching 38/39 weeks term, I think we should consider the request." (Consultant Ruth – interview)

However, in terms of offering induction of labour at an earlier gestation, according to Rydhal, Eriksen and Juhl (2019), this may lead to a rise in the induction rates of 15-20%. In turn, the higher induction rate puts a strain on maternity services and is likely to result in longer periods of hospitalisation for women.

As discussed in previous chapters, elective induction of labour is defined as labour induction in the absence of a clear medical indication (Hastings, 2012). A maternal request for induction may be due to a variety of reasons and this was spoken about during the interviews with midwives and obstetricians and in the discussion group:

“I suppose non-medical indication to me is maternal request. I think a lot of people think about pelvic girdle pain falling into that sort of category and that it's nonclinical, but I think it's very difficult to quantify somebody's pain and I think if you've explored all avenues and made sure that you are managing their pain and they still feel unable to continue with the pregnancy then I think that is reasonable to request (Midwife Amy - interview)

This quotation highlights the issue about what counts as being a reasonable request. There is a conflict here between women’s informed choice whereby the woman has the agency, not what the health professionals want, and the health professionals being the gatekeepers who can determine what is a reasonable choice.

Induction of labour may be viewed as a controversial topic in the absence of medical problems. This was spoken about by one of the midwives during the discussion group:

“*I agree with you there because I think we're medicalising too many women you know. Instead, I know I know the Ockenden says about, you know, not going down the normal route but actually we've gone completely the other way haven't we over the last four or five years, we've gone from being quite a Trust that promotes normal birth, promotes natural induction to one that I've never seen the section rate like it is at the moment ever.” (Midwife Roslyn – discussion group)*

However, Nicholls et al. (2021), describes a parallel narrative whereby for women, social factors including practical, social, and family considerations are more important than clinical risk. From an equity and equality perspective, there are multiple factors that may affect women’s decision-making abilities, including a woman’s intellectual capacity, her communication skills, her assertiveness, her ability to access information as well as family support and her local social, community and

cultural norms (Green and Baston, 2007; Skyrme, 2014). Ultimately, even if a woman has received balanced information, it must be considered that women's thoughts regarding risk are also contained within their own personal values, including physical, emotional, as well as social factors (Leap, 2009; Mitchell, 2010).

Social factors may be missed by health professionals which in turn highlights the need for assessing what may be important to women based on legal requirements to find out what is 'material' to them (Supreme Court, 2015). This requires careful skill in exploring each woman's personal expectations and values to ensure she is able to exercise fully informed consent (Nicholls et al., 2021). In keeping with this, a woman's individual needs and preferences should always be considered, and they must have the opportunity to make informed decisions in partnership with health professionals (Rydahl, Eriksen and Juhl, 2019). Crucially, information provision must be appropriate to the specific clinical situation to enable women to make an informed decision about their preferences and needs for care at each stage of their maternity experience, with women having the autonomy to consent to accept care or to decline care (The Royal College of Midwives, 2018).

In terms of 'informed consent, in the UK, the rights associated with informed consent are affirmed by the UK Supreme Court following the landmark decision of Montgomery V Lanarkshire Health Board (Supreme Court, 2015) that changed the basis on which consent is legally obtained by rejecting the doctor-based Bolam standard that had long governed important aspects of medical negligence. As discussed in detail throughout all the chapters of my research study, 'informed choice' entails ensuring that women understand the options that are available to them and the risks and benefits of each one, to enable them to make decisions about their care (NHS England, 2023).

Most respondents felt that informed consent was universally being undertaken for induction of labour:

"I think, I would never say that .. I've witnessed a woman not given informed consent. I think we're very good at gaining informed consent…it's making sure that they understand the risks and benefits isn't it …so why are you recommending this course

of action? What are the benefits to mum and baby? And what are the potential risks of the induction versus not or vice versa? And ensuring that they understand that. But also, that they do have a choice…" (Midwife Amy - interview)

Some of the responses do suggest otherwise. Additionally, the framing of this quotation suggests that the midwife may not understand the nature of informed consent in terms of where the power to consent actually lies. Indeed, health professionals cannot give informed consent; they can provide information based on which women can give consent. The framing of the quotation in terms of language used appears to imply that health professionals are able to gain an agreement with women for them to be induced. However, this is not informed choice. The midwife does reference choice within the quotation, but this appears to be ambiguous in light of the earlier part of the quotation. Additionally, the data in this study and in the studies of other researchers demonstrates that women do not always have full information on which to make a decision. Overall, this quotation highlights the nuanced nature of informed consent in current maternity services and provides the setting of the scene for the rest of the analysis in this chapter.

The following quotation suggest that some professionals were equivocal about whether women were actually able to give informed consent:

"I don't think we're doing anything wrong necessarily, but I think if you actually look at the definition of informed consent, I'm not sure we're always doing it…"(Consultant Charlotte - interview)

This opinion was reinforced in one of the other interviews:

"…and I don't think we do it… I don't think we're fully informing women about a lot of things actually, not just induction…I think to an extent we think we're doing it. But yeah, I don't think we are" (Midwife Sally)

Again, the implication is that it is the professional who 'does' informed consent, rather than the woman. In terms of the law, informed consent is essential. Understanding the way that UK law and the NMC code require midwives to support decision making is fundamental for health professionals (The Royal College of Midwives, 2018; The General Medical Council, 2020).

The following quotation from the same midwife as above does demonstrate awareness of how nuanced the information and consent process can be:

"…I think how that discussion takes place can sway you one way or another because it depends on who's giving them that information and how." (Midwife Amy - interview)

This quotation is in line with theories of 'protective steering' (Levy, 2006). This refers to situations whereby health professionals may believe that a certain course of action is more likely to be safer for an individual, and so they 'steer' the person towards making a decision that they believe will protect them from harm, which in turn means that women do not have the opportunity to consider other options fully. This process can also happen when staff want to be protected from the consequences of service users making the 'wrong' decisions in terms of local guidelines or practice norms (Levy, 2006). Ultimately however, it is crucial that women know that when options are discussed (in the case of this study, induction of labour), that it is an offer and not an expectation (Rydhal, Eriksen and Juhl, 2019).

Furthermore, according to Yuill et al. (2020), attempting to bridge policy and practice gaps through choice is common in maternity care but there is often limited reflection on the health professionals assumptions about the fundamental nature of making a choice, or what constitutes informed choice (Yuill et al., 2020).

Theme two: Influences on women's choices and expectations

Consumerism

Overall, consumerism is defined as the *theory that an increasing consumption of goods is economically desirable* and as: *a preoccupation with and an inclination toward the buying of consumer goods'* (Merriam-Webster, 2024).

In theory, consumers should be informed decision makers with free choice in a free market society, through the practice of matching consumers with well-founded information (Portin, 2020). Consumption is not only about buying and using things; in fact, inhabiting a consumer society has an impact on how people live their lives and the things they value as well as the direction of society (Clarke, 2004).

For maternity services, the notion of choice emerged in the later part of the 20th century in line with the policies of UK government (Clarke, 2004). This was captured in the call for 'choice, continuity and control' in the 1993 Changing Childbirth report (Department of Health, 1993). In terms of informed consent, it is important to consider that a consumer can only choose from the options available, which is determined by the supplier. The power of withholding of information by those who hold the intellectual capital may also take place (Kirkham, 2004a).

Consumerism is linked into the theme of elective induction which has already been discussed. However, it is important to differentiate between consumerism with the emphasis on having 'choice' and the social zeitgeist of 'not waiting for anything.' These are both aspects for consideration in choice for non-medical induction.

The views that the consumer society is influencing induction of labour choices was captured within various discussions in the staff interviews. One participant suggested that current social norms mean that women are less likely to be prepared to wait:

"*…you know you don't really wait for anything now, do you..." (Midwife Laura-discussion group)*

The next quotation highlighted consumerism in terms of induction being booked around childcare:

"*…there was an induction booked to suit a woman's childcare. So, obviously childcare is one thing but it was.. a half term, so she wanted inducing before half-term, so she didn't go into labour during half term the week after, and we induced at about 38 weeks because of that. I think that was authorised by a doctor." (Midwife Roslyn – discussion group)*

The theme of consumerism may go some way towards explaining more than just the reasons for the higher levels of induction and goes toward theorising my findings. Indeed, it is evident that health professionals may be increasingly nervous about not offering all options to women, even if they feel it may not be in their best interests, as consumerists rights for women to have what they want become more and more dominant.

Previous negative experience and choice against induction

The notion of women's' previous experience impacting on subsequent pregnancies and decision making was captured in the interviews with health professionals. There may be occasions when women opt for an induction due to a previous difficult birth but conversely the following quotations highlight situations whereby decisions were made not to accept the offer of labour induction:

"…she's more anxious about the induction process itself and what happened last time than she is about the fact that she might have a big baby and she wants to wait. So, she's going to wait…and sort of the plan there was that she'll have another scan but on the understanding that it might not be very accurate, you know, so we had a long chat with her about that and but that's what she wanted, and she was happy with that and the consultant was happy with that and because she understood everything that we've said. And yeah, at the end of the day…it's up to her isn't it? ….you know, that's her own experience." (Midwife Amy - interview)

As highlighted in the quotation above, a negative birth experience has been shown to have a significant impact on the well-being and future choices of women (Smarandache et al., 2016). Indeed, after a traumatic childbirth experience, women are often afraid of future pregnancies, and may be at risk of experiencing their subsequent childbirth as traumatic (Smarandache et al. 2016; and Davidsen, 2022)

The impact of a previous negative birth experience is reflected in the following quote:

"…I've just looked after another woman and who didn't birth with us for her first child. She birthed somewhere else. And the reason she came to us is because she'd had quite a traumatic experience with them. And that was she said she felt she was coerced into having an induction…which led to a forceps birth and her son was quite bruised and…marked from the forceps. So, she said like you know, in the first sort of few days after birth she kept looking at him and feeling really guilty. Feeling like it was her fault and she felt like she'd just sort of let them coerce them into having this induction. So, because of that she had when she initially she was going to free birth, and she'd contacted us here at the birth centre and…but that true continuity really, I was able to sort of get to the point where she would let me do things…it turned out really nicely."(Midwife Sally - interview)

A risk society

Charlotte described what she considered to be one of the 'barriers' to informed discussions, for women who are healthy but then go on to develop additional care needs:

"…I think when women are seen in a consultant led clinic, they've often been in that high-risk environment throughout their pregnancy. So, more often than not, they are anticipating that they're going to be having a conversation about timing of birth and hopefully women have been prepped a little bit… I think the barriers are the ones who get referred in late in their pregnancy. And then not expecting that you know everything's been going well… (Consultant Charlotte - interview)

This fits with the research which highlights that a significant change in a woman's birth plan that allows limited choice and control for women as being extremely difficult (Cook and Loomis, 2012).

In terms of anxiety, Midwife Amy described how if a woman is already anxious, that discussions about induction of labour may increase anxiety levels, in turn leading a woman to agree to induction of labour whether this is actually their preference or not:

"… it's how receptive they are to that as well isn't it? because if you've got somebody who's already anxious then you start saying you know this might and that might happen, that that's exactly what they're going to choose, isn't it? You know, they're going to go for that option, because they're already worried you've just made them even more worried. And then you're saying to them but if we do this it will reduce that risk so they'll say yes…" (Midwife Amy - interview)

Furedi (2006), Rooks (2006) and Mitchell (2010), site this in the so called 'Risk Society' (Beck, 1992), whereby a risk culture may make women feel morally obliged to do all that they can to avoid harm to their baby with the fear of being viewed as irresponsible, not only by health professionals but also by society if things go wrong based on the choices she makes. Furedi (2006) and Rooks (2006) and Lothian (2012) describe a focus on risk which may create fear for women which leads to potential inability for women to trust their bodies, which in turn may result in women taking a 'better safe than sorry' approach. Additionally, it must be considered that the very act of offering a form of treatment may be interpreted as a recommendation to accept it, which in turn undermines the notion of autonomous choice and instead

results in informed compliance (Stapleton, 2004). Indeed, Jomeen (2007) and Sakala (2006), indicate that nulliparous women may assume that what is offered to them by health professionals is the option that they should take, therefore meaning that women may not question medical interventions being discussed.

The presence of women's anxiety and health professionals concerns regarding litigation was discussed in the staff interviews:

"I think from a staff perspective risk always, so I think even if there's even an element of risk, even if it's not particularly high, I think we are in a very litigious society and we are in a you know and I think that that does influence some decision making sometimes and we've seen that with the LGA [Large for Gestational Age] *babies, yeah fear of what may happen…and I think that's from the clinician side and from the patient side because that discussion that they have with the patient..is scary if I was listening to that as a pregnant person I'd be terrified but and but yeah that it has to has to take place…"(Midwife Amy - interview)*

The quotation highlights risk to health professionals in terms of litigation, which again may bring into question how much of the discussions are framed in a way to reduce different kinds of risk to health professionals. According to Lothian (2012), what is acceptable risk for the mother and her baby may not be acceptable risk for the health professional or health care provider.

The next quotation highlights that there are occasions whereby women would like the health professional to make the decision for induction or not on their behalf:

"… it's all about you know, shared decision making, isn't it and you know, you give women the information and then they have to do with that what they want. Whereas some women just want you to say well you know, tell me exactly what to do, but we can't. Particularly with LGA, for instance, cause we don't have a lot of evidence…" (Consultant Charlotte - interview)

In these kinds of cases, women have trust in the advice of the health professional (Levy, 2004). Some women may feel a sense of relief at being induced, and induction may therefore be the correct choice for them (Lundh, Ovrum and Dahl, 2023). Additionally, Machin and Scamell (1997) describe that as women go from pregnancy to labour, this experience may lead to them being happy for the health

professional to recommend decisions for them. However, and as discussed throughout this section, wanting the health professional to make the decision may also result in issues regarding the informed consent process. In terms of being part of/witnessing traumatic births or adverse outcomes, the way in which health professionals steer women may also be driven by experience of, or fear of, being a 'second victim' as discussed within this chapter.

Social media

As already discussed in chapter 5, due to the easy access and ability to share information via social media, pregnant women utilise online sources for maternity information (Dekker, 2016). Indeed, online searches for information is the second most popular place for maternity information after the NHS website (Nicholls et al., 2021).

However, during the interviews with health professionals, one member of staff described social media as being a barrier to informed consent:

"I think social media is actually a barrier really. People only ever tell the horror stories." (Consultant Charlotte - interview)

This emphasises the need for health professionals to discuss with women the importance of the difference between information that is opinion based and information that is evidence base (Nicholls et al., 2021). Online information may be informal and unregulated with variable quality (Moorhead et al., 2013). However, as highlighted on page 41, some women find stories from other women more 'real' than the evidence they get from professional and other official sites. Though staff should be aware of the sources for officially endorsed information (Nicholls et al., 2021), it is important to note that this information does not always 'tell it as it is' for some women. Some of the issues around not knowing how long induction could take might be resolved if women's stories of long waits are incorporated into easily accessible information, for instance. The evidence generally points to the need for health professionals to be aware of the wide range of sources women might use, and to discuss their choices respectfully based on what they have read or seen.

Partners/family and friends

Partners, family and friends can have a significant influence on women's decision making (Cook, 2012). One midwife spoke of this as a potential challenge for staff:

"*When they've brought a family member or their partner, obviously you want to involve the partner in the discussion and some partners have a very strong opinion about what should or shouldn't take place and you often find women wanting to wait and discuss it with partner, husband, whoever at home if they're not there when the discussion's taking place. And past experiences so if you've got a mother or a sister, they'll be talking about their own experience maybe and that may influence then what the patient thinks that they want." (Midwife Amy - interview)*

The above quotation aligns with the views of the postnatal women who were interviewed (chapter 5) who found the views of their partner to be beneficial in the decision-making process for induction. However, for this health professional there does seem to be some reservations about this influence on women.

Information overload

Although the provision of information is key to women making informed choices, there is the potential for them to become overwhelmed with the vast amount of information they currently receive from the NHS. This was reflected in the interviews and discussion group with health professionals:

"*Well, they say you only take in 10% of what you're told, don't you? And really, it's a phenomenal amount of information that they're given and they're being asked to make decisions. You know, like a quick clinic appointment, really…where they might have other things that they want to discuss". (Midwife Julie – discussion group)*

Information overload can be defined as a state where the volume of the information exceeds an individual's processing capacity (Khaleel et al., 2021). One midwife described the volume of information that is required for the woman in combination with time pressures:

“I think we do, I think we do give information. I think there's a lot of information to give and I think we have to be really careful that we don't overload the women. I think there's only so much information people can take in at any one point, I think even just describing the process of induction is actually an awful lot of information for women to be taking in and sometimes you know, I find that these women, actually they can't make a decision on one consultation. They may need a second consultation and the issue with that is time pressure, and you know that ability to be able to have those detailed conversations in a pressured antenatal clinic. And I think that can be quite challenging. Can you go through every risk of induction of labour? It's a balance between giving women enough information that they are making an informed choice, but at the same time trying not to frighten them…” (Consultant Ruth - interview)

Expectation versus reality

Pregnancy and childbirth are significant events in women’s lives and most women have expectations or plans for how they hope their labour and birth will go (Webb et al., 2021). In line with some of the comments of women in the interviews for this study, some staff felt that women’s expectations of the length of induction of labour did not match with the reality:

“I feel that the experience for induction could be better in the terms that I don't feel that women fully understand what they're coming into. As in, I don't think that they realise they could be here for a couple of days even though they’re told about the process of it when they're here for day two day three sometimes. I don't think that ever actually registered that they'd be that person if that makes sense” (Midwife Roslyn)

One of the Midwives described how she was unsure why women’s expectations did not always meet the reality:

“*…I think a lot of the irritation for the women is their expectations and their expectations not being sometimes realistic for whatever reason, whether they've not had the information or they just haven't taken it on board…”(Midwife Rebecca – discussion group)*

Another midwife described how the confines of the hospital bays on the antenatal ward sometimes causes confusion for women labouring at different rates:

"*… for some reason women don't understand when they're in the bays that they all do things at different rates. So, when you get someone that comes in later and ends up going across to birth suite before them, they don't understand that. But it works differently with everyone…and that makes it even worse. They sort of lose that rational thinking of that you know it'll happen when it happens and that that's where a lot of the frustrations come from with it". (Midwife Roslyn – discussion group)*

This may be construed as an interesting quote in terms of expecting women to understand the birth process in depth and that it is rational for women to think that it will 'happen when it happens'.

Shetty et al. (2005) and Gatward et al. (2009), contend that, in their view, many women have 'unrealistic' expectations of the length of an induction of labour, along with pressure from family and friends who frequently expect the birth to be on the same day as the induction. This also came up in interviews with the postnatal women (page 133). The expectation of having the baby on the same day was also discussed during the interviews by one of the health professionals:

"I think it's also important that they have an understanding of what the process actually entails because I think sometimes one of the problems that we have is expectations don't necessarily meet reality, so we have patients, for example that might say I'm going to come in for an induction, have my baby the same day and then when that doesn't happen their perception is that the process hasn't gone to plan. Well, that's obviously not quite the case. So, I think it's about making sure that these patients understand the process, the length of time, what could happen, things like that just so that they have a decent understanding of what to expect really. And then they can sort of set their expectations appropriately." (Consultant Ruth - interview)

Indeed, staff felt that preparing women for what to expect during induction and for the likelihood of delays and interruptions is of key importance in enabling women to adapt their expectations of labour:

"I think women don't get a very full picture of how it is and how it can be. And for those women who are on the ward for three days who have had a propess [initial induction agent]*, 3 prostins* [follow up induction agent], *several examinations before they even start the labour process, before they're even in labour. They are absolutely exhausted and on their knees then and then… they have to go through labour" (Midwife Laura, discussion group).*

Theme three: influence of and on the health professional

The framing of risk discussions

Better Births (2016) published by the NHSE, stipulates that women should be able to make decisions about their care during pregnancy, during birth and after their baby's birth, through an ongoing dialogue with professionals that empowers them.
The notion of informed consent was captured throughout the interviews with health professionals. There were various barriers to this that health professionals spoke of during the interviews that had the potential to impact on informed decision making. Some examples include when women receiving the standard offer of care develop additional care needs; when women express increased anxiety; and concerns regarding litigation.

One doctor described the need for a positive approach to discussions about labour induction, even for women with no medical conditions:

"I think, maybe we need slightly more positive approach to induction for low-risk women because I think the difficulty is high risk women get a lot of information and a lot of I suppose scary information at times, whereas actually there'll be an awful lot of mums that start on a low-risk pathway and convert to a high-risk pathway or need to be induced for one reason or another." (Consultant Ruth - interview)

The following quotation describes the challenges of informed consent when risk arises unexpectedly:

"So, I would say..the clinical accumulation of risk so .. I would try and tailor my consultation to say these are my concerns, this is why I'm offering you induction, these are the risks associated with each of these factors and you've got three or four

of these factors and this is why I'm offering you the option of an induction. I try and explain if you don't opt for the induction, these are the potential concerns I'd have and these are things that you .. know want to keep an eye open for and this is the… there may be extra monitoring I might recommend. I'd also judge kind of their feelings about intervention and induction… and you can tailor the information that you give them so that you can try and try I suppose not approve but try and ensure that the kind of birth plan that they were hoping to have, you can still give elements of it and degrees of it and I try and give them that degree of reassurance really." (Consultant Ruth - interview)

The quotation above does not mention about telling the woman the risks of induction, only the risks of not having the induction. It may be argued that unless all elements of a risk are presented, women are likely to agree to the care being offered to them based on the thought that what is offered must be the option to take (Teijlingen et al., 2003 and Kirkham, 2004b). The quotation is based on the notion of protective steering as discussed on page 159 and throughout this chapter. Nicholls et al. (2021) describes the potential for 'clinical framing' which involves framing the consultation in terms of the decision-making process, combined with a clinical risk dominated narrative. It may be that health professionals feel pressure to tell women about the positive benefits of induction for fear of being responsible for any adverse events if a woman is not following a normal care pathway aligned with guidance (Levy, 2004; Lukes, 2005). Furthermore, other studies have highlighted that risk may be exaggerated which in turn means women may choose options to be compliant with hospital guidance and the usual patterns of care (MacKenzie-Bryers and van Teijlingen, 2010; Gigerenzer and Muir-Gray, 2011). This means that health professionals may miss some of the pertinent points about what matters to women. This phenomenon means that discussions become based on what the health professional thinks the woman should choose. This tendency was at times present within my research study as illustrated by some of the quotations within this chapter.

The health professional as second victim

Some examples of experiences that traumatised staff, and that affected their approach to information giving, were discussed during the interviews, including the longer-term impacts:

"…the fertility ones, the one that stands out. I can still picture telling that woman her baby had died. It was horrendous." (Consultant Ruth - interview)

The next quote highlights a reflection of how a previous experience may influence a health professionals approach to information giving:

"Other ones I've had some…acute preeclamptics that have come in with acute abruptions or I have had one eclamptic lady that's come in who again was preeclamptic being monitored and having seen how quickly those ladies can deteriorate you know there is good guidance to recommend delivery after 37 weeks so although I don't try and frighten women that that they're all going to end up with acute onset preeclampsia I do, I .. am honest with them about the potential risks and how preeclamptic deteriorate relatively quickly and when you sort of explain those risks to the mums, I do find most of them actually are relatively amenable to being induced from 37 weeks. So, I think it's probably those acute presentations of those acute conditions for me that potentially I'd say they just kind of like sway my counselling if that makes sense." (Consultant Ruth - interview)

Both quotations highlight the potential of the health professional as the second victim. The 'second victim' refers to the health professional who experiences emotional distress following an adverse event and is shown to be like that of the patient, the 'first victim' (Ulstrom, 2013; Ozeke et al., 2019). Adverse, emotional, cognitive, and behavioural reactions are all potential reactions as the second victim (Seys et al., 2012). Defensive changes on behalf of the health professional have been reported in practice following an adverse event, with coping strategies potentially impacting on patients, colleagues as well as the health professionals themselves (Seys et al., 2012). The notion of the second victim means that advanced support structures are required in the presence of adverse events to enable the promotion of positive safety cultures. This again may mean that the notions of clinical framing and protective steering from the health professional impact on informed discussions and informed consent and result in it not being fully achieved.

Theme four: The NHS hospital organisation: setting and resources

Grey areas within the guidance

It is known that there are many grey areas in maternity care, including how long labour lasts, how labour progresses, when to intervene, when not to intervene and what is acceptable and unacceptable risk (and who decides this) (Dahlen, 2014). The potential for grey areas with the guidance may impact upon the navigation of risk.

"…someone asked the question today about um have we got any, is there any good evidence for or against induction of labour for women having an IVF pregnancy? And .. as far as I'm aware, I think the general reason why it is offered is because it's very much a wanted pregnancy that people have sort of and you know, often spent years and years trying to conceive and it's about sort of obviously trying to get that baby out safely before something else might happen as they go past the due date, but I think in terms of evidence, you know is that really the best option for them you know? …I understand that an IVF pregnancy, obviously these women have been through a lot…to get to where they are and I get why people say it's precious but every pregnancy is precious. And…at the same time, if we are saying this is such a precious pregnancy, should we be putting on them an intervention that potentially is increasing their risks of more negative outcomes?" (Midwife Sally - interview)

The NHS choice and personalised care in maternity services (NHS England, 2023) states that for informed choice to be achieved, the information that women receive needs to be reliable, clear, timely and in a format they understand. However, much of the job of midwives involves navigating the grey zone in between normality and risk (Dahlen, 2014). Additionally, grey areas in the guidance have the potential to lead to errors in care provision, as was highlighted within the interviews:

"…So, particularly for women with diabetes, if you read it and you don't necessarily read it properly, the pre-existing ladies should be offered elective birth by 38+6 but [for] *gestationals* [gestational diabetics] *it's 40+6 so some women read the guidance and hold on the 38+6 when actually it doesn't apply to them because they're not in that group of women but then once they've got it in their heads that's it, like you*

know, and it's kind of well you should be doing this, my babies at risk, I've got diabetes. And I think once somebody is already in that mindset, it's very, very difficult to get them out of it .. so we've had a few, they're not heated conversations but difficult conversations with women who definitely have a preconceived idea that that is what's going to happen and actually sort of saying, well, no, we shouldn't .. be going down that route. We would wait nearer to term and they're not happy. And I would say more often than not, the obstetrician agrees [to the induction] *because they're* [the woman] *not happy about it* [being delayed]." *(Midwife Amy - interview)*

Furthermore, according to Muir-Gray (2011) and Cheyne, Abhyankar and Williams (2012), there is limited understanding of probability statistics amongst health professionals. This may have an impact on all risk discussions, particularly where there may be grey areas within the guidance including for rationale such as IVF and large for gestational age.

Organisational constraints

During the interviews with health professionals, a number of organisational constraints on informed choice were discussed. This included time; accessibility of information; language barriers and hospital resources.

One midwife spoke of appointment times over running:

"…appointment times you know they do overrun, and I am conscious but then for me I do like the woman to discuss her feelings and I try and give her as much information as I can and then if I feel if she does need more information I will try and agree to meet her at the centre for lengthier discussion as well women who need more information." (Midwife Pam - interview)

"…the time element obviously sometimes does mean that discussion is probably a bit more rushed than it needs to be especially in a busy clinic." (Midwife Amy - interview)

Midwives (and other health professionals) work within a time constrained structure that limits the amount of information that can be provided, with short appointment times. Lack of continuity of carer means that midwives may experience a lack of

opportunity to build the kind of relationship that aligns with women's' decision making (Kirkham and Stapleton, 2004).

Additionally, pressures on time may in turn lead to a reactive rather than proactive approach to informed consent discussions on the behalf of health professionals (Kirkham and Stapleton, 2004). Therefore, informed consent may not have taken place despite the best efforts of health professionals within the given time frames.

Furthermore, health professionals also discussed their own knowledge and accessibility to information as being a potential barrier to informed consent:

"…it's those barriers to having those conversations, so your time constraints but also the knowledge.. because there are so many different reasons why we're offering induction…so each situation, each scenario is a different one really. So having all those facts to hand is difficult." (Midwife Sally - interview)

Another midwife also described the challenges associated with giving the information to women at the correct time:

"It's knowing at what point of the pregnancy we give them that information as well." (Midwife Pam - interview)

Women's rights to decision making regarding their care are central to woman centred maternity care (Nichols et al., 2021). However, the data from the study suggests that appointment times, the potential for information overload, issues with accessibility to information and the challenges of knowing when to give women information all highlight the barriers to informed consent.

Language barriers

As already discussed, in information rich post-modern societies, women are exposed to a wide range of information sources (Vogels-Broeke, 2022). The importance of language used in these sources was discussed in the interviews:

"…making sure that you are speaking to someone in a way that they can understand whether that is their own language or just using certain terminology so that they

understand what you're talking about…but having like an interpreter is huge. Definitely not relying on partners because we know that they don't discuss absolutely they don't discuss everything at all. So yeah .. making sure that they understand in a language that they speak is really important." (Midwife Amy - interview)

The quotation above highlights the issues that language barriers may create in the clinical setting and how these impact upon informed consent. Indeed, some language barriers may create difficulties accessing maternity services. They include, lack of access to a suitable interpreter, suspicion around the level of confidentiality interpreter services provide and how well professional interpreters are able to relay information to health professionals during appointments (Rayment-Jones et al., 2018). In addition to language barriers, it is also crucial to consider that high levels of literacy are essential to obtain, understand and assess health related information to be enabled to make informed decisions and that compared to women with middle and high levels of education, women with a low level of education use written information sources like leaflets and websites less often (Vogels-Broeke, 2022).

Iatrogenic impact of induction of labour

One of the midwives felt that women were not fully informed about the multiple examinations that may occur during the induction of labour process:

"…I think they need to know what it actually entails and what to expect, but about the soreness as well because it's not just about the pains in their abdomen. Actually, there's a lot of sensitive areas and it becomes very sore and tender and I don't think … I have ever heard a doctor discuss that pain and the multiple examinations throughout that period of time of induction from start to having the full…pathway of induction, how many .. examinations they have." (Midwife Roslyn – discussion group)

Some of the potential iatrogenic effects and impact of induction of labour were also discussed throughout the interviews with the health professionals in terms of the utilisation of oxytocin, the increased need for analgesia and the consequent cascade of interventions:

"And then we start oxytocin. We've had loads of examinations. So you know, sepsis is a huge thing, I've never seen septic women as I see now and it just is this cascade

of intervention that snowballs and snowballs and snowballs and you know, sometimes you see women on the second bag of synt…. you leave them in the morning having been on birth suite all night and you come back to them, they're still in labour and still haven't had a baby." (Midwife Laura, discussion group)

In terms of iatrogenic effects, another midwife spoke of the need for women to be aware of excessive bleeding and fetal distress:

"… and I think in that information we certainly need to be telling women the information and you know about excessive bleeding and what excessive bleeding actually is and what it means for them because the excessive bleeding…. it's something that's written on a piece of paper but until you know until they feel really blooming awful after they've had a… PPH [postpartum haemorrhage], *they really don't know what, what it is. Erm And..that needs to be included. And the..fact that you know induction of labour can cause your baby to become distressed, even the most robust babies can become very distressed from..oxytocin." (Midwife Fiona – discussion group)*

Another midwife spoke of what she felt to be the irony of carrying out labour induction on an otherwise healthy woman because she had had a post-partum haemorrhage in her previous labour:

"*…I think she was thirty-eight weeks plus, was an induction for previous traumatic birth. So, when you looked into this previous traumatic birth, she'd a PPH post birth last time and that's why she was induced this time. So, to me, there's a low-risk woman, 38 weeks and we're inducing her for previous traumatic birth because she had a PPH requiring transfusion last time. So, you actually look at that, aren't we just going to repeat the same scenario…". (Midwife Laura – discussion group)*

One midwife spoke about the postnatal period where an impact of induction of labour could be a delay in a woman's milk coming in and therefore causing potential challenges for breastfeeding:

"And, and like you said before, those long-acting effects of oxytocin, the delay in the milk coming in." (Midwife Julie – discussion group)

There is some evidence that oxytocin, a drug given intravenously to speed up labour, may interfere with the success of lactation and breastfeeding, therefore having the potential to impair bonding which in turn could impact on a child's development (Khajehei, 2017).

The impact of early transfer to the postnatal ward and consequent increases in rates of postpartum haemorrhage and impact on the ward workload was also mentioned:

"I think I think we're definitely seeing more PPH down here as well. Yeah, because and I don't know whether that's because of the workload across the unit. Like women aren't spending as long in recovery or they're not spending as long postnatally with you up on birth suite because you have to clear those rooms for your next lot of women coming through…" (Midwife Julie – discussion group)

Complex medical need and the extra resources required was likened to intensive care situations:

"You know you've got these women with huge histories, you know, complex medical histories that need looking after as well and if they've got complex medical history it .. leads back to them being induced and it's, you know, it's almost like it's an intensive care. Yeah, some rooms you go into, it's almost like then, you know they absolutely needing one to one, some of them you think well actually probably two midwives could be useful in that room." (Midwife Laura – discussion group)

One respondent spoke about the increasing complexities and the impact on postnatal resources in terms of the additional pressure during this period if women cannot care for their babies, and the impact on the ability of midwives to support breastfeeding due to the pressures on resources:

"*I think the impact, I think it's massively impacted on the workload because we don't have anybody normal down here because of COVID but also all the mums that come to us have either had an instrumental birth or a PPH or a section. So, for that first 12, 18 hours they can't care for that baby at all. And that's putting that extra extra onus on the staff..the frequency of observations is higher..and where..a midwife probably*

two or three years ago might have two normal births in a bay, two forceps and a section we're now looking at five sections and a forceps, so it's completely turned it really into a surgical obstetric ward, not a maternity ward which is a shame because then they don't have time to do the breastfeeding and the hand expression and things like that…. (Midwife Julie – discussion group)

Another midwife spoke of stretched resources and her uncertainty regarding outcomes not always reflecting the interventions taking place:

"The service you know the maternity service is absolutely pushed to its absolute limit and actually if you look at the statistics, these babies, I don't think there's any better outcomes with all you're doing more prevention and we're putting you know we're inducing and we're doing all of this but actually I don't, the outcomes… don't reflect the intervention." (Midwife Laura – discussion group)

The risks of these kinds of iatrogenic consequences were first highlighted more than 25 years ago by Edozien (1999), when rates of induction of labour were much lower. Fox et al., (2019) describe models of care that led to overuse of interventions such as induction of labour in otherwise healthy pregnant women with the cost of these interventions and the potential for poor outcome being substantial.

A further consequence is the knock-on effects on use of clinical and mental health services later in the postnatal period:

"And then they go out into community, and they're traumatised by the care that they've had throughout because they've not been fully prepared. And then…we're throwing them out at like 12 hours… babies 12 hours old. And they are coming back. We've definitely seen an increase in our readmission rate. It's definitely for babies as well." (Midwife Julie – discussion group)

In terms of resources, Rhydal, Eriksen and Juhl (2019) and Coates et al. (2019) comments that increasing induction of labour rates may not only detract from the care of other women but if women consent to induction of labour and are kept waiting, this adds considerably to their anxiety and experiences and that of their partners and families. It is important to note that overuse of clinical resources for those who are unlikely to benefit from them also limits the availability of resources for

those who really do need interventions, like induction of labour, to prevent harm to them or their baby.

Organisational response to the birth partner

My research study was undertaken during the Covid 19 pandemic whereby an inpatient stay for women meant that partners were not always enabled to stay overnight on the antenatal ward and the postnatal ward. According to Vasilevski et al. (2022) for partners, this led to a sense of 'missing out' from the pregnancy and maternity care because of changes in the provision of care, with partners reporting feelings of isolation, psychological distress, and reduced bonding time with babies. Engaging partners and support persons in maternity care has substantial benefits for mother and babies, so the impact of excluding partners from aspects of maternity care can be far reaching (Vasilevksi et al., 2022; Thomson et al., 2022).

In contrast to the widely reported sense of abandonment reported by women when their partners could not be involved, some of the staff in this study felt that the absence of partners, especially on the postnatal wards, could be a benefit for some women:

"We had that in COVID down here .. because there were definitely less inductions through COVID weren't there? And obviously no visitors on the postnatal and the women open the curtains, they talk to each other, but they slept at night because they weren't trying to bedshare with a partner or they weren't sat up in the chair while he slept in the bed. You know, and that's probably the same on antenatal. You probably find more dads in beds than mums at time. And, then these women are going into an induction tired, before they've even started." (Midwife Julie – discussion group)

Even before the Covid 19 pandemic, partners commonly reported feeling excluded by health professionals providing maternity care to mothers and infants (Vasilevski et al., 2022). In fact, during the interviews and the discussion group, health professionals reflected upon how birth partners may have a negative influence on women:

“Yeah, so birthing partners that in general so .. your mums, your partners, your close friends, a lot of the time if you speak to patients on their own, you'll get a completely different viewpoint and different ideology of what they feel should be happening, what they want, compared to you know that mum that's constantly at the nursing station saying she's in a lot of pain, she's not coping very well. She's going to need more pain relief. And actually, she’s coping fine, she's doing her thing, and you know a lot of it is influenced by what they feel they should be doing because of what other people are saying…” (Midwife Roslyn – discussion group)

“And certainly, the people that I've gone over to speak to when I've been called over in the night because people are getting impatient, and it does tend to emanate from the partner or the mother.” (Midwife Fiona – discussion group)

Additionally, the lack of resources to support partners staying overnight in the antenatal and postnatal setting, and the implications of this, was also discussed by health professionals during the interviews:

“I think we've brought in this 24-hour partner support as a Trust and I'm sure many other Trusts have done the same thing without actually having the proper facilities to be able to accommodate them because it shouldn't have to be sitting up all night in a chair and they should not be trying to squeeze into a single bed with the partner either.” (Midwife Fiona – discussion group)

One midwife spoke of the potential for lack of privacy and dignity in the bay setting on the antenatal ward:

“So obviously if you are having an intimate examination and then you've got such and such body next door, the husband's out on the chair thinking oh my God, she's having an examination through there and I can hear everything. Yeah, it, we actually very very uncomfortable in there. You think about that?” (Midwife Roslyn – discussion group)

The following quotations highlight how the offer of partners being able to stay creates an expectation that in this midwifes view, has unintended negative consequences:

“Well, I did a poll on xxxxxxxx about 24 hours visiting and I would say that 95% of the women didn't want it antenatally or postnatally. They said they wanted to be you know, rested. They wanted to eat their own food because they share the food and

everything and they didn't like other people being around so they didn't, and I can understand that on the Antenatal Ward as well. If you're in pain, you don't want the woman and her partner in the next bed space having a Kentucky fried chicken, do you?" (Midwife Julie – discussion group)

"I think because they can stay, they probably feel like they should have to stay for the woman who's being induced, but actually they're probably better going home, getting some sleep for when she's actually in labour." (Midwife Rebecca – discussion group)

These views seem to contrast with those expressed by many women during the Covid pandemic. There appears to be no research about how birth companions experience being with their partner during induction of labour. However, a key objective as part of the quality and safety agenda in maternity care is to optimise woman-centred care, considering women holistically, and caring for them, their babies, partners as well as the wider family (The National Maternity Review, 2016) and NHS Long Term Plan (NHS, 2019). This would include the option for partners to stay overnight with women in the hospital setting. However, the implication of the issues described in the quotations from the interviews and the discussion group illustrate that if birth partners are to be encouraged to support women and to share the induction of labour experience, then more needs to be done to provide the resources that would be required to fully support this. It also suggests that at least some of the day might be kept visitor free, to allow women time to rest, develop feeding skills, and bond with their baby.

Provision of continuity of carer

Continuity of carer was raised by health professionals during the interviews as a crucial aspect of the processes around achieving informed consent. Continuity of carer is a model of midwifery care that provides a named midwife, with the support of a small team, who will work together to provide all of a woman's care during pregnancy, birth and after the birth of the baby (Better Births, 2016)

One midwife described the importance of women seeing the same members of staff for the assurances of the continuity of information giving:

"…I think continuity is really important because the point of having a specialist clinic is that they're seeing the same or .. the same team of people who were all saying the same thing…(Midwife Amy - interview)

This was echoed by another midwife who described how helpful it was to know the women that they are caring for:

"…and it really helps knowing the women." (Midwife Pam - interview)

One consultant described the importance of continuity in terms of building a rapport and trust:

"…building a good relationship with the woman is really important…I think it mainly comes down to building a rapport with women. They need to be able to trust you and that you're being honest with them." (Consultant Charlotte - interview)

The quotations above highlight how health professionals feel that building good relationships with women, ideally through organisational structures that enable continuity of carer, and improve the quality of care that women receive, and the capacity to optimise genuinely informed consent. Indeed, 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, with The National Maternity Review (2016) stipulating a requirement for continuity of carer to ensure that women will be primarily looked after or supported by professionals they know and trust**.** However, Dharni et al. (2021) describe how continuity of carer can be hard to maintain in a system with staff shortages and a depleting workforce, combined with the need to be on-call for births. More recent policy documents require Trusts to set up continuity teams for marginalised groups with a return to the requirement for this approach for all women as staffing levels improve (NHS England, 2023).

Whilst the global Covid 19 pandemic impacted on the ability to implement continuity of carer, this is not a new issue, with discussions about the structural inadequacies of the current maternity care system and how a change in the organisation and resourcing of maternity services at local and national levels is required to address issues arising from health professionals not providing sufficient opportunity for

informed choice (Kirkham, 2004). See Chapter 7 (Discussion) for further discussion about continuity of carer.

Suggested service improvements

In addition to continuity of carer, some of the service innovation ideas from health professionals are captured in the following quotations. A wide range of improvements were suggested by staff including information leaflets, videos on Badgernet, televisions in clinics, accessibility of information for health professionals, the potential for induction of labour consent forms, birth choices clinics and specific multi-disciplinary meetings for induction of labour. These were reflected by the participants in the discussion group:

"Video. They could have a video uploaded to badgernet. Because they're all IT specialists aren't they, they're all dead good with the computers…choose you're language…and a visually impaired person can listen to a video." (Midwife Julie – discussion group)

"I think easy access to the knowledge, by having .. the statistics that we need to be able to give women to be able to you know so they can make an informed choice. It's the access to things like that…or resources that we can at least sign post women to so that they can discuss that and read it in their own time and then make a decision. Often, I think the problem is women are put on the spot with these decisions as well, they have to sort of make that decision then don't they?" (Midwife Sally - interview)

During the staff interviews, one midwife spoke of how she felt it would be helpful for women to sign a consent form to support the informed consent process:

"…I have always wondered why we don't get them to sign a consent form, because it's a medical intervention..." (Midwife Amy - interview)

These are simple and relatively inexpensive tools to support women with informed decision making to ensure the provision of informed consent, woman centred care and to improve the induction of labour experience.

During the interviews with staff, antenatal education was also discussed as a tool for re-introduction post Covid 19 pandemic to assist with informed consent:

"…we need to go back to parent education classes. You know, not NCT, not private ones, actual informative NHS ones with no agenda other than giving accurate up-to-date information and answering questions. And, I think there's a lot to be said for face to face or even you know teams. But that contact with someone where you can ask questions as well. I think it's really valuable and I think we've lost that in, you know, we've all got mobile devices. You can push all these leaflets through, but actually, in an antenatal clinic you know be that an obstetric one, or a midwifery one, there's no time for a lot of questions or to be able to give good answers, whereas if you know you can go back to this, you know more parent education. I think a lot of women would find it valuable." (Consultant Charlotte - interview)

Indeed, childbirth education can help women put risk in perspective and develop a deeper understanding of the relationship between evidence-based care and safety, with this being particularly pertinent in terms of informed decision making which requires knowledge and support (Lothian, 2012). Conversely, antenatal classes in terms of informed consent and induction of labour may be criticised. Women usually attend between thirty- and thirty-five-weeks' gestation, which for some women may be before induction of labour becomes relevant. As already discussed, evidence shows the importance of the timing of information giving to ensure that it is relatable (Cooper and Warland, 2011; Maher, 2008; Stapleton et al., 2002a). Furthermore, too much information can be as ineffective as not enough information (Maher, 2008). Finally, there is evidence to show that first-time mothers of a higher socioeconomic status are among those most likely to engage in antenatal education, which can result in a limited audience in terms of equality and equity (Gagnon and Sandall, 2009). However, despite the criticisms around antenatal education, Lothian (2012) describes how antenatal education may help women to understand that a risk-free life does not exist, and to equip women with the information of how to assess discussions about risk.

Another service improvement that was discussed was to increase women's knowledge and the Trust's service for outpatient induction of labour as an alternative

to an inpatient stay. Outpatient induction is the process of induction that begins as an inpatient or an outpatient procedure whereby women are then discharged home for 24 hours or until labour starts, whichever is sooner. The Trust where the research study took place, has guidelines in place to ensure that any risks are considered and addressed when considering outpatient induction with women.

If discussions between women and health professionals identify that outpatient induction may be a suitable option for a woman based on her care needs, then the benefits of outpatient induction are the potential for a reduction in medicalisation with a reduction in oxytocin use and other associated interventions (Wilkinson, 2021). There is also the potential for an increase in the psychological and social support for a woman in the home environment, enabling autonomy and rest (Wilkinson, 2021).

"I think I definitely think outpatient inductions got .. a role, especially, especially in those more social inductions…" (Consultant Ruth – interview)

The doctor went onto describe how she felt that there was scope for outpatient induction of labour whilst considering the risk factors involved:

"…So, I definitely think outpatient inductions got some scope and I think there seems a bit of resistance with first time mums because I think they're frightened. So it may be that actually, it's more appropriate in those, in those multiparous ladies. But then you've got issues that they may then that the multips are more likely to potentially hyper stimulate, or they might labour more rapidly off the propess medication, so they may not be at home for prolonged periods of time. So, you've got to be thinking again, geography, access to hospital, but yeah, I definitely think there's scope for outpatient induction." (Consultant Ruth - interview)

This quote captures the paradox that is inherent in some inductions of labours that are undertaken whereby the rationale for the induction is that the baby is at risk but then outpatient inductions may be offered for women who do not actually have a real risk but then there is the risk of induction itself.

Summary

Labour and birth can have long lasting physical and psychological impacts on women (Oakley 1980; Kirkham, 2004a; Renfrew et al., 2014; Sandell et al., 2018). Additionally, induction of labour can have an impact on a woman's birthing experience (Baston et al., 2008; Murtagh and Folan 2014; Yuill et al., 2022; Harkness et al., 2023). As discussed throughout my research project, induction of labour is on the increase for a wide range of reasons. Women therefore may need to contend with often complex pregnancy related decision making that may include social, cultural, emotional, and clinical issues. Ultimately, and as discussed throughout my research project, the process of achieving informed consent is complex and multifactorial. The challenges of achieving informed consent for induction of labour was summarised in this quote:

"It's trying to balance, isn't it? Trying to find the balance between doing the inductions that need to be done, not doing the inductions that don't need to be done but trying to keep women well informed and happy with their care. And, you know, like that holistic viewpoint and it's about, you know it's about trying to have that balance and sometimes I think we're going too much the other way. I don't think we've found a good balance of what we're doing, really." (Midwife Laura - interview)

With such challenges, participation in decision making, supported by comprehensive and quality information provision that is tailored to what is material to each woman, is a crucial priority for maternity care (Supreme Court, 2015; Stevens et al., 2016). In terms of birth planning, it is crucial that women should feel supported to make well informed decisions through a relationship of mutual trust and respect with health professionals, and their choices should be acted upon (Better Births, 2016). Findings of the staff interviews highlighted a wide variety of service improvements to enable women to access information at the right time, in the right place and in the right format through both strategic and local level improvements. These need to be considered to support improvements and changes in practice to ensure that genuine and authentic informed decision making, and consent are achieved.

CHAPTER 7

General discussion

Introduction

My research study set out to explore the views, beliefs and experiences of women, midwives and obstetricians having discussions around induction of labour in terms of informed consent and how the process of informed consent impacts upon a woman's pregnancy journey. My research was undertaken through a small-scale, mixed methods study via a triangulated approach utilising the philosophical stance of pragmatism. The triangulated approach included a systematic literature review, a questionnaire with antenatal women having discussions with health professionals regarding induction of labour, interviews with postnatal women about their induction of labour experiences, interviews with midwives and obstetricians and a discussion group with midwives regarding their experiences of induction of labour in the ward areas.

A triangulated approach whilst utilising a pragmatic stance enabled an invaluable insight into the views, experiences, and beliefs of women around all aspects of informed consent and induction of labour as well as an insight into the under researched area of the combined lived experiences of midwives, obstetricians, and women regarding induction of labour on the antenatal ward, the central birth suite, and the postnatal ward.

To form the context of the study, the nature of induction of labour, the reasons why it might be offered, the recent rise in induction rates in recent years, and the nature of informed decision making, and consent have all been discussed throughout my thesis. This chapter begins with a discussion and summary of the overall birth experience in relation to informed consent and then goes on to discuss and summarise the key findings of my research, concluding with an overview of the remaining gaps in women's ability to make informed decisions about induction.

Overall, it is identified that there is an overarching need for improvements to women centred and personalised care. A wide range of influences on the decision-making process have been identified, considered, and discussed throughout my thesis. The

issues I explore further in this chapter were identified as the key themes for exploration within the discussion. The key findings impacting upon informed consent and induction have been identified as ***women's choice and expectation*** (theme 1), ***the influence of the health professional*** (theme 2), ***the NHS hospital organisation*** (setting and resources) (theme 3) and ***external influences on the decision making process*** (theme 4). In the next chapter (chapter 8), I expand on some of the themes identified in the interview and discussion group with health professionals, bringing in the findings from the women to develop the analysis further.

The overall birth experience

Since this study started, there has been an increasing interest in induction of labour, with a consequent increase in research studies about women's views and experiences (Coates et al., 2020; Thirukumar et al., 2021; Dadelszen et al., 2022; Dupois et al., 2023). However, the majority of these studies have tended to focus on healthy women being induced for postdates pregnancy or have been either surveys or qualitative studies. This study includes interviews with women experiencing induction of labour for reasons other than post term induction and therefore adds to the existing research by conveying the views and experiences of those undergoing induction for reasons other than postdates pregnancy, whilst also integrating these findings with the views of health professionals in the same Trust where the case-study women had their babies.

As discussed throughout my study, crucially, the birth of a baby is a pivotal time in the life of a mother and her family, with the health and wellbeing of a mother and baby at birth also determining the future health and wellness of the family unit (Tan, 2019). Induction of labour represents a large change in women's expectations for birth (Gatward et al., 2009), with the importance of psychological wellbeing to the physiology of labour being highlighted in many studies (Oakley, 1980; Wuitchik, Kakal, and Lipschitz, 1989; Kitzinger, 2005; O'Brien et al., 2013). This illuminates the need for women to be enabled to have genuinely informed choice throughout their pregnancy journey to optimise the experience for women, their babies, and their families.

There seems to be some indication in some of the data in this study that the choice around induction is either a healthy baby or a spontaneous labour, and that induction always protects against baby loss. There is some evidence that this is how the offer is often framed, and how it is heard by some women (Yuill et al., 2022; Harkness et al., 2023). This may be true in cases of very complex pregnancies where women or their babies have serious medical or clinical problems. However, as the data on page 22 show, the vast majority of women who are offered induction would not suffer adverse outcomes if they waited for spontaneous labour onset. In others, their risk of perinatal morbidity or mortality is underpinned with a multitude of social determinants, that cannot always necessarily be addressed by induction of labour (Douglass and Lokugamaage, 2021; Draper et al., 2021).

Despite the notion of informed decision making being central to national policy agendas, overall, research continues to highlight that a lack of informed decision making is known to be a barrier to optimal care (Moore, 2014; Coates et al., 2020; Thirukumar and Henry et al.,2021; Dadelszen et al., 2022; Dupois et al., 2023). Many women feel that they are not adequately informed or prepared, and that they are not given information about, or access to, safe alternatives to induction of labour. My research highlighted that whilst overall the women felt well informed, it was clear that there were gaps in women's knowledge regarding the process for induction of labour, highlighting that 'they did not know what they did not know' (see findings chapters 4, 5 and 6). These findings correlate with the available research.

Furthermore, twenty years ago Shetty (2005), identified that labour that is artificially induced results in lower satisfaction rates compared to that following spontaneous onset. This is replicated in the most recent CQC survey of women's views of maternity care (CQC, 2024). In contrast, in the survey undertaken for my study, many women reported being, overall satisfied with the information they had received about induction of labour at the time of asking, in late pregnancy, and at the decisions they had made with respect to labour induction. However, when asked about some specific aspects of the information they should have received, it became clear that many did not know about these aspects. The five case studies of postnatal women suggested that some aspects of the process itself were surprising or even shocking for some women, although three of the five felt that they were well

supported, and four would choose induction of labour again in the future. This may be due to the majority having their labour induced for a medical rationale. However, deeper analysis of the data suggested that some of this was due to lowered expectations, or lack of awareness of what the alternative might have been, and one woman found the process so distressing that, in the future, she would opt for an elective caesarean section.

This more nuanced understanding of the pressures and influences on how women receive information about induction of labour is further developed through the accounts of the health professionals included in this study. Some confusion about what constitutes informed consent did become apparent during the interviews and the discussion group with health professionals. This highlighted the nuances involved with the process of informed decision making and highlighted training for health professionals as a suggestion for practice improvement. The social aspects of the influences on women on informed decision making for example, consumerism and social media were discussed. Discussions with health professionals highlighted organisational constraints as having a large impact on the decision making process including; information overload for women, time constraints within appointments and accessibility of information, availability of information and knowledge base around induction of labour guidance. Health professionals discussed the potential that sometimes they feel induction of labour is being offered too readily and also the challenges involved with holding off from offering induction of labour at an earlier gestation and the potential impacts involved with this. This led to discussions of risk and management of the same. The potential iatrogenic effects of induced labour were also highlighted within the staff interviews. This included discussion around sepsis, the impact of synthetic oxytocin on breastfeeding, postpartum haemorrhages, the impact of women with increasing complexities on postnatal resources as well as the potential for the use of clinical and mental health services in the postnatal period. This led to discussions about expectation versus reality which is suggestive of women not being fully informed of the induction of labour process. Health professionals also discussed the issues with accommodating birth partners with the available estate in the ward areas, for example accommodating partners in bays. This highlighted that more needed to be done from a resource perspective to accommodate partners to enable women centred care. The lack of continuity of carer

was discussed and how this would improve informed decision making if the resources were available to enable it. All of these factors overlap and interlink and have an impact on informed decision making.

The findings of Lou (2019) illustrated that for some women, if they were originally planning a spontaneous labour, then induction of labour may require a shift in expectation. Furthermore, the longer time delay between the start of the induction and the delivery of the induction process plays a significant part in experiences (Shetty, 2005; Robertson et al., 2021; Harkness et al., 2021). This in turn, illustrates a theme of 'expectation versus reality' whereby the information that women receive, and the experience of induction itself, does not always meet with their expectation. These points were highlighted within my research, particularly with the interviews with postnatal service users who had undergone induction (Chapter 5). This highlights that women may not have made a fully informed decision despite the majority feeling that they had (see chapters 4,5 and 6). Indeed, from an information perspective, Gatward et al. (2010) identified a lack of meaningful information regarding the process for induction.

Findings from previous studies reveal that negative accounts of induction of labour may be attributed to a number of reasons but that the birth of a healthy baby may transform this negativity to an overall satisfactory experience (Murtagh, 2014). This suggests that satisfaction appears to be more related to the birth of a healthy baby rather than a woman's actual experience of induction of labour (Murtagh, 2014). This was highlighted in my research, particularly within Chapter 5 whereby both Lara and Saima had relayed a negative experience, but everything was satisfactory overall following the birth of their babies. However, it must be noted that 'satisfaction' is a very weak measure and that women may have both distressing and positive experiences of labour and birth in parallel and it is important to acknowledge the complexities involved with this. For example, women may say in retrospect it was okay and even that they would go through the induction process again, but this may be because they believe that the alternative is worse, without actually knowing what the alternative is.

Overall, the available research highlights that women's experiences identify the need for greater provision of quality information on induction of labour, encouragement to partake in the decision-making process and continued support from midwives in the pre labour phase of induction of labour (Murtagh, 2014). Health professionals counselling mothers concerning the need for labour induction should be aware of mother's perceptions about birth and engage with informed consent to avoid the maternal perception of being pressured into labour induction (Declerq, 2020). Additionally, there needs to be a focus on women's birthing experiences as well as preferences. For example, a woman with a poor medical history may prefer an elective induction of labour to lower the risks of still birth. The experience of being induced may not make much of a difference to someone planning a birth in hospital with an epidural who is keen to give birth quickly and earlier in her pregnancy, but it would alter the planning for a woman aiming for a spontaneous labour and birth, for a birth at home or hospital birth without analgesia. Tan (2019) highlighted a tendency for the unpredictable nature of the intrapartum period as being a neglected part of care planning. This illustrates the requirement of the need for specific information to be given at the appropriate stages throughout the induction process. Gatward (2010) highlighted the need for health professionals to assist women with adapting their birth plans during the induction process. This reflects the findings of much earlier studies, for example, Cartwright (1979) identified the need for more detailed information about induction.

However, despite the notion of informed consent, even if the process of induction of labour is explained thoroughly, women may still be unclear if they need or want to be induced. Additionally, consideration that may impact on informed decision making is that from a birth philosophy standpoint, some women may view birth as a medical event whilst others may view it as natural (Yuill et al,. 2020).

From a retrospective experience perspective, it is also crucial to consider that women's perceptions of childbirth may not stay the same and that perceptions may actually change over time. Indeed, as already noted, some studies have highlighted the positive effect of a healthy baby on women's retrospective recollections of induction and labour (Nuutila et al., 1999 and Shetty et al., 2005; Heimstad et al., 2007; Murtagh and Folan 2014; Webb et al., 2021; Nilver et al., 2022). However,

conversely, it has been suggested that experiences may also become more negative over the passage of time (Jacoby and Cartwright 1990; Van Teijlingen et al., 2003; Baston et al., 2008, Redshaw et al., 2019). This would be interesting to look at when considering further research in relation to my current study.

In summary, informed consent is an essential aspect of care planning with women to enable woman centred care, illustrating a need for thorough and robust preparation and support antenatally to help women gain the required knowledge to be fully informed (Gatward et al., 2007). However, the assumption that providing information for women is a simple transmission of 'facts' from health professionals to service users is belied by the evidence presented in this research study. The information received by women is attenuated by professional norms, organisational constraints, language and conceptual barriers, staff beliefs and values, and equivocal evidence about the benefits and risks of induction or of waiting for labour to start. In addition, as well as the information received from health professionals, many women access information from a variety of other sources and these all impact on the decision-making process. The key findings that influence upon the informed consent process that were identified via my research study are discussed throughout the remainder of this chapter.

Key findings:

Influences on women's' choices and expectations

Rational choice and consumerism

From a decision-making perspective and particularly when discussing elective induction of labour, it is essential to consider what impact societal influences may have upon this, including rational choice theory and consumerism.

Rational choice theory is an approach used to understand human behaviour and can therefore clarify individual and collective behaviours. The emphasis is upon an individual's control of their decisions and that choices are not made because of unconscious drives, tradition, or environmental influences (Buskin's, 2015). The concept of rational choice works on the basis that a choice that seems irrational to

one person may make sense to another, with individuals using self-interests to make choices that will provide them with the most benefit (Bransen, 2001).

However, critics of rational choice theory would argue that it does not allow for the influence of social norms with people following them even when they are not benefiting from them (Elster, 2001). Critics of rational choice theory would also argue that it does not account for choices that are made due to situational factors such as emotional state, social context, environmental factors, and the way choices are posed to the individual (Elster, 2001). Additionally, rational choice theory may take into account individuals who make decisions based on fixed learning rules who make choices because that is the way they have learned to do so even if the decision leads to higher costs and less benefits (Elster, 2001). Simon (2010) argues factors such as imperfect information, uncertainty, and time constraints as impacting on cognitive rationality, and therefore, decision-making skills. Furthermore, concepts of 'satisficing' and 'optimising' suggest sometimes often people settle for a decision which is 'good enough', rather than the objectively 'best' decision as judged without social and cultural and attitudinal contexts (Simon, 2010).

Consumerism is also a crucial concept to consider when thinking about informed consent and induction of labour. Overall, consumerism is the concept that consumption of goods and services is a positive activity within society, and that consumers should be informed decision makers (Clarke, 2010). According to Clarke (2010), inhabiting a consumer society has an impact on how people live their lives, the things they place value on as well as the direction that society goes in (Clarke, 2004). Some have argued that consumerism incorporates the empowerment of the individual through choice in a free-market society, whilst others would say that consumerism works to optimise profit by convincing people that increased consumption of material goods is necessary to be able to live a good life (Oakley, 1993; Clarke, 2004).

In the United Kingdom and in terms of the public sector, the impact of the consumer society and the notion of 'free' choice started to become apparent in the later part of the 20th century and this was aligned with neo-liberal government policies (Clarke, 2004). However, in fact such choices are not completely 'free' as a consumer can

only choose from the options available which in turn is determined by the supplier. It has also been argued that those who hold intellectual capital also have the power to control choices either by sharing information or by withholding information (Kirkham, 2004a). Consumerism is of direct relevance to this study due to the potential influences that it may have on women when making decisions about whether to have their labour induced or not.

Previous birth experience

A woman's previous birth experience may have an impact on thoughts for her next pregnancy, which may in turn have the potential to effect upon informed decision making. A negative birth experience has been shown to have a significant influence on the well-being and future decisions of women (Smarandache et al., 2016). Indeed, after a traumatic childbirth experience, women are often afraid of future pregnancies, and there may be a chance of them as experiencing their subsequent childbirth as traumatic (Smarandache et al., 2016). Davidsen (2022) describes how women with a previously perceived negative experience of childbirth may be affected in terms of their mental health and wellbeing in subsequent pregnancies. Birth trauma stems from frightening, unbearable, powerless, and helpless situations and may lead to post traumatic stress disorder (PTSD), with between 20-40% of women finding birth traumatic, with some of these women possibly having undiagnosed post-traumatic stress disorder (Thomson, 2019 and Leinweber et al., 2022). Some have found that women's positive and negative recollections of their birth experiences are related more to feelings around their choice and control than to the specific intricacies of the labour and birth process (Thomson, 2008; Cook and Loomis, 2012; Leinweber et al., 2022). The evidence highlights that women want access to non-judgemental, empathetic support from health professionals after their birth, to help them to understand what happened. Clinical practice that enables women to experience a sense of control in a subsequent pregnancy and birth underlies positive experiences among women with a previous traumatic childbirth experience (Holopainen et al., 2020). However, there is currently no national guidance to underpin after birth service provision, which means that, where it exists, Trusts implement their own provision with limited resources and variable provision between Trusts (Thomson, 2019). Whilst it is even better to prevent a problem than to have to

deal with it after the fact, limited resources within organisation are often the cause of such lack of a provision. This highlights an organisational constraint.

External influences on decision making

Social media

All women need access to high quality research led information and psychological support during pregnancy, irrespective of whether they choose to obtain that information and support through formal leaflets, in person interactions, or via digital interactions. In my research study, women reported using diverse sources, including information leaflets, books, social media, the internet and partners, friends, and family (Vogels-Broeke, 2022).

Pregnancy is marked with the need to make decisions and therefore, for some, intense information seeking. Historically, most of the information women obtained during pregnancy was via health providers, books, family, and friends (Oviatt and Reich, 2019). However, since the early 2000's, women have become accustomed to being able to access information online 24 hours a day. The easy accessibility and unlimited availability of digital information makes it a convenient additional source (Lupton, 2016; Oviatt and Reich 2019; Vogels-Broeke, 2022). Indeed, digital sources are now among the most used sources of information for pregnant women (Vogels-Broeke, 2022).

Social media is popular amongst pregnant women and is used for sharing information online and is a way of accessing evidence-based information (Neiger et al., 2012 and Dekker, 2016). They also use it for decision making and sharing of experiences (Oviatt and Reich, 2019), especially where this helps them to navigate information and avoid or limit anxiety by gaining additional information to that provided by their health professional (Smith et al., 2020). Additionally, women seek information to feel more confident and comfortable in their communication with healthcare providers to make decisions during the perinatal period and to prepare themselves for their maternal responsibilities (Vogels-Broeke et al., 2022).

Despite this, in general professional sources of information are regarded as more trustworthy and with more useful information than other sources (Vogels-Broeke et al., 2022). Indeed, social media may be regarded as less trustworthy because it is designed for social networking and support (Vogels-Broeke et al., 2022). Conversely, it may be argued that this does not necessarily make it less trustworthy. Indeed, whilst they do not reflect formal population-based evidence, they are a true account of some women's experiences. Lundh reports particular issues with Google in terms of reliability of sources (Lundh, Ovum and Dahl, 2023). The findings of research by Dekker (2016), highlighted that some women plan to use the information that they found online, which may be concerning if the information is inaccurate or of poor quality. Therefore, increasingly, attention has been and is being drawn to the need for the websites of governments and leading industry providers to contain pregnancy health related information that is up to date with current evidence-based research, and that is presented in a format that is attractive to service users, including accounts of service user stories and experiences. As one of the respondents to this study implied, for some women, personal stories are seen to be 'truer' in terms of what might actually happen in labour and birth than high-level population-based evidence and generalities.

Understanding more about social networking sites in relation to pregnancy can inform future work in relation to education and support for women (Oviatt and Reich, 2019). For example, the Real Birth Company Limited which was established in 2017 (Real Birth Company, 2024) and the Dad Pad app which was initially piloted in 2012 (Dad Pad, 2024). The Real Birth Company is a digital tool providing relevant, up to date evidence-based information. Dad pad is to help women's partners with knowledge and practical skills and is an essential guide developed within the NHS. These kinds of resources may help with the development of digital information sources that are both factually accurate, and personally meaningful to women and partners (Vogels-Broeke et al., 2022). Maternity and Neonatal Voices Partnerships (MNVP) (NHS England, 2023) offer another avenue for co-production of locally relevant resources in England (Nicholls et al., 2021).

As a note of caution, over-use of digital media can have a potentially negative effect on psychological wellbeing (Oviatt and Reich, 2019; Smith et al., 2020). Further research is needed to better understand how internet sources inform and support the

psychological wellbeing of individuals during pregnancy, without risking adverse consequences (Smith et al., 2020).

In parallel to those who want as much information as possible, some women may not want to know certain details in advance, and some fear knowing too much (Jay, 2018). In this case, women may avoid or ignore information that might upset them or any information that they think is irrelevant to them (Levy, 1999d). Moreover, although many women may be keen to access additional information, the volume and variety of available resources can sometimes lead them to feel overwhelmed (Sanders and Crozier, 2018). This can lead to either conscious or sub conscious information avoidance and may attribute to some of the gaps in knowledge that women experience and describe (Sanders and Crozier, 2018). Other rationale for lack of engagement may be that it is possible that women have accepted induction of labour as inevitable and therefore have not felt the need to look at further information which may also include the fear of fuelling anxieties (Jay, 2018).

Furthermore, health literacy is crucial to obtain, understand, assess, and use health related information and to make health related decisions (Vogels-Broeke et al., 2022). From an equity perspective, compared to women with middle and high levels of education, women with a low level of education use written information sources like leaflets and websites less often (Vogels-Broeke et al., 2022). Indeed, fulfilling a woman's information needs depends on her access to adequate resources and her ability to comprehend what has been presented to her (Vogels-Broeke et al., 2022). This includes sources from the health care system, conventional sources, and digital sources (Vogels-Broeke et al., 2022). Pregnant women need to have access to information suited to their needs, delivered in the right amount at the right time (Vogels-Broeke et al., 2022).

The influence of partners/families/friends

The influence of partners, families and friends on decision making was discussed within the interviews with postnatal maternity service users. Much of the available literature describes how important the support of partners, families and friends is to women during their pregnancy journey (Al- Mutawtah et al., 2010; Battulga et al., 2021). Overall, the women within my research spoke of how important it was for their partner to be supportive of the decision they were making for labour induction. Two spoke of friends not being particularly useful but this may be due to the women in my

sample being induced for medical reasons which their friends may not have had a full understanding of. The influence of partners/family/friends was also discussed within the staff interviews. One staff member spoke of the potential challenges involved with this and viewed it rather as a potential barrier to informed decision making for women.

Influences of and on the health professional

Wanting the health professional to make the decision

The findings of Stevens (2010) and Skyrme (2014) reflected that, as induction has become more routine over the years that women may view it as normal practice. Furedi (2006) & Rooks (2006) suggest that as medical complications rise, women become more inclined to rely upon medical opinion. Lothian (2012) describes a focus on risk which may create fear for women which leads to the potential inability for women to trust their bodies which in turn may result in women taking agreeing to care, procedures and treatments due to a reluctance to go against medical advice. Ultimately women may also have trust in the health professional, thus wanting them to make decisions on their behalf (Levy, 2004). However, wanting the health professional to make decisions removes the possibility of informed consent.

The health professional as the second victim

Health professionals' previous experiences may influence the discussions they have with pregnant women. As discussed on page 171 the experience of 'second victim' refers to the health professional who experiences emotional distress following an adverse event affecting the patient, the 'first victim' (Ulstrom, 2013; Nieuwenhuijze, Leahy-Warren and Healy, 2024). Adverse emotional, cognitive, and behavioural reactions are all common in the second victim (Seys et al., 2012). Defensive as well as constructive changes have been reported in practice following an adverse event, with ineffective coping strategies (such as overuse of alcohol) potentially impacting on patients, colleagues, and the second victim themselves (Seys et al., 2012). This implies that effective support structures are required for health professionals who have been involved in or who witness adverse events to enable the promotion of the wellbeing of health professionals, and positive safety cultures.

The framing of risk discussions

Linking in with the health professional as the second victim, the potential for framing of risk discussions and how these impact on informed choice was captured within the staff interviews (see page 170). As already discussed in Chapter 6, there are various rationale for such framing, including protective steering, whereby health professionals may gatekeep the kind of information they provide; to persuade women to make the choices they want them to make.

Levy (1999b) describes the potential for such steering being due to health professionals protecting women from difficult decision making. However, there are many reasons why risk discussions may be 'framed.' Kirkham (2004b) describes women as being steered to making the choice that have already been decided by the local organisation. In a health care system that is neoliberal combined with a risk averse political context that is subject to scrutiny by the media, these choices are constrained by organisational worry of exposure if something goes wrong. Care then becomes standardised and part of a protocol, rather than being personalised and individualised, and health professionals are socialised into conforming with this. Ultimately, this routine may then become part of a coping mechanism for staff as part of their daily work (Kirkham, 2004b).

Another reason for protective steering may be attributed to the risk and governance agendas (Kirkham, 2004a) as was reflected within my data collection (see chapter 6, findings of the interviews with health professionals). This again may bring into question how much of the discussions are framed in a way to reduce different kinds of risk to staff. According to Lothian (2012), what is acceptable risk for the mother and her baby may not be acceptable risk for the midwife, obstetrician, or hospital.

Hodnett et al. (1997) and Sakala (2006) discuss how interventions such as induction of labour may be viewed as a standard practice, and this may lead to the thought process that it is therefore the correct decision to take, limiting choice for women and the enablement of individualised, holistic care planning. Furthermore, Cheyne et al. (2012) discuss how risk is poorly understood in terms of individual risk versus wider population level risks. Perneger and Agoritsas (2011) and Fagerlin and Zikmund-

Fisher, et al. (2011) recommend presenting risks in actual or absolute numbers as opposed to relative risk; to talk about both potential benefits and risks; and for health professionals to offer a visual representation of both the risks and the benefits.

Language and the rhetoric of informed consent

Maternity services must ensure that all women and their families have information and support that allows them to make choices about their care (CQC, 2021). Access to evidence-based information is central from a legal and ethical perspective for genuine informed consent, and is crucial for the improvement of health outcomes, especially at a time when perinatal mortality and morbidity rates, interventions and disparities are on the rise (Department of Health, 2022; MBRRACE, 2023). Furthermore, language is an essential element of communication in maternity services (Marsh, 2019). However, the use of language and phrasing in some of the quotations from the interviews with health professionals in this study, may indicate how the underlying thoughts, beliefs and approaches of some health professionals may impact on the transmission of information, in direct contrast with the rhetoric of informed consent.

The NHS hospital organisation: setting and resources

Pregnant women responding to the study questionnaire felt happy with their involvement in the decision-making process, felt they had time to ask questions, that information was clear and that they had received the information they needed (see Chapter 4). However, detailed questions on content they should have received suggested that they may not have had all the information they needed, and the postnatal stories revealed some gaps. The impact of hospital resources and processes upon the informed consent process was discussed throughout all of my findings' chapters. This included time constraints for appointments, information overload, grey areas within clinical guidelines (for example large for gestational age) and errors in information giving. Language barriers also formed part of my findings, and this is discussed within the continuity of carer discussion in the next section. Language barriers further exacerbate the known risk of poor outcomes associated with black and minority ethnic women and those with social risk factors (Rayment-Jones et al., 2018). In terms of hospital resources and informed consent, expectation

versus reality and the role of the birth partner as well as the organisation response to the birth partner have also been discussed throughout my findings chapters.

Continuity of carer

Continuity of carer was highlighted by service users as being beneficial, particularly by Sarah who had received continuity via the diabetic team. This was also highlighted by health professionals as improving care for women. Many authors report that women who experience continuity of midwifery care are more likely to report trusting relationships in which they feel more able to ask questions (Almorbaty et al., 2023). Indeed, the recent Cochrane systematic review in this area reports consistent findings across studies that women randomised to continuity of care reported more positive maternity care experiences. Furthermore, midwifery continuity of care may be a preventative intervention to reduce maternal anxiety/worry and depression (Cibralic et al., 2023). Overall, continuity supports trust and familiarity between women and health professionals, thus reducing power imbalance and facilitating a partnership approach to maternity care (Perdok et al., 2018).

A lack of continuity of care for women can prevent the formation of trusting relationships thought necessary to facilitate informed choice (Almorbaty et al., 2023). Issues resulting from a lack of continuity may include difficulties for women when following up on issues raised in previous consultations and the initiation of questions related to their pregnancy (Stapleton, Kirkham, and Thomas, 2002). Therefore, discontinuity of care may lead to unsafe situations due to loss of information as well as inconsistency in advice and information being given by multiple caregivers (Perdok et al., 2018). Furthermore, evidence suggests that women who asked questions about the norms of practice in the absence of continuity of carer felt that they were not trusted by health professionals (Stapleton, Kirkham, and Thomas, 2002). Overall, trusting relationships can help women to build relationships with midwives and doctors, which in turn can support them through a fragmented unfamiliar system to respond to their individual physical, emotional and social needs as well as clinical needs (Rayment Jones et al., 2020).

Some examples of adverse outcomes for babies associated with late access to antenatal care may include preterm birth or babies born small for gestational age (Gonthier et al., 2017). Late and differential access to antenatal care has been cited

as a potential factor for excess mortality and severe morbidity among mothers from ethnic minority groups compared to white British women in the UK, with the risk of maternal death among Black women being four times greater than for White women (Puthussery et al., 2022).

Overall, continuity of care has the potential to deliver safer and more personalised care (Sandall et al., 2024). Current government policy is to develop targeted continuity schemes for those most marginalised, and to expand this more generally as and when staffing levels allow (NHS England, 2023). Evaluation of initiatives to scale up continuity models for marginalised groups will be useful (Rayment-Jones et al., 2023), including evaluation of the impact on decision making for or against induction of labour in the context of such schemes. This may require the recruitment of more midwives or the adoption of alternative patterns of care provision, such as case loading (Jay, 2018). Providers of maternity care may 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 (Jay, 2018).

Strengths of the study

In terms of induction of labour, this is the first study to employ mixed methods across both service users and a range of health professional groups all working in or using the same Trust. The narrative biographical case study approach taken for the analysis of the women's interviews allowed for an in-depth exploration of how the decision for induction, the experience of it, and birth afterthoughts panned out over the whole episode. This strengthens and widens the scope of what is currently known about informed consent and induction of labour, as well as defining areas where changes to practice have been suggested and identified. The study suggests that the reasons for the rising rates of induction of labour are multifactorial, and that both the quality of information and health professionals attitudes and values influence women's decisions. In some cases, health professionals were highly supportive and the information and associated support for the decision made were completely women centred. In others, there was no option and no information given, and no support for decisions not to have the induction of labour process, or alternatives offered. The barriers to informed consent and the influences for women when making discussions are also both multi factorial and discussed in depth throughout my research study. Service innovation has been discussed, based on the ideas put forward by women, midwives, and obstetricians during the research to improve current provision around informed consent.

Reflexivity

As discussed at the onset of the study, the researcher's background will impact on what the researcher chooses to investigate, the angle, the methods, and their interpretation of findings (Malterud, 2001). Therefore, an integral part of my research study was my utilisation of reflexivity, including consideration of my dual role as research student and midwife matron. Whilst this was challenging, my reflexivity included keeping a reflexive journal throughout my studies to assist with raising and maintaining my alertness to how my subjectivity may influence and impact upon my research study. Being in the dual role assisted with ease of gaining access to the clinical setting for research, bringing my clinical knowledge and insider perspectives to the research, having trust between colleagues which assisted recruitment to the

interviews and the discussion group and having trust with the women that I interviewed.

Limitations of the study

One potential limitation of the study is the inclusion and exclusion criteria utilised for the systematic literature review (chapter 3). In this study I focused on high income countries whereby the provision of maternity care is fairly universal. It is acknowledged that in some of the included countries such as the USA, provision is funded differently to the United Kingdom (with more private/insurance based resourcing). Therefore, these criteria would be revised for future studies.

Whilst there was a good response to the questionnaire with the antenatal maternity service users, the sample size for the interviews with midwives, obstetricians and postnatal maternity service users was relatively small. Postnatal maternity service users were identified for interview via leaving their contact details in the questionnaire they completed antenatally. With hindsight, the sample size for the postnatal interviews may have been increased had I been enabled to meet the potential candidates before they decided whether to take part in order to build trust and rapport. Also, email contact details were left by the potential participants within the online questionnaire and the sample size may have been increased further had I had the opportunity of different methods in addition to email of contacting potential participants. Some women reported that the emails I had sent inviting them to participate in the study had gone into their email 'junk' box and I cannot be sure if and how this influenced the response rate for potential participants to the postnatal interviews. The study did not include stories of women who wanted an induction with no medical indication. However, despite this challenge and the change to the original plan, the use of a small sample size is supported by the literature on research methodology which confirms that this is appropriate for a small-scale project where depth and richness of data are paramount (Mason, 2017; O'Leary, 2021; Silverman, 2019). This approach is also utilised in the sample size of other qualitative studies researching similar aspects of induction of labour such as Murtagh and Folan (2014) and Jay, Thomas, and Brooks (2018).

A further limitation of my study which was not including a question within the questionnaire to ascertain parity of the women responding. This limitation became apparent once the questionnaire was underway and was discussed as part of my reflective discussions with my research supervisors. This issue was a methodological limitation, impacting on the ability to analyse how parity may impact on informed consent based on women's previous pregnancy experiences. This was mitigated during the postnatal interviews with maternity services whereby discussions in the interviews included parity. However, it is important to consider that any future research conducted would include this where appropriate in line with the data being collected for analysis.

For the interviews with the midwives and obstetricians, whilst purposive sampling is common in mixed methods research; from a limitation perspective there may be unconscious biases involved due to the reliance on the researcher's judgement when identifying and selecting the individuals to achieve the studies objectives. For the interviews with the health professionals, two consultants and three midwives were interviewed. Consideration could have been given to interviewing different grades of midwifery and medical staff who would bring differing views, experiences and beliefs around decision making and clinical practice around labour induction, and this should form part of future research.

For the interviews with the midwives and obstetricians, it is important to note that whilst purposive sampling is common in mixed methods research; from a limitation perspective, there may have been unconscious biases involved due to the reliance on my judgement when identifying and selecting the individuals to achieve the objectives of my study. As set out in my reflexive account (pages 49-50), I came to this study as a midwife with a set of views and expectations based on years of experience. I believed that induction of labour could benefit many women and babies, but that for some, it was carried out without strong clinical grounds, and without those experiencing it having full knowledge of the process, or of adverse as well as beneficial potential outcomes. I could also see that the increase in inductions was causing significant pressure on resources, and midwives and obstetricians ability to provide high quality care. It is possible that some of the midwives and obstetricians I interviewed, knew that these were my beliefs, and that they moderated their responses accordingly. This effect could have been increased

because I was also known by the midwives and obstetricians to be in a senior position in the organisation. By virtue of working in the same maternity unit, it is also possible that I was subconsciously aware of some of the views of the midwives and obstetricians that I was interviewing. This could also have affected the interview process and is therefore considered to be a further limitation of the study.

My position as both a local midwife and a researcher may also have affected responses from maternity service users, as these are both positions of power. Though midwives do have skills in communication and counselling, in the experience of many maternity service users, these are focused on the kind of information required by the maternity system, rather than on free telling of personal stories. This may have influenced how women who took part in the interviews framed their responses, and how comfortable they might have been with sharing negative views of local maternity experiences.

Interview transcripts were not checked back with participants. This would be a good way of improving trustworthiness, and I intend to use this approach in any future similar research I undertake. Having more than one person to undertake analysis of a subset of the transcripts would also have improved rigour and trustworthiness, and I would also include this in future qualitative research I undertake, to improve the credibility and the validity of my research findings (Noble and Heale, 2019).

Furthermore, whilst it is vital to balance the needs of valid and reliable research with ethical concerns, maternity service users under the age of 18 years and those who could not read or speak English were excluded from the research study. Unfortunately, due to the resources and limited funding available, translating the questionnaires and interviews was not a feasible option. Given the worry over inequity in maternity care and research, it is a concern that resources are not available to support those undertaking maternity research at all levels to involve the most marginalised service users.

Summary

This chapter has discussed the overarching themes identified from the research data collected in relation to induction of labour and informed consent. It is evident that informed consent discussions can have a huge impact upon informed decision making, with a range of factors having the potential to influence this process and the

overall experience of the birth experience for women. My research highlights some of the influences for decision making relating to induction of labour, and ideas for service improvements to enable women to have genuinely informed decision making and authentically informed consent. The findings suggests that informed consent is inconsistently implemented due to the range of factors discussed. Informed consent in line with the National Institute of Clinical Evidence guidance for induction of Labour (NICE, 2021) and the NHS Long Term plan (2020) in relation to personalised care were not always met for the women in this study, and this was recognised by some of the health professionals. Some of the findings from the data collected indicate that informed compliance may be a norm in maternity care, as opposed to informed decision making and consent. Therefore, and as discussed, future research needs to focus on solution-based approaches for information sharing with women, and on how to provide genuine support for the options they decide on, whatever those may be, to optimise authentic informed consent and personalised and holistic care planning and provision.

CHAPTER 8
Conclusion

This research study aimed to examine the under researched area of informed consent in relation to induction of labour. My research examines this in depth with the aim being to explore the views, beliefs and experiences of women, midwives, and obstetricians in relation to informed consent. This was a small scale, mixed methods study utilising a triangulated approach. The data collected included questionnaires with antenatal service users who had had discussions about labour induction, interviews with postnatal women who had experienced labour induction, and with midwives, and obstetricians, and a midwifery discussion group

Key findings of the research study

Factors highlighted and discussed as having a potential to impact on informed consent arising from this study include; women's previous experience(s), the option for elective induction of labour, societal impacts such as consumerism, influence of partners, friends and family, the influence of the internet and social media, the appropriate timing of information, information overload, information avoidance, timing of information provision and time constraints for health professionals, a poor understanding of risk on behalf of health professionals and women, a fear of litigation on behalf of health professionals, protective steering, grey areas within the guidance, women wanting the health professional to make the decision(s) for them and equity and equality on informed consent, and the potential benefits of continuity of carer.

The data suggest that, while some staff were careful to offer and support a range of options with neutral weight on the information given to women, there was also evidence that bio-medical notions of risk and organisational defensiveness may have promoted informed compliance as opposed to genuinely informed decision making and consent, including choice for non-medically indicated induction. The provision of information was also reinforced by or contradicted by women's actual experience of induction, which translates into the usefulness of women's actual stories as part of information gathering. The experience of induction of labour in multi-bedded wards is a particular example. The impact of this doesn't seem to be mentioned in information

leaflets, but it featured in the women's stories in this study as having an impact of their experiences. For one woman, it was a particularly anxiety-promoting experience, but for another also seen as offering the opportunity for peer-peer support. Knowing this and including it in discussions about labour induction might be important for some pregnant women. Women's emotional state is also discussed within the thesis in terms of the impact of induction of labour on anxiety due to delays, worries and pain and how this may impact on the progress of labour due to the influence on the release of oxytocin.

Practice and policy changes suggested by this study

Utilising a triangulated approach for my research study has added depth to the research already available in terms of what is already known about the subject of informed consent and induction of labour. The triangulated approach has also been pivotal in collating areas where service improvements are required.

As well as the factors impacting upon informed consent, it is evident that induction of labour rates are increasing, and that induction is becoming a normal part of care planning in the United Kingdom. It is therefore essential that informed consent, becomes an integral part of the process for health professionals having discussions with women about induction of labour. It is imperative that all aspects of a woman's background, values, beliefs, and expectations are considered when care planning with her. This includes not only the clinical picture but also her personal, social, cultural, spiritual, family and community norms and values to ensure that information that is 'material' to her is shared, and that genuine decision making, and informed consent takes place. This will also depend on organisational and health professional readiness to support decisions that do not fit in the expected patterns.

From a policy and organisational perspective, future changes in NHS maternity care could include genuinely personalised care planning, tools to aid discussion, induction of labour leaflets, accessible information for women and for health professionals, antenatal education focused on what matters to women (including videos and podcasts of stories of local women who have had induced labours in each Trust), the fact that the early stages will be in multioccupancy wards', birth choices clinics run at 36 weeks gestation, pre induction of labour clinics to include assurances around the

informed consent processes, the possibility of consent forms to make the informed consent process more robust, and a need to increase hospital resources as well as the consideration of provision and staffing of alternatives to induction of labour. Skyrme et al. (2010) also highlights the need for training amongst health professionals. This should go beyond simple information giving, to also address the pressures on health professionals to engage in 'protective steering', and an exploration of how their own attitudes, values and fears may adversely influence a balanced discussion of risk. Induction of labour innovation such as outpatient induction of labour were discussed during the interviews and the discussion group with health professionals. To ensure the provision of some of the suggested service improvements, consideration may need to be given to recruitment of health professionals and the potential for alternative patterns of care such as the implementation of continuity of carer.

Suggestions for future research

As discussed, the findings of this research study suggest that the increasing induction of labour rates have implications for women, for health professionals, for education institutions as well as for the funders of maternity services. This emphasises the need for future research to continue to improve experiences for women and to enhance and maintain quality and safety.

Future and similar research is required amongst women whose first language is not English which could not be covered by the scope of this study (see page 52). This would require more than translation and would take into account any cultural and educational differences and understanding around interventions in pregnancy. This is especially crucial given the available research and knowledge around differential statistics on maternal and neonatal morbidity and mortality in different ethnic groups and other vulnerable groups (Core20PLUS5, 2021; MBRRACE-UK, 2023).

Additionally, my study highlights the need for further research looking at the differing experiences between women induced for medical reasons and those induced for non-medical reasons. Additionally, my research did not differentiate between nulliparous and multiparous women, and it would be pertinent to look at the differing experiences between the two groups.

This study did not include the views, beliefs, and experiences of women's birth partners, although the staff who were interviewed did note the perceived influences on women of their partners in the inpatient setting on the antenatal ward. It is evident that partners influence women's decisions and are a fundamental part of the induction of labour process. There is currently no research available about partner's experiences and therefore, future research regarding the influence and impact of birthing partners may also be a consideration for further exploration. This could also encompass the current national drive toward a more family centred approach to maternity care.

My thesis discusses how some women's perception of childbirth and of the extent to which they had full information about labour induction changed between the antenatal and postnatal period, particularly in relation to unexpected or negative events. Therefore, longitudinal research may be pertinent to capture further detail on women's views, beliefs, and experiences of induction of labour at different points in time in relation to informed consent, including up to at least one year after the birth, to get beyond the 'halo effect' of the relief at having a healthy baby, to the exclusion of all other emotions. In terms of consumerism, research is needed on the impact of this for a woman's decision-making process in relation to informed consent and induction of labour.

Finally, it is recognised that this study was undertaken in a single NHS Trust, so data collection could be undertaken in other Trusts to address a wider demographic. This may enable a more comprehensive picture of women's and health professionals, views, beliefs, and experiences of induction across the United Kingdom in terms of informed consent.

Dissemination of findings

In line with the ethical expectation to make findings public when people have given up their time to take part in research, and to maximise the benefit of the insights of the study (National Institute for Health and Care Research, 2019), I intend to publish journal articles as result of this study. I will also present the key insights to senior clinical staff at the NHS Trust from where the research study was undertaken as part of the maternity quality improvement project board and the wider Local Maternity and Neonatal System (LMNS), to local staff, and to service users through the local

Maternity Voices Partnership. I also intend to share the information at suitable conferences, and on relevant websites.

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Appendices

Appendix 1

University of Central Lancashire
UCLan

PARTICIPANT INFORMATION SHEET

QUESTIONNAIRE FOR MATERNITY SERVICE USERS:
We would like to invite you to take part in a University of Central Lancashire (UCLAN) research study being undertaken at [redacted] Before you decide if you would like to take part, please read this information sheet and talk to others if you wish. If you would like more information, please contact a member of the UCLAN core research team on the details provided on this information sheet.

WHAT IS THE STUDY ABOUT?
The aim of this research study is to find out more about discussions between maternity service users and health care professionals when making choices about induction of labour in relation to informed consent. In this phase of the research study, we will ask maternity service users to take part in an online questionnaire about their views and experiences.

WHY HAVE I BEEN ASKED TO TAKE PART?
You have been asked to take part because you have had discussion(s) with a healthcare professional regarding induction of labour at [redacted]

WHAT WILL THE STUDY INVOLVE?
This part of the research study is an online questionnaire which should take between five and ten minutes to complete. There is a section in the questionnaire for you to leave your contact details if you would like to take part in any further research linked to this study.

DO I HAVE TO TAKE PART?
No, it is entirely up to you if you want to take part or not.

WHAT ARE THE BENEFITS OR RISKS OF ME TAKING PART?
The information you give us will help us inform current maternity care provision and future practice. Completing the questionnaire may not be of any direct benefit to you although participants may find the process cathartic and we hope that you may find it useful to think about your views and experiences. Whilst it is unlikely, there is a small chance that you may find completing the questionnaire a sensitive experience.

WHO HAS REVIEWED THIS STUDY?
Ethics approval for this study has been received from the Health Research Authority (HRA) and the Research Ethics Committee (REC) (Integrated research application reference 296492) and University of Central Lancashire (UCLAN) ethics. The study is logged with the research and development department at [redacted] (reference DEV006).

HOW WILL MY DATA BE USED?
In this research study, we will use information that you provide. If applicable, we only let people know about your information if it is necessary for this study. The team involved in this study will keep your data safe and secure and will also follow all privacy rules. At the end of the study, we will save some of the data in case we need to check it. We will make sure no-one can work out who you are from the reports we write. There are however limits to confidentiality such as the following:

We will speak to your maternity care team if there are significant concerns about you (including if you experience any significant distress while taking part) or if there are concerns for someone else's safety. We will take all possible steps to discuss this with you first and plan together about what to do, but ultimately, we have a duty of care to inform your team of these concerns.

The University processes personal data as part of its research and teaching activities in accordance with the lawful basis of 'public task', and in accordance with the University's purpose of "advancing education, learning and research for the public benefit". Under UK data protection legislation, the University acts as the Data Controller for personal data collected as part of the University's research. The University privacy notice for research participants can be found on the attached link https://www.uclan.ac.uk/data_protection/privacy-notice-research-participants.php

WHAT WILL HAPPEN TO THE RESULTS OF THE STUDY?
The findings from this study will be detailed in a report to the sponsor, for teaching purposes, presentations, publications, and this may also inform a toolkit for any maternity service improvements that may be identified as a result of the research. If you would like to receive a detailed copy of the research study once it is completed, please contact us on the details below.

WHAT DO I DO IF I WANT TO TAKE PART?
Please utilise the QR code below to link into the questionnaire where you will be directed to the consent section, followed by the questionnaire.

WHAT IF I AM UNHAPPY OR THERE IS A PROBLEM?
If you are unhappy, or if there is a problem, please feel free to let us know by contacting **Professor Soo Downe on SDowne@uclan.ac.uk** and we will try to help. If you remain unhappy or have a complaint which you feel you cannot come to us with, then please contact the **Research Governance Unit at OfficerForEthics@uclan.ac.uk**.

The University strives to maintain the highest standards of rigour in the processing of your data. However, if you have any concerns about the way in which the University processes your personal data, it is important that you are aware of your right to lodge a complaint with the Information Commissioner's Office by calling 0303 123 1113.

CORE PROJECT TEAM:

- Rebecca Sessions, Professional Doctorate student at the University of Central Lancashire and Midwife Matron [redacted]
  RJSessions1@uclan.ac.uk
  Professor Soo Downe, University of Central Lancashire - SDowne@uclan.ac.uk
- Dr Nicola Crossland, Research Associate, University of Central Lancashire – NCrossland@uclan.ac.uk

WHERE CAN I FIND OUT MORE ABOUT HOW MY INFORMATION IS USED?

- www.hra.nhs.uk/information-about-patients/

HOW DO I ACCESS NATIONAL SUPPORT ORGANISATIONS:
There are national services who give professional guidance and support around pregnancy, childbirth and parenting.

Just some of the organisations who offer support should you wish to access them:

- The National Childbirth Trust www.nesta.org.uk
- The Royal College of Obstetricians and Gynecologists www.rcog.org.uk

FOR ANY FEEDBACK DIRECTLY FOR [redacted] NHS TRUST, YOU CAN CONTACT:

- Customer relations team [redacted]
- Helpline (freephone) [redacted]
- Telephone [redacted]
- Email: [redacted]
- Or:
- The patient experience team:
- Email: [redacted]

SUMMARY OF HOW YOUR DATA WILL BE USED:

How will my data be collected?	By taking part in an online questionnaire.

How will my data be stored? **How long will my data be stored for?**	Your contact details will only be available if within the questionnaire you have opted to leave your contact details to take part in further aspects of the research study. Your details will be deleted at the end of the research study.
What measures are in place to protect the security and confidentiality of my data?	All data will be stored in password/encrypted computer files at the University. We will not share your research data outside of the research team until they have been anonymised. Quotes from the questionnaire may be used in reports, publications, teaching and presentations, but we will remove identifying information so that you will not be identifiable.
Will my data be anonymised?	When analysis of the questionnaire takes place, where applicable we will remove any names/personal identifying information. When we use any of your quotes, we will use a participant identifier.
How will we use information about you?	We will need to use information from you for this research project. This information may include your name and contact details if you have chosen to take part in further aspects of the research following on from the questionnaire. People will use this information to do the research or to check your records to make sure that the research is being done properly. We will keep all information about you safe and secure. Once we have finished the study, we will keep some of the data so we can check the results. We will write our reports in a way that no-one can work out that you took part in the study. We will use anonymised quotes from the questionnaires in reports, publications, teaching and presentations.
What are your choices about how your information is used?	You can stop being part of the research study at any time, without giving a reason, but we will keep information about you that we already have.
Who will have access to my data?	Only the research team will have access to your data.
Will my data be archived for use in other research projects in the future?	No.

THANK YOU FOR TAKING THE TIME TO READ THIS INFORMATION SHEET

Appendix 2

University of Central Lancashire
UCLan

PARTICIPANT INFORMATION SHEET

Interviews with maternity service users:
We would like to invite you to take part in a University of Central Lancashire (UCLAN) research study being undertaken at [redacted] Before you decide if you would like to take part, please read this information sheet, and talk to others if you wish. If you would like more information, please contact a member of the UCLAN core research team on the details provided on this information sheet.

What is the study about?
The aim of this research study is to find out more about the views and experiences of maternity service users and health care professionals when discussing induction of labour in relation to informed consent. In this phase of the research study, we will ask maternity service users who have had discussions with health care professionals regarding induction of labour to take part in an interview with the researcher.

Why have I been asked to take part?
You have been asked to take part as you left email contact details during an earlier phase of the research (a questionnaire) which was based on your experience(s) of discussing informed consent for induction of labour with health care professional(s) at [redacted]

What will the study involve?
You are invited to participate in an interview with the researcher on Microsoft teams. Information about how to access MS Teams can be provided if needed. The interview will be recorded, and an audio version of the recording saved, transcribed, and then deleted. The interview will be organised at a time and date to suit you and will last approximately 30-45 minutes.

Do I have to take part?
No, it is entirely up to you if you want to take part or not. Even if you say yes now, you are free to change your mind at any point and without giving a reason. During the interview you do not have to answer all the questions and can stop the interview at any time. Even if you do take part in the interview and then decide you do not want your information to be used, you will be able to remove all your information up until one month following the interview. Please contact us on the details below for further information.

What are the benefits or risks of me taking part?
There may not be any direct benefits to you of taking part. We hope that you may find it useful to think about your experiences, views and beliefs and the information you give us may help inform future maternity care provision.

Who has reviewed this study?
Ethics approval for this study has been received from the Health Research Authority (HRA) and the Research Ethics Committee (REC) (Integrated research application

reference 296492) and University of Central Lancashire (UCLAN) ethics. The study is logged with the research and development department at [redacted] (reference DEV006).

How will my data be used?
In the research study, we will use information that you provide. If applicable, we only let people know any information if it is necessary for the study. The team involved in this study will keep your data safe and secure and will also follow all privacy rules. At the end of the study, we will save some of the data in case we need to check it. We will make sure no-one can work out who you are from the reports we write.

The University processes personal data as part of its research and teaching activities in accordance with the lawful basis of 'public task', and in accordance with the University's purpose of "advancing education, learning and research for the public benefit". Under UK data protection legislation, the University acts as the Data Controller for personal data collected as part of the University's research. The University privacy notice for research participants can be found on the attached link https://www.uclan.ac.uk/data_protection/privacy-notice-research-participants.php

There are however limits to confidentiality such as the following:

We will speak to your maternity care team if there are significant concerns about you (including if you experience any significant distress while taking part) or if there are concerns for someone else's safety. We will take all possible steps to discuss this with you first and plan together about what to do, but ultimately, we have a duty of care to inform your team of these concerns.

What will happen to the results of the study?
The findings from this study will be detailed in a report to the sponsor, for teaching purposes, and to potentially inform a toolkit for any maternity service improvements that may be identified. If you would like to receive a detailed copy of the research study, please contact us via the details below.

What do I do if I want to take part?
Please email Rebecca Sessions via the contact details below within **two weeks** of the date of the email invitation you have received, and we will then contact you to organise an interview appointment.

What if I'm unhappy or there's a problem?
If you are unhappy, or if there is a problem, please feel free to let us know by contacting Professor Soo Downe on SDowne@uclan.ac.uk and we will try to help. If you remain unhappy or have a complaint which you feel you cannot come to us with, then please contact the Research Governance Unit at OfficerForEthics@uclan.ac.uk.

The University strives to maintain the highest standards of rigour in the processing of your data. However, if you have any concerns about the way in which the University processes your personal data, it is important that you are aware of your right to lodge a complaint with the Information Commissioner's Office by calling 0303 123 1113.

How do I access national support organisations?
There are national services who give professional guidance and support around pregnancy, childbirth and parenting.

Just some of the organisations who offer support should you wish to access them:

- The National Childbirth Trust www.nesta.org.uk
- The Royal College of Obstetricians and Gynaecologists www.rcog.org.uk

Core project team:

- Rebecca Sessions, Professional Doctorate student at the University of Central Lancashire and Midwife Matron at [redacted] - RJSessions1@uclan.ac.uk
  Professor Soo Downe, University of Central Lancashire - SDowne@uclan.ac.uk
- Dr Nicola Crossland, Research Associate, University of Central Lancashire – NCrossland@uclan.ac.uk

Where can I find out more about how my information is used?
You can find out more about how we use your information at:

- www.hra.nhs.uk/information-about-patients/
- And/or by asking one of the core research team on the email contact details provided.

Summary of how your data may be used:

How will my data be collected?	By taking part in one online interview on Microsoft teams. This will be recorded, transcribed and then deleted.
How will my data be stored? How long will my data be stored for?	Audio recordings of your verbal consent and interview will be stored in secure and password protected folders. Once your interview has been transcribed, the audio recording of your interview will be deleted. Your audio-recorded verbal consent will be destroyed/deleted five years from the end of the study.
What measures are in place to protect the security and confidentiality of my data?	All data will be stored in password/encrypted computer files at the University. The interviews will be recorded and transcribed via Microsoft teams or Sonix and checked by a member of the core research team. We will not share your research data outside of the research team until the data has been anonymised. Quotes from the interview will be used in reports, teaching and presentations, but we will remove identifying information.

Will my data be anonymised?	When the interview is transcribed, we will remove any names/personal identifying information. When we use any of your quotes, we will use a participant identifier.
How will we use information about you?	We will need to use information from you for this research project. We will keep all information about you safe and secure. Once we have finished the study, we will keep some of the data so we can check the results. We will write our reports in a way that no-one can work out that you took part in the study. We will use anonymised quotes from the questionnaires in reports, publications, teaching and presentations.
What are your choices about how your information is used?	You can stop being part of the study at any time up until one month after the interview takes place without giving a reason. In this situation, we will keep information about you that we already have.
Who will have access to my data?	Only the core research team will have access to your data.
Will my data be archived for use in other research projects in the future?	No.
How will my data be destroyed?	After the interview, we will download the interview recording onto a computer and delete the interview from the recording device. Once a typed transcript of the interview has been produced, the interview recording will be deleted. Your consent will be destroyed/deleted five years from the end of the study.

THANK YOU FOR TAKING THE TIME TO READ THIS INFORMATION SHEET!

Appendix 3

University of Central Lancashire
UCLan

CONSENT FORM

PARTICIPANT IDENTIFICATION NUMBER:

TITLE OF PROJECT: Informed consent and induction of labour at term gestation

NAME OF RESEARCHER: Rebecca Sessions

Verbal consent taken on xx/xx/2022 at 0.00hrs by researcher

Please read the following statements. These will be read to you and signed on your behalf at the start of the interview.

		Please initial
1	I confirm that I have read the information sheet dated..... (version.....) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered	
2	I understand that my participation is voluntary, and it is up to me whether I take part or not	
3	I understand that the interview will be audio recorded	
4	I understand that I do not have to answer all the interview questions, and may stop the interview at any time, and without giving a reason	
5	I understand that quotes from the interview(s) will be used in reports, teaching and presentations, but that identifying information will be removed so that I will not be identifiable, and I am happy for quotes to be used	
6	I understand that I can withdraw all my interview data from the study up until one month after the interview has taken place	
7	I agree to take part in the above study	

Name of Participant	Date	Signed on participant's behalf

Statement by the person taking consent: I have accurately read out the information sheet to the potential participant and, to the best of my ability, ensured that the participant understands to what they are consenting.

Name of Person taking consent	Date	Signature

Appendix 4

University of Central Lancashire
UCLan

PARTICIPANT INFORMATION SHEET

INTERVIEWS WITH HEALTH CARE PROFESSIONALS:
We would like to invite you to take part in a University of Central Lancashire (UCLAN) research study being undertaken at [redacted] Before you decide if you would like to take part, please read this information sheet and talk to others if you wish. If you would like more information, please contact a member of the UCLAN core research team on the details provided on this information sheet.

WHAT IS THE STUDY ABOUT?
The aim of this research study is to find out more about the views and experiences of health care professionals and maternity service users when discussing induction of labour in relation to informed consent. In this phase of the research study, we will ask health care professionals to take part in an interview with the researcher.

WHY HAVE I BEEN ASKED TO TAKE PART?
You have been asked to take part due to your involvement and experience of discussing informed consent for induction of labour with maternity service users at [redacted]

WHAT WILL THE STUDY INVOLVE?
You are invited to participate in an interview with the researcher on Microsoft teams. Information about how to access MS Teams can be provided if needed. The interview will be recorded and an audio version of the recording saved, transcribed and then deleted. The interview will be organised at a time and date to suit you and will last approximately 45 minutes.

DO I HAVE TO TAKE PART?
No, it is entirely up to you if you want to take part or not. Even if you say yes now, you are free to change your mind at any point and without giving a reason. During the interview, you do not have to answer all the questions and can stop the interview at any time. Even if you do take part in the interview and then decide you do not want your information to be used, you will be able to remove all your information up until one month following the interview. Please contact us on the details below for further information.

WHAT ARE THE BENEFITS OR RISKS TO ME TAKING PART?
There may not be any direct benefits to you of taking part. We hope that you may find it useful to think about your experiences, views and beliefs and the information you give us may help inform future maternity care provision.

Please note the Trust mechanisms (as per details below) should the interview identify any support that you may wish to access. The Well Team and Occupational Health services offer a wide range of services:

[redacted]

- Employee assistance programme

Your line manager can assist with accessing these mechanisms should they be needed.

WHO HAS REVIEWED THIS STUDY?
Ethics approval for this study has been received from the Health Research Authority (HRA) and the Research Ethics Committee (REC) (Integrated research application reference 296492) and University of Central Lancashire (UCLAN) ethics. The study is logged with the research and development department [redacted] (reference DEV006).

HOW WILL MY DATA BE USED?
In the research study, we will use information that you provide. If applicable, we only let people know any information if it is necessary for the study. The team involved in this study will keep your data safe and secure and will also follow all privacy rules. At the end of the study, we will save some of the data in case we need to check it. We will make sure no-one can work out who you are from the reports we write. There are however limits to confidentiality such as the following:

The University processes personal data as part of its research and teaching activities in accordance with the lawful basis of 'public task', and in accordance with the University's purpose of "advancing education, learning and research for the public benefit". Under UK data protection legislation, the University acts as the Data Controller for personal data collected as part of the University's research. The University privacy notice for research participants can be found on the attached link https://www.uclan.ac.uk/data_protection/privacy-notice-research-participants.php

WHAT WILL HAPPEN TO THE RESULTS OF THE STUDY?
The findings from this study will be detailed in a report to the sponsor, for teaching purposes, and to potentially inform a toolkit for any maternity service improvements that may be identified. If you would like to receive a detailed copy of the research study, please contact us on the details below.

WHAT DO I DO IF I WANT TO TAKE PART?
Please email Rebecca Sessions via the contact details below within **two weeks**, and we will then contact you to organise an interview appointment.

WHAT IF I'M UNHAPPY OR THERE'S A PROBLEM?
If you are unhappy, or if there is a problem, please feel free to let us know by contacting Professor Soo Downe on SDowne@uclan.ac.uk and we will try to help. If you remain unhappy or have a complaint which you feel you cannot come to us with, then please contact the Research Governance Unit at OfficerForEthics@uclan.ac.uk.

The University strives to maintain the highest standards of rigour in the processing of your data. However, if you have any concerns about the way in which the University processes your personal data, it is important that you are aware of your right to lodge a complaint with the Information Commissioner's Office by calling 0303 123 1113.

CORE PROJECT TEAM:

- Rebecca Sessions, Professional Doctorate student at the University of Central Lancashire and Midwife Matron [redacted]
  RJSessions1@uclan.ac.uk
  Professor Soo Downe, University of Central Lancashire - SDowne@uclan.ac.uk
- Dr Nicola Crossland, Research Associate, University of Central Lancashire – NCrossland@uclan.ac.uk

WHERE CAN YOU FIND OUT MORE ABOUT HOW YOUR INFORMATION IS USED?

You can find out more about how we use your information at:

- www.hra.nhs.uk/information-about-patients/
- And/or by asking one of the core research team on the email contact details provided.

SUMMARY OF HOW YOUR DATA MAY BE USED:

How will my data be collected?	By taking part in one online interview on Microsoft teams. This will be recorded, transcribed and then deleted.
How will my data be stored? How long will my data be stored for?	Audio recordings of your verbal consent and interview will be stored in secure and password protected folders. Once your interview has been transcribed, the audio recording of your interview will be deleted. Your audio-recorded verbal consent will be destroyed/deleted five years from the end of the study.
What measures are in place to protect the security and confidentiality of my data?	All data will be stored in password/encrypted computer files at the University. The interviews will be recorded and transcribed via Microsoft teams or Sonix (voice to text software) and checked by a member of the core research team. We will not share your research data outside of the research team until the data has been anonymised. Quotes from the interview will be used in reports, teaching and presentations, but we will remove identifying information.
Will my data be anonymised?	When the interview is transcribed, we will remove any names/personal identifying information. When we use any of your quotes, we will use a participant identifier.

How will we use information about you?	We will need to use information from you for this research project. We will keep all information about you safe and secure. Once we have finished the study, we will keep some of the data so we can check the results. We will write our reports in a way that no-one can work out that you took part in the study. We will use anonymised quotes from the questionnaires in reports, publications, teaching and presentations.
What are your choices about how your information is used?	You can stop being part of the study at any time up until one month after the interview takes place without giving a reason. In this situation, we will keep information about you that we already have.
Who will have access to my data?	Only the core research team will have access to your data.
Will my data be archived for use in other research projects in the future?	No.
How will my data be destroyed?	After the interview, we will download the interview recording onto a computer and delete the interview from the recording device. Once a typed transcript of the interview has been produced, the interview recording will be deleted. Your consent will be destroyed/deleted five years from the end of the study.

THANK YOU FOR TAKING THE TIME TO READ THIS INFORMATION SHEET!

Appendix 5

University of Central Lancashire
UCLan

PARTICIPANT INFORMATION SHEET

Focus group for midwives:
We would like to invite you to take part in a University of Central Lancashire (UCLAN) research study being undertaken at [redacted]
Before you decide if you would like to take part, please read this information sheet, and talk to others if you wish. If you would like more information, please contact a member of the UCLAN core research team on the details provided within this information sheet.

What is the study about?
The overall aim of the research study is to find out more around induction of labour and the experiences, views and beliefs of women and pregnant people as well as midwives and obstetricians working within the clinical area/setting. There are several parts to the research study and in this phase of the study, we will ask midwives to take part in a discussion group to discuss overall experiences of induction of labour in the clinical area/settings.

Why have I been asked to take part?
You have been asked to take part in the discussion group to discuss your views, experiences, and beliefs as you work in the clinical areas where women and pregnant people who are going to have their labour induced are admitted to and cared for.

What will the study involve?
You are invited to participate in a discussion group as a small group of Midwives which will take part on Microsoft teams. The discussion group will be recorded, and an audio version of the recording saved, transcribed and then deleted at the end of the research project. The discussion group will be organised at a date and time to suit the group, it will last approximately 45 minutes and it will be recorded.

Do I have to take part?
No, it is entirely up to you if you want to take part or not. Even if you say yes now, you are still free to change your mind at any point and without giving a reason. During the discussion group you do not have to answer all the questions and the group can be paused at any time. Even if you do take part in the discussion group and then decide you do not want your information to be used, you will be able to remove all your information up until one month following the discussion group.

What are the benefits or risks to me taking part?
There may not be any direct benefits to you of taking part although we hope that you may find it useful to think about your experiences, views, and beliefs. The information you give us may help us inform maternity care provision in relation to shared decision making and informed consent for induction of labour.

Please note the Trust mechanisms as per below should the discussion group identify any support that you may wish to access. The Well Team and Occupational Health services offer a wide range of service to keep you well.

[redacted] NHS Trust mechanisms:

- Well Service: Telephone [redacted]
- Employee assistance programme

Who has reviewed this study?
Ethics approval for this study has been received from the Health Research Authority (HRA) and the Research Ethics Committee (REC) (Integrated research application reference 296492) and University of Central Lancashire (UCLAN) ethics. The study is logged with the research and development department at [redacted] (reference DEV006).

How will my data be used?
In this research study we will use information that you provide. If applicable, we only let people know any information about your information if it is necessary for this study. The team involved in this study will keep your data safe and secure and will also follow all privacy rules. At the end of the study, we will save some of the data in case we need to check it. We will make sure no-one can work out who you are from the reports we write.

The University processes personal data as part of its research and teaching activities in accordance with the lawful basis of 'public task', and in accordance with the University's purpose of "advancing education, learning and research for the public benefit". Under UK data protection legislation, the University acts as the Data Controller for personal data collected as part of the University's research. The University privacy notice for research participants can be found on the attached link https://www.uclan.ac.uk/data_protection/privacy-notice-research-participants.php

What will happen to the results of the study?
The findings from the study will be detailed in a report to the sponsor, for teaching purposes, and may inform a toolkit for any maternity service improvements that are identified. If you would like to receive a detailed copy of the research study, please contact me on the details below.

What do I do if I want to take part?
Please email me on the contact details below within **two weeks**, and we will then contact you to organise an interview appointment.

What if I am unhappy or there is a problem?
If you are unhappy, or if there is a problem, please feel free to let us know by contacting Professor Soo Downe on SDowne@uclan.ac.uk and we will try to help. If you remain unhappy or have a complaint which you feel you cannot come to us with, then please contact the Research Governance Unit at OfficerForEthics@uclan.ac.uk.

The University strives to maintain the highest standards of rigour in the processing of your data. However, if you have any concerns about the way in which the University processes your personal data, it is important that you are aware of your right to lodge a complaint with the Information Commissioner's Office by calling 0303 123 1113.

Core project team:
- Rebecca Sessions, Professional Doctorate student at the University of Central Lancashire and Midwife Matron [redacted]

RJSessions1@uclan.ac.uk
Professor Soo Downe, University of Central Lancashire - SDowne@uclan.ac.uk

- Dr Nicola Crossland, Research Associate, University of Central Lancashire – NCrossland@uclan.ac.uk

Where can I find out more about how my information is used?
You can find out more about how we use your information:

- at www.hra.nhs.uk/information-about-patients/
- by asking the core research team

Summary of how your data is used:

How will my data be collected?	By taking part in one online discussion group
How will my data be stored? How long will my data be stored for?	Audio recordings of your verbal consent and a recording of the discussion group will be stored in secure and password protected folders. The recording of the discussion group will be deleted at the end of research project. The recording of the consent will be deleted after five years.
What measures are in place to protect the security and confidentiality of my data? Will my data be anonymised?	All data will be stored in password/encrypted computer files at the University. The focus group will be transcribed via Microsoft teams and checked by a member of the research team. We will not share your research data outside of the research team until the data has been anonymised. Quotes from the discussion group will be used in reports, teaching and presentations, but we will remove identifying information so that you will not be identifiable. When the discussion group is transcribed, we will remove any names/personal identifying information. When we use any of your quotes, we will use a participant identifier.
How will we use information about you?	We will need to use information from you for this research project. This information will be used to do the research and/or to check your records to make sure that the research is being done properly. We will keep all information about you safe and secure. Once we have finished the study, we will keep some of the data so we can check the results. We will write our reports in a way that no-one can work out that you took part in the study. We will use anonymised quotes from the

	questionnaires in reports, publications, teaching and presentations.
What are your choices about how your information is used?	You can stop being part of the study up to one month after the discussion group taking place, without giving a reason, but we will keep information about you that we already have.
Who will have access to my data?	Only the research team will have access to your data.
Will my data be archived for use in other research projects in the future?	No.
How will my data be destroyed?	After the interview, we will save the discussion group recording into secure and password protected folders which will be deleted at the end of the research project. Your consent form will be destroyed at the end of the research study.

Thank you for taking the time to read this information sheet!

Appendix 6

University of Central Lancashire
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CONSENT FORM

PARTICIPANT IDENTIFICATION NUMBER:

TITLE OF PROJECT: Informed consent and induction of labour at term gestation: process and implication

NAME OF RESEARCHER: Rebecca Sessions

Verbal consent taken on xx/xx/2022 at 0.00hrs by researcher

Please read the following statements. These will be read to you and signed on your behalf at the start of the interview.

		Please initial
1	I confirm that I have read the information sheet dated..... (version.....) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered	
2	I understand that my participation is voluntary, and it is up to me whether I take part or not	
3	I understand that the discussion group will be audio recorded	
4	I understand that I do not have to answer all the discussion group questions, and may stop the discussion group at any time, and without giving a reason	
5	I understand that quotes from the discussion group will be used in reports, teaching and presentations, but that identifying information will be removed so that I will not be identifiable, and I am happy for quotes to be used	
6	I understand that I can withdraw all my dicussion group data from the study up until one month after the interview has taken place	
7	I agree to take part in the above study	

Name of Participant	Date	Signed on participant's behalf

Statement by the person taking consent: I have accurately read out the information sheet to the potential participant and, to the best of my ability, ensured that the participant understands to what they are consenting.

Name of Person taking consent	Date	Signature

Appendix 7

University of Central Lancashire
UCLan

QUALTRICS QUESTIONNAIRE FOR MATERNITY SERVICE USERS (PHASE 2)

1. What is your age?
2. What is your ethnic group?
    - White British
    - White Irish
    - White any other background
    - Indian
    - Pakistani
    - Bangladeshi
    - Any other Asian background
    - Caribbean
    - African
    - Any other black background
    - Chinese
    - Other ethnic category

3. Why did you have a discussion about having your labour induced?
    - Overdue pregnancy
    - Preterm pre labour rupture of membranes
    - Previous caesarean section
    - At my request/wanting labour to be induced
    - My baby was small
    - My baby was large
    - Diabetes

- Other medical complication, for example raided blood pressure (please use free text box)
- I've decided not to have my labour induced

4. Where did you have the discussion for your induction of labour?
    - GP surgery/Midwife appointment
    - Antenatal Clinic
    - Central Birth Suite
    - Antenatal Ward
    - Antenatal Triage
    - Blackburn Birth Centre
    - Burnley Birth Centre
    - Not sure (please use the free text box)

5. Who did you have your discussion about induction of labour with?
    - Midwife
    - Doctor
    - Both

6. Was induction of labour explained to you clearly so that you could make a choice that was right for you and your baby?
    - Definitely yes
    - Probably yes
    - Probably not
    - Definitely not

7. How involved were you in the process to decide whether to have your labour induced?
    - I wanted my labour to be induced
    - I was told that induction of labour was recommended and I agreed
    - I was told that induction of labour was recommended but I needed reassuring

- I was told that induction of labour was recommended and I agreed to it but would have preferred to wait
- I wasn't involved with the decision-making process, I was told that induction of labour would be needed
- I declined to have my labour induced
- Other (please use the free text box)

8. At what point did you make your decision to have your labour induced or not?
    - As soon as I could past my due date
    - 1 week past my due date
    - 2 weeks' past my due date
    - Planned in advance (health condition)
    - When my pregnancy wasn't progressing as expected
    - When my water broke but I didn't go into labour
    - I wasn't given time to think
    - I don't remember
    - Other
    - Please comment in the free text box

9. Were you given information on the following subjects?
    - Why induction of labour was recommended for you
    - What to expect when you are being induced
    - Setting for you induction of labour
    - Timing for your induction of labour
    - Pain relief
    - Prevention and management of any complications
    - Other (please use the free text box)
    - Comments (please use the free text box)

10. Were you given time to ask questions, discuss and explore your options for induction of labour?
    - Definitely yes
    - Probably yes

- Probably not
- Definitely not

11. To what extent did you understand the information you were given about induction of labour?
    - Fully understood
    - Partially understood
    - Didn’t understand
    - Please comment in the free text box

12. Did you receive the induction of labour leaflet?
    - Yes
    - No

13. What other materials did you access for information about induction of labour?
    - Books
    - Internet
    - Social media
    - Other (please use the free text box)
    - None

14. Did you receive any additional advice from anyone else other than a health care professional when making your decision about induction of labour.
    - No
    - Partner
    - Friend
    - Family member
    - Doula
    - Other (please use the free text box)
    - Comments (please use the free text box)

15. Was the additional information useful?
    - Extremely useful

- Very useful
- Moderately useful
- Slightly useful
- Not at all useful

Appendix 8

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QUESTIONS FOR SEMI-STRUCTURED INTERVIEWS WITH MATERNITY SERVICE USERS (PHASE 2)

What do postnatal women and postnatal people say about communication with healthcare professionals in regard to induction of labour and the impact this had on their decision for birth and their subsequent birth experiences?

1. Can you tell me about the discussions you had about having your labour induced?
2. Can you tell me about how and why you made the decision to have your labour induced or not?
3. Can you tell me about whether the information for induction of labour was discussed clearly?
4. Can you tell me about any other information that you accessed for more information about induction of labour?
5. Can you tell me about any advice you received from your partner, family and/or friends about induction of labour?
6. Can you tell me about your birth experience?
7. Overall, do you feel that your decision to have your labour induced or not affected your birth experience and if so how?
8. Do you have any suggestions for how the discussions that you had about induction of labour could be improved?
9. Is there anything else that you would like to talk about?

<u>General prompts for semi structured interviews:</u>

10. Can you tell me about ….. (descriptive)
11. You mentioned that…..can you say a bit more about that…. (follow up)
12. You mentioned that…..is there a particular example that comes to mind? (example)
13. You used the term…..can you tell me what this means to you?.....(clarification)
14. You said there was a big difference between…..and…..can you describe some of the differences for me? (compare/contrast)

15. Allows reflection and opportunity to add to what has been said (silence)

Appendix 9

University of Central Lancashire
UCLan

QUESTIONS FOR SEMI-STRUCTURED INTERVIEWS WITH MIDWIVES AND OBSTETRICIANS (PHASE 3)

"What are midwives and obstetricians' views and experiences of communication with women and pregnant people regarding induction of labour, the impact this has on women's decisions about labour induction or not and on their subsequent birth experience"?

1. Can you tell me generally about your feelings with regards to induction of labour?
2. Can you tell me about how you adapt to women and pregnant people's decision-making processes, for example women and pregnant people who request induction of labour who you feel may not need induction of labour and conversely women and pregnant people who decline induction of labour who you feel need induction of labour?
3. Can you tell me about the key things that help you when having discussions with women and pregnant people about induction of labour?
4. Can you tell me about the main barriers for you when having discussions with women and pregnant people about induction of labour?
5. Can you tell me about how you interpret the guidance for induction of labour for what might be considered a non-medical indication?
6. Can you tell me about what you think the influences are for women when discussing induction of labour with women and pregnant people?
7. Can you tell me about what you think the influences are for health care professionals are when discussing induction of labour with women and pregnant people?
8. Can you tell me about any memorable experiences you have had when discussing induction of labour with women and pregnant people in relation to informed consent and shared decision making?
9. Can you tell me your thoughts about informed consent?
10. Can you tell me about any key improvements that you can think of for improving discussions between women, pregnant people and health care professionals with regard to induction of labour?
11. Is there anything else that you would like to add that we haven't discussed today?

<u>General prompts to utilise for interviews with staff:</u>

1. Can you tell me about ….. (descriptive)
2. You mentioned that…..can you say a bit more about that…. (follow up)
3. You mentioned that…..is there a particular example that comes to mind? (example)
4. You used the term…..can you tell me what this means to you?.....(clarification)
5. You said there was a big difference between…..and…..can you describe some of the differences for me? (compare/contrast)
6. Allows reflection and opportunity to add to what has been said (silence)

Appendix 10

QUESTIONS FOR MIDWIFERY DISCUSSION GROUP (PHASE 3)

"What are midwives and obstetricians' views and experiences of communication with women and pregnant people regarding induction of labour, the impact this has on women's decisions about labour induction or not and on their subsequent birth experience"?

<u>What are midwives views and experiences working in the antenatal and/or birth suite setting with women and pregnant people who have had their labours induced?</u>

12. Can you tell me about your experiences within the antenatal and/or central birth suite of caring for women and pregnant people who have had their labour induced?
13. Can you tell me about your experiences of the impact of induction of labour on your everyday work within the antenatal/central birth suite?
14. Can you tell me about any particular examples regarding induction of labour that come to mind that you would like to discuss from your daily work within the antenatal/central birth suite?
15. Can you tell me what you think are the main influences for women and pregnant people when making decisions about induction of labour?
16. Can you tell me what you think are the best ways to give women and pregnant people information for induction of labour?
17. Can you tell me what you think should be included in the information women and pregnant people receive for induction of labour?
18. Can you tell me about any suggestions/thoughts for key improvements based on your experiences with women and pregnant people who are having their labour induced?

<u>General prompts to utilise for the discussion group:</u>

8. Can you tell me about ….. (descriptive)
9. You mentioned that…..can you say a bit more about that…. (follow up)
10. You mentioned that…..is there a particular example that comes to mind? (example)
11. You used the term…..can you tell me what this means to you?.....(clarification)
12. You said there was a big difference between…..and…..can you describe some of the differences for me? (compare/contrast)
13. Allows reflection and opportunity to add to what has been said (silence)

Appendix 11

University of Central Lancashire
Preston PR1 2HE
01772 201201
uclan.ac.uk

21st January 2022

Soo Downe / Rebecca Sessions
School of Community Health & Midwifery
University of Central Lancashire

Dear Rebecca

Re: Health Ethics Review Panel Application
Unique reference Number: HEALTH 0266

The Health Ethics Review Panel has granted approval of your proposal application 'Informed consent and induction of labour at term gestation'. Approval is granted up to the end of project date*. It is your responsibility to ensure that

- the project is carried out in line with the information provided in the forms you have submitted
- you regularly re-consider the ethical issues that may be raised in generating and analysing your data
- any proposed amendments/changes to the project are raised with, and approved, by the Ethics Review Panel
- you notify EthicsInfo@uclan.ac.uk if the end date changes or the project does not start
- serious adverse events that occur from the project are reported to the Ethics Review Panel
- a closure report is submitted to complete the ethics governance procedures (Existing paperwork can be used for this purposes e.g. funder's end of grant report; abstract for student award or NRES final report. If none of these are available use e-Ethics Closure Report Pro Forma).

Please also note that it is the responsibility of the applicant to ensure that the ethics committee that has already approved this application is either run under the auspices of the National Research Ethics Service or is a fully constituted ethics committee, including at least one member independent of the organisation or professional group.

Yours sincerely

Simon Alford
Deputy Vice-Chair
Health Ethics Review Panel
* for research degree students this will be the final lapse date

NB - Ethical approval is contingent on any health and safety checklists having been completed, and necessary approvals gained.

Appendix 12

Dear Colleagues,

IRAS: 296491

R&D Ref: 2022/001/DEV006

Confirmation of Capacity and Capability at [redacted]

Full Study Title: Informed consent and induction of labour at full term: process and implications

This email confirms that [redacted] has the capacity and capability to deliver the above referenced study. Please find attached the fully signed Organisation Information Document that forms this agreement

- **Please ensure [redacted] is copied in the email when providing the team at [redacted] with the green light to start recruitment.**

Please file this email in your Investigator Site file for future information and reference purposes in case of audit or inspection.

Please do not hesitate to contact me if you require any further assistance.

Kind Regards

Gemma

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

Directorate of Education, Research & Innovation | Learning and Development Centre | Park View Offices, Royal Blackburn Teaching Hospital | Haslingden Road | Blackburn | Lancashire | BB2 3HH

Appendix 13

Professor Soo Downe

University of Central Lancashire

Email: approvals@hra.nhs.uk

HCRW.approvals@wales.nhs.uk

Fylde Road

Preston

PR1 2HE

04 January 2022

Dear Professor Downe,

HRA and Health and Care

Study title:	**Informed consent and induction of labour at term gestation: process and implications**
IRAS project ID:	**296491**
Protocol number:	**N/A**
REC reference:	**21/PR/1583**
Sponsor	**University of Central Lancashire**

I am pleased to confirm that **HRA and Health and Care Research Wales (HCRW) Approval** has been given for the above referenced study, on the basis described in the application form, protocol, supporting documentation and any clarifications received. You should not expect to receive anything further relating to this application.

Please now work with participating NHS organisations to confirm capacity and capability, in line with the instructions provided in the "Information to support study set up" section towards the end of this letter.

How should I work with participating NHS/HSC organisations in Northern Ireland and Scotland?

HRA and HCRW Approval does not apply to NHS/HSC organisations within Northern Ireland and Scotland.

If you indicated in your IRAS form that you do have participating organisations in either of these devolved administrations, the final document set and the study wide governance report (including this letter) have been sent to the coordinating centre of each participating nation. The relevant national coordinating function/s will contact you as appropriate.

Please see IRAS Help for information on working with NHS/HSC organisations in Northern Ireland and Scotland.

How should I work with participating non-NHS organisations?

HRA and HCRW Approval does not apply to non-NHS organisations. You should work with your non-NHS organisations to obtain local agreement in accordance with their procedures.

What are my notification responsibilities during the study?

The standard conditions document "*After Ethical Review – guidance for sponsors and investigators*", issued with your REC favourable opinion, gives detailed guidance on reporting expectations for studies, including:

- Registration of research
- Notifying amendments
- Notifying the end of the study

The HRA website also provides guidance on these topics, and is updated in the light of changes in reporting expectations or procedures.

Who should I contact for further information?

Please do not hesitate to contact me for assistance with this application. My contact details are below.

Your IRAS project ID is **296491**. Please quote this on all correspondence.

Yours sincerely,

Margaret Hutchinson

Approvals Specialist

Email: approvals@hra.nhs.uk

Copy to: *Professor St John Crean* **List of Documents**

The final document set assessed and approved by HRA and HCRW Approval is listed below.

Document	*Version*	*Date*
Covering letter on headed paper [Covering letter re resubmission]	1	31 October 2021
Evidence of Sponsor insurance or indemnity (non-NHS Sponsors only) [Sponsor]	1	31 October 2021
Interview schedules or topic guides for participants [Questionnaire questions]	1	23 November 2021
Interview schedules or topic guides for participants [Interview planning for health care professionals]	1	23 November 2021
Interview schedules or topic guides for participants [Discussion group planning]	1	23 November 2021
Interview schedules or topic guides for participants [IRAS protocol]	1	23 November 2021
Interview schedules or topic guides for participants [Interview schedule maternity service users]	1	23 November 2021
IRAS Application Form [IRAS_Form_31122021]		31December 2021
IRAS Checklist XML [Checklist_31122021]		31 December 2021
Organisation Information Document [OID]	1	13 September 2021
Participant consent form [Consent form - online questionnaire]	2	29 December 2021
Participant consent form [Consent form for interviews]	2	29 December 2021
Participant consent form [Consent form health care professionals and maternity service users]	2	29 December 2021
Participant consent form [Favourable opinion amendment confirmation]	1	29 December 2021
Participant information sheet (PIS) [Participant information sheet online questionnaire]	2	29 December 2021
Participant information sheet (PIS) [Participant information sheet health care professionals]	2	29 December 2021
Participant information sheet (PIS) [Participant information sheet focus group]	2	29 December 2021
Participant information sheet (PIS) [Participant information sheet interviews with maternity service users]	2	29 December 2021
Participant information sheet (PIS) [Consent Form focus group]	2	29 December 2021
Schedule of Events or SoECAT [Schedule of events]	1	13 September 2021
Summary CV for student [CV student researcher (RSessions)]	1	23 November 2021
Summary CV for supervisor (student research) [Supervisor CV]	1	11 May 2021

Appendix 14

IRAS project ID	296491

Information to support study set up

The below provides all parties with information to support the arranging and confirming of capacity and capability with participating NHS organisations in England and Wales. This is intended to be an accurate reflection of the study at the time of issue of this letter.

Types of participating NHS organisation	Expectations related to confirmation of capacity and capability	Agreement to be used	Funding arrangements	Oversight expectations	HR Good Practice Resource Pack expectations
There is one NHS participating organisation; therefore there is one site type.	Research activities should not commence at participating NHS organisations in England or Wales prior to their formal confirmation of capacity and capability to deliver the study.	An Organisation Information Document has been submitted and the sponsor is not requesting and does not expect any other site agreement to be used.	Please note that the SoECAT submitted for this study has not been authorised by an AcoRD Expert. HRA or HCRW sign off is for versioning only. This sign off does not constitute authorisation of the content of the SoECAT or confirmation that the cost attribution is appropriate.	As per the Organisation Information Document, a Local Collaborator will be in place at participating NHS Organisation.	No Honorary Research Contracts, Letters of Access or preengagement checks are expected for local staff employed by the participating NHS organisations. Where arrangements are not already in place, research staff not employed by the NHS host organisation undertaking any of the research activities listed in the research application would be expected to obtain an honorary research contract. This would be on the basis of a Research Passport (if university employed) or an NHS to NHS confirmation of pre-engagement checks letter (if NHS employed). These should confirm enhanced DBS checks, including appropriate barred list checks, and occupational health clearance.

Other information to aid study set-up and delivery

This details any other information that may be helpful to sponsors and participating NHS organisations in England and Wales in study set-up.