A Case Study of Low-Risk Women’s Perceived Decision-Making for Induction of Labour

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Declaration

I declare that the work submitted for this thesis is my own account of my research and that the material has not been submitted for any degree or diploma at any other tertiary education institution. Appropriate acknowledgement has been given where reference has been made to the work of others.

Jennifer Suzanne Wrightson

Signature:

Date: 26 April, 2016
Abstract

The purpose of this study was to investigate the question: ‘What are low-risk women’s perceptions of the influences that affect their decision-making regarding induction of labour?’ A qualitative case study method within the interpretive paradigm, guided by a feminist theoretical framework, explored the perspectives of both women who had recently birthed by induction, and midwives, within a South West Australian regional maternity unit.

The study was conducted in two phases. Phase one involved purposeful sampling of low-risk women (n = 18), while phase two employed convenience sampling of midwives (n = 10) by advertising for volunteers working within the maternity unit. Multiple data collection methods were used, including interviews, field notes and documentary information.

Thematic analysis of data from the low-risk women identified five themes: perceived health risks to themselves and their baby; fear of the childbirth experience; seeking support for themselves and their baby; shared decision-making related to induction; and adequacy and timeliness of information on which to base decisions.

Three themes emerged from the data related to the midwife participants: having limited influence over women’s induction decisions; empathy for the constraints that limited women’s decision-making; and concerns relating to the appropriateness of information influencing women’s decisions. A comparison of the findings revealed three common themes: balancing risk with the choice to have an induction; the influence of contextual constraints on decision-making; and ensuring that timely, appropriate and adequate information is available for decision-making.

Women’s perspectives are essential to inform the development of induction guidelines in midwifery practice. This study’s findings provide many new insights
relating to women’s perceived influences on their decision-making, including the effects of personal, socio-cultural and contextual factors. Recommendations for further research, policy development, midwifery practice and education include an investigation of consistent decision-making tools, the development of induction guidelines, a variety of facilitator-led antenatal education and increased antenatal midwifery contact.
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List of Abbreviations

ACM  Australian College of Midwives
ACNM American College of Nurse Midwives
AIHW Australian Institute of Health and Welfare
ARM Artificial Rupture of Membranes
AWHONN Association of Women’s Health, Obstetric and Neonatal Nurses
BP  Blood Pressure
CS  Caesarean Section
CTG Cardiotography
D&C Dilatation and Curettage
DOHWA Department of Health Western Australia
FIFO Fly-In Fly-Out
GP General Practitioner
IPDAS International Patient Decision Aids Standards
IUGR Intrauterine Growth Retardation
KEMH King Edward Memorial Hospital
LMC Lead Maternity Carers
NBAC Next Birth after Caesarean
NHMRC National Health and Medical Research Council
NICE National Institute for Health and Care Excellence
NSW New South Wales
NT Northern Territory
PCMC Partnership Caseload Midwifery Care
PIH Pregnancy-Induced Hypertension
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<tr>
<th>Abbreviation</th>
<th>Full Form</th>
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<tr>
<td>RANZCOG</td>
<td>Royal Australian and New Zealand College of Obstetricians and Gynaecologists</td>
</tr>
<tr>
<td>RCM</td>
<td>Royal College of Midwives</td>
</tr>
<tr>
<td>RCT</td>
<td>Randomised Controlled Trials</td>
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<tr>
<td>SA</td>
<td>South Australia</td>
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<tr>
<td>SFD</td>
<td>Small for Dates</td>
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<tr>
<td>SROM</td>
<td>Spontaneous Ruptured Membranes</td>
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<tr>
<td>UK</td>
<td>United Kingdom</td>
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<tr>
<td>US</td>
<td>United States</td>
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<td>VE</td>
<td>Vaginal Examination</td>
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<td>WA</td>
<td>Western Australia</td>
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<td>WHO</td>
<td>World Health Organization</td>
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Chapter 1: Introduction and Background

1.1 Introduction

This interpretive case study examines the perceptions of low-risk women and midwives regarding the factors that influence women’s decision-making relating to their induction of labour. The topic emerged when I was practising as a Midwife Consultant and my colleagues and I became concerned about the practice of induction for spurious or non-medical reasons, particularly as the reasons for induction recorded in the birthing register were unclear. Researchers around the world have expressed similar concerns regarding what appear to be social requests for an early induction by low-risk women (Doyle, Kenny, von Gruenigen, Butz & Burkett, 2012). These concerns relate to the fact that an induction of labour for non-medical reasons has been shown to be associated with a cascade of increased interventions such as epidural analgesia, Caesarean section (CS) births, assisted deliveries, morbidity in the mother and baby and an increased hospital stay (Patterson, Roberts, Ford & Morris, 2011). Nearly one decade ago, when this study was first conceived, inductions for non-medical reasons in the local context—that is, the Peel region of Western Australia (WA)—accounted for at least one-fifth of inductions each month. Inductions for non-medical reasons and “for the convenience of the woman and her family” (p.62) have continued to increase in WA since that time (McDonnell, 2011), with the state’s rate of inductions (29.1%) being higher than the national average (26%) for the past decade (Hutchinson, 2015). Induction rates in WA also vary in range from 16%-41.3% depending on whether the birth is in either a public or private facility, with private facilities having higher rates of induction (Australian Institute for Health and Welfare (AIHW), 2015). No statistical information or research data is available related to number of maternal requests for an induction of labour. As the rate of induction in WA is persistently above the national rate, the aim of this study
is to investigate the factors that influence women’s decision-making related to induction of labour for non-medical reasons. The identification of these factors is intended to generate evidence from which recommendations can be developed for midwifery practice.

This chapter provides an overview of the study, including the study context and background, and an overview of existing information related to women’s decision-making and choices. The chapter also includes an outline of the researcher’s assumptions, the purpose of the study, the research questions, the study’s significance and the structure of the thesis.

1.2 Background to the Study

This study is set in the context of growing disquiet among health professionals worldwide regarding rising rates of elective induction of labour for non-medical reasons (Doyle et al., 2012; Jonsson, Cnattingius & Wikstrom, 2012). Historically, an increasing worldwide trend in induction for medical reasons was evident during the 1970s–1990s, then increased rapidly from 20% in 1990 to 25–30% in 2005 (Mackenzie, 2006), and is currently declining. For example, induction rates in the United Kingdom (UK) were 15% in 1965 (Davis, 2013) and peaked at 41% in the 1970s, with a marked decline to 13% being recorded during 2005–2013 (Health & Social Care Information Centre, HSCIC 2015). However, these induction rates may be unreliable, as there are many cases where the reasons for the onset of labour are not reported (HSCIC, 2015). In a historical review of maternity services, Davis (2013) proposed that change of birthplace from home to 100% hospital births recommended by the Peel report in 1967 was responsible for the variation in the induction rates in the UK. Davis (2013) highlighted that home births in the UK declined rapidly from 33% to <5% in 1975. Hence, hospital births in women had increased from 68% to 95% by 1975 (Davis, 2013). The onset of
new technologies including antenatal testing of women and monitoring of babies heart
beats in the 1970s also led to the medicalisation of childbirth (Davis, 2013). Hence,
their obstetrician identified more women and babies antenatally, as at ‘high risk’ of
medical complications during childbirth. Consequently, their medical practitioners
recommended a hospital birth (Davis, 2013).

In the United States (US) trends in labour induction rates were similar to the UK.
They rose sharply from 9.6% to 23.8% between 1990 and 2010, and declined slightly
from 2010 to 2012 (Moore, Low, Titler, Dalton & Sampselle, 2014; Ruhl & Bingham,
2014; Osterman & Martin, 2014). Women and physicians’ preference were cited as the
main causes of rising rates of induction of labour (Moore et al. 2014). However, health
professionals in the US recently expressed concerns about the rising rate of inductions
for social reasons, as it is increasing at a faster rate than elective inductions for medical
reasons (Doyle et al., 2012).

Australia currently has a higher induction rate than other countries. The national
rate of inductions fluctuated slightly between 29% in 2007 to 26% in 2012 and 28% in
2013 (AIHW, 2015; Hilder, Zhichao, Parker, Jahan & Chambers, 2014). Induction rates
vary considerably between Australian states and territories (AIHW, 2013). South
Australia (SA) has the highest induction rate (30.9%), WA has the second highest rate
(29.1%) and the Australian Capital Territory has the lowest rate (22.2%) (Hilder et al.,
2014). Reasons for the variation in induction rates between Australian states and
territories are unknown (AIHW, 2013; AIHW, 2016). However, an influence on the
level of induction rates in women may be related to their type of hospital cover.

Induction rates also vary according to parity and, as reported above, whether
mothers give birth in private or public facilities, with 35% of mothers induced in private
hospitals compared to 30% in the public system (Hilder et al., 2014). In WA, the rates
of induction also vary between 16.9%–41.3% in public and private institutions. Hutchinson (2015) reported the highest rate of induction (41.3%) in a private facility and the lowest induction rate (16.9%) was reported to be in a small hospital in the wheat belt. Private inductions were scarce in the Peel regional maternity hospital. Hence, this would not have been a contributing factor in this study to the high level of induction in low risk women. Comparative information relating to reasons for the higher level of inductions in the private facilities is not available. However, induction rates in first time mothers have risen steadily since 2004 from 31% to 36% in 2013 in Australia (AIHW, 2016). Rates of induction in first time mothers also vary between states the lowest rate 31.2% in Queensland in comparison to 43.1% of women in Tasmania (AIHW, 2016). Induction of the majority of first-time mothers occurred between 37 and 41 weeks (AIHW, 2016). These high induction rates in first-time mothers is concerning, especially given the timing of inductions and the potential for increased intervention at the time of birth (Hilder et al., 2014). There was a significant decline in spontaneous births in Australia—from 63.4% in 1986 to 55% in 2012—because of the increase in birth interventions, particularly surgical interventions (Hilder et al., 2014). Surgical interventions may include an assisted birth, vacuum extraction, forceps or CS (Thorogood & Donaldson, 2015). AIHW (2016) provide support for the concerns of Hilder et al. (2014) as assisted deliveries in first time mothers have risen from 22.8% in 2004 to 25.3% in 2013. Additionally the rate of caesarean section births in first time mothers has also increased from 25.3% in 2004 to 27.5% in 2013.

The increased incidence of CSs and implications for future pregnancies and births in low-risk nulliparous women is currently the focus of considerable professional attention. International and Australian researchers have recognised the association between induction of labour in nulliparous women, who have a singleton pregnancy and

In Germany, a retrospective cohort study of low-risk women (n = 848) > 39 weeks and < 41 weeks’ gestation found that nulliparous women having an induction of labour with an unripe cervix were more likely to have a CS (Tam et al., 2013).

Similarly, Brennan et al.’s (2011) retrospective analysis of CS rates in Ireland from 1974 to 2008 reported a parallel rise in induction rates and CSs in nulliparous women. As in other countries, induction for non-medical reasons in Sweden appears to be increasing faster than the rate of induction for medical reasons (Jonsson et al., 2012). A parallel rise in the induction and CS rate in a Swedish cohort of women (n = 7,973) was also reported, particularly related to the use of cervical ripening agents (Jonsson et al., 2012). The Swedish researchers identified a number of increased risks arising from the use of ripening agents, including failure to progress, longer time to enter the active stage of labour, prolonged labour and foetal distress (Jonsson et al., 2012). All of these risk factors can lead to the decision to perform a CS. Low-risk parous Swedish women who had an induction at 37–41 weeks of pregnancy were twice as likely to undergo an emergency CS compared to women who waited for the onset of spontaneous labour (Jonsson et al., 2012).

More than one decade ago, US researchers raised professional concerns relating to a possible link between rising rates of CSs and induction for non-medical reasons (Dublin et al., 2000). This large population-based comparison study of women who were induced (n = 2,886) and women with spontaneous labour (n = 9,618) between 37 and 41 weeks’ gestation found that nulliparous women who were induced for non-
medical reasons had a 77% increased risk of CS compared with those who had spontaneous labour (Dublin et al., 2000). More recently, a US retrospective cohort of 8,000 nulliparous women who had a CS reported that the use of induction was linked to a higher rate of CS in nulliparous women, regardless of whether the induction was for medical or non-medical reasons (Ehrenthal et al., 2010).

In Australia, a link between the rates of labour induction and CS has also been investigated by concerned researchers in SA (Grivell et al., 2011), WA (McDonnell, 2011) and New South Wales (NSW) (Patterson et al., 2011). The SA researchers examined the state wide perinatal database of 28,626 women and found that an elective induction in women can increase the CS rate by up to 70% (Grivell et al., 2011). A similar study by McDonnell (2011) also focused on the link between induction and CS, highlighting that nulliparous women induced at the tertiary birthing facility in Perth, WA (King Edward Memorial Hospital [KEMH]), between 2008 and 2010 had a higher risk of CS associated with an induction of labour. The NSW study conducted from 2001 to 2007 used a sample of 212,389 nulliparous women to examine linked hospital data, finding that a high proportion of nulliparous women (55%) required an assisted birth, one-third required a CS, and induction in these women was found to be six times more likely to fail (Patterson et al., 2011). It is clear that an induction in low-risk women for non-medical reasons is associated with higher intervention rates and complications in women (McDonnell, 2011). Consequently, caution was advocated by these researchers in relation to the use of induction in women for non-medical reasons.

The link between induction and CS is of concern because of the complications that can arise in the woman from having a CS. Intraoperatively the women can have serious complications including the following: utero-cervical lacerations; severe bleeding from malplacentaion, trauma relating to the bladder, ureters and intestine and
complications associated with anaesthesia (Kulas, Bursac, Zegarac, Planinic-Rados & Hergovic, 2013). Serious post-operative complications include a greater incidence of infection, particularly of the wound and urinary tract, wound dehiscence, wound haematomas and limited post-operative mobility for 24–48 hours (Kulas et al., 2013). Limited post-operative mobility may lead to thromboembolic disorders, including thrombophlebitis, pulmonary embolism and deep vein thrombosis, which are a leading cause of death in women (AIHW, 2015). There are also implications for future pregnancies related to CS, including the potential for haemorrhage due to a ruptured uterus or abnormal embedding of the placenta (accreta or percreta), pelvic pain due to adhesions, longer operative times, infertility, and women may need a repeat CS (Jensen et al., 2013). Additional problems reported by researchers include higher rates of hysterectomy, wound complications post-discharge and hospital readmission (Ehrenthal et al., 2010), all of which can have serious consequences. Serious complications that may occur in the neonate relating to CS include foetal distress, neonatal depression and asphyxia from general anaesthesia, trauma (Neu & Rushing, 2011) and auto immune disease which may cause long term health problems including type 1 diabetes, asthma and obesity (Blustein & Liu, 2015). Major or minor trauma can occur, including cerebral haemorrhage, haematoma, peripheral nerve lesions including facial nerve palsy and brachial plexus, fractures of the skull and bones, facial injury from lacerations, and impaction of the fetal skull (Kulas et al., 2013). Many of these neonatal complications can lead to maternal separation due to the neonate’s admission to the neonatal intensive unit. Findings of a systematic review of 52 studies related to parenting attachment by Stewart-Brown and Scrader-McMillan (2011) suggested that early separation of the mother from the baby may cause alteration in their attachment and can lead to long term mental health problems in childhood including behavioural and educational problems.
Thus, to avoid unnecessary interventions and adverse outcomes in both childbirth and childhood, it is important to reassess decisions to induce low-risk women (Ehrenthal et al., 2010). Reduced induction rates could not only help reduce CS rates, but they could also reduce health and social costs to both the women and the health service, which have been of concern to international health professionals. These concerns have led to policy and practitioner reform internationally, in the UK (www.which.co.uk/birth-choice) and US (Jensen et al., 2013), as well as nationally (Australian College of Midwives [ACM] 2014) and locally (Department of Health, Western Australia [DOHWA], 2012).

1.3 Women’s Childbirth Choices: Effects of Policy and Practice Reform

For decades, professional bodies around the world have recognised the need to ensure maternal choice in making birth decisions. Enabling women’s choices have become a key part of policy and practice reform. For example, the UK Royal College of Midwives (RCM, 2007, p. 1) suggested that ‘maximising normal birth in the context of maternal choice is safe’. The National Institute for Health and Care Excellence (NICE) (2008, updated 2014) also indicated that women’s choices should be enabled through the provision of evidence-based information related to induction, which promotes their participation in decision-making. These guidelines remain unchanged despite a recent review (NICE, 2008, updated 2014). The philosophy of care in the UK is to ‘value free choice’ and allow a physiological process to take place (www.birthchoiceuk.com). In the UK, independent consumer organisations (Which & Birth Choice, 2016) and midwives advocate a system of choices for women through a partnership project entitled ‘Which Birth Choice (2016)’, which provides personalised online support for pregnant women (www.birthchoiceuk.com, www.which.co.uk/birth-choice). Women
can enter their personal demographic details, select their requirements for childbirth using an online midwifery-based questionnaire, and then receive targeted midwifery and medical services information related to their options for care (www.which.co.uk/birth-choice).

Australian midwives have also been proactive in promoting practice reform to enable normal childbirth and continuity of care through the ‘Know your midwife’ website (www.midwives.org.au) (ACM, 2014) and research (Sandall, Soltani, Gates, Shennan and Devane (2015). To investigate the maternal outcomes in midwife led care versus other models of care Sandall et al. (2015) conducted a Cochrane systematic review. Midwife led care includes care from a known midwife throughout pregnancy, birth and the puerperium, and continuity of care is an integral part of this model (Sandall et al., 2015). Collaborative care with the multidisciplinary team and the ‘on-call’ general practitioner (GP) obstetrician is also a part of this model (Sandall et al., 2015). The model promotes autonomy and control relating to women’s birth decisions, which are negotiated with their midwife (ACM, 2014). Despite the commitment to women’s choices in childbirth, a number of programs in the US, Canada, Netherlands, United Kingdom and Australia have attempted to avoid unnecessary inductions for non-medical reasons and restrict women’s choices relating to their request for an induction. Restriction of women’s choices is mainly to avoid the increased costs to the mother, baby and health service of early non-medical inductions. To prevent unnecessary inductions, US strategies have focused on women who have an induction at less than 39 weeks’ gestation for non-medical reasons (Jensen et al., 2013). Government-directed guidelines such as ‘hard-stop’ policies and ‘Medicaid reform’ have empowered many hospital health professionals to review inductions prior to 39 weeks and support their refusal to conduct inductions for non-medical reasons. These policies have had a
significant effect on women’s induction choices and in reducing non-medical inductions prior to 39 weeks by 75% in these hospitals (Jensen et al., 2013). Similarly, government funding in New Zealand, Canada (from the 1990’s), the Netherlands and Great Britain fund primary health care rather than acute health care to reduce non-medical inductions (Donnellan-Fernandez, Newman, Reiger & Tracy, 2013). Funding is decentralised and provides support for both home births and midwifery led community care to increase the incidence of normal birth (Donnellan-Fernandez et al., 2013). Sandall et al.’s (2015) Cochrane review indicated that midwife led continuity of care leads to increased vaginal birth and reduced instrumental birth in women. Hence, this type of funding prevents non-medical induction in women and the medicalisation of childbirth through financial disincentives (Donnellan-Fernandez et al., 2013).

Australian states—notably those with lower rates of labour induction than WA, including Queensland (23.3%) and NSW (27.3%)—have also developed strategies to increase the rate of normal childbirth in women, but with little effect on the induction rate in either state (Hilder et al., 2014). This may be because, unlike the US, Canada, Netherland, New Zealand initiatives, there have been no innovations relating to Australian Medicare reform to encourage a reduction of induction in low-risk women. The implementation of government guidelines/policies also varies. For instance, paradoxically, WA’s online guidelines for women during childbirth (DOHWA, 2012) indicate that an induction is only for medical reasons. However, as mentioned previously, the WA induction rate is the second highest in Australia. Conversely, the Northern Territory (NT) does not appear to have specific guidelines, but it has one of the lowest induction rates (23.6%). Reasons for the differences between different states including WA and the NT are unknown, yet differences may be explained by variations in policy, access and availability of the clinical workforce (AIHW, 2016). However,
there may be unknown complex local cultural factors in WA and the NT that influence women’s decisions relating to an induction of labour.

Potential factors that influence women’s induction decisions, such as women’s and provider convenience, have been investigated from the perspective of health professionals. However, an evidence base does not support these factors, and there is limited evidence of these influences from the perspective of the woman (Moore & Low, 2012). Clearly, it is important to obtain the perspective of the woman to understand why and how she makes her decisions relating to induction of labour. This study is based on the contention that health professionals should know what underpins these choices in order to understand how best to guide women in making choices for a successful outcome.

1.4 Study Context

This study was conducted in the Peel region, south of Perth in WA, to assist in filling the gap in knowledge regarding women’s decision-making for induction of labour. The Peel region is the smallest of nine regions in WA, but it has the largest population (113,531), which is expected to rise steeply to 137,598 by 2020 (Peel Development Commission, 2012). The region’s unemployment rate is the highest in WA (7%) compared with the state wide rate (4%) (Macdonald & Magill-Cuerden, 2011). Therefore, many men seek employment outside of the region to support their families. This means that the region has the highest level of women with ‘fly-in fly-out’ (FIFO) partners, and this figure is expected to rise as the population increases (Chamber of Minerals and Energy WA, 2013). Consequently, women may be isolated from their partner during pregnancy (McDonnell, 2011), and they may not be able to seek another opinion besides that of their health care provider when making decisions about the birth. Separation from their partners may also affect their decision to schedule childbirth when
their partner is home. Together, these factors may lead to a rise in the number of women who seek an induction for social reasons (McDonnell, 2011).

Women in the Peel region tend to give birth at their local maternity hospital, which provides both public and private maternity care options for women. Models of care within this maternity unit include ‘consultant obstetrician-led care’, GP obstetrician, ‘shared care’ between the GP obstetrician and midwife, and ‘midwife-led care’. Low-risk women with a normal pregnancy generally receive care either from their GP obstetrician or from midwives who work in the ‘midwife-led clinic’. The clinic has two senior midwives who deliver the majority of care throughout the pregnancy. Within this clinic, multiparous women see the GP twice: once at 16 weeks to examine their heart and lungs, and again at forty weeks. Women who are pregnant for the first time see the GP three times: at 16 weeks, 32 weeks and at 40 weeks. The midwife is responsible for supporting the woman during childbirth.

The timing of seeing the GP may influence women’s decision-making and induction of labour. If a woman develops complications during pregnancy/childbirth, the midwife refers her to the on-call GP obstetrician. The GP obstetrician may then refer the woman to a consultant obstetrician. The extent of the woman’s involvement in the decision-making process relating to induction of labour is unknown to the midwife as in the consultant and GP obstetrician’s model of care, verbal consent is obtained from the woman prior to admission for an induction of labour. The GP obstetrician also obtains written informed consent from the woman prior to the procedure in the birthing suite. However, what is not known about this process is the woman’s perspective on the following: the type of information she receives regarding induction of labour; how well she understands her options; and what, where and when information should be provided to enable her to consider her choices. Empowerment of women’s induction choices may
then lead to a reduction in both the procedure of induction and the level of childbirth interventions.

Some midwives in this setting have suggested that inductions for social reasons and maternal choices are mainly for women who have FIFO partners. Observations of the data in the birth register and statistics within the unit have revealed that there may be a range of other reasons for their choices, which should be investigated. My experience with women giving birth in the Peel region led me to consider a number of assumptions during the research process. In the next section, these assumptions will be re-examined in relation to the study findings and discussion in order to reduce bias in the interpretation of the data.

1.5 Researcher’s Assumptions and Study Aims

- The increased rate of early induction in low-risk women for non-medical reasons may be due to the increasing FIFO population in the region.
- Women who have an induction without a medical reason may be influenced by other factors, such as their family culture and/or other socio-cultural factors.
- An investigation of low-risk women’s perceptions regarding their decision-making and induction of labour can inform health professionals’ approaches in developing support mechanisms for women who request an early induction of labour.

Therefore, this study aims to investigate low-risk women’s influences on their decision-making and induction of labour from the perspective of the women themselves, and from a group of midwives employed within the same maternity unit. This study is designed to generate information relating to the setting and conditions in which women make their decisions in order to capture the context of decision-making. An interpretive case study is ideal for investigating the socio-cultural and contextual
influences that affect women’s decision-making. The rich data obtained are intended to answer the research questions below and will be useful for developing recommendations for professional guidelines relating to the care and support required by women who request an induction of labour for non-medical reasons.

1.6 Research Questions

1. What are low-risk women’s perceptions of the influences that affect their decision-making regarding induction of labour?

2. What are midwives’ perceptions of the influences that affect low-risk women’s decision-making regarding induction of labour?

3. What are the socio-cultural and contextual factors that affect women’s induction decisions?

4. In what ways can these data be used to inform midwifery practice regarding induction of labour?

1.7 Significance of the Study

This study is original and significant in several ways: First, influences on women’s decision-making/choices and induction of labour are unknown, so the findings represent the first data in Australia to inform strategies for reducing induction-related risks and supporting women and families at the time of birth. Second, women may be making induction decisions without first receiving adequate or timely information. The findings in this study could therefore reveal women’s perceptions of the adequacy and appropriateness of the information they base their decisions on. There is also a paucity of information relating to the factors that are the most influential for low-risk women making induction decisions, so it is interesting to explore whether some influences are given more or less weight in the decision-making process from the mother’s
perspective. This study is also significant in highlighting midwives’ perspectives on women’s induction decisions.

This interpretive case study focuses on a group of women and the effect of socio-cultural and contextual factors on their decision-making. It is important to examine influences such as a woman’s family, education and other contextual factors in order to obtain insights into her autonomy in decision-making. Multiple sources of data collection include participant interviews, field notes and documentary evidence from the birth register, the induction book, and monthly clinical indicators in the maternity unit. Thematic analysis, including the constant comparison of data, enables an inductive reasoning approach to analysis and interpretation. This study is conceptualised within a feminist theoretical framework intended to generate knowledge related to the cultural aspects of womanhood and woman-centred care in the context of birthing and decision-making related to induction of labour. Ultimately, the aim is to investigate the unknown socio-cultural and contextual influences on women’s decision-making to inform health professionals in their production of educational guidelines to support low-risk women in their choices.

Many questions remain unanswered relating to the elective induction of labour—in particular, why social inductions are continuing to rise. This underlines the importance of identifying women’s unknown perceptions of their influences on induction of labour. It is clear that many women are still choosing inductions, even though the overall rate of inductions is declining. The influences on women’s choices are unknown, but they may be related to factors such as a lack of information on care options, persuasion by health professionals, their social situation and the opinion of others. Currently, there is no research evidence to indicate that any one of these potential factors might be more persuasive.
1.8 Structure of the Thesis

Chapter 1 establishes the background for the study. Historical trends in induction of labour are outlined, as well as the researcher’s assumptions. Important trends relating to induction of labour for non-medical reasons are also included. This chapter highlights adverse outcomes related to induction in low-risk women, including the relationship between an induction in low-risk women and CS, and the risks involved in both. The chapter also identifies factors related to the significance and originality of this study, as well as the study’s aims and research questions. Chapter 2 presents an in-depth review of the literature to explore the phenomenon of induction of labour in low-risk women. The review includes the following topics: worldwide professional concerns related to high induction rates; guidelines, policy and practice reform related to induction for non-medical reasons; the role of low-risk women in their decision-making related to induction of labour; and implications of induction of labour for low-risk women. Chapter 3 outlines the methodology and theoretical underpinnings of this research study; namely, an interpretive case study approach using a feminist conceptual framework. Chapter 4 presents the findings of the data collected from the women in phase one and the midwives in phase two of the study, and it combines the findings from each phase into a common set of themes. Chapter 5 discusses the themes that emerge from the data with reference to relevant previous research findings and the theoretical framework. It also includes an overview of the study’s strengths, limitations and implications for health professional policy and practice reform, education and research theory. Additionally, the chapter presents the conclusions from the discussion of the research themes.
Chapter 2: Literature Review

Literature reviews highlight the gap in knowledge; that is, what is not known relating to the research topic. Therefore, this literature review has three purposes. First, it will identify and critically review international and Australian studies on the health implications of induction of labour for mothers and babies. The studies reviewed relate to the following: cost to the health service; global guidelines; policies and practice reform; and workforce issues, all of which could affect women’s induction decisions. Second, the review investigates studies on the women’s role in decision-making regarding induction of labour; in particular, the known influences on low-risk women’s induction decisions. These known influences include the effect of the health professional, models of midwifery care, fear, expectations and experiences of maternity care. Final stages of this review investigated the use of decision aids for women’s childbirth education. A description of the search strategy used for the literature review is included in the next section.

2.1 Search Strategy

A wide variety of sources were accessed in the literature review, including health professional databases, peer-reviewed journals, digital theses, books and health professional guidelines relating to induction of labour. Databases searched included the Cumulative Index for Allied Health (CINAHL), Summon, MEDLINE, Cochrane Database, EBSCO, PubMed, Psych INFO and Google Scholar. Additional professional databases searched included the National Institute for Health and Care Excellence (NICE), Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG), World Health Organization (WHO), RCM and the ACM. Key terms were developed from the research phenomenon relating to the high level of induction in low-risk women for non-medical reasons. Examples of the initial key terms
included ‘induction’, ‘low-risk women’, ‘perceptions’, ‘influences’, ‘decision-making’, complications’, mother and baby. These terms evolved from the use of Problem, Intervention, Comparison, Outcome and Timing (PICO/T) (Schneider, Whitehead, Lobiondo-Wood & Haber, 2013). In this study, the problem is the high level of induction in low-risk women, the intervention is induction of labour for non-medical reasons among the group being studied, compared to national and international rates of induction, the outcome is increased levels of intervention and surgical birth, and inappropriate timing of induction at less than 40 weeks. Extensive searches of the literature were undertaken using the key terms, related terms and databases mentioned above. Filters limited the inclusion criteria related to the currency of articles, use of humans, adults, English language, evidence base and women. Boolean operators were also used to either increase (OR) or refine (AND, NOT) the searches. Truncation was used to identify variations of words when searching; for example, using the word Austral to reveal Australia, Australian, Australia’s and Australasian studies relating to the topic of interest. Phrase searching refined the searches. Texts related to the topic and grey literature identified government policies and reports. To uncover the trends related to induction of labour, the literature reviewed for this study covers the past three decades. To ensure currency of the review, ongoing searches were undertaken throughout this study. Consequently, the literature was comprehensively canvassed and critiqued to identify what is known, what is unknown and what is important to the topic of induction of labour in low-risk women for non-medical reasons.

2.2 Implications of Induction of Labour for Women, Their Babies and the Health Service

Chapter 1 discussed global, local and health professional concerns relating to high levels of induction, particularly for non-medical reasons. A rise in social
inductions in WA (McDonnell, 2011) could lead to increased health complications for mothers and babies in childbirth. Further, researchers worldwide are concerned about increasing costs to the health service because of early induction for non-medical reasons, which may lead to maternal and neonatal complications. Researchers have recognised the risks of induction of labour for mothers and babies for nearly two decades (Dublin et al., 2000; Ehrenthal et al., 2010; Jensen et al., 2013; Peddicord, 2013; WHO, 2011). The decision to intervene is usually a medical one; for example, if the woman’s uterus or cervix is not ready for labour, surgical intervention may be required, and complications may arise for both the mother and the baby (Jensen et al., 2013).

There is confusion among researchers relating to the ideal time for induction. The length of pregnancy (Gestation) is usually 40 weeks or 280 days (Sprong, 2013). Historically an accepted definition of term gestation in a pregnant woman proposed by the American Congress of Obstetricians and Gynaecologists (ACOG, 2013) occurred between from 37-42 weeks of pregnancy. Recently a working group, which consisted of the American College of Obstetricians and Gynaecologists, American Academy of Paediatrics, Society for Fetal Medicine, March of the Dimes, WHO and stakeholders met to redefine the definition of a ‘term’ pregnancy in 2012 to improve outcomes in the neonate and prevent an early term birth (ACOG, 2013). Recommendations of this expert committee reported by ACOG (2013) are that term gestation should be redefined, as early term (37-38 weeks and 6 days), full term (39-40 weeks and six days) and late term (41 to 41 weeks and six days) gestation, these definitions have been endorsed by the ACOG. To achieve the best outcomes in the neonate a woman’s birth should occur between 39-41 weeks gestation (ACOG, 2013). Reasons for this redefinition relate to the length of term, as the 37-42 weeks term period in pregnancy has been associated
with varied outcomes in the neonate (ACOG, 2013). Several researchers have also suggested that induction should occur post-term at 41 weeks, which would reduce the risk of maternal complications and the perinatal mortality rate (Brennan et al., 2011; Dublin et al., 2000; Gulmezoglu, Crowther & Middleton, 2007; WHO, 2011) (see Tables 2.1 and 2.2). A Cochrane review by Gulmezoglu et al. (2007) identified the risks associated with induction of labour for multiparous women when their pregnancy is prolonged. The review found that prolonged pregnancy post-41 weeks was associated with an increased risk of perinatal death, leading the authors to recommend further research incorporating women’s views on performing induction at or beyond term. Other researchers have also argued that the safety of the birth varies according to the gestation of the foetus, and that the outcomes are unclear for women who are at early term gestation (Grivell et al., 2011). Grivell et al. (2011) conducted a cohort study using retrospective data from the South Australian state-wide perinatal database to investigate the outcomes of induction in women related to gestation from 37 weeks. The findings indicated that women have more complications when induced, including increased use of analgesia and epidural. They also have a higher risk of complications, including surgical birth, haemorrhage and third- and fourth-degree tears when induced for non-medical reasons. Grivell et al. (2011) concluded that an induction may be performed at 37–39 weeks due to a lower risk of morbidity in the mother. However, the risk of perinatal death increases with gestation, and complications in the neonate are at their lowest level between 38 and 39 weeks (Grivell et al., 2011). These researchers recommended further randomised controlled trials (RCTs) to identify the weekly difference in outcomes from 37 weeks’ gestation in women induced for non-medical reasons (Grivell et al., 2011). Jensen et al. (2013) similarly reported from the Mayo Clinic in the US that early term deliveries in women occurring between 37 and 39
weeks are associated with significant complications in the mother and the baby, including increased interventions for prolonged labour, vacuum, forceps, CS, post-partum haemorrhage and infection, and prolonged hospital stay. Additionally, Jensen et al. (2013) highlighted that the significant costs of non-medical induction for the neonate and health service are related to increased levels of intensive care admission in neonates for higher rates of hypoxia, cerebral complications, increased ventilator needs, chest infections and prolonged hospital stay. They reported further serious complications in the newborn for 37–38 weeks, deliveries as including cerebral palsy, with rates one to two times higher than that of babies born at 39–40 weeks’ gestation. Additionally, there is a high risk of readmission in these neonates, including high usage of emergency departments. The long-term effects of early term deliveries on the neonate include developmental delays and lower IQ scores (Jensen et al., 2013). Other complications were reported in women who are induced. Dublin et al. (2000) highlighted that birth injury is more common in women who are induced, with the most common injuries being scalp injury, clavicle fracture and brachial plexus injury. The fracture of the clavicle and brachial plexus injury related to the higher incidence of shoulder dystocia was more common in women who were induced (Dublin et al., 2000). Peddicord (2013) indicated that the babies of women who have an elective induction are at risk of jaundice, feeding problems, low blood sugar level and difficulties associated with temperature control.

Clearly, there are serious consequences related to induction for non-medical reasons in both the mother and the baby, thereby indicating an important need to educate women to ensure they understand the neonatal health care risks related to an elective induction. There are also costs to the health system. Currently, there are significant cost pressures on management structures within the health service to ensure
the cost-effective use of resources. In addition, costs accrue to the woman and her family as a result of having the baby in the neonatal intensive care unit following an induction. A contemporary view is that significant costs to the health service related to induction for non-medical reasons cannot be justified, as these monies could be better spent in other areas of health care. Table 2.1 outlines studies on the complications of induction of labour.
Table 2.1.

*Studies on the Complications of Induction of Labour*

<table>
<thead>
<tr>
<th>Author Year Country</th>
<th>Sample Characteristics</th>
<th>Design and Research Aim</th>
<th>Data Collection Approach and Analysis</th>
<th>Key Findings</th>
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</thead>
<tbody>
<tr>
<td>Brennan et al. (2011) Ireland</td>
<td>Group 1: Term nulliparous women Group 2: Pre-labour CS and induced nulliparous women National maternity hospital Dublin</td>
<td>Retrospective study of CS rates To investigate the level of CS in nulliparous women &gt; 37 weeks</td>
<td>CS rates in nulliparous women 1974–2008 Retrospective analysis 10-group classification system Pearson’s correlation coefficient Mantel-Haenszel SPSS 11</td>
<td>Correlation between the rise in induction rates in nulliparous women and a similar rise in CS rates Major variations in practice between institutions</td>
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<tr>
<td>Dublin et al. (2000) US</td>
<td>(n = 2,886) Induced labour (n = 9,648) Spontaneous labour 37–41 weeks’ gestation</td>
<td>Population-based cohort study to investigate the association between induction and outcomes in mothers and babies</td>
<td>Data from Washington State Birth certificates and linked hospital discharge data</td>
<td>Induction associated with interventions and shoulder dystocia If no medical indication for induction, associated with increased risk of CS</td>
</tr>
<tr>
<td>Ehrenthal et al. (2010) US</td>
<td>(n = 7,804) Nulliparous women with a live singleton birth at term</td>
<td>Retrospective cohort study of the association between induction and CS</td>
<td>Electronic obstetric records in large regional hospital Multivariate logistic regression analysis to explore risk factors and CS</td>
<td>Induction in nulliparous women is significantly related to a CS at term Reduction of an elective induction may reduce the rate of CS in women</td>
</tr>
<tr>
<td>Grivell et al. (2012) Australia</td>
<td>(n = 28,626) Women with spontaneous onset of labour,</td>
<td>Cohort study Maternal and neonatal outcomes</td>
<td>State-wide perinatal database (SA) Perinatal statistics</td>
<td>Elective induction for non-medical reasons associated with adverse outcomes and an increased rate of CS by up to 70% Higher epidural rates</td>
</tr>
<tr>
<td>Author</td>
<td>Year/Country</td>
<td>Sample Characteristics</td>
<td>Design and Research Aim</td>
<td>Data Collection Approach and Analysis</td>
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<td>Gulmezoglu et al. (2007)</td>
<td></td>
<td>induction for medical and non-medical reasons</td>
<td>Cochrane Systematic Review of interventions for induction of labour compared with normal labour and maternal/perinatal outcomes</td>
<td>19 RCTs Review manager software Chi-square</td>
</tr>
<tr>
<td>Jonsson et al. (2012) Sweden</td>
<td></td>
<td>(n = 7,973) Parous women No complications Singleton birth 37–41 weeks</td>
<td>Cohort study linking induction and CS in low-risk women</td>
<td>Local database containing antenatal and intra-partum data</td>
</tr>
<tr>
<td>McDonnell (2011) Australia</td>
<td></td>
<td>Women induced 2008–2010 KEMH</td>
<td>Retrospective review of indications and methods used to induce labour</td>
<td>Western Australian tertiary hospital data</td>
</tr>
<tr>
<td>Patterson (2011) Australia</td>
<td></td>
<td>(n = 212,389) Nulliparous women at 37–41 weeks</td>
<td>Retrospective study to determine outcomes by gestational age</td>
<td>Population birth data from NSW Midwives Data Collection 2001–2007 Frequency distributions Cochran–Armitage test SAS 9.1</td>
</tr>
<tr>
<td>Author</td>
<td>Sample Characteristics</td>
<td>Design and Research Aim</td>
<td>Data Collection Approach and Analysis</td>
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<td></td>
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<td></td>
<td>Descriptive statistics</td>
<td>Women with an unfavourable cervix were more likely to have a CS</td>
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<td></td>
<td></td>
<td></td>
<td>Multiple regression analysis</td>
<td>Multiparous women with a favourable cervix were more likely to have a vaginal birth</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>JMP</td>
<td>Increased length of stay and rising costs associated with an elective induction</td>
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</table>
2.3 Global Studies on Guidelines, Policies and Practice Reforms

International concerns relating to complications in the mother and the baby have led to worldwide policy and practice reforms and the development of guidelines to reduce the rate of induction in women. The WHO (2011) guidelines relating to the recommendations for induction of labour do not support the practice of induction at less than 41 weeks, except for medical reasons or for convenience. The reasons for the WHO’s (2011) view are that some women may request an induction for social reasons and inappropriately shorten their pregnancy. In the US, many policies and community-based programs have been introduced to address the rising rate of induction for non-medical reasons, including the following: the March of Dimes’ ‘Healthy Babies Are Worth the Wait’ hospital campaign (Gentry, 2014); the ‘Strong Start for Mothers and Newborns’ campaign, which advocates waiting for spontaneous labour (Peddicord, 2013); the ‘Wait for Labour to Start on Its Own’ community online pledge (Peddicord, 2013); the ‘Hard-stop’ policies and Medicaid reform (Jensen et al., 2013) and redefinition of ‘term pregnancy’ (ACOG, 2013).

A pilot strategy initiated by the American College of Obstetricians in Florida in (2007) and the March of Dimes group, called ‘Healthy Babies Are Worth the Wait’, has significantly reduced early induction rates for non-medical reasons from 27.8% to 4.8% (Gentry, 2014). Participating hospitals in Florida (n = 50) that conformed to the project’s requirements of reducing inductions to 5% in women < 39 weeks were given a banner of recognition that contains the logo ‘Healthy Babies Are Worth the Wait’. In 2012, the program was expanded further and became part of the Department of Health and Human Services’ ‘Strong Start for Mothers and Newborns’ campaign, which also aimed to reduce early inductions and improve outcomes for mothers and babies (Jensen et al., 2013). Another US community-based program aimed at preventing unnecessary
inductions in low-risk women used an online strategy developed by the AWHONN (Peddicord, 2013). The ‘Wait for Labour to Start on Its Own’ campaign encouraged healthy mothers to wait for healthy outcomes and normal onset of labour (Peddicord, 2013). Women, their health care providers, family members and friends were asked to sign an online pledge to support the campaign in the community. Women were encouraged to talk to their health professionals and their friends and relatives regarding the risks of an induction in order to prevent an unnecessary early induction. ‘Hard-stop’ policies in Texas, which included Medicaid reform, also led to a reduction in the induction rate for non-medical reasons because of a lack of reimbursement to medical practitioners for these inductions (Jensen et al., 2013). The program was adopted by South Carolina in 2013 and is currently being considered by other US states (Jensen et al., 2013). Insurers in the US are now considering further incentives for health services to avoid early inductions. The aim of this incentive strategy is cost savings, mainly related to a reduction in neonatal intensive care admissions (Jensen et al., 2013).

In Canada, the Clinical Practice Obstetrics Committee developed a clinical practice guideline on induction of labour to address the problem of early induction in women for non-medical reasons (Leduc, Biringer, Lee & Dy, 2013). The evidence base for these guidelines was a systematic review of the literature conducted by the above committees to ensure the following: appropriate timing and method of induction in women, and optimal maternal and perinatal outcomes. The review led to the recommendation that induction is not performed for the providers or women’s preference, convenience or for macrosomia. Physicians must also consider the relation of an unripe cervix for surgical intervention in nulliparous women, as nulliparous women who have an unripe cervix have a higher induction failure rate and a caesarean
section birth. Hence, women should be offered an induction between 41 and 42 weeks (Leduc et al., 2013).

In the UK, NICE’s internationally recognised induction guidelines support induction between 41 and 42 weeks (NICE, 2008, updated 2014). However, the institute recognises that women require social inductions under exceptional circumstances, such as for the convenience of both partners or when the woman has a partner in the armed forces who wants to attend the birth (NICE, 2008, updated 2014). The guidelines create ambiguity for health professionals by suggesting that they should support women’s decisions, whatever they might be. The decision to request an induction can therefore create a dilemma for women, as well as for those guiding the women in their decision. Health professionals should support women’s decisions, but the guidelines are clear that women’s health should not be placed at risk. This seemingly contradictory advice presents a dilemma for how midwives should deal with maternal requests for induction of labour when it is associated with a cascade of interventions and assisted birth, particularly at 37–40 weeks.

Despite the decline in the Australian induction rate to 26%, there has been ongoing concern relating to the continued high rates of induction in Australian states and territories. Differences in these induction rates have been identified by the AIHW’s (2013, p. 14) national core maternity indicators report, which proposes that the “differences in Australian rates may not readily be explained and may be due to policy decisions, availability of the clinical workforce and access to care”. The report gives no explanation related to the type of policy decisions or access to and availability of the clinical workforce, which may have influenced the induction rates. Australian Government Medicare and community reforms similar to those in other countries have
not occurred, despite recognition of the cost to the health service for over a decade related to early inductions and increased surgical interventions.

Strategies adopted in Australian states and territories to prevent an induction for non-medical reasons revolve around the promotion of education to women relating to normality in childbirth. The ‘Towards Normal Birth’ strategy in NSW aims to achieve an 80% normal birth rate (NSW Ministry of Health, 2011b). However, the NSW Ministry of Health (2015) indicated that an increase in vaginal birth among first-time mothers has not occurred, with a spontaneous birth rate of only 50.6%. In contrast, the CS rate of 27.3% and the reported rate of induction for all first-time mothers in NSW (39.5%) are quite high. Australian health professional bodies (Nursing & Midwifery Board Australia [NMBA], 2006, rebranded 2010; RANZCOG, 2016; ACM, 2014) provide practitioners with competency guidelines to ensure midwives receive guidance for decision-making relating to interventions during childbirth. A guide for midwifery decision-making stated that midwives should enable healthy outcomes in women, but also that decisions should be made according to women’s and babies’ needs (NMBA, 2007, rebranded 2013, p. 11). However, women’s decisions could conflict with safe birthing. The guidelines were unclear regarding what approach the midwife should take if the woman chooses an intervention during labour, as the midwife must consider the risks to the mother and the baby. Similar to the UK situation, the guidelines suggest that midwives should identify risks to protect the mothers; however, they should also support women’s choices in childbirth. National frameworks for midwifery competency recognise the importance of enabling woman to participate in decision-making related to childbirth. These frameworks include the National Competency Standards for Midwives (NMBA, 2006, rebranded 2010), which state that midwives should have effective communication skills to enable women to participate in decision-making.
Similarly, the ACM (2014) emphasised the woman’s responsibility to make an informed decision in childbirth. However, they do not assist the midwife in relation to women’s induction decisions, which are often complicated and difficult to make in clinical practice (www.midwives.org.au). The ambiguity arises when women perceive that there are social benefits related to having an induction for non-medical reasons, especially if they are unaware of the risks associated with an early induction of labour. In contrast, midwives must implement policy and procedures relating to induction decisions, but the decision is ultimately that of the GP obstetrician.

It is not surprising that there are high levels of surgical intervention in Australia, as the RANZCOG’s (2016, p. 6) guidelines emphasise a medicalised framework of risk prevention, highlighting the importance of ensuring that ‘women are given time to consider the risks and benefits of procedures, they understand the concept of risk management and that it underpins interventions’. In contrast, midwifery guidelines focus on the recognition of risk and the promotion of normal birth. It is expected that midwives support the women to consider the risks and benefits of an intervention, but also to consider the alternative options available. The RANZCOG (2016) guidelines advocate respect for women’s wishes if they decline an intervention, providing that they have considered the risks and benefits of the procedure. Local reforms focusing on women’s choices and decision-making relating to childbirth include the provision of information via websites. In WA, the DOH (2012) website, ‘Having a Baby in WA’, enables women to locate information relating to the available models of care, knowledge of WA maternity institutions, and to access the induction guidelines brochure, which have been unchanged since 2009. This online brochure (KEMH, 2009) states that women generally go into labour between 37 and 42 weeks. Therefore, they appear to enable women’s knowledge relating to the onset of normal labour and the
risks of an induction for medical reasons. However, there is no information on induction of labour for social reasons in the brochure for women (KEMH, 2009). Like the WHO, US and UK guidelines, the guidelines of the local tertiary hospital in WA (KEMH, 2015b) relating to prolonged pregnancy indicate that an induction should be completed for medical reasons at 41 weeks. Induction is offered to women at 41 weeks, as a prolonged pregnancy (42 weeks) is associated with high risks in both the mother and the baby, including a risk of stillbirth. The risk of stillbirth reported is relatively low at 40 weeks, but it doubles by 42 weeks’ gestation (2–3 deaths versus 4–7 deaths per 1,000 births); at 43 weeks, the stillbirth rate increases sixfold (KEMH, 2015b). KEMH’s tertiary guidelines have provided a benchmark for local guidelines at the regional hospital in the current study. In relation to the use of their policies and procedures by maternity units, the tertiary institution aims to minimise complications in both the mother and the baby, decrease the use of induction, and encourage normality in childbirth. However, it appears that the policy and practice reforms have not achieved the goal of lower induction rates in WA or other states within Australia. A possible reason for this policy reform failure may be related to the lack of financial disincentives and medicare reform, which were central to the reduction of induction rates in America (Jenson et al., 2013). It is important to investigate other possible influences on induction rates, as suggested by the AIHW (2013).

The AIHW (2013) raised the possibility that access to resources and trained staff affected induction rates within Australia, which differs considerably depending on the mother’s geographic location. A complex process relates to the interactions between the area of residence and women’s health outcomes (Hilder et al., 2014). Poorer health outcomes are often related to multiple factors, including a lack of education, employment, income and access to services (Hilder et al., 2014). Almost one-third of
the Australian population (30%) live in rural, remote or regional areas (Hilder et al., 2014). Hence, access may be a problem, particularly when there are financial constraints. However, as reported in 2014, 97% of Australian women gave birth in a hospital, while 2% gave birth in a birthing centre and only 0.49% birthed at home (Hilder et al., 2014). Consequently, access to care does not seem to be a problem, despite the distance to some maternity facilities. However, these rural women are more likely to attend a hospital for care with a condition that could have been prevented in the community (Hilder et al., 2014). It appears there is a lower threshold to attend for care at a hospital if a problem arises during pregnancy, particularly for those women who reside at a distance from the maternity hospital. Additionally, when clinical expertise is unavailable, there may be a lower threshold for a hospital transfer based on risk factors and distance to a tertiary facility; however, this does not appear to affect the induction rates (Hilder et al., 2014). As reported earlier, induction rates are the lowest in the ACT (22.2%) and the NT (23.6%), which is one of the remotest areas in Australia (AIHW, 2013). In WA, which has a higher rate of induction (29.1%), there are also differences in the induction rates between the smaller and larger hospitals, which are not explained by remoteness or the availability of resources or the workforce (Hutchinson, 2015). The tertiary referral facility of WA—where the clinical workforce is readily available and the women are both low and high risk—has one of the highest rates of induction in the state (33%). However, within the wheat belt, where resources are limited, the rate is the lowest at 16.9% (Hutchinson, 2015). In contrast, Geraldton (WA) has the highest rate at 41.3%, yet it has a regional facility (Hutchinson, 2015). These figures indicate a lack of certainty in the reasons for induction rate variance between states and territories in the AIHW’s report (Hilder et al., 2014). The differences in the rates between smaller and tertiary facilities may be related to risk management strategies. An explanation for the
induction rate in smaller hospitals may be provided by the differences in the social, cultural and contextual factors that affected women’s decision-making and induction of labour. These factors may contribute to the relatively high rates of induction in WA, where induction may have become a normal expectation among pregnant women. McAra-Couper, Jones and Smythe (2010) suggested that, as interventions become more normalised, women more readily seek them as relief from the discomforts and anxieties associated with pregnancy. Women who experience minor discomfort and anxiety may have the misperception that their pregnancies are abnormal; consequently, they may request an induction. As a result, their attending doctor (Doyle et al., 2012) may offer women with minor complaints an induction of labour.

Place of birth may be a further contextual factor contributing to high induction rates. Women who have private cover may be more privileged and have increased access to options, choices and participation in their decision-making related to their mode of birth. As a result, these women may choose to plan their birth and have an induction. Rates of intervention during childbirth were recently investigated by Dahlen et al. (2012), who conducted a large population-based descriptive study (n = 691,738) in low-risk women who were admitted to public versus private hospitals between 2000 and 2008. They found that even if a woman has no complications in pregnancy, she had more chance of a surgical birth than a normal birth within a private hospital. One-third of women admitted to public hospitals had a normal birth with no intervention, compared with only 15 out of 100 women admitted to private institutions. Dahlen et al. (2012) also highlighted the significant cost to the taxpayer of rising interventions in childbirth. Australian researchers in NSW found that interventions are more common in private institutions (Dahlen et al., 2012). The study also found that induction rates in women increased from 25.7% to 30.9% between 2000 and 2008 in private hospitals in
NSW, while they increased more slowly (15.7%–22.8%) over the same period in public hospitals. See Table 2.2 for a summary of guidelines and reforms. It appears that women who have private cover may have more choices, but they are disadvantaged within the private system in Australia because they are much less likely to have a normal birth. Hence, their place of birth and their level of involvement in decision-making relating to childbirth interventions becomes an important predictor of their birth outcome.
### Table 2.2.

**Guidelines and Policy and Practice Reforms Related to Inductions**

<table>
<thead>
<tr>
<th>Author</th>
<th>Type of Strategy</th>
<th>Title and Key Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACM (2014) Australia</td>
<td>National online guidelines for women <a href="http://www.midwives.org.uk">www.midwives.org.uk</a></td>
<td>‘Know Your Midwife: The Benefits of Continuity of Care’ Continuity of care increased chance of normal birth, being satisfied, positive experience at less cost to the health system</td>
</tr>
<tr>
<td>ACOG (2013) America</td>
<td>American Congress of Obstetricians and Gynaecologists committee on obstetric practice convened a working party to redefine ‘term’ pregnancy to reduce early induction of labour</td>
<td>Early term 37-38 weeks and 6 days Full term 39-40 weeks and 6 days Late term 41-41 weeks and 6 days Births are recommended between 39-41 as the lowest morbidity in the neonate</td>
</tr>
<tr>
<td>Birth Choices (2015) UK</td>
<td>Online guidelines for women <a href="http://www.birthchoices.co.uk">www.birthchoices.co.uk</a> professional/index.ht</td>
<td>Professional online information related to women’s birth choices, birth and intervention rates, and models of care</td>
</tr>
<tr>
<td>Doyle et al. (2012) US</td>
<td>Hard-stop policy</td>
<td>Quality improvement project led by the perinatal safety team on the use of an induction scheduling consent form to reduce elective deliveries at 39 weeks in 2009–2011; scheduling consent forms became physician-led</td>
</tr>
<tr>
<td>Frosch et al. (2011) US</td>
<td>Policy documents analysis</td>
<td>Scholarly review of policy reform related to maternity care shared decision-making; several US states have passed federal legislation to incorporate shared decision-making as a key component of improved health care provision Key organisations are developing decision support related to birth interventions sent to women’s via their health care insurance organisations</td>
</tr>
<tr>
<td>Author</td>
<td>Type of Strategy</td>
<td>Title and Key Points</td>
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<tr>
<td>Gentry (2014)</td>
<td>Hard-stop policies</td>
<td>‘Healthy Babies Are Worth the Wait’</td>
</tr>
<tr>
<td>US</td>
<td>March of the Dimes</td>
<td>Medicaid reform</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Reduced rate of early birth (&lt; 39 weeks) 27.8%–4.8% (n = 50 Florida hospitals)</td>
</tr>
<tr>
<td>Jensen et al. (2013)</td>
<td>Mayo Clinic College of Medicine</td>
<td>Professional development review of complications related to early term deliveries at the Mayo Clinic non-medically indicated induction in the early term period of 37–38 weeks associated with more complications for mothers and babies</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>WA</td>
<td><a href="http://www.kemh.health.wa.gov.au">www.kemh.health.wa.gov.au</a></td>
<td>Induction if overdue between 41 and 42 weeks or a medical condition that requires birth</td>
</tr>
<tr>
<td>KEMH (2012)</td>
<td>Online guidelines for women</td>
<td>‘My Baby is Overdue—What Now?’</td>
</tr>
<tr>
<td>WA</td>
<td></td>
<td>Continuation of pregnancies &gt; 41 weeks’ risk of adverse outcomes, perinatal mortality increased x2</td>
</tr>
<tr>
<td></td>
<td></td>
<td>A membrane sweep reduces the need for a formal induction offer &gt; 37 weeks</td>
</tr>
<tr>
<td>KEMH (2015b)</td>
<td>Online guidelines for women</td>
<td>Management of pregnancy beyond 40 weeks</td>
</tr>
<tr>
<td>WA</td>
<td></td>
<td>Induction should occur at 41 weeks because of the risk of stillbirth</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Low risk at 30 weeks; however, risk doubles by 42 weeks</td>
</tr>
<tr>
<td>Kirkham (2012)</td>
<td>Report on the International Conference on Human Rights</td>
<td>International Conference on Human Rights to discuss, debate, explore the woman’s right to choose and the circumstances and location of her birth</td>
</tr>
<tr>
<td>Hague</td>
<td></td>
<td>Women have the right to choose their place of birth in Europe</td>
</tr>
<tr>
<td>Leduc et al. (2013)</td>
<td>Literature review by the Maternal Fetal Medicine and Family Practice Advisory committee to develop evidence-based guidelines on induction</td>
<td>‘Induction of Labour’ guidelines</td>
</tr>
<tr>
<td>Canada</td>
<td></td>
<td>Inductions should be performed between 41 and 42 weeks, and inductions should not be performed for provider’s preference, convenience or macrosomia</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Induction in nulliparous women with an unfavourable cervix associated with a high CS</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Inductions can be reduced if an induction committee is implemented</td>
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<tr>
<td></td>
<td></td>
<td>Induction not considered for maternal request alone</td>
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<tr>
<td></td>
<td></td>
<td>Important to inform women that it is normal to go into labour up to 42 weeks</td>
</tr>
<tr>
<td>Author</td>
<td>Type of Strategy</td>
<td>Title and Key Points</td>
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</tr>
<tr>
<td>NICE (2013) UK</td>
<td>International guidelines</td>
<td>‘Caesarean Section’ Increased morbidity related to CS in women</td>
</tr>
<tr>
<td>NICE (2012) UK</td>
<td>International guidelines</td>
<td>‘Shared Decision Making’ Information should be evidence-based and communicated to women Women should actively participate in decision-making</td>
</tr>
<tr>
<td>NICE (2014) UK</td>
<td>Review of 2008 Induction of Labour guidelines with no change following a Review of high-quality studies related to information and decision-making and induction</td>
<td>‘Induction of Labour’ Elective induction at 37–40 weeks associated with a higher risk of assisted deliveries Induction not used for maternal request unless compelling circumstances</td>
</tr>
<tr>
<td>NMBA (2007; rebranded 2013) Australia</td>
<td>Australian professional frameworks, guidelines, reports</td>
<td>‘National Framework for the Development of Decision-making Tools for Nursing and Midwifery Practice’ Meet the women’s needs, but enhance health outcomes Activities based only on identification of risks and the implementation of strategies to avoid them</td>
</tr>
<tr>
<td>NMBA (2006, rebranded 2010) Australia</td>
<td>Standards for midwifery practice</td>
<td>‘National Competency Standards for Midwives’ Information to facilitate understanding for women’s decision-making during childbirth Respect women’s decisions Midwives must ensure safe and effective midwifery care within a professional and legal framework</td>
</tr>
<tr>
<td>Peddicord (2013) US</td>
<td>AWHONN online pledge strategy</td>
<td>‘Wait for Labour to Start On its Own’ Pregnant women, health care providers, families and friends are encouraged to sign the pledge and wait for normal labour rather than seek an induction; inductions only encouraged for medical reasons</td>
</tr>
<tr>
<td>Romano (2013) US</td>
<td>‘Maternity Shared Care Decision Making Initiative’ Launched by Informed Medical Decisions Foundation and Childbirth Connection</td>
<td>Summary of the ‘Maternity Care Shared Decision Making Initiative’ Shared decision-making a US goal for women</td>
</tr>
<tr>
<td>Author</td>
<td>Type of Strategy</td>
<td>Title and Key Points</td>
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</tbody>
</table>
Consider induction in low-risk women when exceptional circumstances; otherwise, between 41 and 42 weeks |
| RANZCOG (2016) Australia | RANZCOG Standards of maternity care | ‘Organisation of Maternity Care’  
Provision of choice for women and their families, important to ensure women understand the options, risks and benefits associated with interventions |
| Which ‘Birth Choices’ (2014) UK | Which consumer organisation partnership with ‘Birth Choices’ to develop a ‘Which Birth Choice’ project  
Online guidelines www.which.co.uk/birth-choice | ‘Which Birth Choice’ project  
Support for women to better understand maternity options in childbirth  
Women access maternity options during childbirth based on personal needs and choice of maternity unit |
Cochrane Systematic Review of 22 randomised trials evaluated the effect of inducing labour at 37–40 weeks versus 41 and 42 weeks  
Induction of labour at 41 weeks, if no complications, reduces perinatal deaths |
Table 2.3.

Summary of the Research Literature Related to Rates of Induction, Health Professional Guidelines, Policy and Practice Reforms

<table>
<thead>
<tr>
<th>Author, Year, Rates of Induction &amp; Guidelines</th>
<th>Sample Characteristics</th>
<th>Design and Research Aim</th>
<th>Data Collection Approach and Analysis</th>
<th>Key Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hilder et al. (2014) Australia</td>
<td>Australian mothers and babies 2012</td>
<td>Australian population study National perinatal epidemiology statistics</td>
<td>Midwives’ databases Register of births, deaths and marriages Hospital morbidity data Analysis of maternal and neonatal perinatal statistics</td>
<td>WA and SA highest rates of induction in Australia NT induction rates are the lowest</td>
</tr>
<tr>
<td>Dahlen et al. (2012) Australia NSW</td>
<td>(n = 691,738) Singleton baby 2000–2008</td>
<td>Intended place of birth Population-based descriptive study of NSW perinatal data</td>
<td>Contingency table comparing hospital type (private or public) Contingency table analysis</td>
<td>Induction, assisted and CS are highest in private hospitals Low-risk women have less chance of a normal birth in a private hospital Increases the cost to the health service</td>
</tr>
<tr>
<td>Fair &amp; Morrison (2011) US</td>
<td>(n = 31) Primiparous women 26–40 weeks’ gestation At six weeks postpartum</td>
<td>Grounded theory study of women’s perceptions of the strategies used by women and their health professional to enhance their control in childbirth</td>
<td>Interviews Women’s perspectives on their level of control during childbirth ATLAS Grounded theory</td>
<td>Experienced control in childbirth is a significant predictor of satisfaction in women Care from a midwife versus an obstetrician leads to increased control and satisfaction in women during childbirth</td>
</tr>
<tr>
<td>Hutchinson (2015)</td>
<td>WA Women who gave birth 2012</td>
<td>WA mothers and babies 2012 30th annual report of the WA Midwives Notification System</td>
<td>Midwives Notification System Epidemiology and perinatal statistics</td>
<td>WA births 2012 Spontaneous labour 50.1% Induction 29.1% No labour 20.8% A wide variation in induction rates across sites 16.9%–41.3%</td>
</tr>
<tr>
<td>Author, Year, Rates of Induction &amp; Guidelines</td>
<td>Sample Characteristics</td>
<td>Design and Research Aim</td>
<td>Data Collection Approach and Analysis</td>
<td>Key Findings</td>
</tr>
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<tr>
<td>Nilsson et al. (2012) Sweden</td>
<td>(n = 3) Pregnant women who attended for ultrasound at Swedish hospitals</td>
<td>A longitudinal population-based study of pregnant women to explore fear in childbirth and experience and mode of birth</td>
<td>Population-based data Risk ratios (95%) confidence intervals Multivariate logistic regression</td>
<td>Fear was associated with negative birth experiences up to one year after childbirth Important to discuss women’s previous experience antenatally</td>
</tr>
<tr>
<td>Thompson (2014) DOH Australia Northern Territory</td>
<td>Mothers and babies who birthed in the NT 2011</td>
<td>Population study Maternal and neonatal perinatal statistics</td>
<td>NT Midwives Collection data NT Perinatal Death Register NT perinatal epidemiology maternal and neonatal perinatal statistics</td>
<td>Indigenous women low induction rate (24%) High CS rate (32%) High spontaneous birth rate</td>
</tr>
<tr>
<td>Tracy &amp; Tracy (2003) Australia NSW</td>
<td>(n = 171,157) Women having a baby in NSW 1996–1997</td>
<td>Population study A cost formula model derived from population data</td>
<td>Population data regarding the quality and availability of maternity services</td>
<td>Low-risk women present a higher cost to the health system due to the high level of interventions; increase of 50%</td>
</tr>
</tbody>
</table>
2.4 Research into Women’s Roles in Childbirth Decision-making and Policy Developments

Many international researchers have investigated the woman’s role in decision-making and childbirth from the perspective of women’s informed choices (Goldberg, 2009; Goodall, McVittie & Magill, 2009; Soltani & Sandall, 2012). Numerous studies have also investigated women’s rights regarding decision-making and control of the decision-making relating to the mode of birth (DOHWA, 2009; Hadjigeorgiou, Kouta, Papastavrou, Papadopoulos & Mårtensson, 2012; Kirkham, 2012), and women’s rights related to intended place of birth (Dahlen et al., 2012; Frosch et al., 2011; Henderson, Hornbuckle & Doherty, 2007; Johnson, Stewart, Langdon, Kelly & Yong, 2005; Snowden, Martin, Jomeen & Martin, 2011; Tillett, 2009).

The topic of women’s ‘right to choose the circumstances and location of their birth’ (Kirkham, 2012, p. 26) and gain control of the decision-making relating to childbirth is gathering momentum, particularly in Europe. An international conference in the Netherlands (Kirkham, 2012, p.26) discussed and debated the ruling by the European Court of Human Rights (2010) relating to the woman’s right to choose the circumstances of her birth. However, the findings from this debate highlighted that women are limited to the choices that are made available for them by society and their level of autonomy in decision-making (Kirkham, 2012). Swedish researchers have investigated the women’s level of autonomy in decision-making during childbirth. Between 1997 and 2009, Hadjigeorgiou et al. (2012) conducted an integrated review of studies (n = 223) into women’s perceptions of their right to choose their place of birth. However, only a small number of papers met the criteria for inclusion (n = 21). To increase the generalisability of the findings, the researchers used concurrent analysis to evaluate a literature review and interview data. Researchers conduct concurrent analysis
evaluations according to the quality of the methodology rather than the methodological
type, and they treat similar data as equivalent. The study found that the women had a
perception of risk that was instilled by their medical practitioner. Consequently, the
researchers indicated that autonomy is the basis for women’s decision-making relating
to childbirth and birthplace choices. Other researchers in Sweden also emphasised that
women may readily give up their right to choices where there are complications in the
foetus and a perception of risk (Snowden et al., 2011). It appeared from these studies
that the women’s role in decision-making and autonomy was limited by a perception of
risk and the choice of birthplace.

Government policies that enable women’s choices and shared decision-making
between the woman and her health practitioner are also gathering momentum in the US
as a response to the high cost of childbirth interventions (Frosch et al., 2011). Childbirth
Connection in collaboration with the ‘Informed Medical Decisions Foundation’
developed a national ‘Maternity Care Shared Decision Making Initiative’ to ensure that
the goal of shared decision-making is reached by 2020 (Frosch et al., 2011; Romano,
2013). In the US, Goldberg (2009) reviewed the woman’s right to informed decision-
making in childbirth in a continuing education study module, suggesting that every
woman has the right to base her maternity decisions on accurate up-to-date information;
however, their informed consent varies and is limited (Goldberg, 2009). Further,
Goldberg (2009) reviewed the issues surrounding women’s informed decision-making
and indicated that women experience a breakdown between what they want and what
occurs due to the practitioners’ practices. Goldberg (2009) highlighted the breakdown in
the practitioners’ ability to provide information for women. Hence, this review finding
reinforced the need for women’s informed consent in childbirth (Goldberg, 2009).
Fair and Morrison’s (2011) study examined women’s perceptions related to practices during childbirth that maximise shared decision-making and control in women. The findings indicated that women who wanted to have shared decision-making and increased control should access social and health care practitioners to obtain information. Women participants reported that being prepared and having friends with them during the birth empowered them and increased their control of their birthing experience. Provider communication, support and respect related to the provision and sharing of information with women was emphasised. Australian women have also reported a lack of informed decision-making in childbirth. The ‘Having a Baby in Queensland’ retrospective survey of Queensland women five months after birth in 2010 found that women were not informed in relation to many interventions in childbirth. However, the survey response rate was relatively low (34.2%), which may have affected the findings (Thompson & Miller, 2014). The women indicated that their participation in childbirth decision-making varied, but the reasons for their decisions were not investigated. The researchers concluded that there is a need to involve women in decision-making (Thompson & Miller, 2014). In WA, there is also differential access to providers for women during childbirth. Practitioners in private practice do not always support women’s choices or offer women with a normal pregnancy the opportunity to choose midwifery-led care. Another issue affecting women’s choices concerns the DOHWA (2009) directive that women must attend childbirth facilities within their region, which further restricts their choice of where they will give birth. Birthing women cannot have access to midwifery-based care if the maternity institution in their region does not provide it. A lack of choice related to women’s access to midwifery-led care may therefore be an influencing factor related to their role in decision-making and induction of labour.
2.5 Known Influences on Women’s Induction Decision-making

The influences on women’s decision-making relating to an induction of labour are poorly understood. A paucity of literature exists related to low-risk women’s perceptions of their decision-making and induction of labour for non-medical reasons. One study in Scotland (Shetty, Burt, Rice & Templeton, 2005) and one study in New Zealand (Austin & Benn, 2006) were identified relating to women’s perceptions of induction, but both of these studies were completed more than one decade ago. More recently, two studies were conducted in the US relating to women’s perceptions (Moore & Low, 2012; Moore et al., 2014). However, no studies were reported in Australia relating to the topic of women’s perceptions of their decision-making and induction of labour.

More than one decade ago, a large comparative survey in Scotland was conducted to investigate women’s perceptions, expectations and satisfaction with induced labour versus spontaneous labour (Shetty et al., 2005). Questionnaires were used to elicit responses from women (n = 450) prior to induction and women labouring spontaneously. Postnatally, women who had been induced were also asked questions relating to their induction experience and labour process. They were not asked questions related to their decision-making and induction. Limited demographic information was obtained from the women relating to their education, employment, partner’s employment, gestation and whether they had previously been induced. The participants’ responses were also limited, as they were asked to tick the most appropriate response or answer yes or no to questions asked by the researchers. Moreover, further contextual, cultural and social factors were not investigated in the study. Health professionals were not asked to provide information to support the findings from the women. The findings indicated that women who were induced were less satisfied than women who had a
spontaneous labour. Additionally, one-third of these women were not satisfied with the information they received relating to induction, and they requested more information relating to the reasons for induction (Shetty et al., 2005).

The New Zealand researchers (Austin & Benn, 2006) used an interpretive approach in 2002–2003 to compare the perspectives of nulliparous women (n = 79) and their lead maternity carers (LMCs) (n = 74) (midwife, obstetrician and GP) on what influenced their decision-making relating to induction. This study formed part of a larger study that explored birth outcomes following an induction and the risk of CS in nulliparous (n = 157) women compared to women who had a spontaneous onset of labour (n = 347). Influences on the decision-making of the women and their LMC were only briefly examined, as the interviews were limited to 10 minutes in length prior to the women’s induction (Austin & Benn, 2006). Structured questionnaires with open-ended questions were utilised during 10-minute interviews to obtain data from the women (n = 79) and their LMC (n = 74) immediately prior to induction, during the procedure of cardiotography (CTG). Strategies may not have been utilised to ensure trustworthiness of the data, as there was no record of the interviews being taped to prevent loss of information. The women also may not have perceived that they could talk freely to the researcher in front of their LMC, so they may have withheld information. Additionally, the women may have been distracted due to having their baby’s heart rate recorded. Boyatzis’ thematic analysis of the data indicated that the perceived reasons for medical inductions were similar between the LMCs and the women. However, the perceived reasons for non-medical inductions were limited and varied among the women. Five of the 74 LMCs identified social reasons for choosing an induction. However, the women participants, who perceived that there were medical reasons for their induction, including post-maturity or a raised blood pressure, generally
did not acknowledge social reasons. It did not appear that social factors or cultural factors were adequately explored relating to women’s reasons for induction, possibly due to time constraints. Cultural factors may have been evident, as this group of nulliparous women from New Zealand and their LMCs tried to avoid an induction and promote a normal onset of labour. Two-thirds of these women and their LMCs had considered the use of other methods to enable a normal onset of labour, including membrane sweeping, sex and castor oil. Most of these women had been induced for being post-dates > 41 weeks. They appeared to accept an induction as a normal extension of pregnancy when they were post-dates. The women welcomed an end to their pregnancy and regaining control of the birth process to prevent risks. However, only 16 (20%) women in the study perceived that there was an increased risk of surgical intervention related to an induction, suggesting a lack of adequate knowledge relating to the procedure (Austin & Benn, 2006). In the interview, the women were also asked about the source of their information. Most women stated that an induction of labour was covered briefly in the childbirth classes by midwives, whereas others received information antenatally or just before induction of labour. As the LMCs’ opinions varied, the women may have been influenced by their LMC during the provision of information. The LMCs reported that early bookings of inductions occurred to ensure hospital capacity, but many of them advised the women to wait for labour or seek alternative natural methods to enable labour onset. The researcher asked LMCs how the women’s attitudes influenced their decision to carry out induction of labour. However, it appeared from the responses that women’s decision-making relating to induction was limited, as many women were informed by their LMC in early pregnancy that an induction would not be considered until 41 weeks (Austin & Benn, 2006).

Recommendations for change were used to inform health professionals, which included
a need to ensure that women could readily be booked for an induction on the day of
decision. Other strategies used by LMCs related to the promotion of natural evidence-
based methods to initiate labour, including changes to the information leaflet on
induction to promote cervical sweeps post-term and to ensure that the risks of an
induction were highlighted. An audit that was completed following the implementation
of the recommended changes indicated a significant reduction (7–10%) in the induction
rates in nulliparous women. The study indicated a need for clarity with regard to
information, adequate education provided for induction of labour, and a need for caution
when advocating induction for nulliparous women, as induction is related to increased
interventions (Austin & Benn, 2006). The limitations of the study were related to the
age of the study, the trustworthiness of the data and the use of women > 41 weeks,
which excluded women less than this gestation.

Moore and Low (2012) conducted a review of the literature to identify current
trends in scholarship related to influences on the practice of elective induction of labour
prior to 41 weeks, as an induction of labour is associated with increased intervention.
The findings revealed a small number of factors influencing women’s decision-making,
including women’s preference/convenience, pressure and influence, and external
influence. Pressure and influence emanated from the pressures exerted on the women by
childbirth educators, nurses and physicians (Moore & Low, 2012). Although educators
could prevent an unnecessary induction, the physicians’ attitudes towards induction
encouraged the women to choose an induction. The findings of the review indicated that
there was not an evidence base to support induction for the preference or convenience of
the health care provider. To identify the effect of campaigns and strategy reform on
early induction decisions, the researchers emphasised a need to determine which
inductions were medically indicated and which were not. Moore and Low (2012)
concluded from their review that it was important to explore the factors that influenced elective induction of labour, which led them to conduct a US study related to women’s decision-making and induction.

This subsequent study (Moore et al., 2014) used grounded theory to identify nulliparous women’s (n = 45) decisions, perceptions and experiences of induction of labour at 34–41 weeks of pregnancy. The researchers argued that the rise in the induction rate in the US related to women’s preferences and clinicians’ practices (Moore et al., 2014). Telephone interviews were conducted with the women six hours after the induction decision and four weeks’ post-birth to ensure information recall. The findings in the nulliparous participants’ pre-induction indicated that the following factors affected their decision-making: safety of the baby, relief of discomfort/anxiety, diminished risk and their trust in their clinician. Many of the women had requested an induction, and their physician readily agreed to it with minimal discussion or resistance. Half of the women’s physicians had advocated an induction to reduce risk factors. The majority of the women accepted the induction decision due to the risk factors in their pregnancy; however, many were unaware of the risks and the labour induction process. The post-birth findings related to the induction experience, with women reporting a lack of informed decision-making and that they trusted their clinician. However, they wanted opportunities to improve the induction experience. The women believed that their induction had been guided by a checklist, with limited information provided related to the procedure or risks. The study was beneficial because it highlighted the effect of the medical practitioner and the lack of informed decision-making in the women. The study focused on the health professionals’ effect on the women’s decision-making and risk management. Health professionals were not participants in the study, and minimal demographic data were collected on the participants. A telephone was used to collect
the data, but this method may have limited the information received, as cost is a factor when using a telephone, and there is a lack of visible body language. Additionally, the study did not address the potential social factors relating to an induction of labour, including the employment of the women’s partner and the availability of support for the women in their decision-making. Further limitations were that multiparous women were not included because the researchers implied that their previous experiences could influence their decisions relating to induction. Finally, as the study appeared to concentrate on the women’s decision-making with the medical practitioner, it did not appear to focus on what had made the nulliparous woman request an induction.

2.5.1 Effect of the health professional on women’s decision-making and risk management

Research evidence has supported the view that medical practitioners’ perspectives relating to induction may influence women’s decision-making (WHO, 2011). Researchers have also suggested that the obstetrician is the underlying cause for the rising rates of intervention in women (Malacrida & Boulton, 2014; Stevens & Miller, 2012; WHO, 2011). The WHO (2011) argued that health care professionals are completing inductions for risk management and convenience rather than encouraging women to go to term. In a recent qualitative study, Malacrida and Boulton (2014) expressed concerns regarding the erosion of women’s decision-making relating to interventions through increased medicalisation and rising rates of CS. Women’s choices, decision-making and expectations can be disabled through paternalism and the medicalisation of childbirth (Malacrida & Boulton, 2014). This study was part of a larger project to determine the culture of birthing. Semi-structured narrative interviews and a feminist framework were used to investigate Canadian women’s (n = 22) perspectives of their choices, expectations and experiences in childbirth (Malacrida &
Boulton, 2014). The researchers did not investigate women’s reasons for induction. Malacrida and Boulton (2014) argued that it was important to consider the contextual factors and social aspects of women’s lives to provide an understanding of their birthing expectations. The findings highlighted the tensions between women’s expectations and their birthing experiences. Many of the women had unmet childbirth expectations, and they were unable to participate in meaningful decisions related to their mode of birth due to a lack of information. They felt caught up in a cascade of interventions that led to a CS, leaving them feeling that they had lost control of their childbirth experience. Many of the women had previously expressed a desire to have a normal birth. The researchers emphasised a need to empower women to use information to challenge medical discourse (Malacrida & Boulton, 2014).

Goodall (2009) emphasised provider communication and the provision of information to increase informed choices and autonomy for women in Scotland who had previously had a CS. Goodall (2009) conducted a phenomenological study using semi-structured interviews on women’s (n = 10) perceptions of the influences on their decision-making and CS. Many women who had previously had a CS reported a lack of informed choices related to the mode of birth. The women perceived that they had a social advantage when having a planned CS, as they were able to plan their family commitments and time their birth. However, they also felt that they had little control over the mode of their birth. The researcher emphasised the importance of producing insights related to communication between women and health professionals (Goodall, 2009). A limitation of this study was the threat of bias. All women participants in the study were members of the National Childbirth Trust, which promotes normal childbirth. Consequently, all of the women would be more likely to advocate normal childbirth rather than support interventions for non-medical reasons. The findings also
suggested that health professionals could influence women to have a vaginal birth after a CS through positive interactions with women to support vaginal birth after a CS, perhaps in the same way that health professionals may be able to influence women not to have an unnecessary induction of labour.

A large experimental study (n = 595) in Queensland was used to identify the effect of the obstetrician’s discourse on the pregnant woman’s decision-making and induction (Stevens & Miller, 2012). To obtain women’s opinions, surveys were conducted that discussed a hypothetical scenario in which the obstetrician discusses the use of induction with a pregnant woman (Stevens & Miller, 2012). However, limitations were evident in the study, as the participants were not pregnant women. The findings indicated that women who had practitioners who supported an induction also accepted the procedure themselves. If the practitioners did not support an induction, then the women reported that their choices were limited. Further, they perceived that they could not express their preferences. Therefore, obstetricians could influence women through their discourse to not have an unnecessary induction. Similarly, midwives could influence women’s roles in induction decisions according to their practice area and perceived level of risk (Stevens & Miller, 2012).

The influence of perceived level of risk on intrapartum intervention rates has also been examined from the perspective of the midwife rather than the woman (Tillett, 2009). A large-scale retrospective analysis of the computerised records of healthy women (n = 9,887) led to the categorisation of maternity units in Holland as either low intervention units or higher intervention units. The findings indicated that midwives from low-risk units perceived less risk than midwives who worked in higher intervention units. Tillett (2009) emphasised the importance of understanding the dynamics of women’s decision-making during labour, highlighting that ‘social norms’
within birthing units can drive decision-making behaviour to the point where a surgical birth is routinely accepted by midwives. Hence, senior midwives can routinely accept interventions within a maternity unit and control women’s decisions, particularly where policies and protocols are rigidly adhered to. An example of such policies relates to women who want to have a social induction. Policies and protocols may form a barrier between the midwife and the woman’s desire to share decision-making. Tillett (2009) warned that conflict could occur between the midwife and the woman if the available choices are not acceptable to the woman. A power imbalance may then occur, where the midwife/nurse may assume that she has the most adequate knowledge to make the decision for the woman in labour.

Midwifery models of care lead to benefits for both the mother and the baby, including the promotion of a normal birth (ACM, 2014). Soltani and Sandall (2012) conducted a Cochrane systematic review of the literature in the UK in relation to choices and the mode of birth. The review indicated that there is a myth surrounding women’s choices. The researchers conducted a review of 11 trials of 12,276 women to compare midwifery models of care and the factors influencing maternity organisations. The researchers debated the women’s choice of mode of birth and the global trend of reducing normal birth. However, the review focused on the level of vaginal births and CSs rather than inductions. The findings indicated that midwifery-led care leads to reduced interventions and more control in women. Additional findings indicated that influences on women’s decision-making and CS varied according to the geographical location, the type of care provider, convenience, control and timing of the birth. For example, CS rates were higher in Latin American and Asian women. Soltani and Sandall (2012) advocated midwifery-led care and the normalisation of childbirth.
through communication and education to ensure informed choices and an increased level of autonomy for women.

Other large Australian studies have supported the view that the model of care may influence women’s induction decisions. Henderson et al. (2007) reviewed existing models of maternity care and the strength of the evidence that supports them. The main models include community-based midwifery programs, which include planned home births and birthing centres, and continuity of care models, which include team midwifery, caseload options and GP shared care. High-risk models were also examined, including tertiary models with integrated care, which provide community support for antenatal women, including home visiting programs and antenatal day units compared with traditional obstetric care in hospitals. However, there was no mention of women’s perceptions of the influences on their decision-making in the study. The researchers did not mention whether senior midwives could influence women’s decision-making relating to early induction of labour in traditional settings within the hospital. The models of care offered to women differ according to whether their pregnancy is normal or if they develop complications. However, the perception of risk perpetuated by their health care practitioner may increase women’s fears related to childbirth, which may lead them to request either an induction or CS.

2.5.2 Influence of fear on women’s induction and CS decision-making

An influence on women’s induction decision-making may be fears related to risks in childbirth. Fear and its effect on childbirth in subsequent pregnancies has been reported by researchers, predominantly in Scandinavian countries, and particularly relating to women’s request for a CS (Nilsson, Lundgren, Karlström & Hildingsson, 2012; Nordeng, Hansen, Garthus-Niegel & Eberland-Gran, 2012). A longitudinal population-based study in pregnant women (n = 1,984) was conducted in Sweden.
(Nordeng et al., 2012) to identify the associations between fear, medication use and mental health outcomes. An underpinning reason for conducting this study related to the researchers’ concerns regarding the increased number of CSs due to women’s childbirth-related anxiety in Oslo. In Oslo, childbirth anxiety affects 20% of women, and of these women, 5–10% require treatment within the Oslo maternity units. Data were collected via a survey of women participants having routine antenatal care at 17 and 32 weeks of pregnancy, and at eight weeks following birth. Various validated tools were used to identify the level of women’s fear (Wijma Delivery Expectancy questionnaire), anxiety (Hopkins symptoms checklist) and depression (Edinburgh postnatal assessment scale). The researchers acknowledged their limitations regarding these tools, which were not diagnostic. They proposed that clinical assessment is the gold standard for the diagnosis of mental illness. However, a good response rate revealed that the findings supported the view that fear in childbirth is often associated with the woman’s previous negative experience, and with taking psychotropic medications for anxiety (Nordeng et al., 2012).

Quispel, Schneider, Hoogendijk, Bonsel and Lambregtse-van den Berg (2015) used multiple assessment tools to conduct a validation study in the Netherlands to assess the effectiveness of tools utilised in the psychiatric assessment of mental illness in pregnant women (n = 330). Structured clinical interviews were conducted to obtain a psychiatric diagnosis in women (the gold standard for psychiatric assessment). All women completed a questionnaire (Mind2care screen and advice, which included the 10-item Edinburgh Depression Scale and short set item questions). Short triage included questions relating to the women’s previous hospital admissions for mental disorders and use of psychiatric drugs. The women also completed intermediate and comprehensive triage models. In the intermediate model, they completed seven triage items including
mental health questions related to: previous and current experience, previous professional psychiatric treatment, traumatic experience, depressed mood or panic attacks, current psychiatric symptoms, depressive or anxious symptoms, and fear in childbirth (Quispel et al., 2015). In the comprehensive model, 10 psychosocial stressors were added: unplanned pregnancy, insufficient social support, relational problems, financial debts, unstable housing, physical abuse, sexual abuse, alcohol abuse, drug abuse, and smoking. Multiple logistic regression was conducted to analyse these models. To diagnose mental illness, the findings indicated that a minimum of the intermediate items should be used in clinical practice. These findings were based on the level of mental illness in the women, which was identified using the short-item, intermediate or comprehensive models of assessment. The authors recommended that a brief comprehensive triage should also include three high-impact psychosocial stressors: drug and alcohol abuse, unwanted pregnancy, and physical or sexual abuse. These findings implied that the Edinburgh scale is not effective alone in diagnosing depression, anxiety and mental illness.

Nilsson et al. (2012) conducted a large population study in Sweden to explore fear during childbirth and the effect of previous experiences on childbirth fears. Women participants in three Swedish hospitals were recruited in the ultrasound department. Multivariate logistic regression identified factors related to fear in pregnancy and one year after birth. The findings indicated that women who have had perceived bad experiences in childbirth continue to have fear at one-year post-birth. Other factors associated with fear included nulliparity and a CS birth. Other researchers in Sweden have argued that a better experience in the subsequent birth will resolve fear. In Sweden, Hildingsson et al. (2011) argued that an elective CS is not the answer to women’s fear of childbirth; rather, a better birth experience is the answer. A
longitudinal regional survey (n = 697) in three hospital settings in Sweden was conducted by these researchers to investigate the factors associated with alleviating fear related to childbirth. Participants completed four questionnaires in mid and late pregnancy, two months after birth and at one year. They reported that fear in women could be reduced if women regained control and were well informed in their next birth experience.

Other international studies in the UK have highlighted for a decade that fear is the main reason for women choosing to have a CS (Weaver, Statham & Richards, 2007; Humphrey & Tucker, 2009). Women’s and obstetricians’ perceptions of the reasons for rising rates of non-medically indicated CSs were identified in a mixed methods study in the UK, and fear was found to be the main reason underpinning the decision for a CS (Weaver et al., 2007). Women participants (n = 64) were asked to record their comments related to their plans and expectations for birth in a diary. A second cohort of women (n = 44) who had considered alternative modes to a CS were interviewed using semi-structured interviews at six weeks post-birth. Consultants and registrars in the UK (n = 785) were asked to complete a survey relating to their perceived reasons for the rising rates of non-medically indicated CSs. Qualitative data were analysed using the ATLAS.ti package and coding. Quantitative data were analysed using SPSS (21). Data from both the women and the obstetricians indicated that a fear of risks to the baby underpinned the women’s decisions to request a CS.

Similarly, fear may also cause women to request an induction. A comparative analysis of women’s data from the Aberdeen maternity unit and neonatal databank was used to identify the socio-demographic and clinical factors that led to an induction of labour (Humphrey & Tucker, 2009). Retrospective data from women who had been induced (n = 5,727; 32.3%) were compared to women who had a spontaneous labour (n
The researchers used multivariate logistic regression modelling to identify 18 case mix factors indicative of an induction. The majority of case mix factors were related to recognised medical reasons for induction, including high blood pressure, preterm rupture of the membranes and a previous stillbirth. However, 28.5% of the reasons for women’s induction were unknown. The researchers argued that physicians’ variations in practice and women’s preferences could affect women’s induction decisions. A small number of socio-demographic factors identified the distance and time taken for travel to the hospital. Similarly, researchers reported that women in the UK actively seek interventions when they have fear related to risk, and they discuss anxiety as a contributing factor towards women requesting a CS (Nordeng et al., 2012; Humphrey & Tucker, 2009). Humphrey and Tucker (2009) also suggested that an induction of labour may lead to similar requests in women who are frightened of childbirth. However, they did not investigate other socio-cultural factors.

Australian researchers have also linked fear with women’s outcomes (Fenwick, Gamble, Nathan, Bayes & Hauck, 2009; Fenwick, Staff, Gamble, Creedy & Bayes, 2010; Nilsson et al., 2012). Pre- and post-partum fear and the link with women’s outcomes was investigated within a prospective correlational design in WA (Fenwick et al., 2009) using a cohort of women (n = 401) at 36 weeks of pregnancy at KEMH in Perth and postnatally at six weeks (n = 243) in 2005–2006. The study aimed to replicate previous studies in the UK (Johnston & Slade, 2002) and Sweden (Ryding et al., 1998). The findings indicated a higher perception of risk, and fear was associated with a higher level of CS in the women (Fenwick et al., 2009). Moreover, women who were Australian or from the UK reported more fear associated with childbirth than women in a comparison group from Sweden. A low response rate of 43% was a limiting factor of this study (Fenwick et al., 2009), which makes it difficult to assess the actual level of
fear within the cohort. Multiparous women experienced less fear than nulliparous women did in pregnancy. This factor is interesting given the rise in CS rates in nulliparous women.

Another explorative descriptive approach was used by Fenwick et al. (2010) to identify and describe Australian women’s reasons for their request for a CS in their first pregnancy when there were no medical reasons for a CS. Advertisements were placed in newspapers to recruit women participants from Queensland (n = 103) and WA (n = 107). The researchers used telephone questionnaires/interviews and thematic analysis to obtain and analyse the data. Questionnaires that were developed and used in two previous studies ensured analytic consistency. Taping of the telephone interviews prevented loss of data. The findings indicated that the women’s reasons for choosing a CS in their first pregnancy included a fear of childbirth and issues relating to safety and control. Consequently, the women did not choose the normal birth process. When women chose and requested a CS as their mode of birth, medical discourse supported their view that it was safer to have a CS. Hence, the researchers argued that strategies need to be developed to improve women’s confidence in their ability to have a vaginal birth.

WA implemented strategies to try to prevent CSs due to fear (Martin, Hauck, Fenwick, Butt & Wood, 2014). In 2008, a tertiary hospital in WA implemented a ‘Next Birth after Caesarean (NBAC)’ antenatal clinic service for women who had previously had a CS. One aim of this service was to inform women’s choices related to the mode of birth after a CS. Martin et al. (2014) used a comparative study design to evaluate the outcomes of women (n = 47) who attended NBAC service six weeks post-birth and those who attended the hospital facility (n = 45). The outcomes related to changes in childbirth fear, confidence, their desire to have a vaginal birth at 36 weeks’ gestation...
and their knowledge related to vaginal birth versus a CS. Qualitative comments were collected from women at this time. The researchers conducted data analysis using descriptive statistics, chi-square and t-test. Qualitative comments were analysed using content analysis. The findings indicated that the provision of evidence-based information relating to women’s care options following a CS could increase their knowledge and confidence related to a vaginal birth after a CS. However, there was no difference between the women’s high level of fear following a previous CS in either group or their birth outcome. From all of these research findings, it is clear that fear in pregnancy is associated with an increased risk of CS. Similarly, fear may also be associated with women’s request for an induction.

2.5.3 Effect of women’s expectations and experiences on their induction decision-making

Some researchers have indicated that women’s maternity care decision-making and choices regarding the mode of birth can also be influenced by expectations and experiences of maternity care (Green & Baston, 2007; Hauck, Fenwick, Downie & Butt, 2007; Henderson & Redshaw, 2013; Jenkins, Ford, Morris & Roberts, 2014; Moore et al., 2014; Murtagh & Folan, 2014). Other influences include the changing attitudes of women and their partner to interventions during childbirth (Fenwick, Bayes & Johansson, 2012; Gallagher, Bell, Waddell, Benoit & Cote, 2012; Haines, Rubertsson, Pallant & Hildingsson, 2012).

Hauck et al. (2007) conducted a study that addressed women’s expectations of childbirth and their perception of their birthing experience. In this qualitative study, the expectations of a small cohort (n = 31) of women from WA were investigated using an exploratory descriptive design that used in-depth interviews. The findings indicated that women who achieved their specific expectations experienced a positive birthing
experience. Multiparous women reported more positive birth experiences than primiparous women, as their expectations were influenced by their previous birth experiences. In contrast, primiparous women reported more unmet expectations, and women also adapted their expectations to avoid disappointment. The researchers highlighted the importance of midwives’ understanding of women’s expectation, as midwives can resolve unachieved expectations through the provision of support, which will lead to a more positive outcome. A qualitative Australian study conducted by Jenkins et al. (2014) investigated women’s expectations and experiences of maternity care. In this study, (n = 53) women were interviewed in a variety of NSW tertiary, rural regional and remote institutions. Descriptive analysis of the women’s responses found that women valued five aspects of maternity care: women-focused care, staff qualities, systems and facilities, family focused care, and continuity of care/information. The women’s preferences differed according to their area and parity. Rural women emphasised that maternity systems and facilities were important, whereas those in regional and tertiary areas reported that staff qualities were important to their childbirth experience. Similarly, primiparous women more than multiparous women highlighted that staff qualities were important, but they also preferred continuity of care models. The information collected did not include the effect of women’s preferences on the care and whether their expectations were met. The researchers did not investigate women’s perceived influences on their induction decision-making.

In Ireland, Murtagh and Folan (2014) investigated (n = 9) post-term women’s experiences relating to induction in a small phenomenological study. Interviews were analysed using Giorgi’s (1985) method of analysis. The findings relating to induction included negative descriptive accounts. The findings were useful because they indicated a need for quality information relating to induction. The women contended that more in-
depth information relating to the induction procedure would have helped them to feel more mentally prepared and have a more positive experience. Having a healthy baby was the most important aspect of the induction for these women (Murtagh & Folan, 2014). The researchers recommended that both written and verbal information is required to adequately inform women. The limitations of this study included the small sample size and the setting of Ireland. The findings are not transferable to other countries.

In the UK, a mixed methods study in 2009 investigated women’s experiences of an induction (Henderson & Redshaw, 2013). Participants (n = 10,000) were randomly selected from the UK national statistics database. A survey of women (n = 5,333; 50% response rate) was conducted to compare the experiences of women who had an induction (20%) with women who had not. Quantitative and qualitative data from the women’s questionnaires were analysed using quantitative and qualitative statistical packages, STATA (Statacorp LP, US) and NVIVO 9. The researchers maintained credibility through triangulation and two researchers coding themes independently. Increased inductions occurred in nulliparous women with long-term health problems or medical indications. Unmet expectations and dissatisfaction were associated with an induction. Women’s changing expectations and the effect on their perspectives of childbirth may have influenced their birth choices. Women’s changing attitudes and acceptance of surgical intervention in childbirth is not new. Some researchers believe that requests for interventions are increasing, while others believe they are declining. In the UK, a study by Green and Baston (2007) identified that a change in women’s attitudes had occurred between 1987 and 2000. However, this change was also related to the mode of birth and the use of forceps, vacuum or CS rather than an induction of
labour. Currently, women’s requests for a CS are increasing worldwide (Gallagher et al., 2012), which may be due to the changing attitudes of women and their partners. Changing attitudes may also have influenced women’s preferences for birth interventions and an increase in CSs in Australia (Haines et al., 2012). A comparative survey of the attitudes and beliefs of Australian (n = 123) and Swedish women (n = 386) reported an increase in women’s willingness to accept interventions, with Australian women much more likely to accept an intervention (CS) than Swedish women (Haines et al., 2012). The Australian women participants had a much higher level of CSs than the Swedish women. The researchers emphasised the effect of the cultural and social contexts on CS rates. A reason for this difference in attitude may be that Nordic countries have a strong midwifery tradition dating back to the eighteenth century, which has had a long-term moderating influence on birth intervention rates similar to the UK (Wagner, 2007). However, maternal requests for interventions were not documented in the Australian women, so it is unknown whether the midwifery tradition is, in fact, the most important moderating factor in Australia. Hence, research should investigate the contextual and cultural factors, as they shape women’s attitudes towards birth (Haines et al., 2012) and may influence the level of interventions in a group.

To investigate Australian fathers’ experiences and childbirth expectations, Fenwick et al. (2012) conducted a qualitative descriptive design using grounded theory. Study participants (n = 12) completed 1–2 interviews during pregnancy and one following birth, and diary entries were submitted by six fathers via email. The researcher used thematic analysis to analyse the data. The findings indicated that the fathers had perceived anxiety related to their wives’ pregnancy. They also reported that they felt ‘sidelined’ by health professionals antenatally and not included in the decision-
making. Hence, the partners contended that they were inadequately prepared and were unable to support their partner’s childbirth decisions. A limitation of this study was its small sample size. Consequently, further research is required in this area relating to fathers’ childbirth expectations. This study did not investigate the effect of fathers’ childbirth expectations on women’s induction decisions.

Some researchers have argued that women and their partners appear to choose induction for convenience to enable their partner to support them during childbirth (Gatward, Simpson, Woodhart & Stainton, 2009; McDonnell, 2011; McAra-Couper, 2010; WHO, 2011). A retrospective study was conducted by McDonnell (2011) to identify the reasons documented by health professionals in the birth register for induction in women attending a WA tertiary hospital between 2008 and 2010. The analysis indicated that elective inductions are increasing for convenience and social reasons. Interestingly, McDonnell (2011) suggested that the reasons documented by health professionals for these social inductions include a previous rapid labour, a lack of access related to trained staff when living in remote areas, which are a long distance from the KEMH, and having a FIFO partner. However, the findings are limited to the data collected from the women’s case notes, which were recorded from the health professionals’ perspective rather than the women’s perspective. Important factors that were based only on the researcher’s personal experience and view were also reported, including societal expectations surrounding women’s induction decisions, and the finding that women’s perceptions of induction vary between groups. Societal expectations relating to induction identified from McDonnell’s (2011) personal experiences included the differences in women’s perceived benefits and risks of an induction between groups. Women who lived in remote areas in WA chose an induction due to their distance from the maternity hospital. Another example provided by
McDonnell (2011) was related to women with a FIFO partner; these women chose an induction so their partner would not miss the birth, and because their partner had to return to work.

Gatward et al. (2010) also suggested that an induction may be provided for convenience, particularly when women are overdue and they consider pregnancy an inconvenience to both themselves and to others. In this qualitative study of primigravida (n = 23), all of whom were booked for an induction for post-date (41 weeks) pregnancy, the women were interviewed at the booking of an induction at 40 weeks, and then 24–48 hours post-induction at 41 weeks. Eighteen women required an induction, and the remaining five women went into spontaneous labour. The researchers reported that many of the women participants blamed their bodily functions for the need to have an induction (Gatward et al., 2010). The authors argued that women sense that their placenta does not function after a certain date, and they have the feeling that ‘time is up’ and then submit to the timing, policies and protocols of the health service. However, a large number of the participants reported that they had tried alternative methods of self-induction to go into spontaneous labour, including nipple stimulation, exercise, sex, raspberry leaf tea and castor oil. Hence, the women did not appear to accept an induction for the convenience of the health professionals, as proposed by Gatward et al. (2010).

Women’s choice of interventions in some societies is driven by their social and cultural values, including convenience, ease and control (McAra-Couper et al., 2010). Further, McAra-Couper et al. (2010) indicated that some societies, particularly the European middle class, advocate the use of pharmacological, surgical and technological interventions. Consequently, midwifery practice in these countries, as well as the women’s decisions related to childbirth, may be driven by societal norms.
2.6 Use of Decision Aids for Childbirth Education

Global interest has been gathering momentum in relation to the use of decision aids to enhance women’s choices during childbirth (Dugas et al., 2012; Raynes-Greenhow, Nassar, Torvaldsen, Trevena & Roberts, 2010; Simpson, Newman & Chirino, 2010; Stacey et al., 2014; Sheehan & Sherman, 2012; Vlemmix et al., 2012). Internationally and in Australia, decision aids provide information relating to the benefits, risks and alternatives to having an intervention in childbirth (Stacey et al., 2014). Only one international study (Simpson et al., 2010) has included a decision aid related to induction of labour, and there are no similar studies in Australia. Further research is required regarding the use of decision aids in women who have an early induction of labour for non-medical reasons.

Several international studies (Dugas et al., 2012; Stacey et al., 2014; Vlemmix et al., 2012) have shown that decision aids are effective in increasing knowledge related to health conditions. Dugas et al. (2012) conducted a European systematic review and meta-analysis of English and French research papers from 1994 to 2010 relating to decision-making aids/interventions for pregnancy and birth. Ten studies met the researchers’ inclusion criteria. Decision aids were utilised midwives for many conditions in pregnancy where decisional conflict may occur, including the breech mode of birth, mode of birth following CS, prenatal and genetic counselling. The study did not identify decision aids for women making induction decisions. A variety of decisional aid tools or interventions within these studies included discussion trees, computer-based programs, counselling, booklets and audio. The findings supported the use of decision aids such as computerised tools and group counselling interventions to significantly increase women’s knowledge and reduce anxiety and decisional conflict (Dugas et al., 2012).
An extensive international systematic review by Vlemmix et al. (2012) investigated the effectiveness of decision aids to improve choices for women. The researchers searched key databases to extract data, including the Cochrane Database (2011), MEDLINE (1953–2011), Embase (1980–2011) and PsychINFO (1806–2011), regarding the quality of RCTs and decision-making aids (Vlemmix et al., 2012). The researchers assessed data quality according to an RCT grade and decision aids based on the International Patient Decision Aid Standards (IPDAS) criteria (Vlemmix et al., 2012). The findings were similar to those of Dugas et al. (2012) and indicated that decision aids that are used to enhance women’s decision-making in pregnancy can increase women’s knowledge and reduce their anxiety and decisional regret (Vlemmix et al., 2012). The types of decision-making aids that were investigated were related to complex decisions in pregnancy, including prenatal testing, management of a breech presentation, mode of birth after CS and pain relief in labour. Decision aids utilised to aid women’s decision-making included booklets, interactive computer programs, audio guides and structured counselling. Vlemmix et al. (2012) argued that these aids are superior to information leaflets because they encourage and facilitate informed decision-making through the exploration of women’s preferences. Despite clear benefits to women related to the use of decision aids, their application is poor in practice (Vlemmix et al., 2012). Recommendations from this study included the need to provide advice on the barriers to the use of decision aids, and the uptake and implementation of decision aids in clinical practice. The researchers also indicated that decision aids in childbirth were not readily available on the Internet. They proposed that the lack of availability of decision aids on the Internet could be due to either a lack of support or resources (Vlemmix et al., 2012) for their implementation in clinical practice. A limitation of this
study was that it did not investigate the use of decision aids in women who make induction decisions.

More recently, a Cochrane data review used the IPDAS criteria to investigate decision aids among patients requiring health care on choices and decision processes (Stacey et al., 2014). One hundred and fifteen studies were included in the review of participants (n = 34,444). People with the following health care conditions were included: colorectal and prostatic cancer, ovarian and breast cancer. Only two studies were included relating to choices in childbirth, pain relief in labour and the management of a breech presentation. The findings were similar to those of Vlemmix et al. (2012) and Dugas et al. (2012) relating to decision aids and their provision of high-quality evidence that the women had improved knowledge relating to their options and reduced decisional conflict. However, moderate evidence indicated that people participated more actively in their decision-making. The researchers identified low-quality evidence relating to the relationship between patients’ values and their chosen options. The analysis indicated there was a correlation between good communication and the patients who were better informed. Stacey et al. (2014) also identified indications for the use of decision aids, including the use of decision-making aids when there was more than one treatment option, or where there were unclear health outcomes for patients; that is, if both options have risks and benefits. Stacey et al. (2014) identified increased participation in decision-making in women making pain relief decisions during labour, as well as decision-making related to the management of a breech presentation using decision aids. The findings from this study did not relate to women making induction decisions.

Other international studies have investigated the use of standardised decision aids in childbirth. Simpson et al. (2010) conducted an international mixed methods
study on a group of women (n = 1,349) at term in the US state of Missouri to explore the effect of a standardised educational tool on nulliparous women’s induction decision-making and reasons for having an elective induction of labour. Methods included the use of a standardised presentation, which included detailed information relating to the risks and benefits of an induction within antenatal education classes. The researchers used a structured survey to collect quantitative data, with a small number of open-ended questions used to collect qualitative data. Within these questions, only one open-ended question focused on the influences on women’s induction decision-making. This question asked, ‘What was the most influential factor in your decision’ to have an elective induction? (Simpson et al., 2010, p. 25). This question appeared to limit the participants’ responses to the most influential factor from the women’s perspective. The survey’s quantitative responses were analysed statistically using Pearson chi-square correlation statistics and t-tests. Qualitative data obtained from the survey relating to women’s perceptions of the main influences on their decision-making were analysed using thematic analysis. The findings indicated two main influences on women’s decision-making: the positive influence of education and their physician. Physicians’ attitudes towards induction were important to the women; those who had a physician who encouraged them to have an induction were more likely to accept the induction decision. Additional findings also indicated that the women valued the attendance of their provider for their birth (Simpson et al., 2010). The rate of elective induction in the women who had attended these classes declined by 20% following the implementation of this standardised program. In-depth information and insights relating to social aspects, and why women wanted to time their birth or give birth with their provider were not obtained. Moreover, the study was limited to nulliparous women who received childbirth education relating to induction via the standardised tool (Simpson et al.,
2010). Table 2.4 provides a synopsis of the literature on decision-making relating to childbirth.
Table 2.4.

Studies on Decision-making Relating to Childbirth

<table>
<thead>
<tr>
<th>Author, Year, Country</th>
<th>Sample Characteristics</th>
<th>Design and Research Aim</th>
<th>Data Collection Approach and Analysis</th>
<th>Key Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Austin &amp; Benn (2006)</td>
<td>(n = 79) nulliparous women New Zealand (n = 74) LMCs</td>
<td>Interpretive approach to investigate why nulliparous women were having an induction of labour</td>
<td>Interview Structured questionnaire December 2002 to April 2003 Prior to an induction Thematic analysis</td>
<td>Mainly medical reasons for induction post-dates 20% of the women induced at less than 41 weeks Social reasons identified by the carers, but not by the women Booking system influenced the timing of inductions</td>
</tr>
<tr>
<td>Dugas et al. (2012) UK</td>
<td>(n = 10) studies on pregnant women</td>
<td>Systematic review</td>
<td>Prevalence data Meta-analysis 1994–2010</td>
<td>All tools significantly increase women’s knowledge, except decision trees Key themes: preparation/information, communication</td>
</tr>
<tr>
<td>Fenwick et al. (2009) Australia and Sweden</td>
<td>Women (n = 401) at 36 weeks (n = 243) six weeks post-partum</td>
<td>Prospective correlational design to investigate pre- and post-partum levels of fear related to childbirth outcomes</td>
<td>Wijma delivery expectancy experience questionnaire Content analysis</td>
<td>Nulliparous women have more fear than multiparous women Fear higher in Australian women Results may be medically driven</td>
</tr>
<tr>
<td>Fenwick et al. (2010) Australia</td>
<td>(n = 14) pregnant women</td>
<td>Interpretive study to explore women’s experience of CS and decision-making</td>
<td>Telephone interview Queensland and WA Thematic analysis</td>
<td>Childbirth and fear Need to promote natural birth and confidence Women’s decision to have a CS supported by medical practitioners; women requested CS for non-medical reasons</td>
</tr>
<tr>
<td>Fenwick et al. (2012) Australia</td>
<td>(n = 12) Australian fathers</td>
<td>Qualitative descriptive design to explore men’s experiences of pregnancy and childbirth expectations</td>
<td>1–2 interviews during pregnancy and 1 after birth Diary entries (n = 6) Thematic analysis</td>
<td>Increased apprehension and anxiety antenatally Wellbeing of the father associated with maternal wellbeing and child development; hence, this finding of anxiety was important</td>
</tr>
<tr>
<td>Author, Year, Country</td>
<td>Sample Characteristics</td>
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<tr>
<td>Gallagher et al. (2012) Canada</td>
<td>(n = 140) nulliparous women</td>
<td>Survey Women’s requesting CS</td>
<td>Survey Descriptive statistics Bivariate analysis Regression analysis</td>
<td>Positive attitude to CS Normal birth perceived as painful Women may influence each other related to their decision-making Accurate documentation needed to highlight the incidence of maternal request for CS</td>
</tr>
<tr>
<td>Gatward et al. (2010)</td>
<td>(n = 23) primigravida women booked for induction 18 induced and five went into labour</td>
<td>Interpretive study to explore women’s experiences relating to being booked for an induction &gt; 41 weeks</td>
<td>Series of interviews Booking to post-birth Team review of transcriptions</td>
<td>‘Time’s up’ Lack of information Shift in expectations Concerns relating to the risks and induction</td>
</tr>
<tr>
<td>Goodall, McVittie &amp; Magill (2009) UK</td>
<td>(n = 10) pregnant women at 20–40 weeks with previous CS National Childbirth Trust members</td>
<td>Interpretive Phenomenological study of influences of the health professional on women’s mode of birth after CS</td>
<td>Structured interviews Thematic analysis</td>
<td>Key themes Women relinquish decision regarding next mode of birth following CS Lack of knowledge, choices related to decision-making</td>
</tr>
<tr>
<td>Green &amp; Baston (2007) UK</td>
<td>(n = 977) Women eight maternity services 2000</td>
<td>Prospective study of women’s willingness to accept interventions</td>
<td>Postal survey at 35–36 weeks and at six weeks post-partum Binary logistic regression</td>
<td>Increase in women’s acceptance of interventions since 1987 related to mode of birth</td>
</tr>
<tr>
<td>Hadjigeorgiou et al. (2012) UK</td>
<td>(n = 21) literature review</td>
<td>Critical synthesis of women’s concerns related to giving birth 1997–2009</td>
<td>Integrated literature review Research papers met the criteria in seven different countries Comparison table to summarise, synthesise and critically appraise studies</td>
<td>Autonomy the basis for women’s decision-making relating to choice of birth, midwifery model of care and birthplace choices</td>
</tr>
<tr>
<td>Author, Year, Country</td>
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<tr>
<td>Haines et al. (2012)</td>
<td>(n = 386) pregnant women in both countries</td>
<td>Exploratory study to investigate attitude and belief statements relating to birth</td>
<td>Questionnaire 2007–2009 Principal components analysis</td>
<td>Rate of CS in Australia twice as high as Sweden Australian women less likely to value normal birth or perceive they had a right to determine the mode of birth</td>
</tr>
<tr>
<td>Hauck et al. (2007)</td>
<td>Pregnant women (n = 20)</td>
<td>Qualitative study Exploratory descriptive design to investigate women’s perceptions of birthing experiences and expectations for future births</td>
<td>In-depth individual interviews Thematic analysis</td>
<td>Participation in decision-making increases control in women Feeling supported essential to women’s positive feelings in childbirth Unclear whether changing expectations linked to increased interventions needs further debate</td>
</tr>
<tr>
<td>Henderson et al. (2007)</td>
<td>Literature review Phase 1 retrospective (previous 12 months) birth experience compared with 5–6 months post</td>
<td>A review of evidence relating to models of maternity care Main aim to assist with the directions of maternity care in WA</td>
<td>Comprehensive search related to databases Quantitative research articles relating to the use of the following models: community-based midwifery; continuity of care; high-risk women; domiciliary care; antenatal stay units; telemedicine; home visiting following discharge</td>
<td>Substantial gaps in knowledge relating to models of midwifery care</td>
</tr>
<tr>
<td>Henderson &amp; Redshaw (2013)</td>
<td>(n = 5,333) women induced in 2009</td>
<td>Mixed methods study Women’s experience of induction compared to women who had a spontaneous birth</td>
<td>Survey Response rate 55% Thematic analysis</td>
<td>Nulliparity is associated with higher induction rates in women, particularly if they have long-term health problems Women who had an induction less satisfied with their care</td>
</tr>
<tr>
<td>Author, Year, Country</td>
<td>Sample Characteristics</td>
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<tr>
<td>Hildingsson et al. (2011) Sweden</td>
<td>(n = 697) convenience sample Mid and late pregnancy At 2 months and 1 year after birth</td>
<td>A longitudinal regional survey in three hospitals to determine the level of childbirth fear in women Investigate factors related to curing childbirth fear</td>
<td>Questionnaires t-test Summated rating scale Friedman test</td>
<td>A better childbirth experience was related to women cured of fear; these women were more likely to consider vaginal birth in the next pregnancy Significant increase in fear from mid pregnancy to one year following birth Need for women to be informed relating to labour</td>
</tr>
<tr>
<td>Humphrey &amp; Tucker (2009) Scotland</td>
<td>(n = 5,727) women induced versus (n = 12,009) women spontaneous labour</td>
<td>Comparative analysis of induced and spontaneous labours to identify the socio-demographic and clinical factors predictive of an induction of labour</td>
<td>Clinical data obtained from the Aberdeen maternity hospital and Neonatal Databank SPSS 13.1 Pearson chi-square and univariate logistic regression</td>
<td>18 case mix factors predictive of induction, including well-recognised medical reasons and the effect of travel time and distance to hospital</td>
</tr>
<tr>
<td>Jenkins et al. (2014) Australia</td>
<td>(n = 53) pregnant women in different locations</td>
<td>Qualitative study of women’s expectations and experiences of maternity care</td>
<td>Interviews in tertiary, regional rural, remote hospitals and midwifery-led practices 2011–2012 NSW Descriptive analysis</td>
<td>Different perspectives primiparous and multiparous, different stages of pregnancy, rural versus urban women</td>
</tr>
<tr>
<td>Johansson et al. (2014) Sweden</td>
<td>(n = 21) Men Partners CS</td>
<td>Qualitative descriptive study to explore fathers’ attitudes towards CS</td>
<td>Telephone interview Thematic analysis</td>
<td>Mode of birth unimportant; CS readily accepted Medical practitioner has clear responsibility for birth decision Lack of information related to decision-making</td>
</tr>
<tr>
<td>Johnson et al. (2005) NSW</td>
<td>(n = 976) PCMC (n = 2,839) (SHC)</td>
<td>Secondary analysis of data from the obstetric data system to compare partnership caseload midwifery care (PCMC) outcomes versus standardised</td>
<td>Perinatal statistics obtained from the NSW Midwives Data Collection SPSS</td>
<td>Supports the use of caseload midwifery in low-risk women, reduced interventions also in multiparous women including induction</td>
</tr>
<tr>
<td>Author, Year, Country</td>
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<tr>
<td>Malacrida &amp; Boulton (2013) Canada</td>
<td>(n = 22) postnatal women Urban and rural women Snowball sampling 24–40 years of age</td>
<td>hospital care and outcomes in women (SHC) Qualitative feminist theoretical framework to investigate women’s birth choices, expectations and experiences</td>
<td>Semi-structured interviews Thematic analysis</td>
<td>Majority wanted an intervention-free birth 50% CS Counter-assumption that women driving medicalisation Choice and technology shape the practice of health professionals and the public Social values correlated with the use of interventions (e.g., convenience, ease, control)</td>
</tr>
<tr>
<td>McAra-Couper et al. (2010) New Zealand</td>
<td>(n = 9) midwives and obstetricians (n = 33) members of the public European women</td>
<td>Hermeneutics methodology and critical interpretation To identify what shapes public understanding and the practice of health professionals relating to rising rates of intervention in childbirth</td>
<td>6 focus groups Critical interpretation</td>
<td>Midwives in high-risk units had a higher perception of risk Organisational culture also plays a significant role A need to investigate organisational culture and its effect on intervention rates</td>
</tr>
<tr>
<td>Martin, et al. (2014) Australia</td>
<td>(n = 47) women who attended the NBAC (n = 45) women who attended the main hospital clinic</td>
<td>A comparative descriptive study design Evaluation of next birth after CS (NBAC) antenatal clinic on women’s birth intention, fear outcomes, knowledge and confidence</td>
<td>Evaluated at three points: booking visit, 36 weeks and 6 weeks postnatal Descriptive statistics chi-square and t-test analysis and content analysis</td>
<td>Childbirth fears high for both groups Provision of information relating to birth options increases knowledge and confidence No difference in the birth outcomes</td>
</tr>
<tr>
<td>Moore et al. (2014) US</td>
<td>(n = 29) primiparous women 34–41 weeks</td>
<td>Grounded theory factors that influence induction from women’s perspectives Interview pre- and post-induction Constant comparison analysis</td>
<td>Factors of influence pre-induction: lack of information, safety of the baby, trust of medical practitioner, relief of discomfort, reduction of risk. Post-induction perceived influences: lack of information, induction part of a checklist, trust in clinician and acceptance of induction</td>
<td></td>
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<tr>
<td>Moore &amp; Low (2012)</td>
<td>(n = 49) women remainder from the perspective of the provider</td>
<td>An integrated review of current data relating to the factors that influence induction of labour</td>
<td>Prevalence data Clustering and identification of common themes</td>
<td>Only 4 articles evidenced-based Limited evidence related to factors influencing induction of labour Women’s and provider convenience not supported by evidence</td>
</tr>
<tr>
<td>Nordeng et al. (2012)</td>
<td>(n = 1,984) pregnant women Routine antenatal care</td>
<td>Survey Association between medicine use, fear of childbirth and mental health</td>
<td>Survey at 17, 32 weeks antenatally and 8 weeks’ post-partum 2008–2010 Fear measured using the Wijma Delivery questionnaire Hopkins symptoms checklist, Edinburgh postnatal depression scale</td>
<td>Fear of childbirth significantly associated with taking medications for mental health problems</td>
</tr>
<tr>
<td>Quispel et al. (2015)</td>
<td>Pregnant women (n = 330)</td>
<td>Validation study Five-item triage for psychiatric assessment in childbirth</td>
<td>Mind2 Care including the Edinburgh Assessment Scale Gold-standard psychiatric assessment Five-item triage Logistic regression</td>
<td>Need to utilise multiple assessment tools in pregnancy to identify mental health problems Use of the M2 Care tools plus three high-impact psychosocial factors effective</td>
</tr>
<tr>
<td>Schoorel et al. (2013)</td>
<td>Pilot 1 (n = 16) Pilot 2 (n = 9)</td>
<td>Pilot test of women’s decision aids post-CS</td>
<td>Interviews 2012 IPDAS criteria</td>
<td>Predictors for vaginal birth after CS Enhanced involvement of women in decision-making Suitable for European countries; may be adapted Cost and effectiveness to be examined in a controlled trial</td>
</tr>
<tr>
<td>Sheenhan and Sherman (2012)</td>
<td>(n = 28) studies inclusion criteria RCTs</td>
<td>Systematic review of evidence relating to computerised decision aids</td>
<td>1990–2010 Prevalence data</td>
<td>Similar outcomes between computerised decision aids and non-computerised decision aids Need for further research</td>
</tr>
<tr>
<td><strong>Author, Year, Country</strong></td>
<td><strong>Sample Characteristics</strong></td>
<td><strong>Design and Research Aim</strong></td>
<td><strong>Data Collection Approach and Analysis</strong></td>
<td><strong>Key Findings</strong></td>
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<td><strong>Australia</strong></td>
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<tr>
<td>Shetty et al. (2005)</td>
<td>(n = 450) women undergoing induction, (n = 450) women spontaneous labour</td>
<td>Comparison survey</td>
<td>2001–2002 Pre- and post-induction survey Post-birth survey in women spontaneous labour</td>
<td>Women who had an induction were less satisfied 1 in three women not satisfied with the induction information; they needed information in early pregnancy to be reinforced right the way through in the antenatal classes</td>
</tr>
<tr>
<td>Simpson et al. (2010)</td>
<td>(n = 1,349) nulliparous women</td>
<td>Survey</td>
<td>Survey</td>
<td>Classes aided women in their decision-making Results statistically significant p &lt; 0.00</td>
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<tr>
<td><strong>UK</strong></td>
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<tr>
<td>Snowden et al. (2011)</td>
<td>(n = 8) Pre-labour rupture of the membranes, Term gestation</td>
<td>Concurrent analysis</td>
<td>Interview NVivo 8 Concurrent analysis</td>
<td>Importance of facilitation of choice for women Women want to control their choices up to a point of risk, where they relinquish their control for safety</td>
</tr>
<tr>
<td>Soltani &amp; Sandall (2012)</td>
<td>11 trials (n = 12,276) women</td>
<td>Cochrane systematic review midwifery-led care versus other models</td>
<td>RCTs</td>
<td>Rising CS rate in middle-income countries, twice as high in private hospitals Benefits of midwife-led care related to fewer interventions and morbidity in women and babies</td>
</tr>
<tr>
<td>Stacey et al. (2014)</td>
<td>(n = 34,444)</td>
<td>Systematic review related to decision aids versus usual options for people facing screening decisions</td>
<td>RCTs 2009–2012 Two authors reviewed data based on the IPDAS</td>
<td>High-quality evidence-based decision aids improve choices and knowledge and reduce decisional conflict in women Moderate evidence related to improved active role in decision-making</td>
</tr>
<tr>
<td><strong>Author, Year, Country</strong></td>
<td><strong>Sample Characteristics</strong></td>
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<tr>
<td>Stevens &amp; Miller (2012) Scotland</td>
<td>(n = 595) women Convenience sample &gt; 37 weeks</td>
<td>Experimental hypothetical scenarios: obstetrician discusses induction of labour with the woman and preferences for labour and birth</td>
<td>Online recruitment and questionnaire Aberdeen via email 2001–2002</td>
<td>Discourse with the health practitioner can influence the woman in favour of interventions</td>
</tr>
<tr>
<td>Thompson &amp; Miller (2014) Australia</td>
<td>(n = 3,542) women who completed the extended ‘Having a Baby in Queensland’ survey 2010</td>
<td>Survey to examine decision-making processes and the level of consumer involvement related to nine pregnancy, labour and birth procedures</td>
<td>Questionnaire related to receipt of information and the woman’s role in the decision-making Coding</td>
<td>Women are not aware of the benefits or risks relating to childbirth interventions Urgent need to facilitate information to women relating to procedures A need to develop decision aids that enable this process</td>
</tr>
<tr>
<td>Tillett (2009) US</td>
<td>Retrospective study of birthing women</td>
<td>An expert opinion (clinical professor) relating to elective induction prior to 39 weeks; decision-making by women during the process of labour</td>
<td>Prevalence data</td>
<td>Decisional conflict may arise when choices are not clear Social norms of the community or maternity unit are difficult to change Culture change starts with education Labour and birth nurses central to that change</td>
</tr>
<tr>
<td>Vlemmix et al. (2012) Netherlands and Australia</td>
<td>(n = 10) RCTs</td>
<td>Systematic review to investigate the effectiveness of decision aids to inform women</td>
<td>1806–2011 RCTs Review of decision aids according to IPDAS criteria</td>
<td>Decision aids significantly increased knowledge Need to identify the barriers and facilitators of decision aids</td>
</tr>
<tr>
<td>Author, Year, Country</td>
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<tr>
<td>Weaver et al. (2007)</td>
<td>(n = 44) postnatal women</td>
<td>Qualitative study to investigate choice and decision-making in CS</td>
<td>Questionnaire and interview ATLAS.ti Coding and thematic analysis SPSS (21)</td>
<td>Difficulty related to women’s expression of fear related to vaginal birth Medical discourse encouraged a CS</td>
</tr>
</tbody>
</table>
2.7 Summary of the Literature

Worldwide induction trends indicate that the rate of induction for social reasons is rising. However, internationally, the reasons why women have an induction of labour are poorly understood. Additionally, reported rates of induction may not be reliable, as many are performed for unknown reasons. It is also clear that international researchers are particularly concerned with the rising rates of induction in nulliparous women. A number of projects have been implemented in the US that have considerably reduced the rate of induction in women, including the ‘Healthy Babies Are Worth the Wait’ campaign, community based strategies, ‘Hard-stop’ policies and Medicaid reform and the Maternity Care Shared Decision Making Initiative. Hospital-based incentives were introduced in Florida to encourage practitioners to reduce their unnecessary inductions and the induction rate down to 5%. Hospitals in Florida that achieved this 5% induction target could use the logo ‘Healthy babies are worth the wait’. Additional online community based strategies in the US involved women, their practitioners, family and friends signing an online pledge to support women to have a natural birth and avoid induction. Key American strategies included the introduction of financial disincentives through Medicaid reform in Texas and South Carolina and redefinition of the word ‘term pregnancy’ (ACOG, 2013); medical practitioners were not reimbursed for unnecessary inductions in low risk women.

Similar ‘Hard-stop’ government reforms have not been implemented in Australia. However, it is evident that the high induction rate in WA is of concern to health professionals. Additionally, the rate of induction in nulliparous women is also rising. Place of birth appears to be a predictor of induction rates in Australia, as induction rates vary between public and private institutions. In private institutions, the
incidence of normal birth is reduced, and the woman is more likely to have a surgical birth.

In Australia, professional bodies to reduce the high rates of induction have implemented practice guidelines and decision-making frameworks. Professional guidelines and protocols guide practitioners regarding induction for medical reasons (RANZCOG, 2016), but they promote a framework and expectation of risk in childbirth for medical practitioners. Additionally, decision-making guidelines (NMBA, 2007 rebranded 2013) for midwives are unclear. Midwives appear to be conflicted between meeting women’s needs and enabling their choices, particularly if the woman chooses an induction for non-medical reasons. Currently, there are no guidelines to guide practitioners if the woman chooses induction of labour for non-medical reasons. Inadequate guidelines may have contributed to the current induction rates in Australia. Induction rates have fallen slightly; however, they are still higher than worldwide rates. In WA, induction rates are the second highest in Australia. It is imperative that the influences on women’s decision-making are examined to avoid increased morbidity and mortality in mothers and babies.

Where there are increased levels of interventions, there are costs to both the mother and the baby. The literature demonstrates that social induction is associated with major risks and a cascade of interventions, including an increased rate of epidural analgesia, assisted deliveries, increased hospital stay, increased morbidity relating to perineal trauma and increased blood loss in women. Induction in women for non-medical reasons also leads to complications. The neonate is at risk of having a higher incidence of scalp injury, fractured clavicle, brachial plexus injury and shoulder dystocia. Limited information exists on this topic, and although there is clear evidence related to medical reasons for induction, the reasons for social induction are largely
unknown. A review of the literature has identified major gaps relating to what is known about women’s perceptions of the influences on their decision-making regarding induction.

It is also clear that social, cultural and contextual factors need to be investigated. The family perspective on decision-making has been addressed in men having medical procedures, men who have wives who have had a CS and fears related to childbirth; however, it has not been examined in relation to decision-making and induction of labour. Recommendations propose that midwives/nurses should assess informal information sources and the effect of spouses, peers and family members on decision-making. Fear and anxiety within these studies was a reason for women’s induction decision-making. The literature review has identified that the organisational culture, including carers and models of care, needs to be investigated within this study, as it may influence women’s decision-making. New data are also required in relation to the required support, setting and timing of the provision of educational information for women who choose induction of labour for non-medical reasons.
Chapter 3: Methodology

This chapter provides an explanation and rationale for the study’s methodology, design features and the research framework. An explanation for the use of a naturalistic interpretive paradigm is included, with a discussion on the use of a qualitative case study method and the feminist theoretical underpinnings used to guide the study. Finally, design features and methods related to ethical considerations, the processes of sampling, data collection, analysis and steps taken to ensure rigour are explained.

3.1 Research Design

The purpose of this study was to investigate the question ‘What are low-risk women’s perceptions of the influences that affect their decision-making regarding induction of labour?’ The researcher sought a woman-centred focus to explore and describe the women’s perspectives of their induction decision-making. As the researcher aimed to investigate this question from the perspective of the women themselves, as well as a group of midwives employed within the same maternity unit, it was appropriate to conduct the study within the naturalistic, interpretive paradigm using a qualitative case study method underpinned by a theoretical framework of feminism. A summary of this research framework is provided in Figure 3.1.
Figure 3.1. Research framework for the study investigating low-risk women's perceptions of their decision-making for induction of labour.
3.2 Research Paradigm

Crotty (2013) proposed that a research paradigm is a set of beliefs relating to science and scientific knowledge ‘a way of looking at the world and making sense of it’. A number of researchers have defined a paradigm as a worldview or theoretical lens that guides inquiry (Richardson-Tench, Taylor, Kermode & Roberts, 2011). There are multiple paradigms used by researchers in all disciplines to guide their studies. In nursing and midwifery, the two main paradigms used by researchers are positivism and naturalism/interpretivism (Polit & Beck, 2010).

In this study, the naturalistic/interpretive paradigm was chosen because it allows the researcher to sharpen the focus of inquiry on the phenomenon of interest (Polit & Beck, 2010; Richardson-Tench et al., 2011) through the interpretation of ‘how people see the world’ (Langford & Young, 2013, p. 57). Data are analysed using an inductive approach, moving from participants’ explanations of their worldview to a better understanding of their multiple ways of knowing and constructing realities (epistemology) rather than identifying one truth or reality (ontology) (Hardy, 2011; Langford & Young, 2013). Researchers have proposed that people’s realities are complicated, as ‘the way people see the world’ is related to the context (Lincoln & Guba, 1985). Thus, when using a naturalistic paradigm, the researcher interacts closely with the participants in the context of their lives to obtain a ‘whole picture’ related to the phenomenon of interest (Polit & Beck, 2010; Borbasi & Jackson, 2012). Interaction between the researcher and the researched generates an understanding where knowledge is co-constructed in the process of observation and interpretation (Schneider et al., 2013). Data collection methods include interviews, the use of archival documents and direct observations. During the data collection, the close engagement of the researcher with participants allows the researcher to be open to various perspectives as meanings
are shared through dialogue between the researcher and the researched (Schneider et al., 2013). Analysis of the research data involves the interpretation of meanings through inductive reasoning and synthesis by the researcher, who explains the relationships between the emerging concepts (Schneider et al., 2013). During this process, the researcher compares and contrasts the emerging concepts to existing knowledge in order to refine the knowledge and elicit new meanings (Schneider et al., 2013). The emerging knowledge obtained from this relationship between the researcher and the participants is subjective, as the data are based on the participants’ experiences, and multiple realities as expressed in the context of the research situation (Lincoln & Guba, 1985; Polit & Beck, 2010). The research design is flexible, enabling the researcher to collect and analyse the data concurrently (Polit & Beck, 2010). Emergent insights may then generate further questions during the data collection and analysis, thereby creating greater depth and breadth of understanding.

3.3 Case Study Method

Case studies focus on decision-making related to ‘individuals, organisations, processes, programs and institutions’ (Yin, 2014, p.4). Consequently, researchers choose case studies when they need to understand a complex, social phenomenon (Yin, 2014). A case study approach enables the researcher to conduct an inquiry into a single live case within a specific context using a variety of sources of evidence (McGloin, 2008; Schneider et al., 2013; Yin, 2014).

There are three different types of case study: intrinsic, collective and instrumental (Stake, 2009). Researchers who have a genuine interest in the case and want to enhance their understanding of the case use intrinsic case studies. They use collective or multiple case studies when they want to establish differences across the cases. Multiple case studies can be completed in different settings (Baxter & Jack,
2008). Instrumental case studies are useful to understand a phenomenon rather than the case itself, to develop insights into the phenomenon through the examination of contextual factors, and to generate and refine a theory (Stake, 2009). The researcher did not just seek to study the case for its own sake, but intended to examine the implications of the influences on low-risk women’s decision-making and induction of labour for the purpose of guiding women and health professionals. There was also no intention to examine collective cases, so a multiple case study design was not suitable. However, there were two components of the case: a cohort of women having inductions, and a group of midwives with experience of inductions within the same setting. The study was therefore a single, instrumental case study of induction of labour in low-risk women, with two ‘mini nested cases’: the women’s and midwives’ perspectives.

Case studies are popular with many disciplines, including medicine, education, psychology, law, political science, sociology and anthropology (Leedy & Ormrod, 2013). Health professionals who want to describe an intervention in the context in which it occurs (Anthony & Jack, 2009; Baxter & Jack, 2008; Borbasi & Jackson, 2012; Brophy, 2008; Sandelowski, 2011; Yin, 2014) use the case study approach. An extensive search of the literature did not reveal any case studies related to the influences on women’s induction decision-making. In midwifery, researchers have mainly used case studies in a variety of ways to explore phenomena relating to midwifery education and research (Casey, 2011; Frazer, Avis, Mallik, 2011; Hauck, Lewis, Bayes & Keyes, 2015; Kain, Hepworth, Bogossian & McTaggart 2014; Luyben, Wijnen, Oblasser, Perrenoud & Gross, 2013; Marshall, 2012; ).

To explore the collaboration between universities and five hospitals in Ireland Casey (2011) conducted an action research case study. Four phases were used within this action research case study, archival documents, grounded theory, clinical inquiry
and cooperative inquiry. In this research paper, Casey (2011) discussed co-operative inquiry. Co-operative inquiry involves action research with participants not on them. Collaborative partners within the participant group included hospital tutors (n=4), service managers (n=2) and representatives from the university, which included the researcher (n=3). Narratives and tape recordings were used for data collection. Thematic analysis included reflective action cycles. Engagement of the group related to the collaborative arrangements between the institutions included planning, taking action, evaluation of that action then further action. Findings highlighted that collaborative arrangements should be based on a framework to “engage the support of clinical and academic participants”, as key elements of this framework were related to the following: “context, environment, process, skills, outcomes and the role of the coordinator” (Casey, 2011, p.304).

A three-phase design conducted by Frazer et al. (2011) included a case study to evaluate the effect of midwifery educators on pre-registration outcomes. This design included both quantitative and qualitative elements, the first phase was a UK wide online survey of lead midwifery educators (n=51, 93%), midwifery educators (n=228, 50%) and local supervisors of midwives (n=14, 88%). The second phase involved a case study in six universities across four countries in the UK. Data was collected from both lead midwife educators within interviews, midwifery educators via activity analysis, senior student midwives from both the three year and shortened course midwifery programmes within questionnaires and focus group interviews. A limitation of this study may be related to the response rates, which varied between participants. The midwifery educator’s activity analysis (n=37, 64%) and the focus group interviews (n=27, 54%), were not as well attended, as the lead midwifery educator interviews (n=6, 100%). Responses to the questionnaires (n=111, 78%) and focus groups (n=94, 68%) in
the three year programme midwifery students were good. Responses to the questionnaires were also good in the shortened programme midwifery students (n=54, 76%). Yet attendance of the focus group by the shortened midwifery students was poor (n=23, 32%). The third phase of this study involved the data collection from the diaries of newly qualified midwives from both the three year programme (n=28, 52%) and the shortened midwifery programme (n=7, 38%). Findings indicated that two key factors are essential to midwifery teachers including being visible and credibility. A team approach was also considered essential to the effective delivery of midwifery programmes.

A case study using a qualitative and quantitative methods was used by Marshall (2012) in an exploratory evaluation of the development of work-based education in midwifery practice. Participants included midwives who completed a work-based training module (n=12), their managers (n=12) and health professionals (n=28) within six UK based maternity hospitals (Marshall, 2012). Quantitative data collection included the use questionnaires, survey, midwives and their clinical supervisors completed the questionnaires and midwifery managers were asked to complete a survey six months after the midwives had completed their work-based education. Focus group interviews were used to collect the qualitative data from the health professionals who had worked with the midwives completing the project. Qualitative data was analysed using computer-assisted software (NVIVO) and content analysis. Quantitative data was manually analysed to reveal descriptive statistics. Findings indicated that there were benefits for midwives, their managers and other health professionals relating to work-based learning modules. This type of work-based teaching led to personal and professional development of the midwife and enhanced multi-professional collaboration between the university and the six hospital institutions.
A number of researchers have also used a case study approach to explore phenomena related to midwifery research including Hauck et al. (2015), Kain et al. (2014) and Luyben et al. (2013). Hauck et al. (2015) used a case study approach to explore research capacity building within a WA Graduate Research Intern Programme. A survey tool, which included four open ended questions was used by Hauck et al. (2015) to obtain feedback from a small number of participants (n=6, 60%) relating to their graduate research experience. Additionally all outcomes were collated from the research projects that the students had been actively involved in to evaluate the Graduate Research Intern Programme. Analysis was conducted by researchers using Clark and Braun’s six step analysis. The six steps within the analysis include “familiarisation with the data, initial coding generation, searching for themes based on the initial coding, review of themes, theme definition and labelling and report writing” Hauck et al. (2015, p.261). Limitations of this study were related to the small number of participants and the absence of member checking, as coding had been completed independently. However, further discussion with the team of data relating to the initial survey questions did occur. Findings were positive. The researchers indicated that midwifery students had improved their knowledge and insight related to the research process. Output from the Graduate Research Intern Programme was also beneficial as a number of projects had been completed and nine articles had been published relating to the programme. Similarly Kain et al (2014) used a case study to evaluate an inaugural Summer Research Scholarship Programme (SRSP), which was offered to undergraduates between November 2009-February 2010. A survey tool, which included nine open ended questions was used to collect data from a small number of undergraduate students (n=6) and faculty members (n=4) in the School of Nursing and Midwifery SRSP. Data was analysed using content analysis, but no details of the
process of content analysis was described by Kain et al. (2014). Outcomes from this programme were positive. Four main themes included the “acquisition of research skills including the use of data collection and analysis, clear expectations, academic engagement and continued interest in research” (Kain et al. 2014, p. 221). Findings also indicated that this was a valuable programme, which would lead to longer-term outcomes.

A collective case study, which included four narrative cases bounded within four countries Germany, Austria, Switzerland and the Netherlands was used by Luyben et al. (2013) to explore ‘what factors had influenced the development of research in these countries since 1989’. A pioneer of midwifery research was selected based on their individual research experiences and knowledge from each country (n=4). Participants were asked to provide an historical account of the research leaders and factors, which had contributed to the development of research since 1989 in their country. Each narrative was also guided by questions provided by the researcher relating to their country including the location of midwifery practice, government and professional regulation, membership of associations and professional bodies and education. The researchers used narrative pattern matching for the analysis, but no details of the process were reported. Findings indicated that a number of factors had led to the development of research in these countries including the historical development of the profession and movement from hospital-based training to university midwifery programmes, individual research and inter professional collaboration and that characteristics of midwifery education were context specific. It is evident from an extensive search of the literature that the varied uses of case studies in midwifery have been predominantly related to midwifery education and research, it does not appear to have been used related to research and midwifery practice. However, the popularity of case study method
indicated that it would be appropriate to explore the influences on low-risk women’s decision-making and induction of labour.

A case study is also a useful method when the boundaries between the context and the phenomenon are not clear (Yin, 2014). The boundaries between the context of a woman’s decision-making and the phenomenon of low-risk women having an induction of labour are unclear in that it is unknown how, why, when or where low-risk women make their decision to have an induction of labour, or what contextual factors influence their decision. Consequently, the case was ‘decision-making of low-risk women and induction of labour’, and the context was the South West Peel regional maternity setting. The purpose of this study was to contextualise information from the perspective of the women and the midwives in the maternity setting to ensure a deeper understanding (Baxter & Jack, 2008). Understanding the contextual processes and influences will provide invaluable information to help midwives support women in making their choices.

### 3.3.1 Binding the case

Having identified the case, type of case, context and research questions, the next stage involved identifying boundaries to this case to interpret the factors of influence and women’s experiences relating to decision-making (Baxter & Jack, 2008). This case was bounded by specific criteria, including the geographical area of Peel and the social group of women who birthed in this regional maternity unit in 2007–2008. The inclusion and exclusion criteria ensured that suitable participants were included in the study and had a greater understanding of the ‘case’. The inclusion of the midwives’ perspectives was to add greater depth to the understanding of the phenomenon under study than would be possible with only the women’s perspectives. The inclusion criteria for the midwives included: part- or full-time employment in the Peel maternity unit, and
varied experience, level one, two and three midwives. Researching the perceptions of both women and midwives also allows representation from both emic and etic perspectives within the case study. According to Polit and Beck (2010, p. 265), an emic perspective is an ‘insider’s view point’ wherein participants describe their ideas and experiences. An etic perspective is the outsider or external interpretation of their perspective (Polit & Beck, 2010). The researcher in this study strived to obtain the emic perspective of the participants and their view of what social and cultural factors had affected their decision-making. Conversely, the etic perspective consisted of analysing the interview data and the external world of contextual factors, including characteristics of the setting, family structures, and policies governing health care and service provision.

The next section discusses the theoretical perspectives, philosophical beliefs and values that underpin this methodological approach.

### 3.3.2 Theoretical Perspectives

A theoretical perspective is a philosophical position that informs the methodology and provides a framework for the context of the study and an underpinning for the researcher’s logic (Crotty, 2013). The rationale for the researcher’s choice of philosophical perspective and a feminist framework is included in this section.

### 3.3.3 Feminist theoretical framework

A feminist framework was required for this study, as feminist perspectives focus entirely on research with (Richardson-Tench et al., 2011) and for women (Hardy, 2011). Feminist definitions, principles and perspectives are diverse, and they vary according to a researcher’s application (Hill-Karbowski, 2009). Kabasakalarat (2015) supports the view that definitions vary and suggests that feminism is theory that identifies problems associated with women’s subordination. Other authors define feminism as the research
and practice relating to identifying and changing social and intrapersonal factors that maintain the disempowerment of women (Parratt & Fahy, 2011).

Feminist principles include the promotion of empowerment, which overcomes conditions of oppression, inequality and disempowerment to develop mutual respect and sharing (Richardson-Tench et al., 2011). Hill-Karbowski (2009) suggested that three principles underpin feminist philosophy: identification of oppression, valuing women’s experiences and choices, and ensuring benefits for women. Despite having different principles, feminist approaches have common threads. All feminists have egalitarian views, which focus on issues of equality and reciprocal relationships (Barnes, 1999), gender differences, women’s rights, empowerment and identification of oppression, partner-power relationships (Bradley, 2013), and valuing women for their societal roles (Hill-Karbowski, 2009).

A rationale provided by Barnes (1999) for this woman-centred focus is a need to study women to obtain information related to their experiences. Understanding and valuing women’s experiences and perspectives are important to enable reciprocal caring and acknowledge women’s contributions to social change (Barnes, 1999; Richardson-Tench et al., 2011; Paratt & Fahy, 2011). A woman’s perspective generates information, which can be validated when midwives use the information for social and practice changes, which may lead to benefits for women and their emancipation (Barnes, 1999).

Feminist philosophies vary and have been described as arising from three or four waves, which differ according to their political, social, educational or cultural position (Beckett, 2005; Cadden, 2014; Draulans, 2003; Hill-Karbowski, 2009; Rampton, 2015). To explain the different waves of feminism, Beckett (2005) conducted a scholarly review relating to women’s choice of CS, feminism and the politics of childbirth in the US. Within this context, the first wave of feminism related to women expressing their
right to analgesia during childbirth in the 1940s. The second wave of feminism occurred in the 1960s, when women had gained their right to analgesia during childbirth but lost control due to the medicalisation of childbirth. Women had moved from having home births, which were considered unsafe in the 1950s, to giving birth within a hospital technocratic environment. Due to the medicalisation of childbirth and the lack of improvement of outcomes for women and babies, women began to express a desire for natural childbirth and the right to experience pain. These women perceived that natural childbirth was empowering (Beckett, 2005). A third feminist wave in the 1990s referred to women questioning the radical views of feminism relating to childbirth, as homebirth was not acknowledged as suitable for everyone—particularly single mothers—and not all women wanted to experience pain (Beckett, 2005). An anaesthetist/medicalised perspective on this wave was provided by Skowronski (2015), who argued that feminists who emphasised that pain relief was their right and many demanded access to pain relief in childbirth. This author welcomed the third wave of feminism, where women wished to have a technocratic birth and analgesia. Thus, in the nineteenth century, more effective pain relief methods than opiates were introduced by anaesthetists for women during childbirth. Additional pain relief methods provided by practitioners included nitrous oxide and oxygen, ether and chloroform. However, not all women welcomed an introduction of epidurals for women’s pain relief by anaesthetists in the 1960s, with some women wanting to return to a natural, non-medicalised birthing environment where they could have control over their birthing (Skowronski, 2015).

In SA, Cadden (2014) provided an alternative socio-political view of the three waves of feminism. The first wave, ‘Shrieking Motherhood’, related to women’s call for social justice during the nineteenth-century suffrage movement. A second wave related to women’s liberation and their fight for leadership roles. The third wave was referred
to as the ‘Glass Ceiling’, when the first female premier was elected in SA and emphasised a need to shape a more inclusive society (Cadden, 2014). The ‘Glass Ceiling’ referred to the invisible barrier relating to a woman’s career mobility, which prevents her from reaching the top (Draulans, 2003).

Rampton (2015) highlighted the emergence of a possible fourth wave of feminism, where women have revitalised their views of feminism. This fourth wave saw feminist suppression in the context of marginalisation of other groups and genders. Thus, feminism is now not just about women’s struggle for equality, but it includes a call for gender equality related to sexual tendencies and identities (Rampton, 2015).

Other scholars have described the four major feminist theoretical perspectives that are concerned with equality as liberal, Marxist, radical and social feminism. Liberal feminism has occurred in all three waves of feminism. A philosophy that men have the ‘right of governance’ due to their ability to reason relating to leadership is the foundation for liberal feminism. However, it is not appropriate to define women by their reproductive role, as women have an equal level of intelligence with men (Kabasakal Arat, 2015). Therefore, women should have equal opportunities for economic growth, education, employment and integration into male-dominated institutions (Kabasakal Arat, 2015). Liberal feminist perspectives relate to gaining equality for women both in the workforce and at home (Cadden, 2014). This liberalist view indicates that women should seek equal opportunities in the workplace and not be confined to domestic roles such as mothering (Cadden, 2014; Draulens, 2003). However, this liberalist view may not be realistic, as it is not clear whether women will ever have equal opportunities in the workplace. Pregnancy affects women’s employment and opportunities for promotion. Additionally, this liberalist view fails to recognise the invisible ‘Glass
Ceiling’ in the workplace that prevents women from obtaining promotions and highly paid employment (Cadden, 2014; Draulens, 2003).

Marxism is an opposing view to liberalism that emerged in the nineteenth century (Kabasakalarat, 2015). It was important to consider the Marxist perspective in this study, as the essence of Marxism is the male dominance and subordination of women (Kabasakalarat, 2015). Male dominance and subordination in the relationship is due to the woman’s economic dependence and her reproductive role (Kabasakalarat, 2015). Hence, under the Marxist perspective, men controlled women’s behaviour.

Social class is more important to Marxists than patriarchy, as upper-class women differ from lower-class women. The liberation of working-class women would only occur during a revolution, where childrearing would become the joint responsibility of the social class (Kabasakalarat, 2015).

Radical feminism movements first occurred in the 1960’s (Walsh, Christianson & Stewart, 2015). Radical feminist movements were mainly concerned with equality, reproduction, childbirth and anti-discriminatory policies (Walsh et al., 2015). Radical feminists between 1960s-1980s also contended that men are dominant socially, politically and economically. Historically the medicalised childbirth within institutions in the 1960s–1970s led to the oppression and alienation of women from their own bodies and relatives (Beckett, 2005). Thus, feminist activists then began to campaign for natural childbirth through the natural childbirth movements (Beckitt, 2005).

Consequently, within the second wave of feminism, a group of radical cultural feminists had also emerged to challenge the notion of the technocratic birth within medicalised institutions where medical practitioners use a technological approach to what should be a natural experience (Lee & Kirkman, 2008). This use of advanced technology is a concept of ‘bio-power’, which was proposed by Foucault (1979, p. 140), who suggested
that medical practitioners used ‘diverse techniques to gain control’ over women’s bodies.

Radical cultural feminists argued that the movement of women to hospital birth in the 1970’s, medicalisation and technocratic birth had led to the deconstruction of womanhood and their disempowerment (Beckitt, 2005). These radical cultural feminists perceived that gender differences and inequities were determined biologically and that women’s reproductive ability was a source of power (Beckitt, 2005). Subsequently, women contended that they felt liberated and freed from this technology and male domination when normal childbirth occurred (Beckett, 2005). However, views related to radical feminism differ between radical feminists and researchers. Mackay (2015) conducted a survey and in depth interviews with self-identified radical feminists (n=25) in the UK 2011-2012 related to the perceived values of radical feminists. Participants perceived that the relationship between different genders was driven by power inequities rather than biological differences. These participants rejected the view that culturally driven biological differences underpinned gender inequity. Participants perceived that males used a system of patriarchy to oppress both women as a group and individually (Mackay, 2015).

Socialist feminist perspectives were developed due to dissatisfaction with previous feminist views from the 1960s. A belief of socialism was that no one form of oppression is more important than another (Graf, 2012). Within this third wave of feminism, the feminist socialist activists gave voice to marginalised groups (Walsh et al., 2015). Factors of oppression in women acknowledged by socialists include economic, patriarchy, class, gender and race (Holmstrom, 2003; Lane, 2010). Socialists contended that gender differences and inequalities are not driven by biological factors but by overwhelming social factors and patriarchy (Lane, 2010). Holmstrom (2003)
supports this view and suggests that the feminist belief that economic oppression leads to natural patriarchy is an accepted concept in socialist feminism, and related to the home, work and the institutional environment. Women are influenced by their dual role of motherhood and work (Lane, 2010) as exploitation of women through lower salaries and poor conditions has occurred throughout the past century. Economic disadvantage of women in pregnancy is related to employers, who find a guise to alter their working conditions and this may also include termination of their employment (Yuill, 2012).

Sociologists also agree that gender differences and inequality in the home are linked to the ‘transition to motherhood’ and oppression (Oakley, 2016). Patriarchal roles and medical dominance related to decision-making have also been evident throughout the past century (Hill-Karbowski, 2009; Lee & Kirkman, 2008), particularly in relation to CS decisions. Socialist feminists perceive that women are vulnerable to medical influences related to CS due to their social background (Lee & Kirkman, 2008). Women from lower socio-economic backgrounds with a large family may welcome a CS, as they can also have a tubal ligation at the same time, thereby releasing them from their reproductive ties (Lee & Kirkman, 2008). Although there is little information on women’s induction decision-making, it is possible that high levels of induction are similarly linked to an acceptance of patriarchy.

Alcalde (2013) proposed an additional feminist perspective of neoliberalism, which was a feminist movement in the 1980s that drew attention to the needs of middle- and upper-class women who sought more choices related to their place of birth. The lobbying of the US government by neoliberalist women led to the introduction of privatisation, which increased choices for women who were wealthy (Alcalde, 2013). In the second wave of feminism, these women embraced their increased choices related to place of birth and medicalisation of care in private hospitals. However, there was a cost.
to these women, as increased choices led to further oppression of women and a loss of control in childbirth through increased levels of interventions (Alcalde, 2013). Alcalde (2013) argued that medicalisation has intensified over the past five decades from the 1950s, leading to increased interventions, particularly in private hospitals. Similarly, interventions in Australia have increased, as induction and CS rates are higher in private hospitals than in public hospitals (Lee & Kirkman, 2008; Dahlen et al., 2012).

3.3.4 Application of feminist frameworks in midwifery research

An extensive literature search did not reveal any research studies related to the use of a feminist framework in relation to women’s induction decision-making. However, feminist principles and perspectives are applied in a variety of ways by feminist researchers in framing midwifery studies of childbirth and parenting. Barnes (1999) emphasised the relevance of a feminist theoretical framework in midwifery to focus on the woman’s perspective and her evaluation of her childbirth needs. According to Barnes (1999), feminist theoretical frameworks include four key principles: they are for the benefit of women, they are a means of social change, the women direct this social change, and the research process should be transparent. Bortin, Alzugaray and Kalman (1994) utilised a feminist framework to explore homebirth and emphasised the centrality of the woman in childbirth and the woman’s right to choose where, when and how she gives birth. Researchers argued that all of the concepts of care advocated in the philosophy of the American College of Nurse Midwives (ACNM) should be used to evaluate homebirth rather than only safety. The concepts of care proposed by Bortin et al. (1994, p. 148) to evaluate homebirth included: ‘women’s satisfaction, respect for dignity, self-determination, cultural and ethnic diversity, family centred care as defined by the woman herself and health promotion’.
Parrett and Fahy (2011), who suggested that qualitative interpretivist approaches are suitable to study the lived experience of women during childbirth, used a feminist post-structural framework. They argued that the use of Rubin and Mercer’s ‘Transition to Motherhood’ theory is unsuitable for use in midwifery and nursing because it is controlling and disempowering for women. The use of this framework also assumes that midwives (experts) direct women regarding the care of their baby, and that midwives then become agents for social control. This theory appears to be incompatible with contemporary midwifery philosophy, which promotes woman-centred care, shared decision-making and autonomy for women.

Other authors have used a post-structural feminist framework in their study to focus on discourse (Davis & Walker, 2010) and to explore caseload midwifery in New Zealand. This application of a post-structural feminist framework is an unusual approach, as post-structural studies usually critique feminist perspectives. In contrast to the views of Parratt and Fahy (2011), these authors argued that post-structuralist approaches are not incompatible with feminism because discourse shapes human behaviour, thinking and actions, including the practices of midwifery and medical practitioners. At times, this shaping of behaviour between practitioners leads to conflict between the two disciplines as midwives strive for woman-centred care. Some authors do not acknowledge the concept of patriarchy related to this conflict, which at times has been described as fierce (Davis & Walker, 2010). However, Davis and Walker (2010) acknowledge the previous effect of bio-medical discourse on women and their exploitation in New Zealand, where women were expected to comply with recommended interventions during childbirth (Davis & Walker, 2010). The introduction of alternative models of midwifery-led care have released women from this discourse and enabled them to receive woman-centred care in New Zealand. This study
highlighted the fluid relationship between the woman and the midwife, the effect of the context on the woman–midwife relationship, and the need to recognise the discourse of midwives relating to the facilitation of normal birth (Davis & Walker, 2010).

3.3.5 **Principles and theoretical orientations of feminism used in this study**

The current interpretive study focuses on the woman’s voice and the effect of the context on women’s induction decision-making. This focus is reflected in the feminist principles and perspectives related to equality and women’s rights, empowerment, and the prevention of exploitation. Principles reflecting these perspectives are embedded throughout the study and comprise recognition of the woman’s role, choices and rights in decision-making, recognition of women’s rights to informed consent (autonomy) (sampling), confidentiality (privacy), protection from exploitation (justice), protection from risk (beneficence) and protection from harm (non-maleficence). The theoretical perspectives used in this feminist framework embrace the following: equality and promotion of an egalitarian relationship, recognition of the value of women’s perspectives and their contribution to social change, the socialist view that context and culture affect their perspective, empowerment, and identification of oppression. As these theoretical perspectives guide the study, they are integrated throughout the methods section. A rationale is provided below for the researcher’s choice of feminist principles and theoretical perspectives.

3.3.6 **Promotion of equality and the egalitarian relationship**

The promotion of equality and reciprocal relationships are core principles of all feminist theorists. Equality is central to the midwife–woman reciprocal relationship (Page & McCandlish, 2007; NMBA, 2010a, rebranded 2013). A reciprocal/egalitarian relationship between the midwife and the woman promotes the sharing of information (NMBA, 2010a, rebranded 2013) and is essential to the cultural safety of the woman.
Cultural safety relates to how culture shapes power relations between people (McMurray & Clendon, 2015). It is paramount to the midwife who supports the woman throughout the continuum of childbirth. Cultural safety can be maintained by the midwife/nurse in practice and promoted through an active partnership, sharing of knowledge with the woman, encouragement of women’s participation, and nursing support for risk management processes (NMBA, 2006, rebranded 2010). The aim of cultural safety in health care is to develop risk management processes to prevent adverse events related to cultural issues (NMBA, 2006, rebranded 2010). An example of risk management is the promotion of informed decision-making related to induction of labour, which requires the woman to have adequate information, actively participate and make a decision regarding this procedure (NMBA, 2006, rebranded 2010). This active sharing of information may help to prevent an unnecessary induction, which may have led to complications and adverse events in childbirth.

To ensure reciprocal relationships were developed with the women, the researcher developed design features that have been integrated into the sampling and data collection methods. Design features to promote sharing of information between the researcher and participant included the use of informed consent, the facilitation of a time and environment for data collection that was suitable to the women, and the use of probing questions and active listening. Nagy, Mills, Waters and Birks (2010) highlighted that it is important for participants to be aware of the focus of the study and their rights, and the researcher must establish a rapport in order to obtain high-quality data. To establish a rapport between the researcher and the participants, women were interviewed in a quiet room in the hospital unit, and midwives were interviewed in the researcher’s office. The selection of the setting was aimed at securing a quiet area in the ward to ensure privacy and minimise interruptions. The sitting room had comfortable
seating, and the researcher and the participants were at the same level to maximise eye contact. Open body language was used when interviewing the participants to foster mutual respect between the participant and the researcher in order to gain in-depth data.

3.3.7 Valuing women’s unique perspectives

It is acknowledged in this study that women’s views and experiences are unique, different and valuable, and they are the product of the socio-cultural context. It was important to consider the effect of the political and social context on the women’s decision-making in this study, and any effects of the context on the women’s empowerment. In the US, researchers indicated that the effect of the organisational culture and place of birth are rarely considered in relation to women in childbirth (Behruz, Hatem, Goulet, Frazer & Misago, 2013).

Acknowledgement of women’s perspectives and contributions to social change is an important feminist perspective that is integral to this study. The findings will inform practice changes, and knowledge generated from the woman’s perspectives will be disseminated to the midwives. This knowledge can be used by midwives to change their policies and practices related to the support of low-risk women who choose an induction of labour. These findings may benefit women in the future through the development of birth-related guidelines for low-risk women. Eventually this may lead to the empowerment of women’s decision-making by highlighting low-risk women’s choices; explaining the reality of decision-making and induction of labour will give them one voice.

3.3.8 Empowerment and recognition of exploitation

Feminists argue that empowerment through shared decision-making and speech is an essential element of health care, which can lead to the emancipation of women in pregnancy (Page & McCandlish, 2007; Wittmann-Price, 2006). The empowerment of
women during childbirth is important because women who are empowered are advantaged. These women are more in tune with their bodies, gain confidence in their ability to give birth naturally and have increased satisfaction with the birth process, particularly during the antenatal period (Fair & Morrison, 2011). Active involvement of the woman in the birth process is essential to achieve better outcomes for the women and their baby (Barello, Graffigna, Vegni, 2012; Fair & Morrison, 2012; Green, 2012). Women who receive accurate information feel more confident in their participation and decision-making ability (Maputle, 2010).

A group of women may gain information from their peers and feel empowered through cultural knowledge related to childbirth. This knowledge is generated in their setting by their peers’ discourse (Gallagher, 2012). However, women may access information that may not be reliable, especially from the Internet. Moreover, cultural knowledge may also be unreliable and lack an evidence base, as it may be solely based on the group’s previous experiences of childbirth. Consequently, women may feel empowered by their peers’ information, but this is not always the case. Subsequently, women can be vulnerable in childbirth when making decisions (NMBA, 2008, rebranded 2013), so empowerment through the provision of information is essential to ensure accurate evidence-based information. Midwives may provide evidence-based information for women; however, women do not always understand information it women may then become disempowered in their decision-making. To ensure that women are informed in their decision-making, the researcher investigated the appropriateness, adequacy and understanding of information from both the woman’s and the midwives’ perspectives in this study.

The disempowerment of women can also occur through exploitation and control, which can occur in many ways during childbirth decision-making. An example of
exploitation related to childbirth is the patriarchy and misuse of medical technology identified by radical feminists. To avoid exploitation and control in this study, the researcher chose a qualitative methodology and interpretive paradigm that was not constrained by scientific principles and control. The principles of autonomy and beneficence explained in the ethics section also prevented the coercion and exploitation of women. The use of a consent form that included information relating to the study and the option of non-participation ensured the informed choice and non-exploitation of the women participants.

Given that midwifery practice is woman-centred, women-focused and aimed at empowering women in their childbirth experiences, a feminist framework was used in this study to ensure that the findings would reveal the women’s perspectives on their decision-making and induction of labour. To enable women’s choices, it is important to hear women’s views in midwifery practice (Green, 2012). Clearly, feminism is integral to conceptualising the cultural aspects of healthy low-risk women’s decision-making. The approach was embedded throughout the following methods and case study to investigate the use of induction in these low-risk women within the context of the South West Peel region.

3.4 Ethical Considerations

3.4.1 Ethical approval

The Human Research Ethics Committee at Murdoch University (Approval Number 2008/213) (see Appendix O) granted ethical approval for the study. This study has adhered to the ‘National Statement on Ethical Conduct in Human Research’ (National Health and Medical Research Council, 2007, updated 2015). To avoid a position of influence described by the National Statement on Ethical Conduct in Human Research, the investigator did not have direct responsibility for women participant’s
care. Their allocated midwives cared for the women participants to ensure that all of their care needs were met.

3.4.2 Access to the setting

To obtain access to the setting, the researcher sought approval from the Chief Executive and then the hospital’s Medical Advisory Committee, which approved the study with delegated authority from Murdoch University’s Human Ethics Committee. Permission for access was also sought from the Executive Advisor for the maternity area, and the Unit Manager’s permission was also obtained for both phases of the study. Access to medical records to examine data in the birth register, case notes for participants’ personal information relating to demographic details, obstetric and medical history, and reasons for induction of labour in the induction book were obtained with ethics approval and consent from the woman and institution. Care was taken to ensure that relationships were developed and maintained so that future research may also be undertaken (Minichiello, Sullivan, Greenwood & Axford, 2004).

Stakeholders, including midwives and doctors, were also approached initially through an oral presentation that was arranged to inform them of the rationale for the study, the participants and the potential outcomes. As the researcher was in a position of responsibility within the unit, a notice was placed on the boards in the handover and education rooms in the maternity unit to invite midwives to participate in the second phase of the study. This strategy was utilised to avoid the ethical issue of coercion, as junior midwives may have felt in a vulnerable position if approached directly (Polit & Beck, 2010). Midwife participants were informed of how they could access information on the findings of the study through a seminar presentation upon completion of the research, journal articles and information posted on the university website. A copy of the study proposal was provided for the resource room.
3.4.3 Autonomy-informed consent

Informed voluntary consent was obtained throughout both phases of the study. The researcher provided an information sheet and consent form for all participants (see Appendix A, B, C & D). These were designed to be clearly understood and included the following principles proposed by Wood and Ross-Kerr (2006): the study’s purpose; the possible outcomes or benefits; the risks; expectations of the participant; measures taken to protect privacy; and what was required from them.

The information sheet and consent form clearly stated that participation was voluntary and they could decline to participate, withdraw at any time or skip questions that they felt uncomfortable answering to avoid intimidation (Australian Government Office of the Australian Information Commissioner, 2013) (see Appendix A, B, C & D). The researcher ensured that participants were all recruited by the researcher and not by their clinician to avoid any coercion. An information sheet was also pinned to the notice board for the midwives in the maternity setting (see Appendix B). Midwives interested in the study approached the researcher later for more information relating to the study. The researcher answered their questions and provided them with an information sheet and consent form with instructions to return the completed consent form to the researcher’s office if they wanted to participate. Participants were also informed that they might not personally benefit from the outcomes of the research. The researcher also informed participants that information would be shared only with the research supervisors according to National Privacy Policy (Australian Government Office of the Australian Information Commissioner, 2013). The contact details of the researcher and supervisor were also included on the consent form to enable the participants to contact them if they had any queries. The consent form also contained the Human Ethics approval number to show that it had been granted. A copy of the signed consent form
was given to the women and midwives at recruitment following consent. To ensure fair treatment to the participants in the maternity ward, it was also important to include the ethical aspect of justice.

3.4.4 Justice

Justice is another ethical principle outlined by Nagy et al. (2010, p. 72). It is described as ensuring that all participants get an equal share of the ‘benefits and the burdens’ relating to the research. The participants also have the right to fair treatment (Schneider et al., 2013). Protection of women from exploitation through inappropriate selection occurred (Schneider et al., 2013) according to the specific study inclusion criteria (see Appendix E). Additionally, if the women participants had been recruited by their midwife, they could have feared that they would not receive fair midwifery care if they did not participate in the study. The researcher reassured participants that they would get the same treatment and care as anyone else in the maternity unit.

A presentation was given for all of midwives to attend to inform them of the study’s purpose, expectations of participants, risks and benefits. The midwives were also informed that their participation was voluntary and that they could withdraw at any time. The researcher reassured the participants that if they did not participate in the research study, they would not be treated differently from those who did participate. According to Nagy et al. (2010), justice also extends to the dissemination of findings. The researcher asked all participants if they wanted to receive a copy of the outcomes of the study, and all of the women and midwives stated that they did. The women and midwives (see Appendix K, L, M & N) received a written letter as well as a summary of the findings and recommendations for changes in clinical practice through the post. The midwives were also informed through national and local conferences. The publication of findings online in the library’s digital thesis section and through publication in
midwifery journals will also ensure that midwives receive information to inform their practice.

3.4.5 Beneficence: protection from risk

As it was not anticipated that the participants would benefit directly from participating in the study, it was important to protect them from exploitation and harm. According to Polit and Beck (2010), two fundamental principles of ethics are beneficence—that is, striving to do good—and non-maleficence—that is, avoiding causing the participant harm. The researcher was striving to do good by completing the much-needed study of low-risk women’s decision-making and induction of labour. In the proposal that was submitted to the Human Ethics Committee at Murdoch University, the researcher outlined the risks and benefits to the participants, which ensured that the Ethics Committee could assess the risk to the participants and whether it was acceptable or not. Risks to participants have been categorised by the Australian Government National Statement on Ethical Conduct in Human Research (National Health and Medical Research Council [NHMRC], 2007, updated 2015) into inconvenience, discomfort and harm. To avoid inconvenience, the researcher selected a time that was suitable for the participants to complete the study, which was an important aspect, particularly to the women in the first few days following birth, as their time with their family was precious. To enable a suitable interview time, the researcher often returned to the setting in the evening to conduct the interviews. Avoidance of discomfort and protection from harm were essential in this study, including physical, psychological, social and emotional risk and harm (Polit & Beck, 2010). No physical social or financial harm was anticipated because of participating in this study. The participants were protected from financial harm because they were not expected to make any special visits that could incur a cost during the research process.
3.4.6 Non-maleficence: do no harm

It is important to minimise risks to participants in research studies (NHMRC, 2007, updated 2015). Research questions could pose an unanticipated risk to participants’ emotional status due to the direction taken by the researcher’s open questions and the informants’ answers within the interview setting (Streubert Speziale & Carpenter, 2007). Although the participants were not at risk physically, there was a possibility of psychological risk due to women recalling painful memories relating to childbirth. However, no possible psychological harm related to this research study was anticipated. To protect the woman from harmful memories related to childbirth experience, the woman was asked to recall her decision-making process regarding induction only. A provision had been made for referral to a counsellor or GP if the woman suffered distress from recalling painful memories.

3.4.7 Privacy

The researcher adhered to the National Statement on Ethical Conduct in Human Research (NHMRC, 2007, updated 2015) guidelines and the current National Privacy Policy (NPP) guidelines (Australian Government Office of the Australian Information Commissioner, 2013) relating to the collection and disposal of information. This strategy was necessary because the information relating to women in childbirth was classified as sensitive (Australian Government Office of the Australian Information Commissioner, 2013). Following the Human Ethics and Access Approval from the executive of the regional centre, the researcher carefully managed the use of case notes to gain information relating to the woman’s obstetric details. The researcher highlighted a need to access case notes and details in the birthing register during the recruitment of participants, and consent was obtained. Privacy was maintained throughout the data collection from the case notes. The researcher was careful to ensure that only the
required information was collected, and case notes were quickly returned to the reception once details had been obtained (Australian Government Office of the Australian Information Commissioner, 2013). No notes were taken out of the maternity area, and no notes were left unattended. It was also essential to maintain confidentiality of data collected from medical records.

All researchers should recognise the participants’ right to privacy and confidentiality (Leedy & Ormrod, 2013). Moreover, the National Statement involving Ethical Conduct in Human Research (NHMRC, 2007, updated 2015) highlighted the need for anonymity and confidentiality. However, anonymity is not the same as confidentiality (Langford & Young, 2013). Anonymity ensures complete protection of identity in that the researcher is not aware of the name of the participants (Langford & Young, 2013; Schneider et al., 2013). In contrast to anonymity, confidentiality does not ensure protection of a participant’s identity from the researcher (Langford & Young, 2013) or co-researchers (Leedy & Ormrod, 2013). In the current study, complete anonymity of data, specifically concerning the participant, could not be achieved due to the small sample number, face-to-face contact in interviews and immersion of the researcher in the data. Researchers have indicated that it is often difficult to maintain anonymity in qualitative studies due to the ‘face-to-face’ method of data collection (Schneider, 2013). The researcher protected participants’ confidentiality during the research study so that no one else could identify them. Strategies utilised by the researcher to maintain the confidentiality of the participants related to the storage, collection and publication of the data. All tape recordings were given a code by the researcher. Additionally, the researcher stored details of the participants separately from the data to maintain confidentiality. In the presentation of either the data or the findings,
to ensure that participants could not be linked to the data or identified by anyone other than the researcher, the researcher used no demographic data or demographic labels.

The midwives were also not invited to participate in the study unless they were alone. Individual survey responses from the midwife were placed in an enclosed envelope and returned to the researcher at the interview. All consent forms, questionnaires and field notes relating to the demographic data and obstetric history of the participants were stored in the researcher’s filing cabinet under lock and key. The participants were informed that the research would be published in aggregated form to avoid identification and maintain confidentiality, as suggested by Langford and Young (2013). Participants’ identification was protected within interviews. Field notes and questionnaires were allocated a code number only. A list was generated by the researcher of the participants and their codes, but it was kept separately in a secure filing cabinet. The researcher also had individual password access to the computer used to store the transcribed data, which were in coded files. All data will be destroyed by incineration five years after the completion of the research study.

3.5 Design Features

3.5.1 Sampling strategy

This study involved two phases: an initial phase that involved interviews with low-risk women in the maternity unit, and a second phase, where the midwives were interviewed in the same maternity unit.

3.5.2 Women participants

In phase one, purposeful sampling was used to ensure that all participants had the experience of non-medical induction. According to Borbasi et al. (2012, p. 135), women who are ‘information rich’ are purposefully chosen by the researcher. A set of specific inclusion and exclusion criteria were developed for this sample related to
demographic data, the model of care used during pregnancy, previous history relating to childbirth and parity. Women were included if they were low risk and received either midwife-led care, shared care with a GP or care provided by the GP (see Appendix E). Definitions of risk factors may vary between authors, professional bodies and practitioners. A definition of risk in pregnancy proposed by Davidson, London and Ladewig (2012) suggested “risk factors are any findings which have been shown to have a negative effect on pregnancy outcomes either for the woman or her unborn child”. Risk factors can be detected at the woman’s first antenatal or pre-natal assessment in pregnancy or may develop at any point in her pregnancy, during childbirth or following delivery (Davidson et al., 2012). Consequently a woman can be considered low risk initially but when develops risk factors may become high risk. Recognised risk factors can be related to the woman’s socio cultural conditions, pre-existing medical disorders, previous surgery and obstetric considerations (Davidson et al., 2012). RANZCOG (2016) also discusses the recognition of risk in women in pregnancy and suggests “A risk and needs assessment including previous obstetric, medical and social history, must be carried out to ensure that every woman has a plan of care adapted to her own particular requirements for antenatal care, delivery and postnatal care”. This professional body recommends that obstetricians care for women with complex needs (RANZCOG, 2016). Hence, obstetricians appear to work within a framework of risk management and assessment. Yet the concept of risk may vary according to the values of the woman or health professional (Lyerly, 2012). On the one hand, many women may misperceive they are at risk of medical complications in pregnancy particularly if their doctors or peers reinforce this information. However, these women, their health professionals and peers may fear risk, rather than risk being an evidence-based probability (Scamell, 2014).
Peers’ perception of risks can be influenced by the social-construction of risk via the media, books and magazines, which often promote and support a medicalised model of care, which promotes risk management (Healy, Humphrey & Kennedy, 2016; Rodgers, 2015). On the other hand if low risk women and their midwife led care team pursue non-intervention and value normality in childbirth one could expect a reduced rate of interventions (Sandall et al., 2015). Yet the risks of non-intervention in childbirth related to possible complications may also become dangerous for both the woman and their midwife (Lyerly, 2012). An example of this type of risk would be a woman who continues her pregnancy past 42 weeks, as the risks of a stillbirth increase (KEMH, 2015b). This would also place the midwife’s practice under professional scrutiny and possibly put her at risk of litigation. Hence, there should be a balanced careful assessment of risk factors by health professionals, as not all women should be considered at risk. Women in this study were considered low risk if they did not have previous complications in childbirth or medical and surgical risk factors. Women who were high risk or who developed risk factors in pregnancy were excluded. Nulliparous and multiparous women were both included in the research study sample. However, women in their fifth pregnancy who had previously given birth to four babies were excluded, as they were considered at risk for an increased level of maternal and neonatal complications (Mgaya, Massawe, Kidato & Mgaya, 2013). Women of childbearing age, including nulliparous women younger than 35 years, were included. Women over 35 years of age could not be included unless they were multiparous, as nulliparous women over 35 years of age are at high risk of complications during pregnancy (Davidson, London & Ladewig, 2012). Women were included in the study if they were a resident of the South West Peel region, of any socio-cultural background, were single, married or in a de facto relationship, and spoke the English language. Indigenous women were not
included in the study, as they would require a separate ethics application and adherence to the ‘Guidelines for ethical research in Australian indigenous studies’ (2012) to protect their rights, culture and heritage. The number of participants was determined by saturation of the data, when no more new information appeared in the analysis (Polit & Beck, 2010). When saturation of the data occurred, no more low-risk women were recruited.

3.5.3 Midwife participants

The researcher interviewed a selection of level one, level two and level three midwives. Level one-registered midwives vary in experience between full-time midwives who have recently qualified to senior part-time midwives who may have vast midwifery experience. Senior level one midwives can be role models for junior midwifery and nursing staff, student midwives and enrolled nurses in the clinical area (DOHWA, 2016). Level two, sometimes called clinical midwives, are senior midwives with extensive experience. Senior midwives coordinate the maternity unit and are responsible for the care that women receive from nurses, midwives and students in the area (DOHWA, 2016). Clinical midwifery managers are level three midwives who are responsible for the management and standards of midwifery care, resources and midwifery personnel (DOHWA, 2016). This sampling strategy enabled the researcher to access views from midwives with a range of experience regarding what they believed were the possible influences on low-risk women’s decision-making behaviours and induction of labour. The researcher initially used convenience sampling for the selection of midwife participants and included all midwives who volunteered. To ensure participation by midwives with experience at level one, two and three the researcher then introduced convenience quota sampling. This strategy was aimed at increasing the representativeness of the population of available midwives (Schneider et al., 2013).
3.5.4 Setting

The setting for the study was a regional maternity hospital that has approximately 1,200 births per annum, and therefore was considered appropriate to provide an adequate sample for the study. The hospital accepts both private and public women for admission, and one-third of the maternity beds are private. Women may only book at this hospital if they live in the South West Peel region.

Women in this hospital have the opportunity to select from the following models of care: midwife-led care; shared care, GP obstetrician or consultant-led care. Midwife-led care is provided in the antenatal clinic. At about 8–10 weeks of pregnancy, women are referred by their GP for care throughout pregnancy by the midwife. Midwives also have the support of a hospital roster of GPs that they can refer to if the women develop complications in their pregnancy. The GP obstetrician who is responsible for completing the woman’s heart and lung examination at 16 weeks usually sees women twice during pregnancy if they are multiparous and three times if they are primiparous. The extra review of primiparous women at 32 weeks is to review investigations. The doctor sees the woman to discuss induction of labour at 40-41 weeks of pregnancy if they have not already birthed their baby. The midwife provides all of the care throughout the pregnancy.

If the women choose to have a GP, they are cared for throughout their pregnancy by him or her. A shared care model also exists where the woman has care from both the midwife and the GP in the community. The hospital midwife may provide antenatal parent craft classes or an antenatal assessment if the woman presents with a problem. The hospital facilities provided for women in childbirth include ante partum, intrapartum and post-partum maternity care. Approximately 50 midwives, including full time, part time and casual, are employed at this hospital, and midwives work in all areas
of the maternity unit. Women usually have care provided by the consultant if they are high risk and have previously had obstetric complications. Consultant paediatricians and anaesthetists are available to attend if necessary. However, the women participants in this study were all low risk, so they received care from either the GP obstetrician or shared care or midwife-led care in the antenatal clinic.

3.6 Data Collection

The researcher ensured the woman’s perspective in this study through the use of multiple data collection methods, and by becoming immersed in the study, which enabled her researcher to build a non-exploitive relationship with the women. To explore the women’s lived experiences (multiple realities) as they influence, empower or disempower women, it was also important to investigate the cultural and contextual factors that may have affected the women’s induction decisions.

Rich data were collected in the setting from participants through field notes, documents, semi-structured interviews, telephone interview and tape recordings. To investigate the effect of the women’s maternity setting’s organisational culture as a unique factor that may have affected the women’s induction decision-making, the researcher also conducted interviews with the midwives in the maternity setting. Clearly understanding the effect of the organisational culture on women’s decision-making is important in this study.

3.6.1 Field notes and documentary evidence

Documents examined included the regional maternity unit birthing register, the ward induction diary, the women’s case notes and monthly obstetric clinical indicators. Data included documentary evidence of the reasons recorded by health care professionals for induction of labour, as well as additional evidence to determine whether the women participants met the inclusion and exclusion criteria.
The midwifery manager or the coordinator of the unit who usually takes all of the induction bookings by telephone completes the documentation of the reason for induction. The manager or coordinator then documents the reason for induction of labour in the induction diary, which is kept in the ward’s reception area. On admission, the admitting midwife then documents the reason for induction of labour in the woman’s case notes. A midwife who cares for the woman during childbirth and immediately following birth completes the birth register and the clinical indicator form. Additional evidence was also required by the researcher from the women’s case notes to determine whether the women participants met the inclusion and exclusion criteria. Data collected included the model of care during pregnancy, previous obstetric details and the birth outcome of this pregnancy. Demographic information was also documented by the researcher relating to marital status, address and contact details.

In phase two, the researcher used questionnaires to obtain demographic and employment details from the midwife participants prior to interview (see Appendix H). Demographic information obtained included level of experience in the unit, type of overseas experience and information relating to the midwifery models of care in which they were employed. Field notes were also taken during the interview to ensure that the data would not be lost through mechanical failure of the tape recorder. The researcher for the tape recorder kept back-up batteries; however, all batteries were changed prior to each interview to minimise interruptions to the interview through battery failure.

3.6.2 Interviews

Data collection included a semi-structured interview guide to ensure that the research questions would be answered during the interview. Initial questions in the interview guide related to the women’s characteristics and demographic information. Questions relating to the women’s medical, surgical and obstetrical history were also included.
The women’s interview guide included some open-ended questions (see Appendix F) to encourage the participants to talk freely and enable the researcher to obtain in-depth data relating to the women’s perceptions of the influences on their decision-making and induction of labour. To help the women consider whether they felt empowered to make informed decisions relating to an induction of labour, this study was intended to identify the women’s perspectives relating to the provision, sources and adequacy of information prior to an induction of labour. It was also designed to generate information relating to the ways that data could be used to inform midwifery practice (see Appendix F). To ensure the questions were clear, there was a minimum of medical terminology. The researcher aimed to clearly phrase the questions, probe and clarify to ensure depth and understanding of the participants. Hence, to enable the participants’ views to be heard the researcher avoided leading questions. Questions focused on women’s perceived influences on their decision-making, as well as the influences of the context or the setting where women receive information, the sources of information, the family, interactions with family and health care professionals, media, previous experiences of the woman with her family and friends, and the influence of health professionals.

Midwives completed a demographic questionnaire prior to their interview, which included open closed and probing questions relating to their age, experience, employment and models of care (see Appendix H). Open, closed and probing questions were also used within the semi-structured interviews (see Appendix G) of midwives to obtain rich information that could be compared to the women’s perceptions of their decision-making and induction of labour. To gain in-depth additional information, questions were added to the interview guide relating to the reason and the procedure for the booking of an induction of labour, and the type, timing, context, content and level of understanding of information provided. The midwives were also asked whether they
were able to influence the women’s decision-making and how they believed they could increase their support for low-risk women’s decision-making regarding induction of labour. The researcher was able to maintain the focus of the research through the use of triggers in the semi-structured interview guide, which enable the memory of the participant (Schneider et al., 2013).

Tacit or hidden knowledge referred to by Polit and Beck (2010) was also addressed in this study. Through the interactive approach, the researcher was receptive to participants’ views and actively listened to their issues and concerns. By gaining the confidence of the participants and using probing questions, the researcher enabled the participants to reveal deeper knowledge, which they may not have normally revealed. The use of probing questions enabled the generation of thick description related to the cultural aspects that existed within the group. It was expected that cultural factors or norms might be identified through examining the context, timing, source and adequacy of the information that the woman received to make her decision. These data were transcribed immediately following the interview and individually filed in Microsoft Word under the allocated code number so the data could be easily retrieved for analysis.

3.6.3 Storage and management of data

Each transcription was saved separately. However, a secure back-up copy of the data was kept on a thumb drive and hard drive to ensure that the data were not lost through a mechanical failure of the computer, which did in fact occur. A hard copy was kept of the changes to each transcript as it evolved. A copy of the transcription was also printed to share with supervisors for consensus checking. Hard copies of the interview data, including field memos and transcripts, were dated and stored separately in the researcher’s locked filing cabinet to ensure confidentiality, as proposed by Quinn Patton (2015), the NHMRC (2007, updated 2015) and NPP (Australian Government Office of
the Australian Information Commissioner, 2013). The researcher then purposefully copied the individual transcript files and placed them into one single file to manage the data. The researcher also needed to manage the questionnaires from the midwife participants.

Hard copies of the questionnaires, which contained demographic information related to the midwife participants and consent forms, were stored in a locked filing cabinet. A table of all of the midwife participants’ details was created by the researcher and stored in Microsoft Word. Each midwife participant’s details related to age, level and type of experience and the model of care that they had worked in were recorded from the completed information in the questionnaires. A code was used to identify the data, and the researcher kept a list of codes separately in the locked filing cabinet so the participants could be identified.

3.7 Data Analysis

This feminist analysis was framed by three core components recommended by Ramazanoglu and Holland (2002, which include the feminist framework, the researcher’s position and interest (reflexivity) (refer to 3.21 & 3.91), ethics and the process of interpretation.

3.7.1 Application of a feminist framework to the analysis

Use of a feminist ‘lens’ within this analysis was a central part of the feminist theoretical framework, which investigated the influences on women’s decision making and induction of labour from the perspective of the women and a group of midwives. This strategy was appropriate as a feminist lens looks at the world through the woman’s perspective (Bierma & Cseh, 2003). An integral part of feminism is that “Women’s ways of knowing” are based on their perception of their experiences (Westbrook, 2015). Application of a feminist lens within this analysis enabled the researcher to discover the
diverse views of the women and their reality related to the influences on their decision-making. This feminist lens also enabled the researcher to identify strategies proposed by the women related to induction, which would benefit similar groups of women and hence validate and value their experiences (Barnes, 1999).

The framework also included the socialist feminist view that the dominant factors in the socio-cultural context influence women’s views and lead to power differences (Bierma & Cseh, 2003; Lincoln & Guba, 1985). Hence, it was important to investigate the socio-cultural contextual inequities, which had affected and framed women’s lives and their decision-making, within this feminist analysis. The researcher aimed to identify power imbalances, domination, marginalisation, and violation of women’s rights, use of patriarchal discourse, oppression, women’s vulnerability and exploitation within the woman’s decision-making context (Lee & Kirkman, 2008). The researcher also investigated the impact of the culture in this analysis from the perspective of both the women and midwife participants including the impact of peers, employment, relatives, media, GP Obstetricians and midwives and the organisation on their decision-making.

3.7.2 Positioning the researcher

A researcher’s positionality in research may affect the research process, the researcher and the researched (Bourke, 2014), as a multitude of sociocultural characteristics may affect the researcher’s identity. Researchers propose that social factors and their lived experiences mould and shape the researcher’s identity, including gender, race, class, socio economic status, educational background, values, motives, political views, experience and employment (Bourke, 2014; England, 1994). A researcher’s own worldview and background may also affect the researcher’s choice of research and design (Berger, 2013). Additionally the researcher’s background can affect
the research setting, through their actions, behaviours, decisions, choices and perceptions (Lambert, Jomeen, & McSherry, 2010). Hence, it was essential to reflect on my background, as reflexivity and reflection on ‘self’ is an important part of the research process, to prevent bias.

I am a white female Australian citizen having immigrated to Australia in 1979. I have also birthed two children. My birthing experiences occurred in the 1970s-1980 in the United Kingdom. In both these pregnancies, I was induced for medical reasons. I therefore share a number of common bonds with the women participants, which include I am a woman, a mother and have experienced an induction for perceived medical reasons. “Self-conscious awareness of the relationship between the researcher and ‘other’ is important according to Bourke (2014, p.2). Many researchers support this view and propose that there may be benefits related to the researcher having a common bond with the participants. Shared experiences may increase the sensitivity of the researcher to the participants’ views (Lambert, Jomee, McSherry, 2010). Shared experiences may also affect the researcher’s and the researched relationship and access to the setting, as participants are more likely to respond to someone who is sympathetic to their views (Berger, 2013).

A characteristic of a naturalistic paradigm is that the researcher usually has internal knowledge of the study setting (Polit & Beck, 2010). In this study, as the researcher I had valuable internal knowledge of the study setting. A researcher’s knowledge of the researched subject can lead to increased understanding of the phenomenon under investigation (England, 1994). Insider knowledge may also be valuable within an analysis of data, as the researcher is aware of the medicalised terms that the participants use and may also recognise implied data (Berger, 2013). I was an experienced midwife with five years of practical experience as a Clinical Midwifery
Specialist and Midwife Consultant within the maternity unit used in the study. A midwife consultant provides a consultancy service within the maternity unit and leads research, education and quality enhancement projects within the unit (DOHWA, 2016). I also had an awareness of the structural inequities within the organisation related to patriarchy, bio-medical power, marginalisation, oppression and domination. Consequently, I recognised the concept of subordination patriarchy and oppression, which was evident between the GP Obstetricians and the midwives in this setting. Male dominated structures within both the maternity unit and the hospital had led to this subordination and oppression of midwives particularly related to the varied application of policies and procedures within the organisation. Oppression of midwives by dominant structures and obstetricians in maternity settings is not unusual. Yuill (2012) highlights that male obstetricians inappropriately utilise quantitative research to direct and dominate childbirth decisions, which are related to normal pregnancy and the practice of the midwife. Obstetricians also use hierarchical structures to dominate pregnancy decisions and erode the midwives role in normal childbirth (Cheyne, 2013). Yet the midwife has a duty to be the lead carer for normal birth (Healy et al., 2016). However, this concept appears difficult to achieve in practice. Nevertheless, “living in a patriarchal world unites women, who are also oppressed” (Bierma & Cseh, 2003, p. 8). Hence, I had ‘dual knowledge’ related to the setting, as a midwife that researcher I had knowledge related to the phenomenon and my own perspective and was in an ideal position to identify other types of oppression in both the midwives and the women. Yet those who dominate women within the biomedical model of childbirth do not readily identify their behaviours, which cause exploitation and oppression in women (Bierma & Cseh, 2003). Bio-medical models and technocratic birth persist today according to Yuill (2012), who suggests that many women remain undervalued by society and oppressed.
in childbirth today. Hence, patriarchal oppression in childbirth was an important issue to identify from the women’s perspective in this analysis as it may have affected the women’s and the midwives decision-making.

Insider knowledge related to the phenomenon may not always be valuable, as there may be challenges related to familiarity particularly related to the level of the researcher’s position and experience (Berger, 2013). Hence, to minimise bias in analysing and reporting the findings, I was not directly responsible for the operational management of the staff. Familiarity of the researcher with the phenomenon, can also lead to ‘blurring’ of boundaries’ within the analysis and the imposing of the researcher’s own values (Berger, 2013). To prevent this issue at the outset, I sought to minimise personal bias by identifying my motives and assumptions from my midwifery experience in relation to the study to revisit as the analysis progressed. My key motive for conducting this study was related to the high level of induction in low risk women within this maternity unit. My assumptions in this study related to the phenomenon of high levels of induction in low risk women included the following ideas: that the women were influenced by their family and social, cultural and contextual factors to choose an induction. It was also important to revisit the ethical considerations related to the analysis to ensure the protection of the participant’s confidentiality and privacy.

3.7.3 Ethics which have informed the feminist analysis

Ethics, which have framed this feminist analysis have been developed from the requirements of the National Statement on Ethical Conduct in Human Research (NHMRC, 2007, updated 2015) guidelines. This analysis section was underpinned by the women’s rights relating to respect, privacy and confidentiality, autonomy and consent, justice, safety beneficence protection from risk and non-maleficence protection from harm (Refer to Chapter 3 section 3.5). As information within this analysis was
sensitive, it was important to adhere to the current National Privacy Policy (NPP) guidelines (Australian Government Office of the Australian Information Commissioner, 2013) for the storage and management of the data (Refer section 3.57) to maintain the participant’s confidentiality.

### 3.7.4 Thematic Analysis

The researcher used thematic analysis for coding and categorisation of the data. Qualitative data collection methods generate large amounts of data (Polit & Beck, 2010; Richardson-Tench et al., 2011). Rosenberg and Yates (2007) proposed that thematic analysis is useful when there is a large quantity of data. The choice of thematic analysis was ideal for this research study and is commonly used in case studies because it enables the researcher to complete a descriptive analysis of human experience.

Richardson-Tench et al. (2011, p. 177) defined thematic analysis as “A method for identifying themes and patterns in the text”. Thematic analysis begins with the identification of broad themes, and then the development of subthemes. Themes are “phrases words ideas that appear repeatedly in the data during analysis of people’s feelings or situation and experiences” (Macnee & McCabe, 2008, p. 26). Macnee and McCabe (2008, p. 26) proposed that themes “summarise and synthesise discrete ideas or words to form a picture”. According to Richardson-Tench et al. (2011), subthemes are connected to the main themes and provide further detail about the themes. Some themes can be implicit in that they can be hidden and not be easily recognised by the researcher (Richardson-Tench et al., 2011). Implicit themes “relate to the context in which the participants exist” or to the reality of their world (Nagy et al., 2010, p. 143) and may not be easily recognised (Richardson-Tench et al., 2011). Others may be explicit themes that “relate directly to the research questions”. Explicit themes are
central to the phenomenon under investigation because the researcher (Nagy et al., 2010, p. 143) can easily recognise them.

A combined computer-assisted and manual approach described by Richardson-Tench (2011) was used for thematic analysis and categorisation of the data this enabled the researcher to get close to the data. This manual computer-assisted approach of Richardson-Tench et al. (2011) included a number of set phases, which were used for the analysis of the data including transcription and coding, interpretation of the data, identification, reviewing, collating, naming of themes, the combining and development of common themes on the computer (Richardson-Tench et al., 2011).

3.7.5 **Transcription and coding of the data**

All tape recordings had separate files and were coded in the multimedia section of the computer. The researcher listened to the tape recordings from the interviews and transcribed the data from the tape recordings into the Microsoft Word files on the computer. As the researcher could identify the participant from the list of codes held in the filing cabinet, it was possible to then code the data on the computer according to whether the participant was a low-risk woman (W) or a midwife (M) with the number of the transcript.

During transcription, it was important to provide a flowing narrative of the data and include rich, in-depth responses from participants, as proposed by Schneider et al. (2008). The researcher preserved the richness of the data by using the participants’ exact words and descriptions. During the initial transcription of data from tape recordings on the computer, the researcher listened to the tape recordings three times to ensure immersion no lost data (Richardson-Tench et al., 2011; Polit & Beck, 2010).
3.7.6 Interpretation of the data

Following transcription, the researcher had to make sense of the data and identify participants’ intended meanings. The qualitative analysis is therefore a “process that pulls together information or examines connections between pieces of information to make a clearer picture of the information collected” (Macnee & McCabe, 2008, p. 418). Demographic, medical, surgical and obstetrical information relating to the women collected at interview was collated, categorised, presented using descriptive formats, and presented in following figures and tables (see Figures 4.1-4.3 & Tables 4.1-4.2). Similarly, descriptive information obtained from the midwives’ questionnaires, relating to their age, experience, employment and models of care were also categorised and presented in figures (see Figures 4.4 & 4.5). The researcher makes sense of the large quantity of data through inductive reasoning (Leedy & Ormrod, 2013). The researcher then organised the transcripts into sections that had a concept of interest to the phenomenon under study. She then scrolled down the text and examined connections between words and descriptions in order to engage further with the data. Where similarities arose in the transcripts, descriptive headings were used to provide sections in the data. The cut and paste facility on the computer was used to initially organise the data on the clipboard and place them in the appropriate sections, which were then organised under subheadings.

3.7.7 Identification of themes and subthemes

Data collection and analysis were simultaneous in this study to identify the emerging themes. Polit and Beck (2010) suggested that emergent themes can be identified by looking for natural variations and similarities in the data. Descriptive summaries on the computer were made relating to reoccurring and similar comments, which were categorised into themes and subthemes. Explicit themes that ran all the way
through the data like a piece of thread were identified. Data reduction occurred through
the collapsing down of themes, common themes were created through constant
comparison and merging of themes and subthemes on the computer. The researcher then
wrote the themes and subthemes on cards to aid comparison and transparency to ensure
that all explicit themes were recognised. Through the visualisation of all the themes and
subthemes on cards on a wall, the researcher could compare and contrast the subthemes
on the cards and ensure that all themes were identified. Visualisation of the whole
picture was important to ensure that the themes were captured effectively.

A further manual method of thematic analysis (Richardson-Tench et al., 2011)
ensured that all of the women’s views in the transcripts had been heard. From the hard
copies of the original transcripts, the researcher cut data related to the themes. The
researcher had colour-coded sections within the hard copies of the transcript data to
highlight words and ideas, which related to the phenomenon of interest. Similar cut data
was placed under a heading, which had been written on a card and placed on the table.
Reduction of data then occurred to combine data with similar meanings or common
threads to obtain distinct or common themes. To ensure that no subthemes or themes
were missed in the computer assisted analysis she then compared and contrasted the
themes from the hard copies of the data, to the data on the computer. Following the
initial formation of themes and subthemes in the women’s data, transcripts of the
midwife participants were read and reread to look for similarities and natural variations
to the women’s themes. Data were constantly compared and then sectioned using the
cut and paste facility and placed into the women’s themes and subthemes. Care was
taken to ensure that each piece of data was coded according to the midwife participant.
The next step in the data analysis process was to collate the themes.
Richardson-Tench et al. (2011) suggested that to develop a list of themes and subthemes, the analysis file should be copied to eliminate everything except the themes and subthemes. Copying of the analysis file is a useful exercise because it allows the researcher to clearly examine the themes and subthemes to see how they relate to the study aims and outcomes of the research. The final themes that have been generated from the data provide the answers to the research questions.

3.8 Rigour

To prevent the occurrence of errors and maintenance of the woman’s voice, rigorous processes for data collection and analysis were undertaken. The criteria used included those outlined by Lincoln and Guba (1985) to assess the truth and ensure rigour and trustworthiness. The criteria included credibility, dependability, confirmability and transferability. According to Polit and Beck (2010), a fifth criterion of authenticity should also be included.

3.8.1 Credibility

Credibility is the goal of qualitative research to ensure truthfulness and believability of the research findings (Langford & Young, 2013). Hence, credibility is defined as the “confidence in the truth of the data and interpretations of them” (Polit & Beck, 2010, p. 492). Credibility was maintained by spending adequate time with the participants, focusing on the research questions and employing multiple data collection processes (Macnee & McCabe, 2008). Credibility was also enhanced through reflexivity, considering how the researcher’s individual thoughts, feelings, values and assumptions can affect the study (Nagy et al., 2010). The researcher was an experienced practitioner; therefore, there was a possibility of bias and subjectivity when conducting the research in the work environment. Reflexivity included identification and articulation of the researcher’s own beliefs and values. Pre-existing assumptions were
identified at the outset of the study using the semi-structured guideline questions in a self-interview. The self-interview using the semi-structured guideline was an integral component to enable the researcher to heighten her awareness of any preconceived thoughts or ideas that may have biased the study. Assumptions included that family and friends, and medical and midwifery personnel may influence low-risk women’s decision-making. However, the researcher had no preconceived ideas as to the extent of the influence.

3.8.2 Dependability

Dependability relates to the honesty of the data that was generated by the researcher. Macnee and McCabe (2008) pointed out that Lincoln and Guba emphasised in their model the honesty of the participants to achieve stability. To achieve honesty, they proposed that it is essential for the researcher to develop an open relationship with the participants and to demonstrate a real interest in their viewpoint, otherwise they will not tell the truth. The researcher used an open posture to help build good relationships, and she showed an interest in what the participants were saying throughout the interviews. Dependability also relates to “the stability of the data over time and conditions; that is, would the findings be repeated if a researcher used the same or similar participants in a similar context?” (Polit & Beck, 2010, p. 492). Dependability is also linked to confirmability, which ensures that there is a greater likelihood that a similar study will confirm the findings.

3.8.3 Confirmability

The careful maintenance of an audit trail—that is, ‘a trail of evidence’ directly related to the purpose of the study—is essential (Brophy, 2008; Macnee & McCabe, 2008). In this study, the researcher maintained an audit trail on the computer related to the decisions made regarding data collection and analysis. To aid confirmability and
credibility, an accurate description of the setting, participants and data collection design and methods were also carried out. A clear audit trail ensures that the study is confirmable. Nagy et al. (2010) advocated the use of triangulation to ensure confirmability by using multiple data collection sources (Polit & Beck, 2010). Data triangulation included field notes, transcripts from audio tapes and documentation. The additional use of data from both groups (women and midwives) enabled the comparison of findings across the two groups, as well as the verification of the accuracy of the study.

Data accuracy, meaning and relevance were essential to ensure that the research accurately reflected the participants’ voices. Member checking occurred initially within the interviews, to ensure understanding of participants the researcher repeated statements back to them and asked probing questions (Refer Appendix G). Probing questionnaires were also included in the midwives questionnaires (Refer Appendix H). Further measures to ensure quality and accuracy of data included the use of tape recording in the interviews, repeated listening to tapes by the researcher, retyping transcripts from audio tapes by a senior clerk and comparison of transcripts to ensure that the participants were accurately represented. To ensure truth value and the preservation of data quality and the relevance and meaning of the themes and subthemes the researcher used peer review of all transcripts and tapes by supervisors. Finally, the researcher sent an interim report and interpretive summary to all of the participants. This approach strengthened the trustworthiness of the research study.

3.8.4 Transferability

According to Polit and Beck (2010, p. 492), transferability applies to “the extent to which the findings can be transferred to other settings and groups”. It is the role of the researcher to provide the reader with sufficient detail relating to the study context to
determine the transferability of the findings (Langford & Young, 2013). It is anticipated
that the data generated from this research study will be transferable to low-risk women
in similar settings. It is a limitation of the study that the information may not be
specifically applicable to some other groups; however, the data generated could be
utilised to create a list of ‘at-risk’ factors for low-risk women likely to request an early
induction of labour.

3.8.5 Authenticity

The importance of the researcher revealing the feeling and tone of the
participant’s experience was highlighted by Polit and Beck (2010). The researcher has
addressed this in the study by presenting the analysis in a way that allows the reader to
transcend into the world of the woman and to view decision-making from her
perspective related to induction of labour. The researcher has enabled the reader to have
a unique window of opportunity to compare the views of the midwives to those of the
women, to enable an understanding of the decision-making behaviours of this cultural
group of low-risk women. The richness of the data and the language related to the
women’s perspectives on their decision-making behaviour has been preserved to ensure
a feminist approach, which is presented in the next chapter.
Chapter 4: Findings

The purpose of this study is to investigate low-risk women’s perceived influences on their decision-making related to induction of labour. Chapter 1 introduced the study, Chapter 2 highlighted the lack of evidence relating to this phenomenon, and Chapter 3 outlined the chosen method and theoretical underpinnings of this research. This chapter will initially report the demographic characteristics of the participants who were recruited, followed by the findings generated from the thematic analysis of the data from the women’s interviews using a feminist lens. A feminist lens was used within the analysis, the results and discussion section to focus on the main aim of the thesis, which was to investigate low-risk women’s perceptions of their decision-making from the perspective of the women themselves and the midwives. Additionally a feminist lens was used to highlight any gendered or power relationships that may have affected the women’s decision-making and identify any strategies that will benefit future low risk women who have an induction of labour. A report of the thematic analysis of the midwives’ data will also add depth to the study. Finally, findings that compare the women’s themes and subthemes with those generated from the midwives’ data will be presented.

To assure confidentiality of the findings, each participant has been allocated a code according to their transcript; for example, W1 relates to the first woman participant in the study, and M1 relates to the first midwife participant. These codes have been used to identify the sources of data presented in this chapter.

4.1 Characteristics of the Women Participants

Nineteen participants consented to participate; however, the researcher excluded one woman who developed psychological problems following birth, which required a medical review. The sample therefore consisted of 18 women.
Demographic, medical, surgical and obstetrical information relating to the women collected at interview was collated, categorised, presented using descriptive formats, and presented in following figures and tables (see Figures 4.1-4.3 & Tables 4.1-4.2). The majority of women (n = 11) had their care provided by either a GP obstetrician or within a model of midwife-led care (Soltani & Sandall, 2012). In this regional maternity unit, midwife-led care during pregnancy was provided only within the antenatal clinic. Consequently, hospital midwives provided midwifery care for the women during labour and the post-partum period. Only a small number of hospital midwives had the opportunity to work in the antenatal clinic. Three women had private health cover, and the remainder (n = 15) were cared for within the public system. Seven of the women participants within the public system selected midwife-led care, where the GP obstetrician provided medical support for midwife-led care at 16 weeks, 32 weeks and at term.

The majority of women (n = 16) were Australian, with the remaining two being migrants from the UK. Thirteen women in the sample resided mostly in two regional areas—Mandurah and Rockingham/Kwinana—which are situated in the corridor southwest of Perth. Three of these women had husbands whose employment at the time of interview required them to FIFO to mining areas in WA. Most of the women were aged under 25 years (see Figure 4.1).
Figure 4.1. Age of low-risk women having an induction of labour (n = 18). The number of women participants within each range is described as a percentage of the group.

Many women in the sample had previously given birth. Proportions of the sample according to parity are presented in Figure 4.2. It is of note that eight women were having their first live birth after having miscarried previously.

The gestation of women being induced ranged from 38 weeks to 40 weeks plus six days. The majority of women (n = 13) were induced prior to 40 weeks, with six women induced at 38 weeks or more, and seven at 39 weeks or more. A large proportion of the women were induced using both artificial rupture of the membranes and a Syntocinon infusion, with only one woman being induced by artificial rupture of the membranes alone (see Figure 4.3). No women participants were induced using prostaglandins. Five of the women had previously had an induction of labour, and one had previously been augmented.
Figure 4.2. Participants' current pregnancy number expressed as a percentage of the sample (n = 18).

Figure 4.3. Type of induction experienced by the number of participants in the sample.

Note. ARM = artificial rupture of the membranes.

4.1.1 Reasons for women’s inductions

Women had been induced for a variety of reasons (see Table 4.1), and some women provided explanations for their induction. For example, one reported wanting
more control so her husband could be there, and another reported being induced for discomfort in pregnancy. For five women, of whom two were primigravida (see Table 4.2), the reason for induction of labour had been stated in the induction book and birth register as pregnancy-induced hypertension (PIH). There was a wide range of symptoms associated with the reasons given for induction. In some cases, the mothers’ understanding of the reason for induction did not match the reason given by the GP obstetrician. One-third of the mothers identified PIH as a reason for their induction; however, this diagnosis was not supported by either women’s observations or laboratory testing (see Table 4.2). One multiparous woman diagnosed with PIH was symptomatic with a raised blood pressure of 140/90 on two occasions six hours apart (no proteinuria or oedema) (Pairu, Bharathi & Kristine, 2016). Midwives in the midwife-led clinic (see Figure 4.4) cared for this woman, who was induced because of this medical condition. For one multiparous woman, the reason, documented in the induction book was PIH; however, the participant’s understanding of the reason for induction was not clear. She stated to the researcher, “I was induced for discomfort”. This woman had experienced a painful abdomen for five days, in addition to back pain and nausea. However, this reason was not recorded in the induction book, the birth register or her case notes. Two women did report that they had a raised blood pressure and oedema, which could be an indication of pre-eclampsia (Pairu, Bharathi & Kristine, 2016). Hence, laboratory testing of these women also included testing for this medical condition to either identify or exclude early pre-eclampsia. Pre-eclampsia and PIH were excluded as indicators of the women’s blood pressure on the partogram during childbirth were normal, and the laboratory blood test results indicated that serum uric acid concentrations were also within the normal range. One of these women stated, “I had a lot of swelling and a raised blood pressure... the doctor was concerned but my bloods were negative” (W5).
The second woman, for whom no reason was recorded, understood the reason for induction as raised blood pressure and oedema at the end of pregnancy; however, during labour, the midwife also noted her blood pressure to be within normal limits. It is interesting to note that when other indicators are absent, oedema is not clinically significant (Pairu, Bharathi, & Kristine, 2016), as another woman participant was described as normotensive in her case notes, but she did have oedema, although her serum uric acid concentration was normal.

Medical practitioners did not always provide reasons for induction in the induction book, and the women’s perceptions of the reasons for induction were also often unclear. Women whose husbands were FIFO workers appeared to be induced for convenience. However, one of these participants was induced for what was documented as ‘borderline’ intrauterine growth retardation (IUGR) and reduced amniotic fluid (see Table 4.2). However, this woman reported that she had no complications in pregnancy (see Table 4.1). When asked the reason for their induction, the other women reported reasons that were different to what was identified in their notes, such as a ‘large baby’, maternal discomfort due to an irritable uterus, and spontaneous rupture of the membranes (see Table 4.1). The woman who was induced for ruptured membranes reported being desperate to go into labour and had taken her friends’ advice. She stated:

\[I\ had\ tried\ a\ variety\ of\ methods\ to\ induce\ myself,\ including\ drinking\ raspberry\ tea,\ pressing\ on\ my\ belly\ each\ afternoon,\ sexual\ intercourse,\ a\ massive\ shopping\ trip,\ wriggling\ around\ and\ walking\ to\ engage\ the\ head.\ (W13)\]

Her membranes ruptured during sexual intercourse at 39 weeks’ gestation; however, she did not go into labour and was induced the next day. For two women, induction was used as a method of risk management. One of these women had previously had a precipitate labour where the cord was around the baby’s neck, resulting
in the baby requiring resuscitation. The other woman had previously had fertility
problems, required artificial insemination to become pregnant, and progesterone to
remain pregnant.

Table 4.1.

Perceived Reasons for Induction of Labour in Low-risk Women Participants According
to Parity

<table>
<thead>
<tr>
<th>Category</th>
<th>G1</th>
<th>G2</th>
<th>G3</th>
<th>G4</th>
</tr>
</thead>
<tbody>
<tr>
<td>FIFO</td>
<td></td>
<td>2</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>PIH</td>
<td>2</td>
<td>3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Large baby</td>
<td></td>
<td></td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Maternal discomfort—Irritable uterus</td>
<td></td>
<td>2</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Post-dates</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SROM</td>
<td></td>
<td>1</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Safety and control</td>
<td></td>
<td>1</td>
<td>1</td>
<td></td>
</tr>
</tbody>
</table>

Note. FIFO = fly-in fly-out employment; SROM = spontaneous ruptured membranes; Gravida = number of pregnancy; PIH = pregnancy-induced hypertension.
Table 4.2.

*Recorded Reasons for Induction in Low-risk Women According to Maternity Induction Book and Women Participants*

<table>
<thead>
<tr>
<th>Category</th>
<th>Woman</th>
<th>Induction Book</th>
<th>Reasons for Induction</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>(W6) Discomfort</td>
<td>(W6,8)</td>
<td>(W6) Discomfort</td>
</tr>
<tr>
<td>FIFO</td>
<td>(W3,4,10)</td>
<td>(W3,4,10)</td>
<td>(W3) Reduced AFI–IB (W10) Discomfort</td>
</tr>
<tr>
<td>PIH</td>
<td>(W5,7,8,9,14)</td>
<td>(W5,7,9,14)</td>
<td>(W5,8,9,14 no raised BP)</td>
</tr>
<tr>
<td>Large baby</td>
<td>(16,17,18)</td>
<td>(W16) Irritable uterus (W17,18)</td>
<td>(W16) Irritable uterus–IB (W17) Polyhydramnios–IB</td>
</tr>
<tr>
<td>Maternal discomfort—irritable uterus</td>
<td>(W6,10,15,16)</td>
<td>(W15)</td>
<td></td>
</tr>
<tr>
<td>Post-dates</td>
<td>(W1)</td>
<td>(W1)</td>
<td></td>
</tr>
<tr>
<td>SROM</td>
<td>(12,13)</td>
<td>(W12,13)</td>
<td></td>
</tr>
<tr>
<td>Safety and control</td>
<td>(W2,11)</td>
<td>(W2,11)</td>
<td>(W11) Spurious labour, poor obstetric history and scheduling reasons</td>
</tr>
</tbody>
</table>

*Note.* FIFO = fly-in fly-out employment; SROM = spontaneous ruptured membranes; Gravida = number of pregnancy; PIH = pregnancy-induced hypertension; AFI = amniotic fluid index; IB = maternity induction book.

### 4.2 Characteristics of the Midwives

Midwives within the Peel Health Campus regional maternity unit were invited to participate in this study. Ten midwives were recruited as a convenience sample. Descriptive information relating to the midwives was obtained from the questionnaires, which midwives had completed prior to their interview. This information related to their age, experience, employment and models of care. Information relating to the characteristics of the midwives was categorised and presented in figures (see Figures 4.4 & 4.5). Seven midwives exceeded 40 years of age, with a range of 25–65 years (see Figure 4.4). All participants were registered as both a nurse and a midwife. Seven midwives had part-time employment and three midwives worked full time. They
included midwives with a broad range of experience in varied settings and duration of practice. Experience as a midwife ranged from one to 11 years, with four midwives having been employed for more than 10 years at the current site (see Figure 4.5). Midwife participants had mainly worked in the Australian system. However, two midwives had extensive experience overseas, where they had been employed in the UK for more than 10 years, and one had worked in the New Zealand midwifery system for less than one year. All midwives had mainly worked in the hospital system, gaining experience across the continuum of antenatal, postnatal and intra-partum care in settings such as the maternity ward, the antenatal clinic and the antenatal education environment. One midwife had also worked in the community and a GP obstetrician’s surgery.

Although experienced in caring for women having an induction of labour, the midwives’ personal experience of induction varied. Several had personally experienced induction when pregnant. One midwife described her labours as being very painful. She had been induced twice previously because of prolonged rupture of the membranes. Another midwife (M1) who had been induced had scheduled her birth to meet her employment requirements. However, she reported that she “kind of regrets it now” and she wished that she had the experience of going into labour naturally. The remaining four midwives had no personal experience of induction; however, they could recall stories that their friends and relatives had told them about their inductions. One friend had said that the pain relating to induction of labour was three times that of a normal birth, and another midwife reported that her sister was induced for pelvic pain and a sore back at term plus 10 days. However, she also stated that her sister would have jumped at the chance of an induction if she had been offered one because she was so sore that she was in tears and sick of pregnancy. One midwife stated that her “daughter
had a scary experience and was induced when she had an unrecognised breech presentation” (M9).

Figure 4.4. Age of midwife participants as a percentage of the sample (n = 10).

Figure 4.5. Number of years of midwifery experience (n = 10).
4.3 Women’s Perceptions of the Factors Influencing Their Decision to Electively Induce Labour for Non-Medical Reasons

Thematic analysis of the data gathered from the women revealed five main themes and 11 subthemes explaining their perceptions of the factors influencing their decision-making regarding induction of labour (see Table 4.3). The five themes identified were perceived health risks to mother and/or baby, fear of the childbirth experience, seeking support for themselves and their baby, shared decision-making related to an induction of labour, and adequacy and timeliness of information on which to base their decisions.

Table 4.3.

*Low-risk Women’s Perceived Influences on Their Decision-making and Induction of Labour*

<table>
<thead>
<tr>
<th>Major Themes</th>
<th>Subthemes</th>
</tr>
</thead>
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<tr>
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4.4 Theme One: Perceived Health Risks to Themselves and Their Baby

This group of women reported a range of medical conditions, some of which were not borne out by their clinical indicators. Many women suggested that they felt there were risks to either themselves or their baby, despite having a normal pregnancy.
Several reported that they had medical problems during pregnancy, but their health records (e.g., large baby, raised blood pressure, gestational diabetes) did not support this. Many of the women reported an inability to cope due to multiple forms of discomfort, which influenced them to request an induction of labour. Multiple forms of discomfort included insomnia, bowel problems, rashes, backache, spurious labour and depression. Figure 4.6 presents a thematic map of the subthemes that were evident in the findings relating to the women’s perceptions of the health risks to themselves and their baby.

![Thematic map: perceptions of health risks to mother and/or baby.](image)

**4.4.1 Subtheme: perceived medical necessity for induction**

Most of the low-risk women believed that there were medical reasons for their induction of labour, with a large baby being the most commonly stated reason, as reported by one-third of the women:

*Well, like I said, I did not choose to get induced. I was booked in to get induced the day before my due date. That was because of my size. My doctor was*
concerned because I have a small frame. I put on one and a half kg in one week, so I thought if I went another week she might have been really big. (W5)

The reason is medical really, and I did think that I had a valid medical reason at the time. (W6)

In addition, a small number of women believed that they had gestational diabetes; however, their health records did not support this diagnosis: “The doctor recommended an induction because of the diabetes in pregnancy, which makes the child grow too fast, which can be dangerous” (W18).

As well as gestational diabetes, some women believed that they were being induced for being post-date. However, one woman who had been online was confused by the GP obstetrician’s decision to induce labour prior to what she found was described as ‘term’, making the comment that, “Midwives online say ‘no one can make you have an induction before 42 weeks... wait...’” (W1).

One-third of the women reported that their GP obstetrician induced them for a raised blood pressure, despite the fact that all five had only had a raised blood pressure on one occasion. They agreed to have an induction because they thought it was the safest thing to do.

One woman also indicated that the doctor believed that both she and the baby were at risk from infection: “The doctor stated that I needed to be induced because the waters had been broken for such a long period of time... about 16 hours. I think there was a risk of infection” (W12). Another said:

I was monitored and the baby was back to my back with the cord around the neck and dropped his heart rate. Originally I had wanted the baby to be born at home; however, the baby could have been at risk. (W11)
4.4.2 Subtheme: inability to cope with multiple forms of discomfort

Multiple forms of maternal discomfort affected nearly all women during pregnancy, with half stating that they felt ‘fed up’, which resulted in them requesting an induction of labour. Despite the sample being all low-risk women, only two women perceived that they were well during their pregnancy. The difficulties of coping with the discomforts associated with pregnancy led one woman to remark that an induction of labour should be readily available from 38 weeks of pregnancy:

*Induction of labour should be much more of an open-minded thing from 38 weeks, because women do get uncomfortable. It did get to the point where I was an insomniac from 38 weeks, too big, too uncomfortable, couldn’t eat, problems with the bowel… I had every condition known to man and it does make it less enjoyable when you have your child.* (W2)

*I had morning sickness all day from 14 weeks until 20 weeks of pregnancy… From my 20-week scan the baby’s kidneys were a little dilated. They said it was not a problem. I went to my 34-week scan and the problem had cleared itself. When I was 30 weeks I started to notice the swelling of my fingers. At about 35 weeks I had my engagement ring off, the doctor said that I had oedema and that it was common. I had so many problems when I think about it. I had a rash all over my belly, a rash all over my arms and legs at 18 weeks that went away in a couple of weeks.* (W10)

*Got fed up… I started to suffer depression and hadn’t taken my pills for nine months. I had had enough towards the end… I was feeling back pain and my feet were sore and swollen… I was sleeping all day… I would get up for half an hour then just sleep again the whole of the night. I discussed this with the doctor. However, I did not want to take any medication until I had the baby.* (W8)
The physical discomfort and risks associated with having a large baby influenced two other women to request an induction. These women explained to the doctor why they wanted the induction, and the doctor agreed. Spurious labour and the discomfort associated with relentless contractions influenced one-third of the women to have an induction. One woman who was induced commented that she had been contracting every 10 minutes for 21 days:

*I was previously induced due to false labour and contractions. I was contracting for 17 days. The same thing this time: contractions for 21 days. I could not sleep. I had an irritable uterus and I rang the hospital.* (W15)

*I was induced for all of my pregnancies. I had false labour.* (W18)

*Just the fact that I was so heavy and so uncomfortable and... I was actually bigger with her than I was this time.* (W6)

### 4.5 Theme Two: Fear of the Childbirth Experience

Fear was generated by isolation in some of the women participants. Additionally, their previous negative experiences in childbirth, as well as those of their families and friends, compounded their feelings of fear. These fears were expressed predominantly in relation to a fear of harm to either themselves or their baby during the childbirth experience, as indicated in the thematic map of subthemes in Figure 4.7. These fears motivated the women to actively seek out an induction of labour.
Figure 4.7. Thematic map: fears generated by women’s isolation and previous experiences.

4.5.1 Subtheme: fear of harm related to their previous experience in childbirth

Many women reported that their personal experience of childbirth generated a fear of harm in their subsequent pregnancy. The women were influenced mostly by previous pregnancy loss and the complications associated with childbirth:

*I had the eldest baby... I was six and a half weeks early. I only just managed to get to the car park of the hospital that we were going to... that was very much the reason I was induced.* (W2)

A small number of women had previously encountered pregnancy loss. Two women reported that they had believed they had lost their baby when they had not:

*I was bleeding every time I went. I was told the baby had died, bleeding eight to 11 weeks, then it stopped at 12 weeks. Every time it happened after hours... I was told to wait until Monday for a scan... One time they said, ‘You have definitely lost the baby. We will book you for a scrape without even checking the*
baby’. I said, ‘Can you please check?’ and the baby was fine. I had ultrasounds weekly. (W10)

Yes, I have had two severe bleeds in the first few months… I thought that I had had a miscarriage basically. (W12)

The women recalled other previous difficulties associated with childbirth. The combination of a previous history of complications and problems with the current pregnancy influenced one-third of the women regarding their decision to induce labour:

Both of my first children were born with the cord tightly around their neck. My son… they said if he hadn’t have come early he would have ended up losing his hands and feet due to loss of circulation. My daughter, she was not breathing when she was first born as well, so that was part of the shock factor with me. Everyone off the whole floor ended up in the birth room when I was delivering her to help her and sort her out… she needed resuscitation. (W2)

Yes, all three were healthy pregnancies and births. With the first and second birth, I had a retained placenta. When the doctor pulled on the cord and it snapped, I had to have a D&C [dilatation and curettage]. A few weeks after the birth, I lost some clots and then the rest came out. All three pregnancies were induced. With the first one I had pelvic pain, was hobbling about and the doctor decided to induce me. The second birth, I tore badly and had a second-degree tear, which took one hour to suture up. (W17)

4.5.2 Subtheme: fears prompted by isolation and friends’ and families’ concerns

Fear was not only evident in the women due to their own previous experience, but one-third also felt fearful because of family members’ difficult experiences with childbirth, as many had felt isolated during pregnancy and childbirth. To reduce their
fears when isolated, women planned their birthing date so that their partner and other
family members could be present.

I didn’t want to risk anything happening with labour and my partner not being
there. (W4)

When the doctor came up with a date when he was due, my partner asked if I
could be induced and the doctor said he could not do it. I did panic then... I felt
I would not have been able to cope. I had seen my sister afterwards, she couldn’t
drive for almost six weeks, and her husband had to stay home to help
afterwards. I thought if it is going to be like that I just wanted my husband to be
there to help me, especially even if I had a natural birth, I want him there. If he
was away and I had all these problems, I would not leave the hospital. I would
tell them that I wanted to stay for a week until he got leave. (W10)

One-third of the women’s family members, including husbands, mothers, sisters
and aunts, thought that the baby or mother could be harmed by the procedure of an
induction of labour. This view was based on their own childbirth experience:

My sister did not want me to be induced. She went more than 10 hours with the
first one, did not dilate at all and her contractions were painful. (W18)

I did not want to go over 40 weeks, because my sister had such a horrific labour.
She was huge by the time she was due. She had lots of fluid, her nose had spread
halfway over her face; it was super tight and my mum said your doctor should
have induced you earlier. They ended up inducing her at 42 weeks, and the baby
was big when she came out... all her limbs were cramped up; it took days to get
back to normal. (W5)

One little factor that made me think about induction... My cousin had a stillborn
baby last year... She went past her due date, got to 41 weeks, they said, “We will
induce you”. The day that she went in to be induced, they put the heart monitor on and the baby had died overnight. (W10)

Irrespective of family members’ concerns regarding potential problems associated with the procedure, the women in this study accepted the decision to induce labour if the induction was to prevent harm to the baby:

*Mum thought an induction was a good thing. In one of the pregnancy books, mum saw that thing that starts with e… [pre-eclampsia]. She did not want me to get that; she thought with my signs of blood pressure that it would not be good for baby and me… My sister agreed with mum; if the baby and I were at risk, then induction would be a good thing.* (W14)

Another source of fear was that friends willingly shared their previous experiences with the women and at times frightened them. Some had reported good experiences, such as contractions starting straight away and having a faster labour. Others had experiences that had gone on for a couple of days: “Or that the contractions could be more painful than if I went into labour myself” (W6). When this woman was asked whether her fear was based on what her friends had told her, she said, “Yes, horror stories” (W6).

Women also considered that their friends thought that babies should be born at 40 weeks of pregnancy, or sometimes earlier: “I think a lot of people think that you get to 40 weeks and that’s it, the baby has to come out” (W9). Further, “My mate had a premature baby and she told me to get my baby out earlier” (W13).

These experiences affected the women’s decision-making, and many of them wanted an induction to avoid harm to themselves and their baby. Nevertheless, the final theme calls into question whether the women had been adequately supported for their decision-making.
4.6 Theme Three: Seeking Support for Themselves and Their Baby

Perceptions of support relating to the women’s partner, family and friends during their decision-making varied among the participants. When support from their partner was not present, the women sought alternative forms of support from their family and friends. They seemed to appreciate support from women of their own age, particularly their sisters and friends. A thematic map of the subthemes that were evident in the findings relating to perceptions of support is provided in Figure 4.8.

![Thematic map: women’s perceptions of their support relating to induction decision-making.](image)

**Figure 4.8.** Thematic map: women’s perceptions of their support relating to induction decision-making.

4.6.1 Subtheme: varying levels of family members’ support for induction decision-making

The women participants were divided in their perception of their partner’s level of support when making decisions. Many women stated that when their partners were supportive and close by, it helped them to make a decision on an induction of labour. Despite this, they did not perceive that their partner influenced them with regard to their decision-making. Five of the participants’ husbands supported their wives in their decision to induce labour. A number of women considered that their partner just went
along with it: “My husband and I talked about induction and we did agree that it was probably the best option” (W6). Further, “My husband was supportive of me; he said ‘You do whatever you feel is right’” (W10).

Nonetheless, many of the partners would have preferred their wives to go into labour naturally: “My husband did not want an induction. He was hoping that things would happen naturally... It was not something that he was happy about... he was quite sad” (W18). Another woman stated that, “My husband didn’t want an induction” (W8).

One woman’s partner influenced her to have an induction of labour because he wanted to see what the baby looked like: “My partner wanted to see the features... My partner’s Aboriginal” (W13).

When women were isolated from their partners and their support due to employment commitments, this affected their decision-making. Three women had partners whose employment in the mines required them to FIFO, and they all identified feelings of isolation. They reported that limited flight times, time taken to travel and annual leave affected their decision-making and induction of labour. This led them to schedule an induction of labour so they could have support during childbirth. All of the women were aware of the distance that their partners had to travel to attend the birth, and they were concerned that they would not be there because flights were limited to certain days for FIFO employees. This meant that some men could take up to four days to return to their partner. Some of the women even changed their doctor in order to get an induction of labour and have their husband with them for the birth: “Oh... he wanted to be there for the baby, he did not want to miss it, so I conned the doctor into it” (W3).

The researcher asked the participant to clarify this statement, and the woman responded:
Yeah, well he was going to be away on the due date... He has got a couple of weeks' leave now, which was all planned. I did not want to waste the two weeks’ annual leave. I have still got four days to go of his leave. He has spent an extra five days with her, and that’s a bonus! He can only get two flights in a day, and his flight is on a Wednesday. There are no flights at the weekend. It takes six hours to drive to Port Hedland from the mine and two and a half hours on the jet. (W3)

My partner is working in Alaska. It takes him three days to get home, so especially this being our first child, I wanted him there. If he was doing fly-in fly-out in Australia it wouldn’t have bothered me. With him working so far away and because he only has a certain amount of time off, it is really hard because he has to keep to his roster. (W4)

However, the women would not have requested an induction of labour if they had known that there would be risks to themselves or their baby:

My husband’s employment made me ask for an induction. It’s such a common thing, that a lot of people have an induction. At the end of the day, if I thought in my mind that it would put the baby at risk, I would not have done it. Like I said, I did not do any research myself. I assumed that if it was a risky procedure, that I would have been told and warned against it. (W4)

Partners approached their employers for leave to attend childbirth appointments, and a limited number of women found that their husband’s employer was supportive. Some employers ensured that the husbands could finish work early in order to be with their partner during childbirth. However, not all employers were sympathetic, and many partners could not attend the antenatal clinic due to their employment. The women reported that they were often alone and nervous when attending the antenatal clinic
appointments. Consequently, many partners were not present when the women made their decision regarding induction. However, the women reported alternative reasons for their partners not attending the antenatal clinic, including financial constraints and having to work a night shift:

One of the reasons why we did not go to the classes was the partner’s night shift.

We could have gone to the night classes but you would miss out on a couple of weeks, so what is the point? (W1)

My husband was working locally and had only just started work. We could not afford the time off, even though he wanted to come with me to the appointments. (W8)

Women sought alternative forms of support when their partner was not available. Six women reported that they appreciated their mother’s support; however, this support was not available for other participants:

I really did want my mum to be here and present for the clinic appointments. (W1)

The second time I came to clinic knowing we were going to speak about an induction, I brought a support person—my mum. Then my mum and I explained the information to my husband, who was there the morning of my birth. (W2)

They also received verbal information from their family—primarily from their mother and sisters. Women were reassured if their experience of childbirth was good. They were also reassured by their mother’s experience in childbirth:

Most of the information was from my mum. She had two miscarriages and seven children in eight years. Mum provided really good information. With her generation there were more frequent inductions. Mum had a lot of good
information about children. If not for family, if I didn’t speak to them I wouldn’t have known what I was doing. (W5)

Information was sought from the women’s sisters/sisters-in-law regarding their previous experience of childbirth, and the women found this helpful. Further, some women appreciated their sister’s support and said that it influenced their decision-making:

[My] sister was helpful in labour. My sister stayed with me and supported me. She had three children. The last one was an emergency Caesarean for twins... she was a good laugh. (W16)

I guess my sister and mum have been induced, so I wasn’t worried. I guess in the back of my mind, as long as I knew it wouldn’t hurt, I didn’t have a problem with it. I perceived it was okay to do it. I naturally assumed it would fine that it would not have any effect on the baby. Like I said, it would not have even crossed my mind if my partner had been in Australia. (W4)

My sister-in-law’s have children and my own sister has a lot of family. Their stories have helped me. (W5)

4.6.2 Subtheme: influenced by friends to have an early induction

Women often turned to their friends rather than relatives for support when making their decision relating to induction. Friends supported many women—primarily by providing information on the procedure of induction. Some women were reassured if their friends had a healthy baby following an induction of labour for reported complications. One-third of the women were influenced by their friend’s previous experiences, and this was useful when making their decision regarding induction of labour. Some were influenced by friends to obtain an early induction of labour. One woman attempted to start labour herself based on a friend’s advice:
Down south my friend was five weeks early. I was keen... wanted mine like she had had hers, five weeks [early] though extreme, but thought it would be cool. ...It is true what you guys say. I tried everything to bring on my labour, but it didn’t work. [I] tried again closer to my due date and tried again at 37 weeks. I tried many different things. (W13)

My friend told me, ‘If you push your belly down each afternoon, drink raspberry leaf tea or have sex’. I tried being active. I reckon if you lay around, you are longer in pregnancy. My friend also said to ‘do a massive shop, being on the move always doing stuff, wriggling around also makes the head go down’. I walked around for hours; it helped the head to engage. The raspberry tea leaves and the prostaglandins idea is also in the birthing book. I asked the mothers down in the South West; they liked the raspberry tea. They also said that “babies will come when they are ready”. I had sex... ruptured my membranes. It was one week till the baby was due 39/40. No contractions when the waters went; it was hours after I started contracting. (W13)

The women were asked when the hormone had been provided in childbirth, and one woman replied: “Halfway through my labour” (W13). Based on a friend’s advice, another woman believed that women have to know where to go for induction:

One friend did get an induction. The doctor took on board that she had older children and needed to be with them. There are certain people who know where to get an induction straight away and where you cannot. [It] depends on who you see and where you have been. Friends say you have to know where to go and plan where to go. (W2)
However, not all stories from friends reassured the women about an induction. Some friends told the women about the complications of labour, and that contractions were quicker and more painful:

Some had good experiences, contractions started straight away and they had a faster sort of labour. Others had labour experiences that had gone on for a couple of days. Friends just said that contractions could be more painful than if you went into labour by yourself. (W6)

I had been given information that you are given a certain amount of time in normal labour. If you are induced, they follow a protocol. Labour can end in a Caesarean if your body does not want to cooperate. (W2)

I’ve had three friends induced. My friend was induced at 38 weeks. She had a lot of swelling… she had a reason. Another girl I knew from school was induced because she had pre-eclampsia. She was induced at 37 weeks. Another was induced to have a nine-pound baby. She said she was in labour for 24 hours… they used forceps, suction caps, everything… the works. (W10)

When asked if this had put her off childbirth, this woman replied, “No… they said that it is all worthwhile in the end. In the end, they all had healthy babies” (W10).

One woman had a friend who was a midwife, and she provided support for the woman’s decision-making: “A friend of mine was a midwife. She helped” (W11).

However, friends did not always support or help women in their decision to induce. According to the women, friends’ stories of induction were often unrealistic, but they were selective in what they listened to: “Generally, it is not seen as good to induce labour” (W2). Another stated that “A lot of people were very negative, saying an induction was not natural, but they can’t really judge” (W17). When this woman was
asked who these people were, she replied, “Friends, anyone who I knew or came in to close contact with” (W17).

The women usually valued the type of support that relatives and friends provided. However, it appeared that having a baby early was accepted as a normal pattern of behaviour within this group of low-risk women, as was the behaviour of seeking an induction if they were isolated from their family members and friends, or for other social reasons.

4.7 Theme Four: Shared Decision-making Related to an Induction of Labour

The majority of women reported that there was shared decision-making relating to an induction of labour between themselves and their GP obstetrician. However, the women reported that the attitude of health professionals varied in regard to the mothers’ decision-making and the degree of influence they exerted. A contradictory finding was that many of the women believed they lacked choices related to decision-making and induction of labour because the doctor predominantly made the decision to induce. This view lies in contrast to their perception of shared decision-making. A thematic map of the subthemes that were evident in the findings related to the level of the women’s ownership of the decision-making process is provided in Figure 4.9.
**Figure 4.9.** Thematic map: ownership of the decision-making process related to induction of labour.

### 4.7.1 Subtheme: perceptions of shared decision-making with GP obstetrician

More than half of the women interviewed indicated that they felt they shared the decision-making process with their medical practitioner regarding an induction of labour, and they reported that ‘they had a choice’. Some of these women were pleased that they had made the decision to be induced. They considered that they had autonomy in their decision-making, even where the decision was made because of perceived health risks:

> *I had autonomy. I could have said at any time, ‘Wait it out’, and the doctor said, ‘It is up to you. It is your choice’. (W1)*

> *I feel like I had a choice in the matter, definitely. At the beginning, I wouldn’t have thought an option—not for someone like me, because I had pretty straight forward labours. I definitely had the power of choice [this was] between the doctor, my husband and I, although the doctors did push it more positively... rather than the negatively. The midwives were neutral, no viewpoint at all. (W2)*
I felt in control because of what I said I would like and prefer. The doctor agreed with me. It was a joint agreement. (W17)

Women who stated that they could share the decision-making process believed that they decided when they were going to be induced. Three of the women reported that they made the decision to request an induction of labour during antenatal visits. One-third of the women felt that it was acceptable to request an induction of labour, provided that it was not too early in the pregnancy, although they also stated that it would have been easy for health professionals to influence them to change their mind in regard to the request. The women all reported that, when asking for an induction of labour, their GP obstetrician encouraged them to go to their due date:

Every visit I would bring up an induction with the doctor... It seems it doesn’t matter what you think; unless you are persistent, it would not have happened... I think an induction is all right as long as women don’t want an induction when six weeks’ premature. I would have been easy to be put off... but I’m a very determined person... [laughs]. Well, why should the husbands go out and work and work and miss out on all the luxuries of childbirth. It is only five days early; it’s not like it was five weeks. (W3)

Doctor wanted to wait till I was 38 weeks to do the internal examination to see how I was progressing, then try and make a decision at about 39 weeks, roughly about then. He wanted me to wait till my due date, but my partner had his flight booked, but it takes a few days to get home. It was booked for a few days before my due date... we thought we will keep it at that, then just play it by ear because of his flights. There was a risk he did change his roster so that he was home on the 19th, I was term plus 1 day. I had my 38th week visit. I was due on the 18th and he booked me on the 19th... The doctor tried to encourage me if I was going
to be induced to do it as close to the due date as possible, rather than doing it early. (W4)

I went to the doctor’s surgery and asked, “How can I get an induction of labour?” The doctor then said I had got to be more than 38 weeks. The more he was talking about it, the more I thought “Yes, I’ll do it”. Every time I saw him, I was in worse pain and feeling down. (W8)

Women reported varying forms of pressure from their GP obstetrician related to the induction decision. A number of women who wanted an induction felt they were being controlled because the doctor made the induction decision for them. They perceived that they were talked out of an induction of labour and lacked choices in making their decisions related to the types of induction methods:

I sometimes felt that I was being talked out of it to be honest, but I also felt that there was a reason for that and that there were risks involved. (W6)

I suppose it would have been handy to know the different methods. With the gel, labour might have been slower... come more naturally, instead of such an instant thing. A bit of a shock... maybe that might have informed my decision on what type of method to use. (W5)

A number of women who had not anticipated having an induction reported that they did not feel they had a choice regarding whether they would have an induction, as their GP obstetrician informed them that they were having a large baby:

Every time I got my belly checked, he said he is a good size, large for dates, things like that and then he said, “We will do an induction”. (W8)

The doctor wanted to induce me about 38 weeks. He said that the “baby was pretty much grown by 38 weeks onwards”. (W14)
The women who requested an induction of labour prior to term reported that the doctor tried to persuade them to persevere longer in pregnancy. However, the doctors performed internal examinations prior to 40 weeks to encourage them to go into labour naturally:

Yes, I spoke to the doctor who discussed the reasons for induction. I was encouraged to do it on my due date rather than early. I saw the doctor on Tuesday; he was hoping to stretch the cervix to bring on labour naturally. He didn’t want to risk anything happening when my partner was not there. (W4)

At 37 weeks of pregnancy I asked the doctor for an induction of labour. The doctor did a vaginal examination [VE]. The cervix was 1 cm dilated. He said he “would rather wait till the next week as there was a strong outcome of a Caesarean”. I said “Yes, but do you think I will be able to give birth?” He never said yes or no, just got to be open-minded; don’t flap if you have to have a Caesarean. (W10)

Three women reported that they needed to feel they could trust their doctor with regard to decision-making, discussing concerns and receiving information. Women who changed their GP to a GP obstetrician in pregnancy felt more comfortable with their GP obstetrician rather than just their GP: “I won’t trust anyone unless trustworthy. That’s why I liked the doctor; he was brilliant all the way through. Initially I didn’t feel I was getting looked after at the previous medical centre. I changed doctors when 18 weeks” (W5).

Despite trusting their GP obstetrician, the women appeared to perceive that the inductions were medically indicated; however, the evidence often did not support this. Some inductions conducted prior to the women’s due date were completed to allow for the scheduling of social events and the convenience of the mother and her family.
Health professionals often label these types of inductions as ‘social inductions’. Three women had previously organised an induction of labour to fit in with their employment schedule and to have more control in their life. One woman also scheduled childbirth in order to be home for her child’s first day at preschool:

*First child going to start pre-school on the Monday and I wanted to be at home.*

(W13)

*Yes, in 2007 I worked in a business. There was a three- or four-day window when I could have the baby so my husband could be there.* (W11)

**4.7.2 Subtheme: interactions with and support from health professionals**

Women reported that the attitudes of health professionals varied in response to social inductions and the women’s decision-making regarding induction of labour. Some women commented that their doctor supported their decision, and that they appreciated their doctor being open-minded about induction. Many were surprised that their GP obstetrician’s attitude towards induction was so positive:

*The fact that both doctors didn’t think an induction was such a bad thing. If the doctor had been neutral or didn’t think induction would be a good thing, I would not have done it because the doctors both had the same opinion and both saw it in a positive manner.* (W2)

*The doctor must know the baby is a decent size, and is obviously happy with the way she is progressing. I know a doctor would not have suggested it if it was too early. Because he had suggested it, this made it clear in my mind to go that way. I am sure there are people out there that if he suggested it, they might be completely against it.* (W5)

In contrast, a few women did not feel that midwives were as open-minded as doctors in relation to their decision to have an induction of labour for social reasons.
However, two women disagreed and felt that midwives were neutral in their attitude towards social induction:

*Midwife at the doctor’s surgery, yeah, one of the midwives said “induction is frowned upon”. I said ‘well, you will be frowned upon if he misses it’. She just looked at me...* They don’t want to induce you I suppose... They are going to have to get used to it... a lot more people want it. (W3)

*They gave advice when I asked for it; they weren’t pushing for me to have it done. There was no opinion in either direction.* (W2)

When this woman was asked, “Did the midwives sway you either way regarding an induction of labour?”, she responded:

*No, they were very neutral. They gave me an information worksheet and answered any questions that I had on induction when asked... no, they were very open-minded.* (W2)

However, the women reported that the GP obstetricians’ approach varied in that they did not always share the decision-making with the women. A small number of women were influenced by their doctor’s suggestion that it was all right to have their baby at 38–39 weeks. When asked about the factors that influenced her in her decision to undergo an induction of labour, one woman gave the following response:

*More the doctor, he said that the baby was healthy and ready, and if I went longer that the baby might be distressed. I was pretty much ready when I had an examination of the cervix at 39 weeks.* (W15)

### 4.8 Theme Five: Adequacy and Timeliness of Information on Which to Base Decisions

Some women did not feel prepared for the decision-making related to an induction of labour, which compounded their fears of childbirth. Although the majority
of women believed that they had received useful information, many thought the information was not sufficient. Many also believed that information was received too late in their pregnancy, so it was difficult to understand and did not help them in their decision-making. A number of women reported that they could not remember the information provided by health professionals. The women also wanted to be told clearly that it was normal to go more than 40 weeks, as most of them expected to give birth at 40 weeks. A thematic map of the subthemes that were evident in the findings relating to the adequacy and appropriateness of information is provided in Figure 4.10.

4.8.1 Subtheme: women sought alternate sources of information when information was inadequate.

Most women reported that they received most of the information regarding an induction of labour from the doctor:

*I received verbal and written information on the risks of induction, Caesarean section and pain relief required for labour. I knew basically what was going to happen. I was booked to have the induction at term plus one day. When I saw the doctor, he was hoping to stretch the cervix to bring me on naturally. (W4)*
Figure 4.10. Thematic map: accuracy and timeliness of information on which to base decisions.

One-third of the women commented that midwives in the midwife-led clinic usually informed them about induction of labour. One woman received information from both the midwife and the doctor within the midwife-led clinic. All of the women participants who had midwife-led care received information from this source:

*Midwives were very good. Each time I came to clinic, they always asked if I had any worries or questions.* (W6)

*Every time I would write down some questions [for the midwives]. I asked a few times regarding induction and was told babies come when they come.* (W13)

The majority of the women were given hospital information sheets, consent forms or verbal information prior to admission, which indicated that an induction would be recommended at 41 weeks. However, despite this information, all women were induced early; that is, prior to 41 weeks. The women considered most verbal information that was received on admission and in the midwives and doctors’
clinics/surgeries useful. Some of the women appreciated the consistency of the information, the clarity of the written information sheets and the knowledge of the midwives and doctors:

*When I was in hospital the midwives were telling me what to do. Clearly the midwives did know what they were doing. All the midwives were keen on you not having an epidural or drugs, but this was what I wanted. I understood the hormone makes you have contractions and it helps get the baby out, especially if you have been in labour for a few hours.* (W13)

*The day before being induced, the midwife and doctor had the same viewpoint. An appointment was made at 2 pm to be induced the next day at 7.30 am.* (W2)

When information was inadequate, the women actively sought information from a variety of alternate sources, including their family and friends, books, the Internet, chat rooms and baby exhibitions. The information from these sources was important to them in making their decision regarding induction of labour. Half of the women read a variety of baby books to find the information they required on induction of labour and pregnancy. The women appreciated the knowledge available from books, including those written by midwives. One woman was well informed, having obtained information on the alternative methods of induction of labour:

*When I found out that I was pregnant, I bought the book by a practising midwife and the next book that goes with it. My ‘birthing book’ was my bible. I read about methods of inducing labour naturally, like having sex and producing prostaglandins... read other magazines and books about ladies wanting to induce labour... I didn’t have anyone to ask. My mum passed away when I was 13 of cancer.* (W13)
Two of the women commented that they could not find the information they required on induction of labour. A number of the women also asked to be supplied with some good book references: “Read the complete book of pregnancy and childbirth... there is nothing much about an induction of labour... I need more information in books on an induction of labour to read. I find them hard to find”. (W16)

The women chose a variety of Internet sources for their information when they thought other information was inadequate. However, they perceived that the quality and reliability of the Internet sources varied. Sources on the Internet included chat rooms, Google, Baby Centre and Bub Hub. Eleven women considered that they received much of their information online and asked questions about the procedure of induction of labour. Three women stated that they had not obtained online information:

*I can tell you of two sites, which are really good... Baby centre.com and Bub hub.com. They had instant information on everything... Baby centre.com had week-by-week pictures of what the baby would look like. They gave you an idea of where you are at and what is normal. I liked the sites; there was no negative information. I had heart burn; I looked it up and they said that was normal. I did not even bother to go and see the doctor.* (W10)

The women went online to look up symptoms in their pregnancy. They remarked that they found some useful information, with some indicating that additional information from the Internet reduced their stress levels. They also searched the Internet for natural ways to induce labour, and three women obtained information about ‘How to self-induce’. When women were asked about the content, they responded:

*All the information online was useful; I came into hospital reassured. Artificial rupture of the membranes... I thought let’s go. I never thought anything could go wrong.* (W10)
I know about how to bring on the baby, about natural methods without getting drugs... natural raspberry leaves and hot baths. I did not want any drugs, wasn’t going to have any. I preferred natural methods. (W8)

I looked on the Internet from 36 weeks at the risks and the benefits of induction. I think induction... it depends on whether the baby gets stressed. With an induction, it is better to get them out if the heart rate is not good. Inducing them can stress them out as well, if they don’t come out, if their labour is too long. I can’t remember the benefits of induction. (W14)

Several women remarked that they wanted reliable websites on induction of labour and CS. They thought the information contained on current websites was confusing: “Everyone had different opinions on everything” (W14).

In addition, many women wanted a chat room where they could have contact with a health professional. However, they did not consider that the telephone support system provided by Health Direct was useful to them during pregnancy: “Not keen on a chat room and talking to people you don’t really know. It could be really helpful if it was by the midwives” (W18).

A large proportion of the participants mentioned that they required adequate audio-visual material to help them with their decisions, and some wanted to watch a video/DVD on induction of labour.

4.8.2 Subtheme: ability to understand and recall information

Although the women received information, some were affected by a lack of recall or understanding of the information given to them. Most reported that, at times, they could not remember the information they had been given, such as the information sheet or the consent form. Many women reported that their doctor explained the procedure; however, they had difficulty recalling the information given to them. All of
the women were influenced by what the doctor said; consequently, they were compliant with their doctor’s suggestion to induce labour. One participant could not remember the information despite booking in late and receiving the information in the past five weeks. A number of women did not fully understand the procedure until after their labour, but they believed this was too late: “I can’t remember all the information regarding induction” (W4), and “Halfway through I got the hormone. I was out of it on gas, I kind of understood, only afterwards when I understood induction properly” (W13).

A few women had difficulty remembering the information given to them in their childbirth classes, and they wanted more information on induction of labour in the parenting classes: “went with our first child to childbirth classes, but I can’t remember if I got any information regarding an induction” (W18).

The women also expressed a need for clarity when given information by the doctor or midwife, or from online and in books. They remarked that, at times, the information was not consistent; this was confusing and did not help with their recall of information:

When I presented to hospital on Boxing Day, there were 30 different sets of opinions. They all differed considerably. A lack of commitment by staff... they were reluctant to say ‘This is what I want you to do’. I need you to tell me what to do... I wanted a medical answer... that is why you go to the doctor. Every induction is different. We need to understand. We need clarity. (W11)

Most books like ‘Up the Duff’ say that you usually have your baby at 38–42 weeks. But when she got to 40 weeks [in the book], you know she had her baby. It was very stereotypical to get to 40 weeks. (W9)
At the last appointment, the doctor just said he would rupture the membranes and start the hormones, no explanation. Probably if it was my first baby he would have been more thorough. (W17)

4.8.3 Subtheme: preferences related to timing and provision of information

The women suggested that they should be given information at the right time, as they need information on induction at the beginning and all the way through pregnancy. However, their opinion varied regarding when information should be given. Further, the women sought information from 20 weeks to 30 weeks from a variety of sources, including free hospital Bounty bags, books, relatives and their doctor. Nonetheless, they thought that the information should only be provided to women who were at risk of being induced. One woman referred to the provision of information throughout pregnancy as ‘conditioning’:

I want continuity of information called conditioning... what is going to happen next... at every hospital visit. I wouldn’t let anyone leave without knowing, there are a number of ways you might go into labour. (W11)

I would like information at booking on an induction of labour. (W10)

Give information at 32 weeks or towards the end of pregnancy. I would like written information as well as verbal, so that you know the advantages and disadvantages. (W5)

The women reported that information was often received too late. They were often given information when the decision was made, the day before or during the procedure of induction. A number of women received their consent form and information sheet on the procedure of induction in the labour ward, while nearly half of the women received information when the procedure was being performed. Women felt that it was too late once they were in labour because they could not change anything. A
few women said that their doctor did not explain the procedure until afterwards, and
they were surprised that they had not received any information: “[I] thought people
would have given you information about the risks involved. At least the doctor would
have tried to talk about it” (W4).

One woman added that a woman needs time to think and absorb the information
regarding an induction of labour:

A pamphlet or booklet would be good [forms of information], but you need time
to go home and read about all the different things that can come up. (W16)

Whatever information it is, you need time to think, time to read it. (W16)

In addition to the timing of the information, the majority of the women remarked
that they did not have sufficient information to make their decision regarding induction
of labour. An exception to this view was that the level of information provided by the
midwives in the midwife-led clinic appeared to be adequate to satisfy the women’s
needs. Although the women were generally satisfied with the adequacy of information
from the antenatal clinic, a small number of women required further discussion:

When I came into the clinic at 39 +5… the Doctor said if nothing has happened
next week we will discuss an induction. That’s when I then went back online and
asked the questions about induction. (W1)

I was given the information sheet in the antenatal clinic. But then I went on the
Internet to find out more (about induction) and I just read up a bit about it. (W9)

Most women were not satisfied with the written or verbal information they
received on induction from either the hospital midwives or the doctors. Many women
stated that the procedure of induction should be fully discussed. They also reported
issues relating to informed consent. One-third of the women did not receive either
verbal or written information on the procedure of induction. Many could not remember signing the consent form for an induction of labour:

On admission I got told nothing but to come in at 0700. (W8)

I suppose it would have been handy to know the different methods of an induction of labour. They never really sat down and discussed an induction. (W5)

The inadequacy of information also made women feel frightened and stressed:

Only thing I didn’t like about induction was the build-up from the night before. I couldn’t sleep, got all worked up, got really stressed. I think that caused problems with my heart rate. I generally have a high pain threshold, but I was so nervous, I pretty much passed out before the pain started... It took the joy out of what I was doing. (W2)

When I was induced it was a shock to my body. As soon as the waters broke, my legs started trembling, then I started vomiting. Mum had warned me that my body would get straight into it. I wanted to go home I felt so sick. (W5)

I was Group B Streptococcus positive. They said I had to have penicillin during labour and that there was a 1% chance that the baby can get sick and die. We freaked out... We did not know anything about this; it frightened us. (W8)

While two women thought that, they did not need written information to inform their decision-making. Many women wanted a combination of written and verbal information that included the advantages, disadvantages and risks of induction of labour. They also wanted information regarding their pain relief options prior to induction, as inductions were perceived to be more painful:

Good if pain relief options are discussed fully and you are informed regarding what is normal. I found when I went into labour; contractions were one minute
apart all day until 7 pm at night. You have no redress to say ‘I can’t do this anymore’; just staying alive. I felt at that point I did not have a say because my mental and physical state wasn’t in a condition to discuss anything. (W18)

Nearly half of the women did not attend parenting classes, and for those who did, there was insufficient information on induction of labour to enable their decision-making. Four had attended antenatal classes previously, with some reporting that they could not always fit them in with their lifestyle. One woman recalled that the topic of induction was covered in a previous antenatal education class: “I couldn’t fit in the breathing classes until the end of January, which was too late” (W14). Another woman stated that, “I only went with the first child. I’m pretty sure that they didn’t include information on induction]” (W17).

4.9 Summary

The data in phase one of this research study revealed five major themes and 11 subthemes (see Table 4.3). The five major influences on women’s decision-making and induction of labour were: perceived health risks to themselves and their baby; fear of the childbirth experience; seeking support for themselves and their baby; shared decision-making relating to induction of labour, and adequacy and timeliness of information on which to base decisions. The majority of the women perceived that they shared the ownership of the decision-making regarding an induction of labour. However, a number of women differed in their opinion and perceived that their GP obstetrician influenced their induction decision-making. Most women, despite being low risk, perceived that they had medical risks to either themselves or their baby during their pregnancy. To enable them to make their decision, the women believed that they needed the support of their family and friends, many of whom exerted considerable influence over the women in their decision-making. For those women who were isolated and alone when attending
antenatal clinic appointments, fears of harm were sometimes generated by family members, which influenced their decision-making. Despite feeling supported by family and friends, some women also had thoughts and fears of harm relating to either their own previous experiences in childbirth, or the experiences of their family and friends.

The women’s fears may have been underpinned by inadequate information. The women perceived that the information they received was insufficient for them to make a decision regarding induction of labour. Not only did they feel that this information was inadequate, but the vast majority either did not understand or could not recall the information. When they felt they had received inadequate information, they sought information from alternative sources—primarily from the Internet, books, and family and friends. The women also suggested that resources on the Internet relating to information on the procedure of an induction of labour were inadequate. They suggested that reliable resources should be developed by health professionals, including websites, chat rooms, books and DVDs.

The next section presents the findings from the midwife participants (n = 10) in phase two.

4.10 Midwives’ Perceptions of the Influences on Women’s Decision-making and Induction of Labour

Three themes emerged from the data collected from the midwife participants: having limited influence over women’s induction decisions; empathy for the constraints that influenced women’s decision-making, and concerns relating to the appropriateness of information influencing women’s decisions (see Table 4.4).
Table 4.4.

*Midwives’ Perceived Influences on Women’s Decision-making and Induction of Labour*

<table>
<thead>
<tr>
<th>Major Themes</th>
<th>Subthemes</th>
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<tr>
<td><strong>Theme one:</strong> Having limited influence over women’s induction decisions</td>
<td>Timing and contact with women limited antenatally&lt;br&gt;Practising within the constraints of the health service environment&lt;br&gt;Midwives’ concerns about the culture of medical intervention</td>
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<tr>
<td><strong>Theme two:</strong> Empathy for the social constraints that influenced women’s decision-making</td>
<td>Feeling conflicted between mothers’ preference for early induction and concerns for safe childbirth&lt;br&gt;Empathy for women who held fears related to their isolation and their own experiences of childbirth, as well as those of their family and friends’</td>
</tr>
<tr>
<td><strong>Theme three:</strong> Concerns related to the appropriateness of information influencing women’s decisions</td>
<td>A need for accessible and timely information to support women’s induction decisions&lt;br&gt;A lack of easily understood and reliable information to support women’s induction decisions</td>
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**4.11 Theme One: Having Limited Influence over Women’s Induction Decisions**

The midwives believed they had limited influence over the women’s patterns of decision-making regarding induction of labour; instead, a culture of medical dominance exerted considerable influence over their induction decisions. They perceived that the GP obstetricians controlled the decision-making process regarding decisions to induce labour, which they generally predetermined prior to the woman’s admission to hospital to accommodate risk. A thematic map of the subthemes relating to the midwives having limited influence is provided in Figure 4.11.
Figure 4.11. Thematic map: midwives having limited influence over women’s induction decision-making.

4.11.1 Subtheme: timing and contact with women limited antenatally

For this group of women, contact with the midwife was scarce until they were admitted for an induction. The midwives suggested that low-risk women were usually cared for by their GP obstetrician or by midwives who practised within the antenatal clinic. Unless they worked in the antenatal clinic, antenatal parenting classes or within the doctor’s surgery, the midwives had a limited opportunity to discuss options with the women and assist them with their decision-making. It was perceived that their opportunity to support and provide information to the women on their admission to the maternity unit was limited due to constraints on their time as the result of busy case-loads.

The midwives said that their contact with women on admission was far too late. Consequently, once the women had made up their mind to be induced, the midwives did not seek to change or influence the decision. They perceived that women’s behavioural
patterns indicated that they were not receptive to the risks of an induction, even when they were informed:

_We can’t ensure support for women unless we are providing antenatal care ourselves. If we don’t see them in the antenatal clinic, usually they are not seen by us until admission. I could give them information the morning of induction, but I don’t feel able to do this… [women are] not receptive; they want an induction… they have planned everything, the kids organised etc. Part of it is we don’t have that relationship with the woman. If we tell them that there are increased risks, the women feel it won’t happen to me._ (M3)

One midwife thought that midwives had an opportunity to provide information that might influence the mother’s decision, but that they chose not to. She emphasised that she could not provide adequate support for decision-making unless she was the provider of care:

_Sometimes I go with what the doctor says regarding induction. They say she had two quick labours last time and I don’t want her to have it in the car… have to go along with it._ (M6)

_I think we could influence women but we don’t. We think we do but we don’t. It is too late to influence by the time we get to them._ (M6)

It was considered that due to their heavy workload, even if they had contact with the women in the antenatal clinic, they did not have sufficient time to build a trusting relationship that is necessary to influence women’s induction decisions:

_I think that really true antenatal education, the best model is that they have continuity of carer with the one midwife that they see antenatally, and with time enough to discuss and explore. Really chat and have a cup of tea… in an ideal world, none of that actually happens. I think that is really where you can make a_
difference, when a trusting relationship is built up. I don’t think we really have time. [At the] antenatal clinic we have a certain amount of trust, but not sufficient, I don’t think. (M1)

Frequent contact and the development of a trusting relationship with the women were important to the midwives. They perceived that continuity of care in pregnancy would lead to better outcomes. However, their confidence in their ability to provide an alternative view relating to induction decisions varied:

*Midwife probably as good, if not better [than the GP obstetrician] for care in pregnancy, women to women makes it [the midwife–woman relationship] more trusting. They know we have been there before [discussed childbirth interventions]. They look to you as a role model. Good continuity of care [leads to] better outcomes.* (M8)

A small number of midwives remarked that the opportunity to assist the women’s decision-making was for a shorter period, and it depended on how often they saw the women. However, when the opportunity to discuss these issues arose, the midwives felt that the women respected their perspective on the risks of an induction of labour. One midwife reported that she tried to reduce and manage the factors that make a woman want an induction. Additionally, this midwife highlighted the risks to the baby that may encourage the woman to wait for normal labour:

*We see them for such a short timeframe, but have such a big influence on them.* (M10)

*Yes… I influence them by giving them the facts and being fairly straight about the risks involved and just allowing them to come to that decision themselves. I am working on the factors making them want an induction of labour, reducing the pain, dealing with the particular problem so that they can manage to*
continue a bit longer in pregnancy... also by bringing back the focus to the baby and the risks to the baby, perhaps separation, breathing difficulties, the fact that it is induction prior to term. (M10)

In contrast, a number of the midwives doubted whether extra contact with the women would increase their ability to influence the women’s induction decisions:

“Midwives can stand together and say no; however, obstetrics brings money to the hospital... As midwives, we don’t have that strong voice” (M2).

4.11.2 Subtheme: practising within the constraints of the health service environment

The midwives identified a number of constraints within the health service environment that affected their influence on the women’s decision-making, including policies and procedures, the ward induction diary, and the availability of resources. The midwives perceived that policies and procedures should enable them to influence decision-making and question decisions that are made outside of the guidelines. However, this was not the case; in this maternity unit, the midwives believed that the local guidelines regarding indications for induction were not enforced at the hospital level, as they should be. Instead, it appeared that GP obstetricians culturally accepted early inductions within the maternity unit. When asked whether policies or procedures influenced decision-making and induction, one midwife replied, “I don’t think so. I think it is more the unwritten rule for induction. I don’t think that I have seen anything where it is policy and procedure to induce someone at 37 weeks that is low risk.” (M2)

One midwife, who suggested that local policies and procedures had improved care for women within the setting, provided an alternative view. This midwife also appeared to accept inductions that were completed after 38 weeks:
Looking at benchmarking the evidence base and looking at the guidelines for induction of labour is good. Hospital policy has had a positive influence on bringing the induction of labour to a safer place. It is safer because the women are not being induced prior to 38 weeks without the women having an obstetric review. The women know that it is policy and everyone knows that is the policy. Previously it was not so specific and it was not as uniform, as now it has assisted everyone to come to a similar place for an induction of labour. It probably has reduced social induction in our area. (M10)

Regimentation of childbirth and induction by default was another interesting perception related to local policy, as it limited the midwives’ influence even further:

_I think being pregnant and having a baby, all very much regimented… they know they have to book in, they know they have to fill in forms, they are talked to at an early stage about epidurals and if you need an induction…The way we run our clinics and procedures, it [induction] is not given as an exception to the rule; it is given as a 50:50 possibility._ (M1)

When asked to clarify the 50:50 possibility of an induction, the midwife replied, “Definitely by the medical staff and by the sheer fact that the midwife has to give the information in written form, they are presenting it by default really” (M1).

Midwives tried to encourage women and GP obstetricians to adhere to national policies and procedures related to induction of labour. To book inductions and manage risks midwives within the maternity setting used an induction diary. A few of the senior midwives tried to change non-urgent induction decisions with the GP obstetrician to avoid an early induction, and to enable medically indicated inductions to take priority:

_As much as I hate that book, I know we have to have it. We couldn’t cope without it, without having a regular flow of inductions going on_ (M8).
They [induction diaries] are great, except occasionally you will see some doctors write in the book themselves. It works well if the right people ask the right questions [inferring that midwives question the rationale for the induction]. Some doctors say that back pain is a good reason for induction. I said ‘everyone gets back pain’ (M7).

Small for dates [SFD] was the documented reason for an induction. However, the woman said “I think I have gestational diabetes”. I told them “I don’t know why they think you have gestational diabetes”. I just went along with it. I did stop the induction with ARM/Syntocinon. However, the woman still had prostaglandins. (M4)

When midwives tried to adhere to policy through the reorganisation of non-urgent early inductions, they felt that the women did not always perceive that they were being helpful. Women who had their induction cancelled could become aggressive. When this occurred, the midwife found it difficult to influence the women’s decision-making relating to the induction, and they would often go ahead with the induction to avoid confrontation:

Sometimes you will have women that are quite aggressive wanting an induction to carry on. They are then allowed to continue with the induction, whereas some are not. This creates mixed messages to the community. However, women don’t realise what an induction is... it is almost them against us. They are not realising, we want what is best for the woman and the baby... it is crazy... need an across-the-board standard relating to induction of labour. (M2)

In contrast, other women were grateful that an early induction had protected their baby from increased risk:
One woman was all psyched up for birth, heartbroken when the doctor had said he would induce at 37+2 not 38+2. When we worked her dates out, she was only 37+2. We said “you can’t deliver; this baby’s lungs will not be mature and you will spend more time in hospital”. I told her “if you come back next week, it will make a big difference”, and when she came back the woman was glad she waited. She thanked me. (M8)

The induction diary was also used every day to manage the caseload to ensure that the labour ward was not too busy. There were only three labour wards in this maternity unit; however, midwives also used the assessment room for childbirth when the labour rooms were full. Consequently, the midwives supported the use of the induction diary to control the level of inductions and manage risks. Hence, resource constraints also affected the midwives’ influence relating to induction decisions and practice:

Because we are a smaller hospital, we have only three labour wards, so we need to induce to keep numbers at a level that we can manage... just so that all the labour wards are not full and we would have nowhere to put the women in labour. Induction of two a day is okay as long as it is for a valid reason. An example: on Monday we had an influx of seven women altogether; there were three Caesarean sections and four deliveries: a big workload! What would it be like if women went naturally? We have only three labour wards and limited staff. (M8)

4.11.3 Subtheme: midwives’ concerns about the culture of medical intervention

The midwives remarked that they worked in a medicalised model that had a strong element of power and control by the doctor—particularly the GP obstetricians—who owned the decision-making process. Many midwives were concerned that the
medical model created a culture of intervention in this setting. They were frustrated by the clash of birthing models between their approach, which was naturalistic, and that of the GP obstetricians, which seemed to be interventionist:

_Midwives are governed by a different set of principles, a different set of ideals. Midwives look at the well woman, healthy woman. Doctors look at the pathophysiology of pregnancy related to the women. Midwives don’t have the same insight into the full pregnancy and the changing condition of the woman._ (M10)

_With doctors, I do think sometimes because it is just really a difference in models, the medical model versus the midwifery model. Medical model is much more conducive to an induction with drugs... your midwifery model is against that, so it’s sort of... a clashing of models._ (M1)

Control was also an issue addressed by the midwives, who reported that they did not want to control the women. However, like the GP obstetricians, they were concerned with managing risks. The GP obstetricians were especially cautious with the women due to the distance from a tertiary hospital, and they wanted women to give birth in the hospital at a time when resources were available. To control the situation, they were not prepared to wait for normal labour and risk litigation if complications occurred in either the woman or the baby. The midwives understood these reasons for the GP obstetricians’ decisions, and they too were concerned about the risks, but they felt that the women should have greater autonomy to make informed decisions:

_A lot of ‘preventative practice’ this could go wrong... so let’s just have this baby._ (M1)

_Doctors go towards the safer side of practice here because we are a little bit country [regional area] down here... The distance of getting someone that is_
really ill to Perth. That can also sway doctors’ decisions, I believe, to inducing women, letting them have their baby. This provides a controlled environment rather than going into labour… Sometimes I wonder whether the fact that it is their first baby, will they [doctors] predict a long, arduous labour. They think they should induce at 40 weeks, let us just get his baby out now to control it [the situation for risk]. (M1)

Probing this issue further, the midwives were asked whether there was an element of control, to which they replied ‘Control, yes absolutely’ (M1) and “Absolutely, that is what the medical model is, it is controlled” (M1).

One midwife suggested that GP obstetricians had an obligation to make a judgement call, particularly when there were complications during pregnancy. This midwife suggested that the ongoing relationship between the doctor and the woman meant that the doctor had a comprehensive view of the woman’s condition, which was important in preventing adverse incidents and litigation: “Doctors have a much broader view of the whole situation—not just the pregnancy, but the whole demographics of the family. They have that ability to make a judgement call not just about clinical decisions.” (M10)

Other influences on inductions were linked to the doctors’ schedules to coincide with the doctor taking leave and public holidays. In preparation for public holidays such as Christmas, births were scheduled to prevent risks from doctors not being in attendance and from having fewer hospital staff and services, such as theatres. However, the midwives did not agree with doctors scheduling births in this way because the women were not offered the option of having a normal birth. A number of midwives also commented that the women did not want to have their baby on Christmas day. They believed that when women were induced early to accommodate holidays, there
was an increase in interventions during childbirth, which created a risk. One midwife said “Well... last year that they want to clear the slate for Christmas, as simple as that. Women are being induced whether they are ready or not” (M4). When asked why the doctors wanted to clear the slate for Christmas, the midwife answered:

[I] hate to say it, they wanted a break... there is always going to be one doctor on-call. They were all going on leave last year. It was black and white... all women were induced and ended up having Caesareans... only one vaginal birth in 18. (M4)

It was like a mad house here at Christmas. Nobody wanted their baby on Christmas Eve or Day. They needed to have their baby two days before and go home at whatever the cost. Even if the information about induction is given out, they don’t understand the implications of it all because they don’t want [the information] given to them when they are really fed up. They just want the pregnancy over. (M4)

What happens over Christmas when the theatres are closed: less staff; holidays are booked; inductions are an inconvenience if they are going away for Christmas. (M5)

The majority of midwives said that the doctors just wanted to get the women to 37–38 weeks. A small number of midwives felt that some GP obstetricians were trying to avoid an earlier induction by reassuring the woman that they would perform a VE and cervical sweep in their surgeries at 38 weeks:

Doctors do VEs at 37–38 weeks. The doctor examines them, kind of encouraging them, trying to stir things up. Maybe it does; I don’t know. (M3)

Yes, doctors, I think they plant the seeds in their mind ‘when you get to 38 weeks, we will do a stretch and sweep of your cervix’. (M8)
The practice of predetermined scheduling was also perceived by midwives to be driven by the women. The midwives recognised the women’s autonomy in relation to predetermined scheduling, accommodating family schedules and constraints. Some women pressured their GP obstetrician to schedule childbirth to avoid Christmas, birthdays or the anniversary of a relative’s death. Other women wanted control over their childbirth and requested an early induction due to discomfort in their pregnancy:

*If [the woman] does not go into labour, the woman starts to pressure [their GP obstetrician] every other week.* (M8)

*These women say to the GP obstetricians they are sick of being pregnant. I’m uncomfortable and want it now. If the doctor says no … and then something happens in those last two weeks—the baby dies or the baby is born very ill—the doctor is afraid of the legal ramifications.* (M5)

*Well, this is a generalisation, but from what I’ve seen here, doctors are happy to do an induction at 38 weeks plus to 39 weeks for pelvic pains or sore back. Their GP obstetrician books them in for an induction of labour. They do influence them when the women come in and say they have a sore pelvis or sore back. I don’t know who suggests it, but either way the doctor is happy to go along with it and will endorse it. Because the woman has faith in her doctor, she will go with it because the doctors suggest it. They are the professionals. They know best.* (M3)

*I’ve heard in the antenatal classes [from the mothers] “My doctor told me… because my family has four birthdays in that fortnight and I don’t want the baby on the birthday he can wave a magic wand and make sure that the baby does not come on anyone’s birthday”. [M7 asked the mother] so when are you due? … ‘Oh not for another week and a half after that week’.* (M7)
If a woman requested an induction for pain, the midwives remarked that it was not difficult to obtain one from the GP obstetrician. They believed that the women exaggerated their pain at times to obtain an induction:

*If the woman says she is in excruciating pain and the doctor is pro-induction, she is more likely to get one. In fact, she may not have much pain; she may just want to finish the pregnancy. So I think that the word is out there, that you can get an induction if you ask for one... Yes, you do need a medical reason really, and it’s not that hard to get one.* (M1)

The midwives also suggested that women searched health care facilities to find a practitioner who would agree to an induction of labour. They were concerned that once a woman has had an induction, this makes her more likely to request another in her next pregnancy:

*Women are impatient... they are just so persistent in asking for an induction, whoever their doctor is.* (M10)

*May be actively seeking an induction... they just don’t want to be pregnant. A cascade of effects: the woman is then induced and the next time she will also want an induction.* (M2)

*Three ladies yesterday; a lady with symphysis pubis pain wanted it out. She wanted any excuse to give the doctor... She was 32 weeks, the really stressed one. She wanted a 36 weeks’ birth. They delivered her last one also at 36 weeks for the same reason.* (M9)

A small number of midwives suggested that GP obstetricians should support natural childbirth rather than advocate interventions. Most of them strongly believed that women should go to 41–42 weeks in pregnancy:
Doctors have a role to play in promoting natural childbirth the benefits of going through normal labour, normal gestation. So you are going to have your baby at 40–41 weeks unequivocally promote natural childbirth. (M4)

So if the hospital has doctors that say no and are anti-induction, this would be the best thing. (M2)

I guess I would let them know that induction is not a priority and it could be rescheduled if they are low risk. In the absence of medical conditions or a valid reason, then induction before term plus seven days is not clinically indicated. (M10)

The majority of the women in this study had been induced prior to term. To some extent, this was attributed to a view that, in regional centres, GP obstetricians practice differently to those who work in tertiary centres, as they tend to encourage induction of labour:

Women get it into their heads they don’t have to wait... this is not a teaching hospital where they have got their registrars and house officers. They [the doctors] give presentations here but are not evidence-based; they are only a ‘Little bubble down here’. They are not challenged in a bubble. (M3)

To prevent predetermined scheduling of inductions in this setting, the midwives believed that the consultant obstetrician should have the overall accountability and responsibility for decision-making to avoid inductions for non-medical reasons:

Permission for an induction needs to come from the obstetrician (consultant). Then if the doctor goes against the obstetrician’s instructions, (s)he needs to be accountable. It is all about accountability. No one has been accountable. We work in a medicalised model. (M2)
Another midwife perceived that a consultant obstetrician who had recently been appointed had made a positive difference to the culture of intervention, stating that “A change of consultant has had an influence. I have noticed things have changed since the new obstetrician has been appointed. There are more post-dates inductions” (M7).

Nevertheless, other midwives appeared to be concerned about what they saw as a local culture of intervention for non-medical reasons. Further concerns were related to their limited contact with the women, which prevented them from promoting the naturalistic approach to childbirth. In fact, it appeared that GP obstetricians tried to avoid an early induction by completing early VEs to ripen the women’s cervix. Hence, in some cases, it appeared that the GP obstetricians were willing to succumb to pressure from the women to induce for family reasons, perhaps demonstrating their desire to accommodate the wishes of the women and manage risks.

4.12 Theme Two: Empathy for Constraints That Influenced the Women’s Decision-making

The midwives felt empathy for the women’s decision to induce; however, they also felt conflicted due to concerns for the women’s safety in childbirth. Although they were frustrated and conflicted with the predetermined scheduling of childbirth, they also had empathy for the women who had misperceptions of risk and fears generated by their family and friends. Most participants reported that they did not support induction when the women were low risk or induced for social reasons due to their perceived health risks associated with an early induction, especially those who thought it was all right to have an early end to their pregnancy and be induced at 37–40 weeks. A thematic map of the subthemes relating to this theme is provided in Figure 4.12.
Figure 4.12. Thematic map: midwives feeling empathy for the social constraints that influenced the women’s decision-making.

4.12.1 Subtheme: feeling conflicted between the mothers’ preference for early induction and concerns for safe childbirth

For these midwives, their lack of confidence in their ability to influence induction decisions led to frustration over the women’s impatience, especially given their understanding of the risks of early induction. International midwifery experience also added another layer of concern. Some midwives compared their previous international experience with their experience in WA, suggesting that there were cultural conditions in Australia that affected women’s decision-making. It was highlighted that, in many countries, both the health care practitioners and the women frowned upon induction of labour for social reasons. This was not the case in WA, as it appeared to be an accepted cultural norm by the women:

Most people are pregnant until 41 weeks... In Western Australia, women think they should have their baby at 38 weeks of pregnancy. In Ireland and the UK, the midwife would have a fit if she was asked for an induction at 38 weeks. (M4)
I think it’s the culture over here. They know how to say the right things, and it isn’t really hard to get an induction. Whereas... back in New Zealand, again a generalisation, you get induced at term plus 10 days... must be > 10 days over... that is the culture. It’s the culture, they don’t have an option. Back in New Zealand, the independent midwives don’t encourage induction. (M3)

Also the cultural aspects... you don’t see Asians or Indigenous women coming in for induction unless for a medical reason. Yeah... it seems to be a Caucasian thing to do. In the antenatal class, you get diverse women and you see this girl in the corner from Thailand, who is mortified when they are all talking about induction. (M7)

However, the midwives also remarked that health professionals needed to view childbirth from the woman’s perspective. The midwives perceived that an induction in childbirth had become a fashionable trend over the past 10 years—a normal part of childbirth—and that women expected to have choices in childbirth related to their mode of birth. At times, the midwives considered that women held their health care provider to ransom in order to fulfil their desire to have an early induction:

In my opinion, a lot of it is to do with... timing. We are in a society where planning and timing is everything. Part of it is to then plan the date of your birth. I also think the willingness of the doctors to accommodate this planning and facilitate it by not refusing inductions and sometimes perhaps introducing an option or by planting the seed...Well, just... I think that it is becoming ‘fashionable’, almost think it is a choice you have. You can have a choice in whether you are induced or not. I don’t think women really believe that the induction is there for medical reasons. (M1)
Slowly, the idea of early induction has crept up on us. It has been there at least the last six or seven years... crept in easily... been there for 10 years. (M5)

Well, it’s two-tiered, really; the new generation or younger generation who want to have everything instantaneously. They never save for anything. Why would their pregnancy be any different? Why would they have to do the full 40 weeks when they can sweet-talk the doctor and get an induction at 38 weeks? Back in our day, you knew that you were pregnant until 40 weeks. Everyone said “you won’t go into labour until 41 weeks”. To go to 41 weeks of pregnancy does not seem to be the mindset of women today. Now they think that they can have their babies when they are 36–37 weeks. (M4)

The midwives thought that some women were in denial at times when, given the information relating to induction of labour, they ignored midwives’ warnings regarding the consequences and risks of induction. One midwife stated that “Even if the information about induction is given out, they don’t understand the implications of it all because they don’t want [it] given to them when they are really fed up. They just want the pregnancy over” (M4).

However, there were consequences to ignoring the midwives’ warnings. The women could become devastated and feel guilty if complications occurred:

Yes... It was like they could plan their life around this induction... they know exactly when and where this baby is coming out. I can see the upside to it... you can be totally ready for it or I can see the other side you can get a sick baby. They are devastated or if it doesn’t go right and they have a Caesar and are stuck for five days because it’s not perfect in their rose-coloured-glasses world... they are devastated because it is not the picture-perfect end they all envisaged. (M7)
The midwives showed empathy for the women’s discomfort during pregnancy, which made them feel tired and stressed. They knew that some women were just fed up and they wanted to get the pregnancy over with, but their misperceptions about the health risks to themselves and their baby were concerning:

*The women are fed up. They tell the doctor that they have backache and they just want to get the baby out. Yesterday a lady was in the clinic with symphysis pubis pain. She wanted the baby out. Women use any excuse to get to see the doctor. Backache and having enough... three women yesterday that complained of this.* (M9)

Many midwives highlighted that the majority of the women believed they had medical reasons for their induction, which were not all professionally recognised indications for induction. Most midwives suggested that the women’s perceived reasons were not supported either by the clinical symptoms or the outcome of their birth:

*There is often no backup information. When you check the information, you don’t know if it is intra-uterine growth retardation [IUGR] or not. The woman has had no scan, nothing. The baby is born and the weight is 3.7 kilograms [kg]. High blood pressure [BP]... but the BP is 110/70 or previous precipitate labour, then they take hours and hours [to deliver] and the cervix is not favourable.* (M3)

*According to the obstetrician, a big baby is not a reason for induction. If the baby is small, it needs an ultrasound to confirm. However, some places that do ultrasounds are not accurate. I do find it frustrating if they get induced for a small baby and a 3 kg baby pops out... this is misleading. Women are being induced for pregnancy-induced hypertension. They have had the blood tests, including uric acid. They are all normal. The blood pressure has only been up*
Once, and this is due to the woman running about all morning prior to her appointment. (M5)

Nevertheless, the midwives respected the relationship that the women had with their doctor and were once again reluctant to change their induction decisions:

I think as a midwife, if I go in the labour ward, I’m told why they are being induced and I don’t think they should be. I don’t think it’s my place to say. In all fairness, the doctor has built up a relationship with them. Who am I to say ‘have you thought about the risks? Do you really want to do this?’ You can make suggestions, but you respect the doctor’s decision. (M3)

4.12.2 Subtheme: empathy for women who held fears related to their isolation and their own, family and friends’ experiences of childbirth

The midwives had empathy for the women’s fears and concerns, especially where there had been previous complications and a difficult childbirth. These women seemed to lack confidence in their body’s ability to cope with childbirth, which affected their decision-making:

There is a lot of fear around childbirth, not realising that induction is the reason for fear, but they fear their own bodies. This goes back to the media that, in a way, has emphasised that fear. If they don’t go into hospital and have an obstetrician, clearly you don’t care about your baby, not realising that induction and being induced before you are ready, is in fact more harmful. (M2)

The midwives also demonstrated an understanding of the reasons why family members put pressure on women to have an induction:

Knowing they will have better outcomes when the baby comes out, sooner rather than later. Family pressure, especially from the partner and mother who thinks we are going to have this girl in a heap [not able to cope]... knowing that she
has kids to bring up, to be cared for because if the baby is sick and the mother has to go with the baby, that leaves the family stranded for weeks at a time.

(M8)

Providing comfort, safety and honesty to the woman and her family during the explanation of the procedure was important to the midwives. They supported having the support person there when the woman received information relating to the procedure of induction in order to avoid misperceptions. They repeated the information and prompted questions to ascertain the woman’s understanding of the procedure:

I structure information at the level of their understanding. (M10)

Making sure women have a choice and a say... I think including the family in the education, that they feel supported. Ensure [they are] not alone in their decision... when you are educating and discussing induction options with them that you are actually including their family, so that they can make some decisions with that person, so that they do not feel alone and pressured. Give them time if you can; if you can’t give them time, explain this way ABC or that way ABC and it is ultimately their decision. (M1)

I think it is better if two go to the doctors. Sometimes women say ‘Doctor says this’, then the doctor says ‘I didn’t say that’. It can be what the woman has perceived. You have to protect yourself... it might not be what was intended. The perception can be what you want to believe. You can twist that round to anything you want, so... if you were desperate to receive this information. (M8)

One midwife suggested that all of the women’s reasons for an induction were authentic. A midwife may be unaware of all of the factors influencing their decision:

Need to look at each woman... her reason is authentic for her. It might not be medically authentic; however, [it] is authentic to her. (M10)
Sometimes midwives don’t hear all the facts relating to the woman’s condition. She might say “doctor said I have a big baby”, that baby’s growth might be on the 90th percentile. She might have had a previous horrendous birth or a previous third-degree tear, or a shoulder dystocia. (M10)

Some of them [the mothers] have poor resources, very little stamina and no reserve to be able to cope to manage anything else mentally and physically. You know that you are only going to get them to term, get them to 39 weeks and then they will manage for another few days. Women go from coping to dyscopia; they are then at risk of perinatal depression. Women are not coping, they want the baby out and some are not prepared to wait. They don’t consider their own or the babies’ safety. (M10)

Another midwife highlighted the importance of talking to the woman and trying to consider various supportive measures to avoid an induction: “Talking to women, finding out the reason why they want to be induced. I suggest physiotherapy if they have back pain; if they have social issues, the possibility of a social worker” (M5).

They acknowledged that the women had fears related to family culture, and some had fears related to isolation. One midwife stated that “You hear from friends that they went into hospital too late or went post-dates and the baby died” (M2).

Like the women, the majority of the midwives reiterated reasons for scheduling, including a lack of support due to geographical isolation from family members, and a need to have relatives present for the birth. Almost all of the midwives suggested that if the husband’s employment was FIFO, the woman would schedule the birth. This represented a cultural norm within this group to have an induction of labour:
Husbands work/employment... fly-in fly-out, holidays booked at certain times might influence, or their other children who need to get looked after when [the mother] goes into labour. That would be a big influence I think. (M5)

It seems that workplaces are rigid... they can’t get the time off, but in times gone by, if your husband could not make it, you would have your mother or sister there. I know it is all wonderful now, the ‘new-age man’ wants to come to appointments. I wonder about this... They are a different generation, which can accommodate this, at the risk of inducing the baby. There are risks if induced too early. (M4)

The midwives demonstrated empathy for the women’s choices in these circumstances. They believed that women needed the support of their partner, and that FIFO and defence force employment had a significant effect on family dynamics. Despite this, the midwives did not necessarily agree that induction was an acceptable way to handle the issue:

FIFO, the dad needs to see the baby... that has merit. Don’t think you can say can’t do an induction for that reason. Genuine reason: mum needs support and dad needs to know their partner’s okay if on the mine site, before flies off again.

I feel sorry for the guys in Iraq. A few people in Peel [with partners in Iraq] speak by telephone. I really feel for them that they cannot be there. FIFO women want the partner there at the birth. However, induction is not a good idea. (M9)

The women wanted their partner at the birth and following birth, which meant scheduling the birth. Some partners also pressured the women to have a planned induction. When this occurred, the midwives were unable or unwilling to change the women’s decision:
There is the whole FIFO community... people want their partners there... at the birth and obviously not only for the birth but that they are around longer... I think the partners do like it if they get told they can have their baby. They have a date set and they are coming in for an induction... Often when they come in and get told it's been put off for another reason and to come back, often the partner seems to be annoyed, as well as, you know, the woman herself. (M3)

Partner/de facto [has] a huge influence if their work involves a need to FIFO. They are thinking “I can have my two weeks off there and four weeks here” etc. They don’t have an idea about induction of labour. If I ask, “why do you want to be induced?” The woman often looks at their partner; their partner is quite embarrassed. They will know then that you know they are calling the shots. (M4)

If a FIFO partner women are induced early, but the labour may end up more painful and require an epidural, vacuum extraction, forceps, Caesarean section or it can be a failed induction. (M6)

One midwife thought that FIFO might become another valid reason for induction of labour:

On a study day three years ago, three midwifery students were studying FIFO partners... it was so interesting. It left the question of what are valid reasons for an induction of labour wide open. Perhaps this is another valid reason for induction of labour. (M10)

Some midwives recalled that the partners were more flexible and just went along with the decision to induce labour, even though it could be prior to their partner’s due date. The partner was usually supportive of the woman, but often did not appreciate what an induction entailed and may have been basing their views on their own norms and expectations:
If asking for an induction, the partner will support them in what they want. Nice to know that the partner goes with them to ensure they don’t miss any information. Husband or partner is pleased that the baby is going to be here... an end to pregnancy. He can be worried, but is happy that the baby is coming. All the time they don’t realise what is involved. (M9)

I don’t know that partners take that much of a role in the decision-making; they don’t really have much to do with it... because they are not informed and have not been to many antenatal appointments. (M2)

The partner said nothing...he was just keeping the mother and the daughter happy. He did not say anything; the mother and daughter had the same dominant personalities. Baby came out... was due at Christmas; however, was born at the beginning of December. (M8)

A small number of midwives felt that the partners’ expectations were sometimes problematic in that they could be domineering when they had had enough of their partner being pregnant and not coping. Some partners were also seen as impatient when the women were pregnant. One midwife said “Just the way partners speak when you are asking the women questions; they state ‘Will this interview take long?’ ...just their attitude; it is almost an imposition for the husband to be there at the clinic” (M9).

One midwife demonstrated compassion and a supportive attitude, but acknowledged that it was the woman’s choice to have an induction. This midwife did not perceive that induction did any harm if the Bishop’s score indicated that the cervix was favourable to birthing:

I try to remain compassionate, calm and objective. I just tell them the facts about induction... That is primary health care. I have given them the information... they then have the ability to choose... not about me being anti-
induction of labour if not term plus seven days. I would rather that but I know there are a whole lot of reasons why inductions happen. I’m not going to get on my soapbox... That is their choice; that is a World Health Organization primary health care objective. My child health experience taught me that. (M10)

In research evidence, if the Bishop’s score is greater than six, there is no difference in the outcome of labour and birth. (M10)

Socio-economic factors also appeared to influence the women and their partners’ attitudes towards induction. The midwives observed that if the partners were in a lower socio-economic group, the women would often go alone to antenatal appointments or rely on support from other family members, particularly their mothers:

If they are young and they are from a reduced socio-economic group, they live at home with the parents, or if older, have a home themselves. (M2)

Women sometimes have almost decided to have an induction of labour. Their mother was induced and had a baby and was all right; therefore, they will be. (M2)

Some midwives perceived that the mother’s effect on her daughter’s decision-making varied:

A two-tier system: those who have got their family and those who have not. I like to think that older mums [of women] would not influence. (M4)

Many mothers do not have an impact on the decision to induce. However, some women say their daughter is not sleeping well. (M5)

The midwives also thought that mothers were often not aware of the consequences of an induction of labour:
Mother... Yes... they don’t know the risks themselves. They are happy to be a grandma; excited. However, there has not been a lot of thought about induction and the consequences. (M9)

They recognised that women valued their parents’ presence during childbirth, especially women who were isolated or who often had difficulty finding babysitters for antenatal appointments and childbirth:

A few years ago I had a lady in the clinic wanting to be induced, and she ended up a Caesarean section. She wanted to be induced. I was very critical and said ‘no, this can’t be done’. I found out afterwards that her parents had come from France and were leaving in four days. The woman was not coming back to be induced until after they had left. You know that’s a big emotional thing... she hadn’t told me... I felt like I had held her to ransom, by our rules... there needs to be some flexibility for that type of thing. That was her support network. (M10)

However, a woman’s mother-in-law could have a different influence. A small number of midwives reported that the mother-in-law was sometimes more vocal than the woman’s own mother, particularly if they had a good relationship:

A mother-in-law can sometimes influence a woman depending on their nationality (e.g., Italian mother-in-law). (M9)

Mother-in-laws, they have a different influence. It depends what the relationship is between the girl and the mother-in-law. Sometimes [the relationship] is a good one... mother-in-law’s have even more influence over them than their own mothers. However, sometimes not a very good relationship, so they don’t have any influence or can have the opposite effect. (M10)

Other family members’ opinions were valued and influenced the women’s patterns of behaviour. Many midwives thought that sisters supported and influenced
women in their decision-making. However, subtle sibling pressure to schedule an early induction was observed if the sister had previously been unwell and had an induction:

*When I was pregnant, they gave choices when I can have my baby. Also, the fact if they’re not feeling well, with sister’s sibling pressure, “I did this, I did that”, and you want to do it even better.* (M8)

When the women were tired and stressed, they were seen as being more receptive to their relatives’ suggestions to induce:

*Depends how close they are to the family. Lots of families are alone. They don’t have that sort of contact. They are just interested in making sure that you have a healthy baby. They think if the baby is big, they will say “look how big you are”. The baby may be 4 kg but might have immature lungs. The women are getting pressure from the whole family. The women are tired and stressed and they will listen. The women listen to their own bodies as well.* (M8)

*I don’t think they would be negative if the woman said she was sick of being pregnant.* (M5)

The midwives saw the value in women receiving support and advice from friends their own age, especially when they were isolated. The friends helped by looking after the women’s children when they were attending the antenatal clinic, and some friends provided reassurance:

*Friends of the same age who are not pregnant or a friend in early pregnancy, I think they enjoy the pregnancy together. They interact with each other. People pregnant at the same time share health issues, health problems and share a lack of sex they know they will understand. They are good to have around when you’re pregnant. They look after each other’s children when each one goes to*
the antenatal clinic or hospital, often more so than their own family. Often because they are so isolated, they become your family. (M8)

The main thing that influences them though is verbal information shared between friends.

A lot of the time the women are sick to death of being pregnant... as far as they know, their friend’s babies came out at 37–38 weeks, their friend’s [baby] came out perfectly and their baby is ready to be born, so why not have the baby? (M5)

Knowing they can have an induction from talking it over with friends, they are over it or saying the right things to get an induction. When they get to the end of their pregnancy, they are tired, they are sick of being pregnant. If they know they can have an induction, then they will jump at the chance... It’s known in the community that you can get an induction if you push hard enough for it. (M3)

The midwives also identified issues related to the provision of information on the induction procedure.

4.13 Theme Three: Concerns Related to the Appropriateness of Information Influencing Women’s Decisions

The midwives reported that the quality of the information received by women varied. The women also did not appear to understand the induction procedure.

Maternity areas where health professionals provided information for women relating to the induction procedure included the GP obstetrician’s surgery, the antenatal clinic, the antenatal assessment room within the hospital maternity unit, and the maternity unit on admission. However, many midwives were unaware of the information provided on the induction procedure by their colleagues. The ability of the midwife to provide information was also varied and depended on contextual constraints such as a lack of timely and accessible information to support the women’s decision, and a lack of easily
understood and reliable information to support their decision. A thematic map of these subthemes is provided in Figure 4.13.

![Thematic map: midwives’ concerns related to the appropriateness of information within the context where women’s decisions are made.](image)

**Figure 4.13.** Thematic map: midwives’ concerns related to the appropriateness of information within the context where women’s decisions are made.

### 4.13.1 Subtheme: a lack of accessible and timely information to support the women’s induction decision

The midwives identified a gap in the accessible and timely information resources that were necessary for the women’s decision-making. The women received information from the doctor in his or her rooms, which meant that midwives were often unaware of the information or type of information given out. They were also not aware of the type of information provided in the antenatal clinic or the antenatal education classes by the midwives working in those areas. This indicated a lack of effective inter- and intra-professional communication, which may have affected the women’s decision-making. The provision of information also varied in the antenatal education classes, in the antenatal assessment room within the maternity unit, and on admission for an induction of labour. Unless the women had a medical background, they may not have
asked appropriate questions related to the induction procedure. These factors may have inhibited the women’s access to relevant information from their GP obstetrician and contributed to a lack of understanding. One midwife said that “I’m not sure what GP obstetricians do [related to the provision of information]” (M1), while another stated that “People are not medical people so therefore they don’t ask the questions that we would ask or like them to ask” (M9).

If the midwives worked in the doctor’s surgery or antenatal clinic, they had more knowledge of the type of information that was given to women. It was believed that the GP obstetrician varied the information according to the professional status and age of the woman. According to one midwife, it “Depends on the patient’s level of education; the higher the level, the more they will get. If the patient is younger, they will get a limited amount” (M7).

One midwife explained that women were given information by both the GP obstetrician and the midwife in the doctor’s surgery:

*At the General Practitioner’s surgery, midwifery education is provided at each appointment in the surgery. Women are given the written information sheet [produced] by the Royal College of Obstetricians Gynaecologists and the information sheet at Peel [produced by the hospital].* (M10)

Many midwives reported that women within the antenatal clinic received verbal and written information regarding the advantages and disadvantages of an induction of labour:

*The main thing that influences them is if any midwifery input from antenatal care...* We get women from 34 weeks on complaining about the discomfort of it all. It’s your chance to tell them the advantages and disadvantages of induction. (M5)
One midwife related the types of things she covered in the antenatal clinic setting:

In the antenatal clinic, if girls have different aches and pains, I like to think they receive the pros and cons [of induction]. I point out the negative side of an induction of labour: that the baby might not be in a good position; there is increased pain when induced and more need for more pain relief; longer labour; more interference vacuum extraction, forceps or Caesarean section; lots of things might happen… A big negative is that monitors are attached the whole time. You [the woman] cannot be up and about… [the] antenatal clinic midwife, when [the woman is] 40 weeks, starts to discuss the possibility of induction. I am reluctant to talk about induction before 40 weeks unless necessary. (M5)

Induction information was not always accessible for women. When women attended for hospital for assessments, the midwives sometimes had an opportunity to provide the women with information relating to induction of labour. However, workload, time constraints and the varied attendance of women limited their ability to provide sufficient information:

You do get a few women coming in antenatally. A girl who came in and had to be induced for intrauterine growth retardation; someone else looked at the growth. It had been plotted wrong; the induction was cancelled. They made her come every day to get a CTG, and I did one of these and she was not impressed at being put off for her induction of labour. She wanted the baby out, and so I talked to her about keeping the baby in as long as possible... Talking is better, advising women to go as long as possible in pregnancy, about the benefits of natural birth. I’ve had a woman ringing up saying “how do I book an induction?” (M3)
Access to information was also dependent on the antenatal class midwife. The type of information provided in antenatal classes varied according to the views of the midwife teaching the antenatal class:

*Education depends on the midwife who is teaching the class going to get different views between them... Yes... you’ve got your set thing, but some people put their views more than other people. Say they’re talking about analgesia, they will push, push, push... you don’t need it. So the woman thinks she is going to be a failure if she has an epidural... Parent education helps, but people who come to parenting classes are not necessarily the people you want to catch anyway.*

(M6)

Other midwives remarked that the emphasis of antenatal education should be on normal pregnancy rather than complications and inductions. The midwives believed that information should emphasise the normal length of pregnancy, and that an induction should not be offered before 41 weeks:

*I strongly believe information must be given antenatally, and not when the woman is afraid, because they are not taking in the information. It needs to be done at the first interview. Talk about the process of labour; it needs to be discussed.*

(M2)

*Emphasis should be on the normal; introduce information on induction at the end.* (M1)

However, the midwives believed there was valuable information available relating to the induction procedure in the antenatal education classes:

*Written charts on the antenatal education wall on induction of labour and endorphins... I use all the information from the university which suggests that you shouldn’t induce women, heaps of articles in the antenatal classes, Saturday*
group discussion, [in the] second half open discussion. I trigger someone to speak on induction because there are a lot of incorrect facts, which need to be straighten out. (M7)

The midwife also has got the chance in antenatal education classes to give a full picture of what is involved with inductions. (M5)

In the antenatal clinic had the nice (antenatal) parent education pack, put on the toco transducers and explained that induction should only be done for medical reasons. (M7)

Despite having excellent resources in the classes, the midwives perceived that women did not always get sufficient information relating to induction due to the size of the classes and time constraints. For example, “Such big classes on a Tuesday evening, there is not enough time. Doesn’t give people time to comprehend” (M2).

Some midwives felt that the provision of information on admission was too late to influence women in their decision-making. One-third of the midwives believed that the ‘right time’ to provide information on an induction was at term:

Well, when I see the woman on admission, I see the woman in labour ward, don’t see them antenatally, don’t know anything about her, and you arrive on your shift and are given information from handover. This is almost too late, really. (M2)

Many midwives suggested that the main opportunity for them to provide information was on admission. Women were often given an information form on induction of labour, which would generally be accompanied by verbal information about the procedure. One midwife related the types of things she discussed with the woman:
Well, it is an abnormal start to labour. You usually have a longer labour. It will be more painful and because you’re induced, you will have more interventions: forceps, vacuum extraction, even Caesarean section. I tell the ladies that you may also react to the prostaglandins and have a Caesarean more or less straight away. (M9)

You would discuss their conditional status at that point in time, so they would have a baseline on why they were having a discussion on induction... So that you are educating them as to where they are at now... then present possible options at that point, so that they will feel in control of their own birth. (M1)

Contextual constraints that affected the information received by women included the following: the large number of women who attended the antenatal class; the varied approach of the midwives conducting antenatal classes; and, at times, their heavy workload within the maternity ward.

4.13.2 Subtheme: a lack of easily understood and reliable information to support women’s decision-making

Most midwives acknowledged that there was little information that was easily understood and reliable regarding induction of labour:

I don’t think they fully understand... like I said, being hooked up to a foetal monitor... the side effects of drugs, they don’t understand that they are going to have a drip put up... I don’t even think they are informed of the induction. I don’t think they know what is involved. It can be quite disappointing for them when they find out. (M1)

Many midwives tried to address the women’s misunderstanding of the reason they were being induced:
Not always... I have had women who have come in and said ‘the doctor is inducing for FIFO’, and then on the documentation it is an induction for large baby for dates. Doctor will give a medical reason, whereas the woman’s perception of the reason for induction is more social. (M1)

The woman hasn’t got a clue why she is being induced; unless she thought to ask the reason, she hasn’t been told. Most ladies do what the doctor says. He is the professional; go by what he says... he knows what he is doing. (M9)

Three midwives disagreed, commenting that if it was an induction for social reasons, the women were aware of the reason they were being induced: “[It] depends on the reason... if a social induction, the women would perceive why” (M2).

The midwives appeared to be concerned about the reliability of the information resources, especially when women sought alternative forms of information from sources such as books, magazines and interactive media sources. They knew the women met in coffee lounges and chatted about pregnancy, including discussing information found in magazines. The midwives were concerned about the fact that books and magazine articles were not always realistic or reliable, and they may make childbirth appear to be normal from as early as 37 weeks’ gestation:

Newspapers magazines, chit-chat coffee lounges, friends. (M6)

Books and magazines are a huge influence on women... not a good thing; you’re not looking at clinical books... you are looking at novels which are not going to give accurate or up-to-date information. The magazines seem to embellish the stories because they are sensationalised to sell... it sounds like a better story. (M10)

The midwives perceived that women were being misled by the media to have an early induction. They generally believed that induction of labour prior to term would
lead to complications. However, once again, they reported that women who had referred to the Internet for information were not aware of the implications for their baby:

*What they read states after 37 weeks, the baby is ready to be born, appears uncomplicated.* (M4)

*I think information on the Internet and magazines needs to be taken with a pinch of salt [keep an open mind, as they are not always reliable]... often does have personal stories: ‘Gee I was so fed up at 38 weeks that my doctor induced me’.*

[This midwife thought] this is great. You should think about it. (M1)

*You see the television at 26–27-‘weeks’’ gestation, babies are surviving and they are doing well. Women are not realising the full implications of what they are doing.* (M4)

Of particular concern was that this was a new generation that readily used various media sources to obtain information that may, in some cases, be different to Australian procedures, policies and practices:

*Read a little bit on the Internet. A new generation of women on the Internet, usually aged more than 30, career people, women having their baby later on, or the second relationship.* (M4)

*Women find a lot of different information, not necessarily Australian practice, a lot of USA websites... a lot of practices quite different to West Australian practice.* (M10)

*Often the problem is misinformation—not so much misinformation as misunderstanding. The women don’t hear all the facts, and sometimes the midwives for induction don’t hear all the facts and reasons relating to the woman’s condition.* (M10)
To assist the understanding and reliability of information, the midwives suggested that a booklet and new information sheet on the procedure of induction of labour would be useful for women in their local setting. One midwife suggested “A nice booklet; something not boring, something visual always works, easily explained in terms they can understand. Provide at the ninth day post-term, not the first. Don’t push the date for induction forward!” (M4).

A suggestion was made that women required a simple one-page information sheet on induction of labour that could be easily understood. One midwife remarked that information could be presented within the women’s handheld notes: “Have handheld notes; more likely to look at them [within these notes] then state normal to go to 42 weeks” (M6).

Another midwife disagreed with the use of pamphlets on induction of labour, as she suggested that women do not read them: “A lot of pamphlets are a waste of time. To be honest, women don’t read a lot of what they have been given to them information-wise” (M6).

The midwives also reported that there was a need for evidence-based midwife-authored reference books for women, suggesting that “Midwifery textbooks written by midwives [are] very good, follow a midwifery model” (M1).

Additionally, they perceived that a good professional website, perhaps provided by a government agency, could provide information to women regarding induction of labour and childbirth:

_A free professional online forum which promotes normality in childbirth would be useful._ (M1)

_A website produced by midwives would be good. Perhaps the West Australian government could sponsor one._ (M5)
Website on the reasons for induction, the risks—positive and negative—and how it is done, so women can see it. (M7)

An educational DVD that emphasised normality was also proposed, and it was suggested that it should also cover the legal requirements related to the provision of information about induction. However, the midwives did not think that all women would view it. Another midwife remarked that posters relating to the length of a normal pregnancy would also be a good idea:

*Provide posters and a DVD of normal pregnancy, which state that it is not normal to have an induction.* (M3)

*A professional DVD during the antenatal period, saying that an induction is not normal, covering what is involved and the restrictions, would be a good idea.*

*You could introduce that at term.* (M1)

4.14 Summary

The analysis of the midwives’ data revealed three themes and seven subthemes. The themes included: having limited influence over women’s induction decision-making, feeling empathy for constraints that influence women’s decision-making, and concerns related to the appropriateness of information influencing women’s decisions.

The midwives believed that they had limited influence due to medical practitioners’ dominance of women’s decision-making processes related to induction of labour, as well as the fact that there were fewer opportunities for midwives to influence the women’s decision-making. Unless they worked in the antenatal clinic, the midwives had limited contact prior to admission for an induction. A heavy caseload in the maternity area also affected the time they had available to spend with the women. They believed that increased contact with the women through continuity of care models would enhance their opportunity to support women’s decision-making.
The midwives had empathy for women related to the factors that affected their decision-making; however, they also expressed concerns relating to a number of contextual constraints that affected their practice. These included limited time and contact within the antenatal period, the fact that national policies and guidelines were not enforced at the local level, and the scheduling of early inductions by GP obstetricians. Limited contact with women antenatally had affected the midwives’ opportunities to influence women’s induction decision-making. It appeared that there was a clash between the naturalistic model of the midwife and the interventionist model provided by the GP obstetrician. The midwives promoted natural birth versus intervention, and they did not want to control women’s decisions. However, women who actively sought out an early induction of labour placed the GP obstetrician in a difficult position. A number of midwives reported that these women had frequently asked for an induction prior to term, which had placed pressure on their GP obstetrician. A number of GP obstetricians were keen to apply a risk management model for safer options for childbirth and control, encouraging women to wait until 38 weeks’ gestation to avoid risks.

Early induction in this regional maternity unit appeared to be readily accepted by the women, and scheduling of induction appeared to be a cultural norm and accepted practice in this context. The prevailing socio-cultural conditions included isolation from family members and the perceived power of friends and family to influence women’s views, particularly in the absence of midwifery influence. The midwives had empathy for the women and their fears and concerns generated by themselves and their family members. They recognised that the women had fears relating to their own previous childbirth experiences and were influenced by the experiences of family and friends. All of these factors influenced their decision-making. The midwives believed that induction
was viewed as a normal part of childbirth by this group of women, which caused them to have conflicted feelings between being woman-centred and being concerned for safer childbirth. Despite the different perspectives, the midwives believed that women did not appear to have been well informed regarding the risks of an early induction of labour.

The midwives had major concerns regarding the perceived lack of informed choices being made by these women. The varied sources, types and timing of information among health care practitioners raised issues related to the availability of information and women’s choices prior to their consent for induction. Moreover, there were differences in women from different backgrounds, particularly in the perspectives of women from a lower socio-economic background, compared with those from an educated background. A comparison of the themes that emerged from the women’s and midwives’ data is outlined below.

4.15 Comparison of Women’s and Midwives’ Findings

A themed comparison of the common and individual views held by the women and midwives is outlined in Table 4.5. Three common themes have arisen from the comparison of findings, and they provide clear answers to the research question, ‘What are the perceived influences on women’s decision-making and induction of labour’?

An initial theme clearly demonstrates that the women and midwives were balancing risk with the choice to have an induction. The women sought control of the induction decision where possible, mainly due to their perception of medical risk and discomfort. Therefore, in seeking control of the induction decision, these women were trying to maintain their own safety, as well as that of their baby. The majority of these women also explained that they trusted both the doctors and the midwives. The midwives also appeared to be balancing risk with woman-centred care and the promotion of choices for women. This was reflected in the midwives’ need to reconcile
tensions between managing perceived health risks and woman-centred care. Although the midwives were trying to support the women to achieve a natural birth and spontaneous labour, they were also trying to minimise risk and maintain the women’s safety.
Table 4.5.

*Shared and Individual Findings from the Women’s and Midwives’ Data*

<table>
<thead>
<tr>
<th>Findings Shared by Midwives and Women</th>
<th>Findings Individual to Either the Women or Midwives</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Major findings</strong></td>
<td><strong>Women’s views</strong></td>
</tr>
<tr>
<td>Women and midwives were balancing risk with choice to have an induction for personal and social reasons</td>
<td>Women were influenced to induce by perceived medical necessity, discomfort, social convenience, family, friends, the media, isolation and fear of the childbirth experience.</td>
</tr>
<tr>
<td>Women and midwives believed that contextual constraints affected their decision-making</td>
<td>Women believed that family constraints and geographical isolation were valid reasons for scheduling an induction.</td>
</tr>
<tr>
<td>Women who were influenced to induce readily accepted induction as a normal part of childbirth and sought varying levels of family support for their induction decision.</td>
<td>Women who gained strong support/advice from family and friends, and were selective in what advice they listened to.</td>
</tr>
<tr>
<td>Women who wanted an induction actively sought a supportive GP obstetrician.</td>
<td>Women who wanted an induction actively sought a supportive GP obstetrician.</td>
</tr>
<tr>
<td>Many women perceived that they shared the decision-making with their GP obstetrician.</td>
<td>Many women perceived that they shared the decision-making with their GP obstetrician.</td>
</tr>
<tr>
<td>Adequacy, reliability and timeliness of information on which to base an induction decision are important for women to make an informed decision. Reliable information needs to be provided earlier and all the way through pregnancy related to normality and specific information related to induction. Women also need time to discuss induction information with their families.</td>
<td>Adequacy, reliability and timeliness of information on which to base an induction decision are important for women to make an informed decision. Reliable information needs to be provided earlier and all the way through pregnancy related to normality and specific information related to induction. Women also need time to discuss induction information with their families.</td>
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<tr>
<td>Ensuring timely, appropriate and adequate information for decision-making</td>
<td>Ensuring timely, appropriate and adequate information for decision-making</td>
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A second common theme was related to the constraints that affected the women’s decision-making, including employment, isolation, family preferences, culture and fears. The midwives showed an in-depth understanding of the system issues that affected women’s choices, including a heavy workload, limited availability of labour ward beds and theatres on public holiday, as well as their limited contact with the women prior to their induction. The midwives had attempted to reschedule births when the maternity unit was full to maintain a safe workload and according to the risk factors of the women. They also had empathy for women’s fears related to childbirth. However, they perceived that women accepted induction as a normal part of childbirth, and this negatively affected their decision-making. Consequently, all of these social and system constraints influenced the women’s induction decision-making.

The final combined theme was related to ensuring timely, appropriate and adequate information for decision-making (see Table 4.4). Women’s fears were compounded by a lack of adequate, reliable and timely information to inform their induction decisions. When information was inadequate, all women sought additional information to increase their knowledge of the induction procedure (see Table 4.4). However, the information they obtained was not always reliable or consistent. Consequently, many of these women did not understand the risks associated with an induction procedure for non-medical reasons and were keen to accept this intervention in childbirth.

Chapter 5 will discuss the themes that have emerged from the data with reference to relevant previous research findings and the theoretical framework. Additionally, the chapter will present the conclusions that have been drawn from the discussion of the research themes. An overview of the study’s strengths and limitations will be provided, as well as recommendations for professional guidelines in clinical
practice, education and further research relating to induction of labour in low-risk women.
Chapter 5: Discussion of Findings

This chapter discusses the findings, which answer the questions and aims of the study. This study examined the influences on low-risk women’s decision-making in relation to induction of labour. The findings reported in Chapter 4 generated comprehensive and unique new data related to the influences on women’s decisions about induction from the perspectives of the women and a group of midwives. These influences included personal, socio-cultural, contextual and organisational factors, including the gendered power relationships that affected the women’s induction decisions. The study has also provided important information for the care and support required by women who request an induction of labour.

A case study approach investigated women’s induction decisions. The ‘case’ constituted two mini (or nested) cases: the women and the midwives. The use of a case study approach enabled the researcher to explore the women’s decision-making in context. The researcher sought to view the responses of both the women having an induction and a group of midwives through a feminist lens to examine any gendered or power relationships that influenced the women’s choices. It was important to include midwives who typically use a woman-centred model of care that is embedded in feminist views. Their input was integral to understanding the overall case, although each mini-case was analysed separately. Five key themes were identified from the women and three from the midwives, and the combined thematic analysis identified three main themes. The findings also indicated that there were some common and unique perspectives on the women’s decision to have an induction. These revolved around the following three themes: women and midwives were balancing risk with choice to have an induction for personal and social reasons; women and midwives contended that contextual constraints affected their decision-making; and timely,
appropriate and adequate information was required to assist their decisions. Major contextual factors that appear to have influenced the women’s decision-making and induction included geographical location and the social and cultural conditions present in this group of low-risk women. Social and cultural conditions related to the influence of family included the husband’s employment (particularly FIFO workers), isolation from family members, family preferences and culture. A discussion of all of the main and combined themes from the findings within a feminist, social and cultural context is presented below. This discussion is followed by an outline of the study’s strengths, limitations and implications for health professional policy and practice reform, education and research.

5.1 Balancing Risk with Choice and Control in the Women’s Decision to be Induced

The women’s perceptions of medical risks to both themselves and their baby played a significant role in the choices they made in relation to their induction decision-making. This was evident in the fears they expressed in connection to the birth and the types of support available. Support for the women’s induction decision-making varied and was dependent on personal, social, cultural and contextual factors. Hence, to manage their fears, the women sought control of the induction decision to enable their safety and support in childbirth.

5.1.1 Management of fears related to the childbirth experience

Identifying and addressing the precursors to women’s fears is essential to build confidence and self-efficacy around the birth process and to empower mothers in their birthing decisions. The women in this study reported that decisions around induction were often related to their fear of the birth experience and the apparent risk factors that may affect a healthy outcome. However, the latter appears to have been associated with
a number of misperceptions, with many of the women believing they required an induction for medical reasons. However, the medical reasons they reported, such as hypertension, macrosomia, potential shoulder dystocia and miscarriage, were not borne out by clinical signs either prior to or at birth. Also of concern is that even when, for instance, macrosomia exists, local (KEMH, 2015d), national (NSW, 2011a) and international (WHO, 2011; NICE, 2008, updated 2014) guidelines do not recognise it as a potential reason for induction. It is understood that offering an induction of labour to a woman with a macrosomic foetus is a risk for cephalo-pelvic disproportion and can lead to further complications, including a ruptured uterus in multiparous women and foetal distress (MacDonald & Magill-Cuerden, 2011). It was also puzzling that a number of women reported that their previous history of miscarriage led them to fear harm to the current baby. The women perceived that this was a valid reason for their induction, despite there being a minimal link between previous miscarriage and a safe birth process in a subsequent pregnancy (Kinsey, Baptistte-Roberts, Zhu & Kjerulff, 2015).

Fear related to safety has been reported by Haines et al. (2012) women who experienced fear related to safety did not see childbirth as a natural event, as they were worried about the effects to their body related to possible complications and increased pain.

Many women also expressed a fear of harm relating to their previous negative childbirth experience, or that of their family and friends, which led them to either request or accept an offer of induction if their treating doctor recommended it. The midwives had empathy for the women’s fears, particularly when they were related to a previous difficult birth. The midwives also perceived that the women commonly had fear related to their own or their friends and families’ experiences. Fear of childbirth is common, with a higher perception of risk and fear, particularly related to previous complications and childbirth interventions (Fenwick et al., 2009; Haines et al., 2012).
Intense fear, which may be disabling, has been reported in 6–10% of women (Otley, 2011; Fenwick et al., 2013).

In some cases, the women’s fear was also linked to social isolation and inadequate preparation and knowledge related to induction. The midwives also reported that they understood the women’s fears when they were isolated and would not try to change their induction decision. Although the level of fear was not measured in the current study, Queensland researchers have conducted a survey of women (n = 1,410) to determine the psychosocial predictors of fear and the level of fear in women (Toohill et al., 2014). Participants recruited from a sample in the ‘Belief project’ were screened for fear using the ‘Wijma Delivery Expectancy/Experience Questionnaire’. The findings indicated that there was a high level of fear reported in nulliparous antenatal women between 12 and 24 weeks of pregnancy (31%) versus multiparous (21%) women in pregnancy. Various precursors to fear in women were revealed in the findings, including depression, decisional conflict, low social support networks, non-supportive partner’s inadequate knowledge and CS intervention (Toohill et al., 2014). Interestingly, Toohill et al. (2014) reported that women with moderate pain or discomfort had fear. Women in the current study who had a previous experience of miscarriage or no social support had multiple forms of fear, but not those who had multiple forms of discomfort or were just ‘fed up’. Women also did not appear to have decisional conflict, as a number had actively sought an induction of labour. However, low support networks and isolation appeared to be related to fear in this study.

When women feared that, they or their baby were at risk during childbirth, they sought to control those fears through their decision-making processes. Snowden et al. (2011, p. 1) defined choice and control of childbirth by women as “an act, which requires intimate connections between reasons and rationality, a weighing up of the
risks”. According to Snowden et al. (2011, p. 3), control is where “the person is in charge of their own experiences”. The majority of the women in the current study reported that they did not regret making the decision to induce, and they appeared to be empowered by the use of induction as a control mechanism in their birth. However, Hildingsson et al. (2011) suggested that other forms of control have a greater chance of reducing fear, particularly when women are facilitated to experience and be in control of their own bodies during a normal vaginal birth.

The level of control in decision-making is an important influence in the women’s confidence and management of their fear in childbirth (Fair & Morrison, 2011; Fenwick et al., 2010; Fenwick et al., 2013; Snowden et al., 2011). As such, the concept of control in childbirth and what this means has received much attention, with some researchers proposing that women can still feel a ‘sense of control’ when they choose to hand over control of their decisions to their health care professional (Fenwick et al., 2010; Green, 2012; Namey & Lyerly, 2010). The ‘Good Birth Project’ in the US, which investigated birthing women’s views on what makes a good birth experience, found that some women tend to have a ‘sense of control’ (Namey & Lyerly, 2010). Content analysis of the interview findings revealed five domains related to a good birth experience: self-determination, respect, personal security, attachment and knowledge. The findings indicated that women (46%) viewed control as self-determination, defined in three ways: related to their level of options and choices, their ‘sense of control’ and a perception of the power of having choice. Women also viewed control and self-determination as agency. Agency related to their control of ‘birthing’ being the ‘birther’ gave them primary control. Hence, women placed an emphasis on ‘self’ in self-determination (Namey & Lyerly, 2010), particularly related to personal security. Similarly, Fenwick et al. (2010) conducted a small qualitative study in Australia related
to low-risk women’s reasons for choosing a CS without a medical indication. The findings indicated that the issues of control and safety, childbirth fear, devaluing the female body, and the birth process were leading women to request a CS. The women had indicated that the birth process was just about ‘getting a baby’ by CS and ending their pregnancy. They also perceived that they had a greater sense of control and safety through a Caesarean birth. Hence, to these women, it was ‘all about getting the baby out safely’; it was not about their level of fulfilment related to the birth process. The women did not have confidence in their ability to birth naturally or value a vaginal birth. The women participants perceived that their doctors also reinforced the decision to have a CS for safety reasons (Fenwick et al., 2010). In the current study, the women perceived that an induction was a suitable choice to manage their many fears relating to medical risks, previous experiences, isolation and a lack of support. Induction gave them a ‘sense of control’ related to having the power of choice and a ‘sense of safety’ when they were isolated from family and friends. However, many personal, social and cultural factors influenced the women to seek an induction.

5.1.2 Women’s need for support as an influence in seeking an induction

Some women in the current study found that choosing an induction afforded them a sense of control when used to ensure support from their partner at the birth, particularly in cases of inflexible employment situations such as FIFO, which required pre-planned days for appropriate leave to be taken. Despite the downturn in the mining industry due to economic influences, FIFO is still prevalent as a form of employment, especially in the study context, and it is likely to persist into the future. The issue with FIFO employment may have a long-term influence on women’s choices to have an induction. The Chamber of Minerals and Energy of WA’s (2013) federal election report suggested in 2012 that 7% of the workforce were employed in the mining industry.
Projected employment and resource needs for WA indicate that the number of people employed in the mining industry will grow from 110,000 in 2012 to 150,000 by 2020 (Chamber of Minerals and Energy of WA, 2013). However, more recently, the Australian Government Department of Employment (DOE, 2014) indicated that mining industry employment has plateaued. Nevertheless, the report indicated that in the past five years to 2014, WA has had the highest growth of employment (13,300) in Australia (DOE, 2014). Predicted employment statistics indicate that there will be a decline, but it will not be significant (DOE, 2014). Hence, a high level of FIFO employment in the mining industry will continue to influence the number of women requesting an induction of labour. McDonnell (2011) also mentioned the influence of FIFO employment on birthing, as husbands do not want to miss the birth or have to be away for any extended amount of time from work due to financial reasons. In the current study, the women reported that the father definitely wanted to attend the birth, but neither the women participants nor the midwives raised this as a financial issue.

The effect of FIFO extended beyond the issue of providing support at the birth. Fathers were not only at risk of being unable to attend the birth, but they could also be unavailable to attend antenatal visits or, if they did, they did not always contribute to a discussion about the decision to induce. Non-attendance of fathers at antenatal visits during pregnancy were explained by Dolan and Coe (2011) as contributing to fathers feeling marginalised and experiencing a ‘loss of control’ during pregnancy and childbirth, which makes many of them feel vulnerable during the childbirth process (Dolan & Coe, 2011). Other researchers have reported that fathers generally like to be in control, but this control is lost because they often feel invisible and sidelined at this important time (Fenwick, Bayes & Johansson, 2012). The majority of the women participants in the current study confirmed that the fathers were passive in their
approach to decision-making related to an induction of labour. However, they may have
gone along with the decision, as they also saw it as a means by which they could attend
and be part of the birth. The midwives in the current study indicated that any change
around the induction plans could be threatening to the fathers’ sense of control. This
was reflected in some fathers who, due to their limited leave and availability, could
become aggressive if the plans relating to induction changed.

A number of researchers have drawn attention to the importance of the father’s
involvement in childbirth, indicating that there is not only emotional support for the
woman, but a positive influence on health outcomes for the man, his partner and his
child (Plantin, Olukoya & Pernilla, 2011). Internationally, the trend for fathers to attend
the birth is common (Sapountzi-Krepi et al., 2010), it is also common for Australian
fathers to attend their partner’s childbirth (Fenwick et al., 2012). To ensure the father’s
attendance and support during childbirth, the women appeared to be balancing the risk
that might be associated with the induction with their own and their partner’s personal,
social and emotional needs.

Women with FIFO partners appeared to have special psychosocial needs due to
their isolation from their intimate partner’s support, and these needs should be
addressed as early as possible in the antenatal period (Thomson, Dykes, Singh, Cawley
& Dey, 2013). However, in the current study, these psychosocial needs did not appear
to have been recognised by some of the midwives. The findings showed an apparent
disconnection between the women’s and the midwives’ understandings of the influence
of FIFO employment. Although all women participants who had FIFO partners valued
their attendance and attempted to ensure that they would be present during the
childbirth, many of the midwives did not believe the attendance of the father during the
childbirth was essential. The midwives appeared to understand that the women wanted
their partners there, but they did not think an induction was an appropriate way to achieve this. The midwives tended to stereotype the women with FIFO partners as always being someone who would want to seek an induction. Support for women in childbirth is important, but it appeared in this instance that the midwives were not always sensitive to the women’s needs for their partner’s support. A number of previous studies have mainly focused on maternal outcomes related to a lack of social support (Edmonds, Paul & Sibley, 2011; Emmanuel, St John & Sun, 2012; Webster, Nicholas, Velacott, Cridland & Fawcett, 2011). Many researchers have underlined the need for social support and its effect on mental health in the post-partum period to prevent depression and anxiety, pre-term labour, poor labour progress and low birth weight (Edmonds et al., 2011; Emmanuel et al., 2012; Webster et al., 2011). It is also important to obtain qualitative data related to specific life events within the context that they occur in order to inform the type and level of support for women during childbirth; especially for those who lack support (Edmonds et al., 2011).

Previous studies have not specifically examined the effect of social support on women’s induction decision-making, although some have acknowledged the importance of social support networks for women’s behaviour (Green, 2012). Social support was important to the women in the current study, as they perceived that they had strong support from friends and family members related to many family issues; however, many felt unsupported when making their actual decision relating to an induction of labour. The women clearly valued the social support from their family and friends, and it was also appreciated by the midwives, particularly when the women were isolated, even though family and friends were often a source of influence in encouraging women to request an induction. The importance of woman-to-woman social support within the context of childbirth is particularly emphasised in developing countries (Edmonds et al.,
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2011; Golbasi, Kelleci, Kisacik & Cetin, 2010). Social support mechanisms for women include information, emotional support, companionship and financial support. Kitzinger (2012, p.304) suggested that women need to regain the “woman to woman support and celebrate birth as a social process”. A social birth reinforces the relationships of the women and ensures that the woman is the focus of the birth. This is in contrast to a technocratic birth, which occurs within a hospital and is a medical event brought about by a focus on risk (Kitzinger, 2012). However, a very different outcome was evident in the findings from the current study, where the support from other women actually encouraged a ‘technocratic birth’ because of either their own experiences with induction or those of their family and friends.

The women in this study were selective in what they listened to when receiving advice from friends and family; many misperceptions were evident among their friends and family, which made it difficult for them to interpret the information they received. These experiences often included an early induction of labour from 37 weeks of pregnancy, resulting in this practice becoming a culturally accepted part of childbirth within the study context. This culture of induction was also evident among the women’s friends, who appeared to believe they were being helpful when informing the women of which local doctors would readily provide an induction of labour. Consequently, one-third of the women in the current study perceived that it was acceptable to request a late pre-term induction of labour.

In this study, women’s attitudes towards an induction were surprising. A number of women appeared to have been empowered to make the induction decision themselves. Moreover, these women appeared to have adopted feminist views, which were expressed through self-empowerment in their decision-making. These women had actively sought out doctors who would provide an induction of labour. Women in
this study had gained confidence in their ability to obtain an induction of labour through their friends. Acceptance of an early induction has also been reported elsewhere in US women (Simpson et al., 2010; Rodgers & Cox, 2013), indicating that women’s changing attitudes towards interventions is internationally pervasive. It appears that there are also parallels between induction and a CS, as many young women are now influencing others to have a CS based on their experience of this medical intervention (Gallagher et al., 2012). A number of midwives also reported that the women participants appeared to accept interventions more readily than previous generations. There may have been a generational effect on decision-making, and perhaps even a subculture within this group of low-risk women related to their environment. Indeed, cultural identity is complex, as each member belongs to many different groups with values, beliefs, expectations and cultural norms (O’Toole, 2012). The norms and values of this group seemed to reflect the distinct values of their generation. The women were in a similar age group of 20–30 years, the majority were from the Peel region, and many were isolated from their family members because of husbands with FIFO employment and a lack of support from extended family members. The midwife participants reported that the trend in the acceptance of an intervention as a means to address social issues, such as ensuring support at the birth, had increased over the past decade. Similarly, there was a view that an induction was a culturally suitable solution to address the multiple forms of discomfort so common to late pregnancy, with half of the women in this study requesting an induction due to multiple forms of discomfort and ‘being fed up’.

These changes in the women’s attitudes and needs raise issues around how midwives should respond, particularly in relation to woman-centred care. Nurses and Midwives board of Australia (2006, rebranded 2010) midwifery competencies suggest
that woman-centred care should acknowledge not only the lifestyle needs of the woman, but also their emotional, social and cultural values and beliefs. While it is important to recognise that “each person has a unique identity that reflects their cultural or ethnic origins” (O’Toole, 2012, p. 15), the recent trend towards women’s acceptance of medicalised interventions as being normal also conflicts with midwives’ beliefs around facilitating natural childbirth where possible.

In this instance, it appeared that it was difficult for the midwives to maintain a woman-centred focus when conflicted with balancing woman-centred care and risk. Maputle and Donovan (2013) proposed that the concept of woman-centred care is complex, as characteristics of woman-centred care include open communication, engagement and active involvement in decision-making, mutual respect and listening. Balancing the risks of an induction with woman-centred care is important. Midwives had concerns related to the use of an induction for social reasons, which reflects midwives’ concerns globally, including the use of social induction, the risks of early term deliveries, and the need to ensure adherence to induction procedures according to research findings and international guidelines (Grivell et al., 2011; Jensen et al., 2013; NICE, 2008, updated 2014). The WHO’s (2011) recommendations for induction of labour highlighted the serious risks associated with induction, including uterine hyperstimulation, uterine rupture and foetal distress. However, the women appeared to be uninformed regarding the risks of an induction.

It appeared that both the women and the midwives were considering their risk differently. The women were balancing risks, fear and personal, social and cultural needs with their choice of an induction. Perceived risk in women related to their geographical isolation, medical risk, partner’s employment and cultural norms. In contrast, midwives, like medical practitioners, were balancing the women’s induction
decisions with the risk of serious complications relating to the procedure. However, the women did not appear to have been properly informed of these risks prior to making their induction decision, and even if they had been informed, they did not have time to consider the decision with their partner.

5.2 Contextual Factors Affecting Women’s Perceptions Around Induction

This study found ambiguity surrounding the ownership of decision-making relating to induction. Many people assume that women have full participation in decision-making during childbirth, but the findings from this study have shown evidence to the contrary. It is clear that some of the women believed they shared decision-making on induction with their GP obstetrician, and they considered this an important aspect of their childbirth experience. Elwyn et al. (2012) proposed that shared decision-making is based on women’s choices, options and discussion of preferences. However, it is also important to recognise that partnerships with health professionals promote shared decision-making through the development of trust and respect for the women’s rights to options and choices in childbirth (NMBA, 2006, rebranded 2010). Hence, the basis of partnerships between the woman and the health professional are trust and equality in decision-making, which is the cornerstone of feminist thinking. Each member of the partnership should also recognise individual choice and recognise the woman’s right to informed decision-making (NMBA, 2006, rebranded 2010).

However, the women’s choices and their perceptions around induction were influenced in this setting by contextual constraints, the medical model of care, and the cultural beliefs of their family and social groups.
5.2.1 Contextual factors influencing choice and shared decision-making

Despite the belief that women had a choice in their decision-making, this was not reflected in the data. The choice appeared to be constrained by a number of factors, including: a lack of transparency relating to childbirth statistics; a lack of choice related to birthplace, and limited choices related to guidelines for the care and support of women who choose induction for non-medical reasons. Additional factors that affected the women’s decision-making related to the model of medical and midwifery care that was the associated framework of risk management.

Researchers have agreed that in order to empower women in their pregnancy and provide support for their decision-making related to induction, delivery of information regarding maternity care should be readily available and transparent (McAllister, 2008). This is particularly so in relation to knowledge of hospital intervention rates, their outcomes and available support mechanisms. Clarity of this information is essential if women are to make informed decisions in consultation with their health care provider (RANZCOG, 2016; Queensland Clinical Guidelines, 2015). However, constraints relating to these aspects were evident, despite attempts by the WA Department of Health (2007) a decade ago to address and improve transparency and maternity choices for women. Two of the key strategies recommended then were to publish data on the level of interventions within institutions, and to inform women of the risks and benefits related to interventions in childbirth (DOH, 2007). Despite this, information on the level of interventions and induction rates in each hospital in WA is still not readily available to the public, and a lack of informed choices for women in this area has continued to be an issue (Hadjigeorgiou et al., 2012). This is in contrast to other countries, such as the UK, where statistical information relating to hospitals’ and health services’ induction rates is readily available online (Birth Choices, 2014, 2015).
Even if this statistical information was available in WA, further constraints exist for women related to birthplace choices, as they are required to only access services for the birth within the geographical location dictated by their health service (DOHWA, 2012). As discussed in the literature review, many researchers have indicated that women should have the right to choose the place of birth (Dahlen et al., 2012; Frosch et al., 2011; Kirkham, 2012; Snowden et al., 2011; Tillett, 2009). The European Court of Human rights also determined in 2010 that women had the right to choose both their place of birth and mode of birth (Kirkham, 2012). It appears that the Australian women in this study were denied their global human rights to choose their place of birth. Women in this current study did not comment on their lack of choice related to place of birth, but they did perceive that they had a right to choose an induction.

Currently, no guidelines exist in Australia relating to the support of women who choose an induction of labour when there are no medical indications. A lack of standardised evidence-based guidance for health professionals related to reasons for and timing of induction may affect approaches to induction. There appears to be varying guidelines available from state to state, institution to institution and between professionals. For instance, current frameworks that support midwifery practice and midwives’ decision-making do not actually provide guidelines for midwives relating to the care and support of women who request an induction of labour. However, the NMBA’s (2006, rebranded 2010) competencies, which were designed to provide a framework to enable midwives to empower women in their decision-making, emphasise the woman’s right to self-determination, control and choice in childbirth.

In contrast to the midwifery situation, professional induction guidelines exist for GP obstetricians in Australia (RANZCOG, 2016). However, there are differing professional guidelines and models of care in each state. Variations in international and
national guidelines can also be confusing for health professionals. The WHO’s (2011) guidelines clearly indicate that inductions should only be completed where there are clear medical indications; however, the guidelines indicate that health professionals should also consider the women’s wishes and preferences relating to childbirth (Queensland Clinical Guidelines, 2015; NICE, 2008, updated 2014; NSW ministry of Health, 2011a; RANZCOG, 2016; WHO, 2011). Acceptance of the women’s choice relating to interventions by professional bodies varies. Guidelines provided by professional bodies internationally recognise women’s choices related to interventions for non-medical reasons in exceptional circumstances (NICE, 2008, updated 2014). It appears that professional attitudes in Australia may be changing towards the acceptance of social reasons for induction given that the Queensland Clinical Guidelines (2015) for induction of labour now suggest that the obstetrician should consider individual circumstances. The RANZCOG’s (2016) professional guidelines suggest that health professionals should assist the woman to manage her options in pregnancy and birth. Nevertheless, they also emphasise that women should understand the ‘concept of risk management and how that underpins obstetric care’. The guidelines also state that the GP obstetrician should consider the woman’s individual needs and ensure that she is fully informed in relation to the risks and benefits in Australia (RANZCOG, 2016).

The variable availability of local tertiary guidelines relating to an induction of labour has also not helped health professionals who seek to clarify information on the procedure of induction in regional settings, particularly in settings like the study region, which has developed its own hospital guidelines to guide care. Professional tertiary induction guidelines are readily available relating to types of interventions, the procedure of induction, as well as the use of ARM, (KEMH, 2015a) oxytocin (KEMH, 2015c) and the trans-cervical catheter (KEMH, 2015e). The indications for an induction
are not readily available for health professionals in regional centres, as they are contained within a restricted area that requires a special request to the clinical director to access.

A lack of access to guidelines may have caused confusion in health professionals relating to the optimal timing of inductions. Ideally, to avoid risk, a woman should only be offered an induction of labour between 41 and 42 completed weeks of pregnancy if she has not already given birth (Queensland Clinical Guidelines, 2015; KEMH, 2015b; NICE, 2008, updated 2014; Simpson & Stanley, 2011; WHO, 2011). Moreover, evidence shows that the majority of women go into labour naturally between term plus two days and term plus three days (NSW Ministry of Health, 2011a). However, the current study demonstrates that the scheduling of inductions at a much earlier time of 38–40 weeks was common in this regional setting, and that this was acceptable to both the mothers and doctors. The women appeared to be unaware of the recommendations around the timing of induction, which may be related to the lack of clarity in the language and definitions of terms such as pregnancy, term, post-maturity and prolonged pregnancy. According to the midwives in this study, many of the women’s GP obstetricians considered ‘term’ to be from 37 completed weeks of pregnancy. Tertiary guidelines in WA and the international NICE (2008, updated 2014) guidelines were not observed within the study setting. As a result, the midwives were concerned that there was now a regimentation of childbirth and that the majority of women were induced early for perceived rather than actual risks; for example, a large baby or spurious labour.

McAllister (2008) suggested that doctors have withheld information from patients for many years relating to the risks of procedures. Crossley (2007) warned that this can contribute to an illusion of choice for women during childbirth. This illusion is
supported by the medicalisation of childbirth that has endured over the past 30 years and remains a feminist concern. Crossley (2007, p. 544) argued that medical practitioners are “powerful agents of social control” who can mould women’s values and beliefs. This is evident in the current study, where half of the women perceived that they had fully shared in the decision-making related to their induction, despite obvious misperceptions surrounding the reasons for their induction and a broader lack of system-provided information available to them on which to base their decision.

Major influences around women’s requests and doctors’ recommendations for an induction appeared to include not only their individual perspectives of what constituted risk, but also the risk imposed by the medical model of care, the hospital setting and its availability of resources. The midwives suggested that doctors’ leave and a lack of theatre and pathology resources on public holidays were the predominant reasons for the regular scheduling of inductions, which was designed to ensure the management of risk when doctors were unavailable. These scheduling constraints required weighing up the possible outcomes related to the inadequate after-hours hospital resources versus the benefits of continuing the woman’s pregnancy. Cheyne, Abhyankar and Williams (2012) suggested that thresholds for GP obstetricians’ decision-making are determined by their values and probable consequences, and they provided support for this view. Indeed, the Queensland guidelines also suggest that an induction option is provided to women when the risks of continuing the pregnancy outweigh the benefits (Queensland Clinical Guidelines, 2015). However, the guidelines did not refer to the scheduling of inductions for GP obstetricians’ holidays and personal lives, particularly where they may be an issue in regional areas, as systems and resources may not be available to manage these scenarios.
In the current study, the women generally accepted, without question, decisions advised or agreed to by their doctor. Women contended that they had autonomy and choice even when the decision was made for them relating to risk. They also perceived if there were risks relating to an induction procedure the doctor should have been against an induction. This applied in the case of either doctors recommending an induction or agreeing to a woman’s request for one, with the women indicating that that they would not have accepted an induction if their GP obstetrician had been against it. The way that choices are explained to women is a crucial element in their attitudes towards medical intervention. Feminists argue that medical models of care exert a gaze that includes an emphasis on pathology, intervention and risk (Crossley, 2007). To investigate this issue, Stevens and Miller (2012) analysed the association between women’s preferences and their communication with their health care provider, finding that those who had received favourable information related to an intervention were more likely to choose that intervention. Internationally, this influence on decision-making has also been argued by the Nursing and Midwifery Research Unit in the University of Stirling in the UK related to elective induction, communication and interpretation of risk (Cheyne et al., 2012). Cheyne et al. (2012) suggested that how risk is framed also makes a difference to women’s decisions. However, not all doctors in the current study emphasised risk, and a small number of the doctors were against social induction, according to some of the women, who indicated that their doctor had tried to talk them out of wanting an induction. These women perceived that they lacked choices relating to the induction decision. A number of the midwives reported that they were surprised that the doctors tried to talk low-risk women out of an induction, as many midwives believed that the doctors supported the use of inductions. Perhaps some women’s
inductions could have been prevented if the risks related to an induction had been framed differently.

The issue of informed choice relating to the risks of induction appears to be complex and unclear. Consequently, this raises the question, ‘Can women ever be fully informed relating to their choices and childbirth if the outcomes are uncertain?’ The women in this study appeared to be happy to accept the doctor’s decision to induce due to perceived risk. Hence, this raises another question as to whether anyone can truly predict risk in childbirth. According to Snowden et al. (2011), perspectives on the level of risk in childbirth can differ, and the choice is a gamble because no one can be certain of the outcome. The choice was even more of a gamble for the women, as they did not have enough time to consider their options and risks, which was an issue identified by RANZCOG (2016). Hence, the induction decisions were not always shared decisions—a situation that has also been identified in international studies. A national ‘blueprint for action’ on shared decision-making in maternity care in the US identified barriers to shared decision-making that included the following: inadequate information mainly related to untrustworthy sources; insufficient opportunity for sharing information; a culture of fear; medicalisation of childbirth; and limited options and factors, which lead to a lack of choice (Transforming Maternity Care Symposium, Steering Committee et al., 2010). It is clear that all of these barriers were present to one degree or another in the context of this study, despite the women perceiving that they shared the decision-making.

5.2.2 Midwives’ influences in women’s induction decisions

Midwifery practice and women’s choices were also restricted by contextual constraints that tended to disempower the midwife, which then had a flow-on effect of women not having opportunities to access midwifery-based birth information and
support. Due to the models of care used in the study, partnerships with women were predominantly between the women and their GP obstetrician, who managed care for the women throughout their pregnancy. The midwives reported that the women trusted their GP obstetricians and were able to build a good relationship with them. However, under this medically led model of care, the midwives perceived that this trust, and the lack of midwife input, could lead to the women’s disempowerment in the decision-making process around induction. An example of this was the scheduling of inductions for the doctors’ personal convenience relating to annual leave. It is surprising that trust led to disempowerment of women, as it could be expected that trust would lead to women’s increased confidence and control. However, trust can also be disempowering if it leads to increased interventions for the convenience of the obstetrician (Soltani & Sandall, 2012).

Trust was not the only factor that disempowered the women. The model of midwifery care used in this setting marginalised the midwife in the care and support of the women prior to their induction decision. Various midwifery models of care assist birthing women, including ‘case load’ midwifery, ‘team midwifery’ and ‘shared care’ between the doctor and the hospital midwife (DOHWA, 2012). An alternative to the medical model of maternity care is a ‘continuity of care model’, which varies but usually involves the provision of care by either a group of midwives or by the same caregiver (Henderson, Hornbuckle & Doherty, 2007). In the context of the current study, the ‘continuity of care’ model was in place only in the antenatal clinic in the form of midwife-led/shared care between the GP obstetrician and the midwife. This limited model of ‘midwife-led care’ enabled a small number of midwives in the antenatal clinic to develop partnerships, provide information, enable and share women’s induction choices, and subsequently influence the women’s decisions related to induction. In
contrast, other midwife participants practising in the more common medical model of care had limited contact and time with the women leading up to the birth. Women’s views of partnerships between women and the midwife were investigated in a small qualitative study (n=16 participants) in the United Kingdom. The findings supported the findings of this current study women in that highlighted that without continuity of care they could not form effective partnerships with the midwives. Women emphasised that time, contact, mutual cooperation, negotiation, trust, mutual respect and shared responsibility with the midwives was an integral part of the midwife woman relationship (Boyle, Thomas & Brooks, 2016). Similarly, a lack of contact with women antenatally and marginalisation in this current study contributed to midwives feeling powerless in influencing a change in induction decision-making once the woman and their doctor had made it. However, midwives did indicate that increased access to women antenatally would enable them to increase the women’s confidence in their decision-making. In fact, developing confidence and autonomy in women has been described as part of the midwife’s role (Fenwick et al., 2010; Page & McCandish, 2007). A small number of midwives perceived that any contact with the women, however small, may enable them to influence at least the timing of the induction. The midwives had reported that when the women attended for assessment late in pregnancy in the maternity ward area, they had the opportunity to discuss the risks of an induction then. The midwives tried to promote normality in childbirth by influencing the later rescheduling of non-urgent and non-medical inductions. This then provided the women with a wider timeframe to go into spontaneous labour, but it did not ultimately effect a change in the actual induction decision. It appears that the concept of woman centred care and partnerships are difficult to achieve when there is fragmentation of care.
Fragmentation had occurred in this setting as many health professionals were involved in the woman’s care. The majority of women participants had received one to one care from either their GP obstetrician or midwife led care during their pregnancy. Yet during labour and postnatally they all received care from the hospital multidisciplinary team. Consequently, care was decentralised, as multiple health professionals were responsible for the woman’s care. It is argued by Fahy (2012, p.151) that when care is decentralised no one person is responsible for the woman’s care and “no one cares enough to get involved”. Perhaps this was the case in this case study. Midwives did not want to get involved and just went along with the induction decision. Indeed midwives’ considered in this setting that the decision had already been made and it was now too late to change the woman’s mind. Hence, in this case midwives did recognise the women’s autonomy, rights to self- determination in decision-making and they also appeared to support and respect the women in their choices.

The partnership between midwives and women is reflected in mutual respect for their differences, and valuing each other’s experiences and respect for each other’s rights (Boyle et al., 2016). Partnership principles are usually the basis for shared power and decision-making between the woman and her midwife. Yet midwives did not always recognise the women’s rights to self-determination and choice in decision-making. Midwives reported they were frustrated with the women’s requests for an early induction as this intervention was associated with increased risks. They perceived this was a generation of women who wanted everything now and they were not prepared to wait for the natural childbirth. It was unfortunate that some women in the current study perceived that some midwives appeared to be judgemental upon hearing of the women’s induction decisions, as this was unlikely to facilitate open communication on the topic. When communicating with women, Macdonald and Magill-Cuerden (2011, p. 151)
advocate that midwives use “unconditional positive regard”. Midwives in this study appeared to use terms that were not consistent with a feminist approach, including the terms ‘ladies’ and ‘patients’. Some described women’s childbirth as a ‘delivery’, or having ‘delivered’ and ‘caesarean section’ rather than the feminist appropriate terms women, birth, birthed or caesarean section birth.

This issue has also attracted the attention of editors/researchers in the US, who took part in a round table discussion relating to language and birth (Simkin, Stewart, Shearer, Glantz, Rooks, Lyerly, Chalmers & Keirse, 2012). This discussion on 2012 explored the interactions between the health professional, the woman and her family (Simkin et al. 2012). The discussion highlighted the impact of language, terminology and health professional attitudes on the women’s level of understanding and behaviour, with authors drawing the conclusion that language can be ‘deceptive and confusing for mothers’ (Simkin et al., 2012). It was highlighted that inappropriate terms including ‘ladies’ implied that the woman “belonged to a man and was a possession” (Lyerley, 2012, p.157). Lyerley (2012) indicated that the terms ‘my women’ or ‘ladies’ were patriarchal and should not be used by midwives to describe women, as midwives work in partnership with women. She argued that the term ‘women’ does not have patriarchal undertones, and therefore is more fitting. Use of the term ‘patient’ to describe women is also inapplicable, as midwives usually consider women in pregnancy and childbirth as healthy. The term ‘delivery’ is also ill chosen, because the midwife supports the woman during birthing and childbirth. Hence, it is the woman who gives birth to the child the midwife does not deliver the baby. Use of the term ‘caesarean section’ may also be misplaced, as it is more appropriately described as a ‘caesarean section’ birth. Glantz (2012) argues that use of the term ‘caesarean section’ rather than ‘caesarean birth’ is more suitable, as women now see caesarean as an available alternative to natural
childbirth. As our attitudes and language can influence the woman’s behaviour, midwives need to ensure that they enable partnerships and shared decision-making with women, recognise women as individuals have respect for their choices and do not stereotype them, which is more closely aligned with the feminist principle of reciprocity.

The varying interventionist/non-interventionist approaches to childbirth adopted by the midwives and GP obstetricians was sometimes perceived by the women to be conflicting; as a result, the women sometimes felt unsupported by the midwives in their decision to request an induction. Soltani and Sandall (2012) had similar findings, and as a result, they suggested that midwives should be careful in these cases not to impose their beliefs and values on women, as it is important to ensure that the women’s voices are heard. The line between the simple provision of information and influencing choice can be a difficult one to tread, particularly when perceptions of the nature and the degree of risk relating to induction differ. The midwives in this study expressed concerns that induction for non-medical reasons would also lead to further interventions—a situation that the mothers generally seemed unaware of. However, midwives’ appeared sensitive to the families’ needs once the induction decision was made. This approach by midwives was realistic given the constraints of their organisation and a lack of access to women prior to the induction decision.

Although these women appeared to have autonomy through shared induction decision-making with their GP obstetrician marginalisation of their decision-making through disempowerment was evident. The women were disempowered in their decision-making by a lack of choices, which related to information transparency, choice of birthplace, provision of information through medical discourse and patriarchy. In addition, the midwives had few opportunities to develop long-term partnerships and
provide comprehensive information to guide the women’s choices based on adequate, appropriate and timely information.

5.3 Ensuring Timely, Appropriate and Adequate Information for Decision-Making

The women participants in the current study needed accurate, reliable and consistent evidence-based information to empower them and enable their choices. The women reported that they felt that the information related to the intervention of induction, as well as the information related to the normal length of pregnancy, was inadequate. It appears that women internationally also lack clear information relating to the procedure of induction, as US (Simpson et al., 2010; Moore & Low, 2014), Irish (Murtagh & Folan, 2014) and Scottish (Shetty et al., 2005) studies show that women there lacked information related to the procedure and risks associated with an induction of labour. The lack of appropriate information for induction decision-making seems to be a persistent issue given that research from a decade ago found that additional in-depth information for women relating to the induction procedure would have helped them to feel more mentally prepared and to have a positive experience (Shetty et al., 2005). When the women in the current study perceived that they had inadequate information, they sought additional information online with no guidance from health professionals. However, the women reported that these websites were not reliable and did not meet their need for consistent information. A global study by Lagan, Sinclair and Kernohan (2011) examined the effect of the Internet on women’s decision-making and pregnancy in the UK. The findings indicated that health professionals should provide information for women on suitable evidence-based websites (Lagan et al., 2011), which coincides with the view of the WA women in the current study. However, the women’s views relating to the adequacy of information differed from the midwives’
views. The midwives perceived that the majority of women received information related to the induction procedure from a variety of sources, including the hospital antenatal clinic, antenatal classes and the maternity ward.

The women who attended the midwife antenatal clinic felt supported and informed by the midwives, but some of these women were also unaware of the procedure of induction, possibly from inadequate transfer of antenatal information. However, the midwives reported that they provide women with verbal and written information in the antenatal clinic from traditional hospital sources. Sources of information included induction information sheets, pamphlets and antenatal education classes. The midwives also reported that women who receive care from their GP obstetrician may receive information in his surgery, but they were unaware of the type of information that the women received. Induction decision aids should be consistent and reliable to aid women’s understanding. In Australia, the quality of decision aids and sources varies between health care professionals, hospitals, across states and nationally. In contrast, international researchers using the IPDAS criteria have standardised complex childbirth decision aids in Europe (Dugas et al., 2012) and the Netherlands (Vlemmix et al., 2012). Complex decision aids based on IPDAS criteria that have been investigated by these researchers include those used for women who have previously had a CS (Dugas et al., 2012; Vlemmix et al., 2012), and women with a breech presentation in pregnancy (Vlemmix et al., 2012). The findings indicated that the use of these complex decision aids can increase women’s knowledge and reduce their anxiety and decisional regret (Dugas et al., 2012; Vlemmix et al., 2012). It appears that the use of decision aids based on the IPDAS criteria may also be suitable to provide appropriate information to meet the women’s induction decision-making needs.
Antenatal classes also provided inadequate information for women’s induction decisions. The women reported that they received information on normal childbirth in these education classes, but insufficient information relating to the induction process. The midwife participants also reported that some midwives who taught antenatal classes had a naturalistic approach, as they appeared to be focusing on promoting natural childbirth rather than providing information on potential interventions and risks. In Missouri, researchers investigated the use of standardised teaching aids to guide midwives in the provision of information relating to the risks and benefits of induction (Simpson et al., 2010). The findings indicated that the use of these teaching aids reduced the induction rate by 20%. It appears that midwives in the current context missed this vital opportunity to inform the women’s induction decision-making.

The women often attended antenatal classes in large groups, which did not help them understand the induction procedure or risks. Hence, they reported that the timing of the classes and the type of antenatal classes did not meet their needs. To aid their understanding, they wanted education throughout pregnancy rather than just from 30 weeks. In their qualitative study, Cook and Loomis’s (2012) narrative findings of women’s birth stories provided support for the view that women need information throughout their pregnancy to enable understanding, informed choices and decision-making in pregnancy (Cook & Loomis, 2012). The women also required antenatal education in small groups to enable their understanding of their choices in childbirth. Nolan’s (2009) systematic survey indicated that women also prefer small antenatal education groups, as well as receiving information relating to their individual needs. The women in the current study did not seem to have the opportunity to explore their individual needs, feelings or options related to an induction in the antenatal education classes, as the classes were too large, and this made it difficult for the women to actively
engage with the facilitator. Researchers in the UK have emphasised that women should actively participate and clearly understand the information that is provided for them during their pregnancy (Green, 2012). Engaging women to increase their understanding should be a key factor in the delivery of information in midwifery practice. Researchers have also recognised engagement as a core factor internationally, which relates to improved and greater satisfaction with health care (Barello et al., 2012).

To enable engagement with women and increase their understanding, facilitative antenatal education and communication can be used (O'Toole, 2012). Indeed, some of the main elements of facilitative communication are active listening, open-ended questioning, clarification, reflection and the use of silence (O'Toole, 2012). The use of open-ended questions with women empowers them to lead the conversation rather than be led. Facilitator clarification of information enables understanding in the women (O'Toole, 2012). Macdonald and Magill-Cuerden (2011) also suggested that interactive parenting programs have benefits such as increased learning, transfer of knowledge and parents’ confidence in their own ability. Women can then obtain consistent information for themselves and their families. Therefore, group education during pregnancy appears to offer the opportunity to empower women and enable their understanding related to the process of induction decision-making.

5.4 Strengths of This Case Study

The identification of a gap in women’s decision-making and induction of labour in Australia generated the research questions explored in this interpretive case study. The use of this approach ultimately generated comprehensive unique data relating to the setting, constraints and conditions that influenced women’s decision-making.

To ensure trustworthiness of the data, the researcher utilised a number of approaches to ensure truth-value. Confirmability was ensured through triangulation and
collection of data from a variety of sources. Authenticity and preservation of the women’s voice was maintained in this study through a peer review by the researcher’s supervisors to assess the truthfulness and accuracy of the data. The researcher also employed a senior administrative assistant to retype the transcripts, and these retyped transcripts were then compared to the original transcripts to ensure there was no loss of data.

The findings have revealed many examples of social, contextual and cultural constraints that marginalised and disempowered the women’s decision-making. Validation and recognition of the women’s ‘voice’ through recommendations for social change occurred through the generation of a number of implications for health professional policy and practice reform, education and research.

5.5 Limitations

Although the study was limited to one context, the findings may be transferable to low-risk women who have similar characteristics in similar contexts. This case study can be used as a valuable resource for midwives who want to complete similar studies in other settings, or who want to use the data as a basis for local and national guidelines relating to induction of labour in low-risk women and the influences on their decision-making. Health professionals in this maternity unit may be able to use the information to amend existing policies related to induction of labour to incorporate low-risk women’s views.

5.6 Recommendations and Implications for Policy, Practice, Education and Research

This section will summarise the extensive recommendations and implications for health professionals policy and practice reform, education and research (see Table 5.1)
that were generated by this study. Concluding thoughts will follow in the final part of the chapter.
Table 5.1.

*Recommendations from the findings of this study for policy, practice, education and research*

<table>
<thead>
<tr>
<th>Policy Reform</th>
<th>Practice</th>
<th>Education</th>
<th>Research</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urgent development of clear, concise induction guidelines that incorporate the perspectives and active participation of women</td>
<td>Development of resources within this study context</td>
<td>Empowerment of women through improved antenatal education, including: women-focused A/N sessions and small group sessions to facilitate women’s intervention decision-making from 12 to 40 weeks</td>
<td>Use of this case study as a basis for comparison with other settings and populations</td>
</tr>
<tr>
<td>Strengthened governance by professional bodies relating to birth interventions</td>
<td>Increased availability of theatres and onsite pathology 24-hour services</td>
<td>Staff development sessions are required relating to facilitative antenatal classes, development of online antenatal classes and retrieval of reliable online resources for women</td>
<td>Mixed methods studies to investigate the use of induction decision aids based on the IPDAS criteria</td>
</tr>
<tr>
<td>Improved availability and transparency of hospital maternity statistics</td>
<td>Development of a prenatal ‘At risk of intervention’ checklist to guide increased support</td>
<td>Development of the midwifery role within settings similar to that of the study to empower midwives’ partnerships with women</td>
<td>Studies to investigate the parallels between induction and CS and their respective outcomes</td>
</tr>
<tr>
<td>Lifting of government restrictions relating to place of birth</td>
<td>Increased midwife participation in the team governance structure</td>
<td>Increase midwife contact antenatally</td>
<td>Studies of the link between social support and women’s birthing decisions</td>
</tr>
<tr>
<td></td>
<td>Implementation of pre-admission clinics for women having interventions</td>
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Staff development sessions are required relating to facilitative antenatal classes, development of online antenatal classes and retrieval of reliable online resources for women.
5.6.1 Recommendations for health professional policy and practice reform

Australia and WA require unique midwifery and obstetric professional guidelines to take into account women’s views, WHO (2011) recommendations for induction of labour and the attitudes of Australian health professionals. Many women may not have sought an induction for social reasons if the health professional had not been so willing to comply, and if they had been better informed early in their pregnancy. National consistent, clear and accessible guidelines would enable health care professionals to provide consistent, reliable information for women. Guidelines should include the following points: clear definitions of the reasons for induction in low-risk and high-risk women; the gestation at which women should be offered an induction of labour; support required for low-risk women who request an induction; provision of time for decision-making and consideration of induction in special circumstances. A description of the procedure, options, risks and benefits for women should also be included in the guideline. Special circumstances may include FIFO employment, as there is inequity in induction protocols between Australia and the UK relating to women with partners that have employment that require them to be away from home and where, in Australia, women appear not to be well informed about the risks, benefits and alternatives of the procedure. Health professionals need to incorporate the views, values and beliefs of the women to validate their voices through social change and practice reform. To enable this practice reform, health professional guidelines should be available for both public and private hospitals. Increased availability of these guidelines would provide benchmarking for regional and remote hospitals relating to the development of protocols.

To fully enable decision-making, women need statistics that are readily available relating to the intervention rates in WA hospitals. Importantly, the Australian
Government should enable women’s choices by lifting restrictions related to postcodes for childbearing women. Women could then choose where they would give birth and avoid hospitals with high intervention rates, or it might result in a rise in inductions with women seeking hospitals that readily perform them. Improved choices for women may then lead to a fall in intervention rates.

Increased governance relating to induction decision-making in regional hospitals would also prevent unnecessary inductions. Increased accountability by consultant obstetricians for decision-making and support for GP obstetricians making the decisions regarding an induction of labour may assist with this. RANZCOG (2013) developed guidelines relating to the care and support of women who request a CS. These guidelines could be extended to include the care of women who request an induction of labour. Professional bodies in Australia need to investigate the definition of ‘term’ pregnancy as this definition has changed in America. Examination of this term by professional bodies may also prevent unnecessary early inductions. GP obstetricians and midwives also need to recognise women who are likely to request an induction for non-medical reasons through the development of an ‘at-risk’ checklist. Such a tool could include risk factors identified in this study, such as demographic isolation, partner’s FIFO employment, multiple forms of discomfort, perceived risk of harm and inadequate knowledge and preparation for childbirth.

The provision of inadequate theatre and pathology resources also restricted health professionals’ decision-making. The midwives in this study suggested that inductions were scheduled by GP obstetricians to avoid risks associated with a reduction in these resources on public holidays. All maternity hospitals should have available and adequate theatre services (WHO, 2011) throughout the year, 24 hours per day, for women who are in labour. Theatre, medical and pathology staff should be close
to the hospital or onsite when on-call to avoid delays in assembling the team for an emergency CS. Consequently, through the provision of adequate obstetric services within this institution, unnecessary inductions would be avoided.

**5.6.2 Midwives’ roles need to be strengthened**

An increased level of team participation in governance structures is required to strengthen the role of midwives within contexts such as that examined in this study. To enable increased participation of midwives in governance structures, the multidisciplinary team should agree on a time for their meetings.

New midwifery models of care that strengthen their partnerships and contact with women are required within this context. Increased midwifery-led care would increase the opportunities for contact with women. The need to strengthen partnerships and collaboration with women is important. If a woman is well informed relating to an intervention, it increases her self-esteem, determination and active collaboration in the decision-making process (Maputle & Donovan, 2013). Midwives should ensure the women’s understanding of the procedure of induction through the provision of information related to interventions for women (NMBA, 2006, rebranded 2010).

Increased contact with the midwife and collaboration in decision-making has many known benefits, such as reduced intervention during childbirth. Unequivocal evidence in a systematic review of midwife-led care indicated that increased contact with the midwife through midwife-led care leads to normality in childbirth through effective communication skills (Soltani & Sandall, 2012). Such recommendations should also be extended to enable the provision of information by midwives, including the role of interventions, as women in this study reported that they needed this information.

Strategies such as the development of a midwifery pre-admission clinic could ensure that women are able to reflect on their alternate induction choices through a
discussion of the recommended timing of induction and the relevant risks and potential complications. Reflection is an important part of women’s decision-making (Wittmann-Price, 2006). Contact with the midwife at this stage would enable the midwife to clarify the woman’s understanding and facilitate her decision-making. Additionally, the clinic would provide an opportunity to discuss and reflect on their previous experiences to relieve fear and anxiety.

Debriefing and a discussion of fears is an important part of midwifery care. To this end, a midwife-led RCT has been proposed by Fenwick et al. (2013, p. 1) to investigate the use of a psycho-educational counselling tool called “Belief: Birth Emotions—Looking to improve expectant fear” in antenatal women who report elevated levels of fear. This large study of antenatal women (n = 1,200) in Queensland will be conducted between 2013 and 2016 at 24–34 weeks of pregnancy. Researchers expect the reported findings to indicate a reduced level of fear, decisional conflict, less depression, increased self-efficacy and improved childbirth outcomes. In the current study, the women did not report that they had the opportunity to discuss or debrief their inner fears antenatally in relation to childbirth, which may have led to a normal birth. However, the women received an opportunity to discuss their fears postnatally with the researcher. To meet women’s needs, opportunities should be provided that facilitate a discussion of their fears early in pregnancy. Nonetheless, finding a solution to fear in childbirth is complex. An alternative opinion on the effectiveness of counselling in a Swedish longitudinal study of childbirth suggests that prenatal counselling does not reduce fears (Hildingsson, Nilsson, Karlström & Lundgren, 2011). However, this finding related to the country where the research was conducted.

It is important that midwives consider the psychological and psychosocial needs of the mothers when balancing risk and woman-centred care. There is no doubt that the
midwives in this study demonstrated empathy and understanding towards the women’s requests for induction. They had empathised with the women’s fears related to previous experiences and isolation, and they recognised the importance of family and friends’ support when women were isolated. Moreover, the midwives also perceived that they fully understood why women put pressure on their doctor for an induction due to their fears and need for partner’s support. However, midwives were not aware of all of the social-cultural factors that had affected the women’s decisions. This study provided rich information to enable midwives’ understanding of these factors. However, a change in attitude is required if midwives are to provide the unique individual support and options needed by women who have FIFO partners in WA.

5.6.3 Recommendations for education.

Researchers have indicated that it is important to enable and support women’s choices, be non-judgemental and be flexible (Wittmann-Price, 2006; Maputle, 2010). Strengthening of education for midwives in relation to the importance of social support and its relevance to women’s decision-making is essential. Antenatal education classes should also be reformed to meet women’s unique needs. Antenatal classes should be women-centred and led by a facilitator to enable women to actively participate (O’Toole, 2012). The use of small groups of women and their partners would enable group facilitation and the transfer of information more effectively to parents. The women’s active participation will then lead to increased confidence. Equally important, the timing of antenatal classes should be changed to support the views of the women in this study. Ideally, there should be a variety of classes to meet the women’s needs from 12 weeks to term. Researchers support this view and suggest that information that is non-judgemental, balanced and appropriate should be provided all the way through pregnancy (Maputle, 2010). It is also important to develop midwife-led online
interactive classes to address the needs of women who cannot attend the classes. A ‘one size fits all approach’ to antenatal care is also not advocated by Thomson et al. (2013); hence, a flexible approach to antenatal education is required.

Women need a variety of reliable educational media. The midwives did not direct women to electronic resources; thus, staff development sessions should be conducted for midwives regarding the use of electronic technology and the resources available for women relating to an induction of labour. Health professionals should develop their Internet skills related to the retrieval, interpretation and application of evidence in order to provide women with evidence-based information from reliable sources. Pre-service education is also required relating to the implementation of facilitator-led antenatal classes that cover pregnancy, naturalistic childbirth, interventions, women’s childbirth options, care of the newborn and parenting. The midwives could then help the women to obtain further information from reliable sources when required.

It is also evident that personnel of FIFO companies need to be educated relating to the health risks relating to women who have an early induction of labour for non-medical reasons, as women are scheduling their birth so that their partner can be there. Companies should be encouraged to revise their roster practices when their employee’s wives are pregnant to enable their partner to be at home during the ‘term’ weeks and immediately following birth.

5.6.4 Recommendations for research

The key recommendations for research include studies of the empowerment of women through the development of new induction decision-making tools based on the (IPDAS) criteria (Viemmix et al., 2012) to enable midwives to adequately inform women of the risks of induction. Further research studies are also required relating to
the parallels between induction decision-making and CSs, and the link between social support and the women’s decision-making.

Research studies should be conducted on strategies that strengthen the midwives’ role and enable them to better inform birthing women. A national database of decision aids is necessary to recognise the unique views of these women relating to their information needs. It appeared that the women’s rights in the ‘Australian Charter of Health Care Rights’ relating to the right to communication and information about the procedure of induction of labour were being ignored (Australian Commission on Safety and Quality in Health Care, 2010). Currently, the quality of the information that has been designed to aid women’s decision-making during pregnancy has not been assessed nationally. This includes leaflets, information sheets and website-based information. Aids for complex maternity care interventions based on the IPDAS criteria related to induction are not available in Australia. In midwifery, only two decision tools relating to pain relief and breech birth have been based on the IPDAS criteria (Stacey et al., 2014). It is important to develop consistent and reliable decision-making tools for midwives relating to the complex interventions in childbirth, as women’s use of decision aids will increase their engagement and shared decision-making (Romano, 2013). A complex intervention could include both an induction of labour and a CS. An inquiry by an institutional body such as the DOHWA into the available international decision aids that have been assessed using the IPDAS criteria could assist in the development of a national database of decision aids for complex interventions.

All women need to be actively involved in their decision-making relating to complex interventions such as induction. Previous studies have investigated the links between induction and CS and fear and women’s requests for CS, but they have not investigated the parallels between CS and induction. Parallels appear to exist in this
study between the influences on women’s induction decision-making and CS relating to the women’s acceptance of intervention, seeking interventions due to fear and the need for support. Findings have also indicated cultural factors and social support affect women’s decision-making. A lack of social support related to geographical isolation and partner’s employment, family fears and a cultural acceptance of induction as a normal part of childbirth impacted on the women’s decision-making. Hence, the link between social support and women’s birthing decisions needs further investigation. To provide support for this study’s findings, it would be useful to extend the study to other similar settings with a broader population group to enable a larger sample.

5.7 Conclusion

This study aimed to examine the factors that influenced women’s decision-making regarding induction of labour to address the rising rate of induction. This research was necessary due to the cost of increased interventions to the woman, her family, the health system and the gap in research. This in-depth interpretive case study has revealed new insights into the influences on women’s decision-making from both the women’s and the midwives’ perspectives. Many social, cultural and contextual factors appear to have influenced the women and their decision-making relating to an induction of labour. Social factors included women with partners who had FIFO employment and geographical isolation from friends and family. All of the women readily requested an induction so that their partner or family and friends could be present during the childbirth. Generally, the women wanted to plan and control their time of birth to suit their family needs. The majority of the women believed that they shared the decision-making; however, this was a misperception, as all of the women appeared to have been confused and misled regarding the reasons for their induction. Cultural factors that affected the women’s induction decision-making included the
following: an acceptance of medical intervention for risk management; women’s perception that an early induction prior to 40 weeks’ gestation was a normal part of childbirth, a belief by family and friends that induction was a safe alternative birthing option to address fear, late pregnancy discomforts and restrictions in the availability of family support. Many contextual factors also marginalised the women’s induction choices and participation in the induction decision-making. These factors included scheduling of induction for risk management; medical patriarchy; disempowerment of the midwife; confusion relating to terms such as ‘term’ and ‘gestation’; a lack of available resources; a lack of available governance; and a lack of national and local policies that incorporate women’s views. The midwives were also frustrated with the regular scheduling of inductions for risk management in this context. However, the GP obstetrician had also been trying to balance risk with the constraints of the organisation. There were no position statements that included information on the care and support of women who request an early induction, or on the perspective of the women. Hence, it appeared that the professional bodies had ignored the values, beliefs and needs of the women relating to an induction for non-medical reasons. Consequently, the women’s preparation for their induction decision-making was not evident.

At times, the midwives’ attitudes varied towards woman-centred care, particularly when considering the risks of an induction versus the woman’s social needs. Some midwives appeared to be judgemental, particularly towards women who made induction requests for social reasons. The midwives perceived that women should not make the decision regarding an induction, as it was the doctors’ decision. Antenatal classes did not always aid the woman’s induction decision-making. The midwives appeared to be conflicted between their naturalistic model and the interventionist model of the doctors. Therefore, some midwives provided information that promoted natural
birth, but they limited information relating to interventions. To meet their needs, women require information on both natural birth and interventions.

The women could not readily identify outcomes from interventions at their local hospitals, and they were restricted in their choice of ‘birthplace’, which was determined by their postcode. Inadequate and inappropriate sources of information led to their further disempowerment, confusion and marginalisation in their decision-making. It was concerning that the women readily accepted the culture of intervention, and that the women and their families accepted an induction as a normal part of childbirth. This led the women to request an induction from their GP obstetrician.

Although the women perceived that they shared induction decision-making with their GP obstetrician, it appeared that this was a myth. Organisational constraints and patriarchal structures had disabled both the women’s and midwives’ participation in decision-making. The midwives had demonstrated empathy, compassion and understanding relating to the constraints, which had affected the women’s decision-making. However, the midwives lacked options relating to the women’s induction decision-making. The midwives were not involved in the decision-making and had minimal contact with the women prior to admission. It is unacceptable that the midwives’ role was eroded to this extent, as it affected the women’s level of empowerment. The women appeared to be inadequately prepared for their induction decision-making, as they lacked choices and were misled in relation to their level of risk. The midwife’s role needs to be strengthened through increased participation in governance and more contact with women antenatally if they are to support women in their decision-making. It is important that the women’s concerns about inadequate preparation are taken seriously. They need clear, consistent, readily available and reliable information antenatally to guide and empower them in their induction decisions.
Active participation and engagement in their decision-making may lead to a reduction in women’s induction requests.
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Appendices
Appendix A: Women’s Information Sheet

For Phase One of the Research Project:

‘A Case Study of Low-Risk Women’s Perceived Decision-Making for Induction of Labour’

Principal Investigator:
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Researcher/PhD Candidate:
Mrs Jenny Wrightson, Clinical Midwife Consultant PHC

The research team conducting this study would like to invite you to participate in Phase 1 of this project, which is described below.

WHY IS THIS STUDY BEING DONE?

This study forms the basis for research undertaken by Jennifer Wrightson as a requirement for completion of her Doctor of Philosophy at Murdoch University. Induction rates are rising amongst women who have healthy pregnancies. Currently there is limited knowledge regarding the influences on women’s decision-making in regard to non-medical induction of labour. The information you provide will assist us to develop a questionnaire designed to investigate the reasons associated with non-medical induction of labour in a much larger sample of women. The results from the questionnaire will assist us to inform health professionals so they can provide education and support to women who request inductions for non-medical reasons.

HOW CAN YOU BECOME INVOLVED IN THE STUDY?

If you have had an induction of labour and a normal pregnancy without medical problems, you will be invited to take part in Phase 1 of the study in the first few days
following the birth of your baby. Phase 1 of the study consists of interviewing between 10 and 15 mothers to find out what influenced them in their decision to have an induction of labour. The researcher will explain the study to you and you will also be provided with this information sheet giving you details of the study. If you wish to participate, you will be asked to sign a consent form.

WHAT IS INVOLVED IN THE STUDY?

In this, the first phase of the study, we ask you to participate in an interview with the researcher. The interview is expected to take between 20 and 45 minutes depending upon the amount of information you wish to discuss. The researcher will visit you in the first few days in hospital to arrange a convenient time for you to do the interview. The interview will be conducted in private either at the hospital or, if you prefer, the researcher can visit you in your home. The interview will be audio taped so that no information is missed during the analysis.

In addition, the researcher will request access to your Peel Health records to obtain details relating to your medical and surgical history, and details of current and previous pregnancies.

WHAT WILL HAPPEN TO THE INFORMATION COLLECTED IN THE STUDY?

Your privacy will be protected at all times:

- interviews will take place in a private area within the ward or your home
- interview data will be stored securely in the researcher’s locked filing cabinet
- your name will not be used in any reports relating to the study
- you and your information will be identified by a code number
- any identifying information will be kept securely behind locked doors.

On completion of the study you will receive a summary of the results. The study findings will also be submitted for publication in a health-related journal.
WHAT ARE THE RISKS OF TAKING PART IN THE STUDY?

There are no known risks to participating in this study.

ARE THERE BENEFITS TO TAKING PART IN THE STUDY?

If you agree to take part in this study, there may not be direct benefits to you, but we hope that the information you provide will enable us to better support other women in the future who request inductions for non-medical reasons.

WHAT IF I DON’T WANT TO TAKE PART IN THE STUDY?

If you decide not to take part in this study, you will experience the same level of care given to all women giving birth at Peel Health Campus.

WHAT ARE MY RIGHTS AS A PARTICIPANT?

Taking part in this study is voluntary. You may choose not to take part or may leave the study at any time. You may skip questions that you feel uncomfortable answering. Deciding not to take part, or deciding to leave the study, will not result in any penalty or any loss of benefits to which you are entitled.

In addition to this Information Sheet, you will be given a copy of this signed and dated Consent Form.

WHO DO I TALK TO IF I HAVE QUESTIONS OR PROBLEMS?

If you have questions about taking part in this study, you can talk to either the researcher or one of the research supervisors. These people are:

Dr Cathy Fetherston (Supervisor) on 9531 8570 or
Mrs Jenny Wrightson (Researcher) on 9531 8230

If you wish to talk to an independent person about any concerns you may have, you can contact Murdoch University’s Human Research Ethics Committee on 9360 6677 or email ethics@central.murdoch.edu.au. The ethics officer will act on your behalf as an independent agency to protect your interests.
We would like to thank you in advance for your assistance with this research project.

This study has been approved by the Murdoch University Human Research Ethics Committee (Approval 2008 No213).
Appendix B: Midwife Information Sheet

Phase Two of the Research Project:

‘A Case Study of Low-Risk Women’s Perceived Decision-Making for Induction of Labour’

Principal Investigator:

Professor Anne McMurray AM, RN, PhD, Professor of Nursing, Murdoch University

Associate Supervisor:

Dr Cathy Fetherston, Senior Lecturer, Murdoch University

Researcher/PhD Candidate:

Mrs Jenny Wrightson, Clinical Midwife Consultant, Peel Health Campus

The research team conducting this study would like to invite you to participate in Phase 2 of this project, which is described below.

WHY IS THIS STUDY BEING DONE?

This study forms the basis for research undertaken by Jenny Wrightson as a requirement for completion of her Doctor of Philosophy at Murdoch University. Induction rates are rising amongst women who have healthy pregnancies. Currently there is limited knowledge regarding the influences on low-risk women’s decision-making about non-medical induction of labour, and we are gathering information from the perspectives of the birthing women having inductions and midwives who have assisted them. The results from the interviews will be used to develop recommendations to inform health professionals so they can provide education and support to women who request inductions for non-medical reasons. This may lead to a reduction in the induction rate for low-risk women.
HOW CAN YOU BECOME INVOLVED IN THE STUDY?

Midwives who work at Peel Health Campus will be invited to take part in Phase 2 of the study in November and December 2009. Phase 1 of the study consisted of interviewing 18 mothers to find out what influenced them in their decision to have an induction of labour. This phase is gathering information from the midwives’ perspectives. The researcher will explain the study to you and you will also be provided with this information sheet giving you details of the study. If you wish to participate you will be asked to sign a consent form.

WHAT IS INVOLVED IN THE STUDY?

In this, the second phase of the study, we will ask you to complete a small survey at a time convenient to you, prior to participating in an interview with the researcher. The survey is expected to take approximately ten minutes to complete and the interview is expected to take between 30 and 45 minutes depending upon the amount of information you wish to discuss. The interview will be tape-recorded to prevent the loss of data. The researcher will liaise with you to arrange a convenient time and place for you to complete the interview.

WHAT WILL HAPPEN TO THE INFORMATION COLLECTED IN THE STUDY?

Your privacy will be protected at all times:

- interview data will be stored securely in the researcher’s locked filing cabinet
- your name will not be used in any reports relating to the study
- you and your information will be identified by a code number
- any identifying information will be kept securely behind locked doors.

On completion of the study you will receive a summary of the results. The study findings will also be submitted for publication in a health-related journal or a paper may be presented at conferences.
WHAT ARE THE RISKS OF TAKING PART IN THE STUDY?
There are no known risks to participating in this study.

ARE THERE BENEFITS TO TAKING PART IN THE STUDY?
If you agree to take part in this study, there may not be direct benefits to you, but we hope that the information you provide will enable us to better support women who, in the future, may request inductions for non-medical reasons.

WHAT IF I DON’T WANT TO TAKE PART IN THE STUDY?
If you decide not to take part in this study, your decision will be respected.

WHAT ARE MY RIGHTS AS A PARTICIPANT?
Taking part in this study is voluntary. You may choose not to take part or may leave the study at any time. You do not have to answer any questions which may make you feel uncomfortable. In addition to this information sheet, you will be given a copy of this signed and dated Consent Form.

WHO DO I TALK TO IF I HAVE QUESTIONS OR PROBLEMS?
If you have questions about taking part in this study, you can talk to either the researcher or one of the research supervisors. These people are:

Dr Cathy Fetherston (Supervisor) on 9582 5516 or
Mrs Jenny Wrightson (Researcher) on 9531 8230

If you wish to talk to an independent person about any concerns you may have, you can contact Murdoch University’s Human Research Ethics Committee on 9360 6677 or email ethics@central.murdoch.edu.au. The ethics officer will act on your behalf as an independent agency to protect your interests.
We would like to thank you in advance for your assistance with this research project.

This study has been approved by the Murdoch University Human Research Ethics Committee (2008 213).
Appendix C: Women’s Consent Form for Phase One

‘A Case Study of Low-Risk Women’s Perceived Decision-Making for Induction of Labour’

PARTICIPANT

I acknowledge that I have read the women’s information sheet that explains the nature and object and possible risks of the investigation. The information has been explained to me to my satisfaction. I have been given a copy of the women’s information sheet to keep and will be given a copy of the signed consent form.

I agree that research data gathered from the results of the study may be published provided my name or any identifying data is not used. Before signing this document, I have been given the opportunity to ask questions relating to any physical and mental harm I might suffer as a result of my participation and I have received satisfactory answers. I have also been informed that I may not receive any benefits from participating in this study.

I also give consent for the researcher to access my personal Peel Health Record to gather data required for the study Yes ☐ No ☐ (please tick)

Signature of the participant…………………………… Date……………

I would like to receive information regarding the results and outcome of this study

Yes ☐ No ☐ (please tick)

INVESTIGATOR

I have fully explained to the woman……………………………………………… the nature and purpose of the program and the procedures to be employed as described above and such risks as are involved in their performance, and I have provided the woman with a copy of the Women’s Information Sheet.

Signature of the investigator…………………………… Date……………

Print name……………………………………………… Date……………
Appendix D: Midwife Consent Form for Phase Two

‘A Case Study of Low-Risk Women’s Perceived Decision-Making for Induction of Labour’

PARTICIPANT

I acknowledge that I have read the midwives’ information sheet that explains the nature and object and possible risks of the investigation. The information has been explained to me to my satisfaction. I have been given a copy of the midwives’ information sheet to keep and will be given a copy of the signed consent form.

I agree to the interviews being taped and agree that research data gathered from the results of the study may be published provided my name or any identifying data are not used. Before signing this document, I have been given the opportunity to ask questions relating to the research and I have received satisfactory answers. I have also been informed that I may not receive any benefits from participating in this study.

Signature of the participant…………………………….. Date………………

I would like to receive information regarding the results and outcome of this study

Yes ☐ No ☐ (please tick)

INVESTIGATOR

I have fully explained to the midwife…………………………………………… the nature and purpose of the program and the procedures to be employed as described above and such risks as are involved in their performance, and I have provided the midwife with a copy of the midwife Information Sheet.

Signature of the investigator…………………………….. Date………………

Print name…………………………………………….. Date………………
Appendix E: Inclusion and Exclusion Criteria

**Inclusion criteria**

Low-risk women

Primigravida

Multigravida

Women in the Mandurah area

Women who speak English

All low-risk women who gave birth at Peel Health Campus between June 2009 and December 2009

**Exclusion factors**

High-risk women

Grand multiparous

Women from outside the Mandurah area

Women who do not have English as their first language
Appendix F: Demographic Data and Interview Guidelines

45 minutes—Interview questions/guide

Demographic details

(All of the following details will be obtained from the women’s health records prior to interview, following consent)

Name (a code will be allocated)

Date of birth

Address

What type of relationship—Married/single/de facto

Cultural background

Private versus public women

Medical history

Surgical history

Obstetric history

Gravida and parity

Gestation

Spontaneous labour or induction/augmentation

Type of birth

Outcome

Expected date of confinement this pregnancy

Model of care

Midwife-led

GP obstetrician

Shared care
Actual date of birth

Type of induction

Recorded reason for induction

Outcome of induction

Semi-structured interview questions/guide—women

Is this your first baby?

If no: Have you previously had healthy pregnancies, labour and birth?

Did you have any problems in this pregnancy?

Have you been induced previously?

What factors influenced you in your decision to undergo induction of labour?

Prompts:

Relatives—husband, mother, sister, aunt etc.

Health professionals—doctor, midwife

Medical reasons

Information

Did you have information provided to help you in your decision-making?

Where did the information come from? Who, What, When, How?

Prompts:

Medical personnel

Midwives/midwife-led care

Media

Relatives

Friends

Family
Other factors experience

**What information did you receive?**

Verbal information

Department of Health leaflets

Peel Health Campus information and consent for induction of labour

Online information—Internet

Other

**When did you receive this information?**

Early pregnancy

0–20 weeks

20–30 weeks

30–35 weeks

35–40 weeks

41 weeks

42 weeks

Prior to admission for induction

On admission

**In what setting did you receive the information?**

General practitioner’s surgery

Antenatal clinic

Parent craft groups/classes

Hospital maternity ward

At home

Other
Did you have a support person with you?

Partner/de facto

Husband

Mother

Friend

Other

Did you feel that you were able to influence the decision to induce your pregnancy?

What helped you the most when making your decision? What helped you the least?

What was your understanding of the reason for induction?
Appendix G: Interview Guidelines—Phase 2: Midwives

45-60 minutes: Interview questions/guide

Demographic details

Following consent and prior to the interview, midwives will be asked to complete a short survey related to their demographic and employment details. Additional details regarding any personal experiences of induction in labour they may have had will be obtained from the midwife at the beginning of the interview.

Name (a code will be allocated)

What type of personal experience have you had relating to induction of labour?

Semi-structured interview questions/guide

What do you think influences low-risk women to have an induction of labour?

Prompts:

Relatives—husband, mother, sister, aunt etc.

Health professionals—doctor, midwife

Medical reasons

Hospital policies and procedures regarding induction of labour booking procedures

Written advice from books, magazines etc.

Other factors

What information do you provide for low-risk women who are having an induction of labour?

Prompts:

Verbal

Written

Online

Where does the information come from?
When do you provide the information?

**Prompts:**

Early pregnancy

0–20 weeks

20–30 weeks

30–35 weeks

35–40 weeks

41 weeks

42 weeks

Prior to admission for induction

On admission

How do you provide this information?

What other sources do you think women might obtain their information on induction?

**Prompts:**

Medical personnel

Midwives

Media

Relatives

Friends

Family

Other

In what setting do you think that women obtain their information?

**Prompts:**

General practitioner’s surgery
Antenatal clinic
Parent craft groups/classes
Hospital maternity ward
At home
Other

How do you ensure that the information provided for women has been understood?

Who supports low-risk women during their decision-making regarding induction of labour?

Prompts:
Partner/de facto
Husband
Mother
Friend
Health professionals
Other

Do you feel that you are able to influence low-risk women’s decision-making regarding induction of labour?

What do you think helps low-risk women when they are making a decision to induce labour?

Do you think that women fully understand why they are being induced when they are low risk?

What do you think are the documented reasons for women having an induction of labour when they are low risk?

Is the documented reason for induction of labour similar to that perceived by the woman?
How can midwives increase our support for low-risk women when they make their decision to induce labour?
Appendix H: Midwife Survey

‘Perceived influences on low-risk women’s decision-making and induction of labour’

Demographic details

Name (a code will be allocated)

--------------------------------------------------

1. What is your year of birth?

☐ ☐ ☐ ☐

2. How long have you worked as a midwife?

--------------------------------------------------

3. Do you work full time, part time or casual?

--------------------------------------------------

Please place a tick in the correct box

4. What is your title?

☐ Registered Nurse

☐ Registered Midwife/Registered Nurse

☐ Clinical Midwife

☐ Manager/CNS
5. How many years have you worked at this level?

-----------------------------------------------

6. How many years have you worked in these systems?

☐ Australian

☐ United Kingdom

☐ New Zealand

Other, please specify

-----------------------------------------------

7. How many years have you worked at Peel Health Campus?

-----------------------------------------------

8. Which areas of the Maternity Unit do you normally work?

--------------------------------------------------------------------------------------------------
9. How long have you worked in the following midwifery models of care?

You may want to tick more than one box for this answer.

- Midwife-led antenatal care
- Hospital-based midwife
- Team midwife
- Community midwife
- GP obstetrician/midwifery practice

Thank you for taking the time to complete this questionnaire. Could you please return the completed questionnaire by hand to Jenny Wrightson when you complete your interview.
Appendix I: List of Resources

Time one day per week leave without pay: $220–$440 dollars per week
  (utilising grant to partly subsidise salary for three years) $34,302–$68,620

Forty packets of Reflex printer-quality paper (500 sheets) $200.00

Print cartridges (50 black-and-white cartridges) $1,150.00

Install phone point for Internet use $204.90

Computer/printer—depreciation with use over three years $2,000.00

Bigpond Internet access over six years $3,000.00

Tape recorder with microphone $100.00

Bridgeton desk and hutch desk $2,099.00

Bridgeton three-drawer filing cabinet $843.00

One two-drawer filing cabinet $629.00

Binding PhD $100.00

Editing of thesis $2000.00
Appendix J: Glossary of Terms

Antenatal care
The care provided for women from conception to the onset of labour.

Apgar score
The midwife will assess the condition of the baby using a scoring system at 1 and 5 minutes immediately following birth.

Augmentation of labour
Interventions used to correct slow progress in labour; for example, artificial rupture of the membranes or oxytocics.

Birth centre
Midwife-led centres that provide care for women during childbirth.

CS
An operative procedure where the birth of the baby, placenta and membranes takes place through an incision made in the lower part of the uterus.

Caseload care
Midwives take care of a number of pregnant women throughout their childbirth.

Continuity of care models
A team of midwives, or a ‘named midwife’, provide continuity of care for women throughout their childbirth.

Epidural
An injection of local anaesthetic through a fine catheter blocks the sensory nerves as they enter the spinal cord.

GP obstetrician shared care
Midwives and general practitioners provide care throughout childbirth for a group of low-risk women.
Gravida

Gravid means ‘pregnant’. Gravida means a pregnant woman. The number of pregnancies a woman has had is included after the word; for example, Gravida 1 means one pregnancy.

Gestation

Gestation is the number of weeks the woman has been pregnant.

High-risk pregnancy

Midwives and medical practitioners describe a woman as high risk if she has had obstetric or medical problems in her current or previous pregnancies.

Induction of labour

Labour is artificially started in a woman using medical interventions.

Instrumental birth

The use of surgical means to assist the woman to deliver; for example, forceps.

Lactogenesis

The initiation of lactation.

Low-risk pregnancy

A woman is described by midwives and general practitioners as low risk if she does not have any current, or a previous history of, obstetric or medical problems.

Multiparous

A woman who has carried more than one viable pregnancy.

Parity

The number of times a woman has given birth to a viable child.

Perinatal mortality rate

The number of stillbirths and neonatal deaths occurring per 100 total births.

Perineal trauma

Injury to the perineum that occurs during the birth of a child.
Prolonged pregnancy
A pregnancy that exceeds 42 weeks.

Pulmonary embolism
A blood clot that occurs in the lungs.

Social induction
A colloquial term used by health professionals for an induction undertaken for non-medical reasons.

Team midwifery
A group of midwives who provide care for the pregnant woman throughout her pregnancy.

Term
A woman’s pregnancy between 37 and 42 weeks is described as term.
Appendix K: Letter Interim Report Women Participants

Dear Mrs Maloney,

I do hope that you and your family are well. Thank you for participating in my PhD study, ‘A Case Study of Low-Risk Women’s Perceived Decision-Making for Induction of Labour’, which I commenced part time at Murdoch University in September, 2007–2015. I really appreciate the precious time that you gave post-birth at the Peel Health Campus to participate in an interview relating to the influences on your induction decision-making in 2007/2008.

I am now making good progress with my part-time study. Consequently, I am now in the final stages of writing my thesis. Interviews conducted with you and seventeen other women in the early post-birth period in Peel Hospital have provided very good information relating to the influences on yours and their induction decision-making. These influences on women’s decision-making were previously unknown. Hence, these results are important. Results will be useful to health professionals who wish to develop guidelines for the support of low-risk women in their decision-making related to an induction.

When you signed your consent form to participate in this study, you indicated that you would like to receive information relating to the results and study outcomes. Providing you with feedback is a very important part of my study. Hence, I am making
contact with you to provide you with an interim report of my study results and outcomes. Findings in this report relate to all the women who participated. I would like to again thank you for your valuable contribution to this piece of research. If you have any concerns related to the findings on women’s decision-making and induction of labour, you may contact either me or my supervisors on the contact details which are provided below. If you wish to talk to someone not connected to this piece of research, you may also contact the Human Research Ethics Committee at Murdoch University on ethics@murdoch.edu.au.

Yours sincerely,

Jennifer Wrightson

Researcher/PhD candidate

Email address

jenny.wrightson@bigpond.com

Mobile phone number 0467772262

Supervisor contact details

Principal Investigator:

Professor Anne McMurray AM, RN, PhD, Emeritus Professor of Nursing, School of Nursing and Midwifery, Gold Coast, Gold Coast Campus, Griffith University Qld. 4222

Email address

a.mcmurray@griffith.edu.au

Telephone contact number (07) 55529167

Associate Supervisor:

Dr Cathy Fetherston, Associate Professor, Discipline Head Nursing, School of Health Professions, Murdoch University, Mandurah WA 6210

Email contact details

c.fetherston@murdoch.edu.au

Telephone contact number 95825516
Appendix L: Letter Interim Report Midwife Participants

School of Health Professions
Discipline: Nursing
Peel Campus
Education Drive, Mandurah
Western Australia 6210
PO Box 1937
Mandurah WA 6210
Telephone: +61 8 9582 5504
Facsimile: +61 8 9582 5515

Dear Michelle,

Thank you for participating in my PhD study, ‘A Case Study of Low-Risk Women’s Perceived Decision-Making for Induction of Labour’, which I commenced through Murdoch University in September, 2007. I really appreciate the precious time that you gave at the Peel Health Campus to participate in an interview to discuss the issues surrounding this subject.

I am now making good progress with my part-time study. Consequently, I am now in the final stages of writing my thesis, which should be completed in December, 2015. Interviews conducted with you and nine other midwives in Peel Hospital have provided very good information relating to the influences on women’s induction decision-making. These influences on women’s decision-making were previously unknown. Hence, these results are important. Results will be relevant to health professionals in the Peel region who wish to develop guidelines for the support of low-risk women in their decision-making related to an induction.

When you signed your consent form to participate in this study, you indicated that you would like to receive information relating to the results and study outcomes. Providing you with feedback is a very important part of my study. Hence, I am making contact with you to provide you with an interim report of my study results and outcomes. Findings in this interim report relate to all the midwives who participated and provided information.
I would like to again thank you for your valuable contribution to this piece of research. If you have any concerns related to the findings on women’s decision-making and induction of labour, you may contact either me or my supervisors on the contact details which are provided below. If you wish to talk to someone not connected to this piece of research, you may also contact the Human Research Ethics Committee at Murdoch University on ethics@murdoch.edu.au.

Yours sincerely,

Jennifer Wrightson

Researcher/PhD candidate

Email address

jenny.wrightson@bigpond.com

Mobile phone number 0467772262

Supervisor contact details

Principal Investigator:

Professor Anne McMurray AM, RN, PhD, Emeritus Professor of Nursing, School of Nursing and Midwifery, Gold Coast, Gold Coast Campus, Griffith University Qld. 4222

Email address

a.mcmurray@griffith.edu.au

Telephone contact number (07) 55529167

Associate Supervisor:

Associate Professor Cathy Fetherston, Discipline Head Nursing, School of Health Professions, Murdoch University, Mandurah WA 6210

Email contact details

c.fetherston@murdoch.edu.au

Telephone contact number 95825516
Appendix M: Interim Summary of Findings from the Women Participants

‘Perceived influences on women’s decision-making and induction of labour’

It is my pleasure to provide this interim summary for you and the other women who participated in my study, contributing to this valuable piece of research in the Peel region of Western Australia, 2007–2015. The following interim report includes the major themes that relate to all the findings from the 18 women participants who were interviewed during the study.

These findings will be useful to health professionals who wish to understand your induction experience. Findings may be used by health professionals to develop guidelines for support of low-risk women in the Peel region who wish to have an induction of labour. A number of themes and subthemes relating to the low-risk women’s perceived influences on their induction decisions emerged from the data collected from the women. Data in phase 1 of this research study have revealed five major themes and eleven subthemes. A summary of the major themes is provided below.

Summary of the women’s data

The five major influences that women described as influencing their decision-making around induction included:

- perceived health risks to themselves and their baby
- fear of the childbirth experience
- seeking support for themselves and their baby, particularly for those who were isolated
- shared decision-making relating to induction of labour
- adequacy and timeliness of information on which to base decisions.

Most women, like you, understood that they had medical risks to either themselves or their baby in their pregnancy. Hence, a risk of complications in their pregnancy had made them seek an induction. Additionally, many of these women had multiple types of discomfort in pregnancy. Family members were concerned about the discomfort of the women and they encouraged them to request an induction.
Family concerns were also evident when women were isolated. Family members were concerned that they may be unsupported and were at risk, and some encouraged the women to have an induction. Some of the women had personal concerns related to either their own previous experiences in childbirth or experiences of their family and friends, which also influenced their decision-making.

The women welcomed the support of their family and friends in making their induction decision, especially when their family and friends had previously had an induction. A number of these women also wished to have an induction due to family occasions and their husband’s employment. When women requested an induction from their GP obstetrician, many felt that they were able to share the induction decision-making with their doctor. However, some of these women reported being influenced by their GP obstetrician in their decision-making regarding this procedure. A number of women reported that their doctor encouraged them to wait until later in their pregnancy to have an induction to ensure a safe birth.

Unfortunately, a number of women reported that they could not recall the information that they received relating to the induction procedure. When women contended they had received insufficient information, they sought information from alternative sources; primarily from the Internet, books, and family and friends. Women also suggested that resources on the Internet relating to information on the procedure of an induction of labour were inadequate and not always reliable. The women suggested that resources should be developed by health professionals, including reliable websites, chat rooms, books and DVDs.

This information will be used to develop recommendations to assist health professionals to help guide women in their decisions about induction. Again, I would like to thank you for your contribution to this important work.
Appendix N: Interim Summary of Findings from the Midwife Participants

‘Perceived influences on women’s decision-making and induction of labour’

It is my pleasure to provide this interim summary for the midwife participants who contributed to this valuable piece of research in the Peel region of Western Australia, 2007–2015. The following interim report includes major themes that relate to all the findings from the midwife participants.

This interpretive case study examined low-risk women’s perceptions and the perceptions of midwives regarding the factors that influenced women’s decision-making relating to their induction of labour. The topic emerged whilst practising as a Midwife Consultant, when I and my fellow midwives in the unit became concerned about the practice of induction for spurious or non-medical reasons, as reasons for induction recorded in the birthing register were sometimes unclear. Other midwifery researchers have also expressed similar concerns over what seemed to be social requests for an early induction in low-risk women both in Australia and internationally (Doyle, Kenny, Gruenigen, Butz & Burkett, 2012). Their concerns, like mine, revolve around data that shows that an induction of labour for non-medical reasons is associated with a cascade of increased interventions such as epidural analgesia, Caesarean birth, assisted deliveries, morbidity in the mother and baby as well as an increased hospital stay (Patterson, Roberts, Ford & Morris, 2011). In the Peel region of Western Australia, induction for non-medical reasons accounted for one-fifth of the inductions each month in 2007. Hence, the aim of this study was to investigate the factors influencing women’s decision-making, which have led to high levels of induction of labour for non-medical reasons in this setting. Identification of these factors was to generate evidence from which recommendations for professional midwifery practice could be developed.

Ethics approval was gained from the Human Ethics Committee at Murdoch University and Peel Health Campus Executive Committee in 2007/2008. Informed consent was obtained from all participants. Participants were allocated a code to maintain their anonymity and confidentiality. Unique data was then collected from 18 women in the postnatal period (Phase 1) at the Peel Health Campus in 2008. I also investigated the influences on low-risk women’s induction decisions from your
perspective (Phase 2) as well as nine other midwives. Data in phase 2 of this research study was analysed using thematic analysis and has revealed three major themes and seven subthemes. A summary of the major themes is provided below.

Midwives’ Perceptions of the Influences on Women’s Decision-Making and Induction of Labour

**Summary of midwife participants’ data**

Themes included: ‘Having limited influence over women’s induction decision-making’; ‘Feeling empathy for constraints that influence women’s decision-making’ and ‘Concerns related to the appropriateness of information influencing women’s decisions’.

Midwives considered they had limited influence due to the medical practitioner’s key role in women’s decision-making processes related to induction of labour. In contrast to the medical practitioner’s continued contact with the women, there was only a short period of time for midwives to influence the women’s decision-making. Unless the midwives worked in the Antenatal Clinic area, they had limited contact prior to admission for an induction. A heavy caseload in the maternity area also impacted on the midwives’ available time to spend with the women. Midwives perceived that increased contact with the women through continuity of care models would enhance their opportunity to support the women’s decision-making.

Limited contact with women prior to an induction was not the only constraint perceived by midwives to impact on the women’s decision-making. Midwives in this maternity unit supported a naturalistic model of childbirth. However, it appeared that there was a clash between the naturalistic model of the midwife and the interventionist model provided by the GP obstetrician. Yet General Practitioner Obstetricians appeared to have been placed in a difficult position by the women, many of whom had actively sought out early inductions of labour in this South West regional area. These women’s wishes to have an induction were acknowledged and supported by their GP obstetricians, who were seen to apply a risk management model for safer options for childbirth and control.

Midwives perceived that an early induction in this regional maternity unit also appeared to be readily accepted by the women. Cultural conditions were thought to
influence this practice of early intervention in pregnancy and included: isolation of the women from family members and the perceived power of friends and family in swaying the women’s views. Midwives had empathy for the women and their fears and concerns generated by themselves and family members. They also recognised that the women had fears relating to their own previous experiences in childbirth and were influenced by the experiences of family and friends. Midwives believed that these cultural factors had changed women’s views of induction and it was now viewed as a normal part of childbirth.

Some midwives expressed frustration with this generation of women, particularly those who either scheduled their births to fit into their social calendar or erroneously perceived that there were health risks to either themselves or the baby that necessitated induction. This caused some inner conflict among the midwives, as they were committed to a woman-centred approach and concerns for safer childbirth. In spite of the different perspectives, midwives considered that women did not appear to have been fully informed relating to the risks of an early induction of labour. This lack of information led to major concerns about the lack of informed choice in these women. Varied sources, types and timing of information between the health care practitioners raised issues related to the resources which were available for the women’s induction decisions. Issues were mainly related to different types, levels and sources of information from which women make choices prior to their consent for an induction, they were particularly evident among women from a lower socio-economic background, compared to those from an educated background.

These findings will be reported in the thesis, and it is expected that they will form the basis of a journal article to disseminate the information to midwives beyond this region. Once again, thank you for your contribution to my study.
Appendix O: Human Research Ethics Committee Approval

Thursday, 19 November 2009

Prof Anne McMurray
School of Nursing
Murdoch University

Dear Anne,

Project No. 2008/213
Project Title Perceived influences on low risk women’s decision to induce labour

Your application for an amendment to the above project was reviewed by the Murdoch University Human Research Ethics Sub-Committee and was

APPROVED

AMENDMENT:

- Title change
- Investigation of low-risk women’s decision making from the midwife’s perspective
- Change of design to ethnographic case study

As a condition of the approval of your human research ethics application you are required to report immediately any adverse or unforeseen events that might affect the continued ethical acceptability of the project. In addition, you must continue to meet the HREC’s Standard Conditions of Approval

Please quote your ethics permit number in all correspondence.

Kind Regards,

Dr. Erich von Dietze
Manager of Research Ethics

cc: Dr Catherine Fetherston; Jennifer Wrightson

HREC Approval Letter 221107

CRICOS Provider Code: 00115I
ABN 61 616 369 313