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1 **Abstract**

2 **Background**

3 Induction of labor currently accounts for around 25% of all births in high-resource
4 countries, yet despite much research into medical aspects, little is known about how
5 women experience this process. This study aimed to explore in depth the induction
6 experience of primiparous women.

7 **Method**

8 A qualitative study was undertaken, using a sample of 21 first-time mothers from a
9 maternity unit in the south of England. Semi-structured interviews were conducted in
10 women's homes between three and six weeks postnatally. Data were recorded,
11 transcribed and analyzed thematically.

12 **Results**

13 Women awaiting induction on the prenatal ward appeared to occupy a liminal state
14 between pregnancy and labor. Differences were noted between women's and
15 midwives' notions of what constituted 'being in labor' and the ward lacked the
16 flexibility to provide individualized care for women in early labor. Unexpected delays
17 in the induction process were common and were a source of anxiety, as was
18 separation from partners at night. Women were not always clear about their plan of
19 care, which added to their anxiety.

20 **Conclusions**

21 Conceptualizing induction as a liminal state may enhance understanding of women's
22 feelings and promote a more woman-centered approach to care. Thorough

23 preparation for induction, including an explanation of possible delays is fundamental
24 to enabling women to form realistic expectations. Care providers need to consider
25 whether women undergoing induction are receiving adequate support, analgesia and
26 comfort aids conducive to the promotion of normal labor and the reduction of anxiety.

27 **239 words**

28 **Key words**

29 Induction, labor, liminality, woman's experiences.

30

31 **Introduction**

32

33 Induction of labor is one of the most commonly performed medical interventions in
34 childbirth, accounting for up to 25% of births in most high-resource countries, and
35 over 27% in the United Kingdom (1-4). Despite extensive research into medical
36 aspects of induction, women's subjective experience of this procedure has not been
37 fully explored. In the light of recent policies and professional drivers for woman-
38 centred care and informed choice (5-8) this study aimed to explore in depth the
39 induction experience of first-time mothers and how they perceived the effects of this
40 on their overall birth experience.

41

42 **Background**

43 Studies on women's experience of induction have often provided a negative picture,
44 highlighting the disparity between women's expectations and experiences (9-13) and
45 a lack of satisfaction with their labor (12, 13). The seminal work of Cartwright (1979)
46 in the UK, which remains among the largest studies in this field, concluded that more
47 power needed to be devolved to women in order to improve the induction experience
48 (11). More recent national and international studies have given a more nuanced
49 picture, with some describing induction as a positive experience (14-16), whilst
50 others identified lower satisfaction with the overall birth experience (17, 18). Most of
51 the earlier studies relied on closed-question surveys, offering limited insight into how
52 women felt and made sense of their experiences. More recent qualitative research
53 has attempted to analyze the overall induction experience from the women's
54 perspective (19-22). However, women's subjective experience of undergoing
55 induction remains a little-known area and further research has been called for (23-

56 25). Furthermore, there is verbal evidence from staff and students in local maternity
57 units suggests that the gulf between women's expectations and experiences of
58 induction is a growing source of complaints. This in turn suggests that despite a
59 succession of high-profile governmental drives to promote woman-centred care in
60 the UK since the 1970s, women's feelings about induction have not changed
61 significantly since the days of Cartwright's study. In view of the lack of current,
62 qualitative evidence from UK sources, a study was undertaken to explore the overall
63 phenomenon of induction from the woman's perspective within an urban maternity
64 unit in the UK. The study was set within the contextual framework of theories of
65 choice and control. During the process of data analysis, it became apparent that the
66 experience of induction in hospital could be interpreted through theories of rites of
67 passage and liminality. Van Gennep's theory of rites of passage was therefore drawn
68 upon (26), offering a new way for health professionals to understand induction from
69 the woman's perspective.

70 **Methods**

71 A qualitative interview study was undertaken between September 2012 and January
72 2013, using a purposive sample of women drawn from an NHS (state-run) maternity
73 unit in the south of England. Purposive sampling has been criticised for allowing
74 'hand-picking' of participants, but has the benefit of increasing the scope of data from
75 information-rich cases (27). Data were collected using single, face-to-face interviews,
76 followed by a hand-search of maternity records for entries relating to induction in
77 order to gain a wider perspective and to contextualize events. Ethical approval was
78 obtained from the Health Research Authority (NRES Committee South Central –
79 Oxford A) and from the local Research and Development committee.

80 The sample consisted of primiparous women induced at or close to term. All women
81 were aged 18 or over and had been classed as low-risk at the start of pregnancy.
82 Due to cost constraints, it was not possible to employ translators for non-English
83 speakers, thereby excluding this group. All women who met the inclusion criteria
84 were included within the sampling frame, with access controlled by the 'gate-
85 keeping' actions of the senior midwife on duty, who used her professional judgement
86 to decide which women were too vulnerable to be approached. This included
87 women with severe mental health problems and those whose babies were very sick.
88 The value of gate-keepers in protecting vulnerable members of the public has been
89 acknowledged (28) and was required as a condition of ethical approval.

90 Women were approached by the principal investigator (PI), who explained the nature
91 of the study and sought consent to contact them at a later date. Approximately three
92 weeks later, women were contacted by the PI and invited to participate in the study.
93 Those who agreed were interviewed in their own homes, following verbal and written
94 consent. The final sample comprised 21 women, who identified their ethnicity as
95 white British (n=16), non-white British (n=1) and white non-British (n=4). All were
96 married or cohabiting and most were educated to tertiary level. Most had been
97 induced due to uncomplicated, post-dates pregnancy. All interviews were conducted
98 by the PI and lasted between 30 and 100 minutes. One participant opted to be
99 interviewed by telephone. A semi-structured interview format was adopted, using a
100 flexible schedule of open-ended questions. All interviews were audio-recorded,
101 except in the case of the telephone interview, where at the participant's request, only
102 hand-written notes were made.

103 All transcripts and data from records were anonymized and pseudonyms allocated,
104 which, to further protect anonymity, do not necessarily reflect the ethnicity of the

105 participants. Thematic analysis was undertaken - an inductive process whereby
106 small units of data are scrutinized, interpreted and grouped into themes, following an
107 iterative process until all categories of meaning are exhausted (28-31) The software
108 package NVivo10© was used to enhance the categorization of data and the search
109 for recurrent words or phrases.

110 All 21 participants were induced in hospital. Sixteen were administered vaginal
111 Prostaglandin (PGE₂) on the prenatal ward. Four were deemed not to require this
112 and were transferred to the delivery suite for artificial rupture of the membranes
113 (ARM) and synthetic oxytocin. One woman received only intravenous synthetic
114 oxytocin due to spontaneous, pre-labor rupture of membranes. Four women
115 progressed to a spontaneous vaginal birth, six had instrumental births and eleven
116 had cesarean sections due to complications in labor.

117

118 **Results**

119 Key themes relating to the experiences on the prenatal ward whilst awaiting or
120 during induction are detailed below.

121 ***Delays and anxiety***

122 All women in the study recalled being given specific instructions about arriving at the
123 hospital early in the morning. Despite this, nine women reported delays of several
124 hours between the time of admission to hospital and the time of receiving their first
125 dose of PGE₂.

126 *Yeah, coz we were just like "why have you told us to come so early?" and*
127 *we're just sitting here waiting". (Rose: CD)*

128 *I was told I'd have this, this tab thing. [...]. I'd have that inserted, sort of in*
129 *the morning and I didn't actually get it until like 3 or 4 in the afternoon....*
130 *(Olivia: CD)*

131 In the example below, delays in commencing induction was perceived as conflicting
132 with the aims of preventing prolonged pregnancy:

133

134 *I think the delay and the anxiety, being told that there's a risk if it doesn't come*
135 *out, then not actually cracking on with that process. (Emily: forceps delivery)*

136 Reported reasons for the delays included staff shortages, a busy ward and lack of
137 rooms on the delivery suite. It was evident that many women had either not been
138 prepared for the possibility of delays or had not been informed of the reasons for
139 starting their induction later than anticipated.

140 Some women had not been informed of the likely duration of induction and had
141 assumed that a single administration of PGE² would lead swiftly to birth. The
142 expectations of family and friends added to a sense of urgency to produce a baby:

143

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

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

150 Of the sixteen women who were induced with prostaglandins, only seven spent less
151 than 24 hours on the prenatal ward; eight women were there for between 24 and 48
152 hours and five remained for between 48 and 72 hours.

153

154 ***Being in a strange place, surrounded by strangers***

155 Many women had no previous experience of being in hospital. Lack of privacy and
156 proximity to strangers was particularly uncomfortable and distressing to those who
157 had not been expecting to share a bay. Women were conscious of the effects of their
158 behaviour on other women undergoing induction.

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

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

165 Shared bays inevitably meant night-time interruptions from routine observations and
166 the movement of other women. Several women reported sleep disturbances, which
167 one woman cited as a cause of subsequent adverse events during her labor:

168

169 *... I mean, my problem right at the end was that I didn't push effectively and I*
170 *always wonder was it partly because I hadn't had enough sleep and food that*
171 *evening and that then led to the forceps and the episiotomy? [...] (Emily:*
172 *forceps delivery)*

173 All women had attended some form of pre-natal classes, yet most seemed
174 unprepared for what to expect of the induction process or of life on the
175 prenatal ward. Those who had been expecting to go to the low-risk birthing
176 unit once in labor were disappointed to discover that this option was only open
177 to women in spontaneous labor. Others were surprised that inhalational pain
178 relief (nitrous oxide and oxygen) was not available on the prenatal ward.

179

180 ***Feeling alone and forgotten***

181 Women were generally surprised and disappointed that the hospital policy required
182 partners to leave the prenatal ward at night, thus depriving women of their chief
183 source of support at a time when they felt most vulnerable:

184 *... the scary bit is you're going to start labor totally on your own, surrounded*
185 *by strangers. (Emily: forceps delivery)*

186 *...everybody else that goes into labor naturally, they have their husband or*
187 *partner with them, whereas if you're induced you're just sort of left to get on*
188 *with it on your own. (Wendy: forceps delivery)*

189 The sense of neglect extended into the daytime for some women, who felt that they
190 received minimal attention from staff, due to the hierarchy of priorities on the ward.

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

195 *[...] you're only high priority once you're actually in labor. (Emily: forceps*
196 *delivery)*

197 There was a notable disparity between women's expectations of induction and the
198 reality they faced. Women had been advised to arrive early, yet the start of induction
199 was often delayed for several hours, due to lack of staff or space on the delivery
200 suite, causing frustration and stress. Furthermore, women had understood that
201 induction was necessary for the safety of their baby and became anxious at finding
202 themselves low on a list of priorities or not monitored as frequently as they had
203 expected.

204

205 ***Information and communication***

206 Although most women reported feeling adequately informed of their overall plan of
207 care, this was not universally applied. Lack of information relating to delays in
208 induction was a source of confusion and stress.

209

210 *I was so confused the whole time; I just didn't know what was going on.*
211 *(Vicky: CD)*

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

215 Persistence was sometimes required to gain information.

216 *...I was trying to grill people [for information]. 'What's the statistics? I said [...]*
217 *if this happened to men, there would be every stat... (Jasmine, spontaneous*
218 *vaginal birth)*

219 More assertive women like Jasmine (above) could secure the information required.
220 Other, less naturally confident women might have been deterred for challenging staff
221 in an unfamiliar environment, especially as it was generally noted that the ward was
222 permanently busy and often short-staffed.

223

224 ***Midwives know best***

225 Trust in the judgement of professionals emerged strongly from women's accounts,
226 yet several stories revealed a tendency for women's perceptions of their bodily
227 sensations to be dismissed by midwives.

228 *What we did keep saying to the midwives was "Look, I'm in real pain", and*
229 *they were saying "Oh no you're not, this is nothing, it's going to get worse"*
230 *(Megan: spontaneous vaginal birth)*

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

233 These examples suggest the exercise of power, subjecting women to patient hood
234 and engendering a sense of loss of control. This is further illustrated by Megan's
235 midwife reinforcing the dominant position of the staff:

236 *We were told [...] 'six hours later, you'll come up [to the delivery suite] and if*
237 *you're far enough gone we'll let you have the baby'... (Megan: spontaneous*
238 *vaginal birth)*

239 The implication is that women's bodies ceased to be under their control once in
240 hospital and that they could not be trusted to understand their own bodily sensations.
241 This heightened the impression of induction as a confusing and sometimes
242 frightening experience.

243

244 There was no obvious pattern of relationship between the reasons for induction and
245 women's retrospective evaluation of the experience. Furthermore, most of the
246 women who had experienced complications associated these with interventions
247 during labor or with mode of birth and not necessarily with induction *per se*. Not all
248 comments were negative; several women reflected favorably, particularly on
249 individual staff members.

250 *...the phenomenal midwife, really lovely, made me feel really comfortable [...]*
251 *they were fantastic. (Fay: CD)*

252 Three of the four women who progressed to a spontaneous vaginal birth responded
253 more positively overall, yet two of these were recent immigrants from countries
254 where concepts of choice in childbirth and woman-centered care were in their
255 infancy, therefore expectations may have been lower than those of others.

256

257 **Discussion**

258 The voices of the women in this study highlight the need for a more personal,
259 woman-centered approach to care on the prenatal ward and for better information
260 and preparation for the process of induction. Interpreting women's stories of
261 induction through the lens of liminality (26) offers a new way of understanding this

262 experience, which may help health professionals to adopt a more empathic
263 approach.

264 The concept of liminality, identified by the ethnologist Arnold Van Gennep (1873-
265 1957), describes a state which is entered at the threshold between one stage of life
266 and the next, such as birth, coming of age and marriage. In this state, normal order
267 is suspended and the person undergoing change is displaced from their everyday
268 context into a state of strangeness (26). Van Gennep's concept of liminality has
269 spatial connotations, involving ritual removal to a different place (32, 33), which in
270 the case of induction is represented by admission to the prenatal ward. This paper
271 posits the notion that the state of suspense, strangeness and uncertainty during
272 induction is consistent with a state of liminality.

273 The concept of liminality has been applied to other childbirth-related situations, such
274 as the experience of parents with a very pre-term infant (34). Labor has long been
275 identified as a liminal state between pregnancy and motherhood (35-37). Although
276 this has not previously been applied to induction, it is alluded to in the findings of
277 other, small-scale interview-based studies conducted in a single place of care.
278 Gatward et al (2010) identified the temporal disruption felt by women booked for
279 induction for post-dates pregnancy, leading to a shift in expectations and sense of
280 being '*on someone else's clock*' (19). Moore et al (2014) and Murtagh and Folan
281 (2014) highlighted the lack of information prior to and during induction which left
282 women feeling unprepared, particularly for the duration of the process and the pain
283 of contractions (20, 21). In comparison, Henderson and Redshaw's (2013) large-
284 scale, mixed-methods study of 5,333 women from several UK maternity units also
285 highlighted the distress caused by separation from partners at night, lack of privacy,

286 delays, feelings of neglect and not being believed when in labor, suggesting that
287 these experiences are not isolated (22).

288 Evidence from the current study builds on previous works in demonstrating how
289 induction separates women from their everyday surroundings, upturns their expected
290 trajectory of labor and birth and places them in an unfamiliar and sometimes
291 frightening environment, where control is relinquished. This is consistent with a
292 liminal state (26). Women generally expect to begin labor at home, whereas in-
293 patient induction means starting labor '*surrounded by strangers*' (Emily). This sense
294 of chaos and displacement may be enhanced by indefinite and unexplained delays in
295 the induction process, lack of information and policies which confuse and
296 disempower. Spontaneous labor, once established, normally leads to birth within a
297 matter of hours provided skilled help is at hand. Conversely, induction may fail or be
298 indefinitely postponed or interrupted for reasons which are entirely beyond women's
299 control. In such circumstances, women find themselves powerless to progress
300 without the agency and permission of another.

301 Women in this study were on a threshold: unable to go home, yet unable progress to
302 the labor ward or have access to labor support until labor was 'officially'
303 acknowledged. The latter depended on the clinical judgement of midwives rather
304 than women's own instincts, emphasizing differences in the understanding of 'being
305 in labor' between women and health professionals. This may arise from
306 epistemological differences in the concepts of labor between medical and social
307 models of care, as aptly illustrated in Christine McCourt's (2009) narrative accounts
308 of women's birth experiences in a London hospital (36).

309 It is recognized that long periods of discomfort and isolation from their usual support
310 networks can cause women to become physically and emotionally drained by the
311 time labor is fully established (36, 38), which may result in dysfunctional labor, due to
312 the effects of stress hormones on the production and release of oxytocin (39-41). It is
313 possible, therefore, that the stresses caused by induction could have contributed to
314 subsequent delays in labor, which may have accounted for the high rate of operative
315 or instrumental births among this sample of women.

316

317 **Limitations and strengths**

318 Participants were drawn from a single maternity unit in England. However, guidelines
319 of the National Institute for Health and Care Excellence (NICE) set the standards for
320 IOL in the UK and despite local differences in the type of prostaglandins used, there
321 is no reason to conclude that practice in the unit is atypical. At the time of data
322 collection, the use of shared bays and the exclusion of partners at night was
323 common to many NHS units and remains so today. The problem of understaffing will
324 be familiar to many health professionals worldwide. This was a small-scale study and
325 as such, makes no claims to be generalizable; what it has achieved is highlighting
326 the experiences of a purposive sample of women at an NHS maternity unit that is not
327 atypical of others in the UK or in the region. These findings provide an outlook on
328 the induction experience to which health care professionals in the UK and worldwide,
329 may be able to relate and thereby consider how care in their own units can become
330 more woman-centred.

331 At the time of data collection, many non-white or non-British women spoke very
332 limited English and were therefore excluded under the terms of ethical approval.

333 Most previous studies of women's experiences of induction, regardless of size or
334 design, make no mention of ethnicity, thus there are few points for comparison. One
335 similarly-sized US study noted that the majority of participants were white, despite
336 being conducted in an ethnically diverse area (20). It has previously been observed
337 that where the sample is self-selecting, participants from higher socio-economic
338 groups are commonly over-represented (42). It may be surmised therefore that the
339 relative homogeneity of the sample may reflect the socio-economic status of non-
340 white women in the area.

341 Rates of operative and instrumental birth were high among the sample group
342 (marginally over 80%). Local statistics on the mode of birth following IOL could not
343 be obtained from the maternity unit, however, rates of all CD and instrumental births
344 were approximately 4% higher than the national average, although lower than some
345 other maternity units in the region.

346 Since this study was undertaken, the maternity unit from which participants were
347 selected has introduced a policy permitting partners to remain overnight on the
348 prenatal ward and has introduced outpatient induction for women with uncomplicated
349 post-dates pregnancies. Although interest in this area pre-existed the culmination of
350 this study, the presentation of these findings to senior clinicians and managers at a
351 very well-received seminar was likely to have been a contributing factor.

352

353 **Conclusions**

354 To provide a better environment for women undergoing induction in hospital, health
355 professionals must firstly endeavor to prepare women for life on the prenatal ward

356 and for the reasons for, delays and interruptions, so that women can build realistic
357 expectations of the likely trajectory of induction. Outpatient induction is increasingly
358 being offered to low-risk women (45, 46), but where this is not advisable, attention
359 should be focused on creating an inpatient environment that does not treat healthy
360 women as sick patients. Conceptualizing induction as a liminal state may enhance
361 midwives' understanding of women's feelings during this process and promote a
362 more woman-centered approach to care. In particular, there is a need for greater
363 recognition of the experience of early labor following induction and
364 acknowledgement of women's instinctive understanding of being in labor. Care
365 providers need to value women's time and consider whether they are providing
366 adequate support, analgesia and comfort aids conducive to the reduction of anxiety
367 and the promotion of normal labor.

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