

1 **Abstract**

2 **Objective** – To explore the use of high quality research evidence in women’s and maternity
3 care professionals’ decisions about induction of labour (IOL).

4 **Methods** – a qualitative study underpinned by a social constructionist framework, using
5 semi-structured interviews and generative thematic analysis.

6 **Setting** – a large tertiary referral maternity unit in northern England in 2013/14.

7 **Participants** – 22 randomly selected health care professionals involved in maternity care
8 (midwives, obstetricians, maternity service managers), and 16 postnatal women, 3-8 weeks
9 post-delivery, who were offered IOL in their most recent pregnancy.

10 **Findings** – Three themes were identified in the data; (1) the value of different forms of
11 knowledge, (2) accessing and sharing knowledge, and (3) constrained pathways and default
12 choices. Findings echo other evidence in suggesting that women do not feel informed about
13 IOL or that they have choices about the procedure. This study illuminates potential
14 explanatory factors by considering the complex context within which IOL is discussed and
15 offered (e.g. presentation of IOL as routine rather than a choice, care pathways that make
16 declining IOL appear undesirable, blanket use of clinical guidelines without consideration of
17 individual circumstances and preferences).

18 **Key conclusions** – This study suggests that organisational, social, and professional factors
19 conspire towards a culture where (a) IOL has become understood as a routine part of
20 maternity care rather than an intervention to make an informed choice about, (b) several
21 factors contribute to demotivate women and health care practitioners from seeking to
22 understand the evidence base regarding induction, and (c) health care professionals can find
23 themselves ill-equipped to discuss the relative risks and benefits of IOL and its alternatives.

24 **Implications for practice** – It is important that IOL is recognised as an optional intervention
25 and is not presented to women as a routine part of maternity care. When IOL is offered it
26 should be accompanied by an evidence informed discussion about the options available to
27 support informed decision making. Health care professionals should be supported to
28 understand the evidence base and our findings suggest that any attempt to facilitate this
29 needs to acknowledge and tackle complex organisational, social and professional influences
30 that contribute to current care practices.

31 **Keywords** - Induction of labour; Decision Making; Knowledge mobilisation; Social marketing;
32 Maternity Care; Pregnancy

33 **Title**

34 How is high quality research evidence used in everyday decisions about induction of labour
35 between pregnant women and maternity care professionals? An exploratory study.

36 **Introduction**

37 Almost a third (32.6%) of births in England currently involve induction of labour (IOL), with
38 rates increasing by more than 10% in the past decade (NHS Digital, 2018a). A substantial
39 evidence-base regarding IOL has developed, mainly focused on methods of IOL (e.g.
40 Mozurkewich et al., 2011) and the risks and benefits of IOL in specific circumstances (e.g.
41 low risk post-term (Middleton et al., 2018)). National guidelines for IOL in England and
42 Wales were published in 2008 (The National Institute for Health and Care Excellence, 2008)
43 however significant, unexplained variations in IOL rates exist; for example, in 2017-18, the
44 IOL rate varied between 26-35% in English regions (NHS Digital, 2018b). . Studies
45 exploring women’s experiences of IOL report perceptions of inadequate information
46 provision, lack of choice, directive counselling, and limited involvement in decision-making
47 about the procedure (Akuamoah-Boateng and Spencer, 2018; Coates et al., 2020; Coates et
48 al., 2019; Dupont et al., 2020; Jay et al., 2018; Jou et al., 2015; Lou et al., 2019; Moore et
49 al., 2014; Schwarz et al., 2016; Stevens and Miller, 2012). The few studies exploring
50 clinician views highlight variations in practice based on factors such as risk perception and
51 resource availability (Blanc-Petitjean et al., 2018; Klein et al., 2011; Nippita et al., 2017).
52 Overall, these studies suggest that research evidence is not being consistently and
53 effectively translated into everyday clinical care; either in terms of healthcare providers
54 offering IOL in a consistent way, or communicating the evidence to support pregnant
55 women’s informed decisions about IOL.

56 The reasons behind this apparent ‘research-to-practice’ gap are unclear. There are also
57 regulatory requirements for midwives and doctors to deliver evidence-based care (The
58 General Medical Council, 2019; The Nursing and Midwifery Council, 2018), and legal
59 imperatives to support informed decision-making (Chan et al., 2017). Barriers to information
60 sharing have been suggested in the literature; they include pregnant women’s perceptions
61 that maternity care professionals are rushed and have little time to discuss IOL (Jay et al.,
62 2018) and limitations in the ability of midwives and obstetricians to understand and
63 communicate risks extrapolated from population level data (Cheyne et al., 2012).
64 Perceptions of risk, clinician preferences, resource availability, care relationship with women,
65 accountability for decision-making, and level of involvement of pregnant women in decision-

66 making have also been suggested to affect the behaviour of clinicians and those in their care
67 (Akuamoah-Boateng and Spencer, 2018; Coates et al., 2020; Coates et al., 2019; Jou et al.,
68 2015; Nippita et al., 2017; Stevens and Miller, 2012).

69 Addressing variations in IOL practice requires consideration of these issues and the concept
70 of knowledge mobilisation (KM) offers a suitable lens for such exploration. KM is concerned
71 with understanding the connections (or lack thereof) between research, policy and practice
72 across a broad range of disciplines (Cooper and Levin, 2010). . KM research, as described
73 by Kislov et al. (2014), "*seeks to strengthen connections between research, policy, and*
74 *practice across sectors, disciplines and countries, attempting to harness the benefits of*
75 *research for organisational and societal improvement*". Key concepts within the KM
76 literature include acknowledging different forms of knowledge, understanding KM as a social
77 and relational process, recognising the importance of context; and understanding how all of
78 this can shape whether, and how effectively, knowledge is translated into practice (Cooper
79 and Levin, 2010; Crilly et al., 2010; Holmes et al., 2016; Kislov et al., 2014).

80 Reflection upon the KM literature and the evidence around IOL led us to ask the question
81 'how is high quality research evidence about IOL used in everyday clinical practice and what
82 contextual factors influence its use?'. We chose to explore this in a large teaching hospital
83 in the North of England, from the perspective of both health care professionals and pregnant
84 women. It formed part of a larger project that aimed to increase the use of such evidence in
85 everyday practice around IOL using an established framework (social marketing [Kotler and
86 Lee 2008]). The aim of the study was therefore to explore the use of high quality research
87 evidence in everyday clinical practice from the perspectives of women who have been
88 offered IOL and health care professionals involved in the care of such women.

89 **Methods**

90 **Study Design**

91 The exploratory nature of the research question led us to choose social constructionism
92 (Berger and Luckmann, 1966; Bryman, 2012; White, 2017) as the underpinning theoretical
93 framework for an interpretative qualitative interview study (Pope and Mays, 2020). This
94 allowed consideration of the ways in which pregnant women and health care professionals
95 conceptualise high quality research evidence and the social constructed beliefs, interactions
96 and practices that guide the ways in which it is and is not used. This interpretative,
97 qualitative study design, using face to face semi-structured interviews to collect data was

98 chosen as the most appropriate way in which to gain insights into the lived experiences of
99 those providing, and receiving care in this context. Generative thematic analysis (Braun
100 and Clarke, 2006; Braun and Clarke, 2019) of the transcribed interviews was used to identify
101 and develop key themes that form the findings.

102 **Participants and recruitment**

103 Participants were (a) health care professionals (HCPs) involved in the delivery or
104 management of antenatal care, or (b) postnatal women who had been offered IOL in their
105 most recent pregnancy. All participants worked in, or received care at, a large tertiary referral
106 centre in the North of England. Usual procedure at this hospital was for pregnant women to
107 be offered IOL by either their midwife (in the case of postdates pregnancy) or obstetrician (in
108 the case of a medical indication). Women were given a leaflet about IOL that detailed
109 practical information (e.g. what time to arrive at the hospital, whether partners could attend),
110 alongside information about how and when the IOL medication would be administered). For
111 ease, postnatal women are henceforth referred to in this paper as women (accepting that
112 some of the HCPs were women also). Only women who spoke English were included in the
113 study as resource limitations precluded access to translation resources during data
114 collection and transcription.

115 Eligible women were identified within 1-2 days of birth via the postnatal ward and provided
116 with a study invitation letter and service user/participant information sheet by a research
117 midwife (XX) (see). Women interested in participating completed a 'consent-to-contact'
118 form which could be returned to XX immediately or by post after discharge from hospital.
119 Women returning consent-to-contact forms were contacted by telephone 2-3 weeks later, to
120 ascertain if they still wished to take part. HCPs were identified randomly from a staff list
121 provided by the participating Trust using a random number table. An invitation letter was
122 sent via the internal post system to those selected, together with the staff participant
123 information sheet, a consent-to-contact form and XX's email address and telephone number.
124 Those HCPs returning consent-to-contact forms by post, or those contacting XX directly by
125 email or phone, were subsequently contacted by phone or email.

126 Women participants were postnatal women, over 24 weeks gestation at delivery, and who
127 were offered IOL in their most recent pregnancy (even if IOL was declined or delivery
128 occurred before IOL date). Women were excluded if they were; unable to understand verbal
129 English language, being offered IOL following an intrauterine death, or were under 16 years

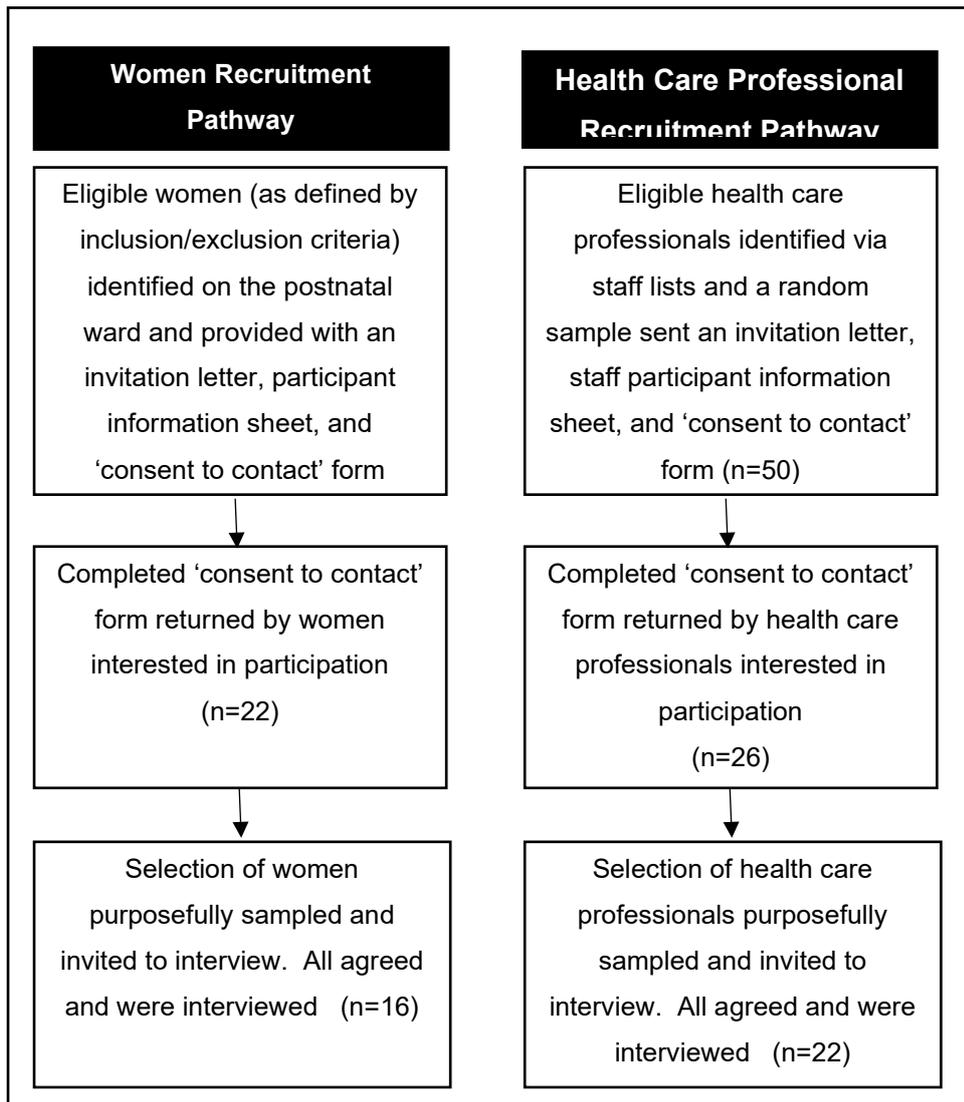
130 of age. HCP participants were healthcare professionals employed by the participating Trust
131 directly involved in the delivery or management of antenatal care

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134 Recruitment and data collection occurred concurrently across a 5 month period. Purposeful
135 maximum variation sampling (Suri, 2011) was used to invite and select participants with a
136 range of attributes likely to influence their experiences of delivering/receiving care (e.g. for
137 HCPs their profession, seniority and gender; for women their age, parity, reason for IOL (as
138 reported by the participant), and decision to accept/decline IOL). Data analysis began as
139 soon as data was collected and interviews continued until data saturation was achieved and
140 no new emergent themes were identified in the data (Saunders et al., 2018). To reach data
141 saturation (Hinton and Ryan, 2020), 76 individuals (50 HCPs and 26 women) received a
142 study invitation pack and 48 (26 HCPs and 22 women) returned a 'consent-to-contact' form.
143 Thirty-eight of these individuals (22 x HCPs, 16 x women) were invited to interview; all gave
144 informed consent to participate and were interviewed. A flowchart detailing recruitment
145 pathways for women and health care professionals is shown in Figure 1.

146 **Figure 1. Recruitment Flowcharts**



147

148 Ethical approval was obtained from the Dyfed Powys Research Ethics committee (ref
149 13/WA/0289, 04/09/2013). The study was funded by an NIHR Knowledge Mobilisation
150 Fellowship held by the lead author.

151 **Data collection**

152 Data were collected via individual semi-structured interviews between October 2013 and
153 March 2014. Two interview guides (one for HCPs and one for women, available on request
154 from the author) were developed by XX in consultation with other members of the research
155 team, which included a lay representative (ZZ, YY, WW, VV). In order to focus on collecting
156 data that might facilitate improved use of high quality research evidence, the questions and
157 prompts in the guides were informed by the social marketing framework (Kotler and Lee,

158 2008); for example, we asked participants what kinds of information they accessed, how
159 they accessed them, and how that information was used to inform the decisions made about
160 IOL. We used this framework with the aim of understanding the overall context within which
161 high quality research evidence is accessed, understood and mobilised to support decision
162 making and the factors that influence this.

163 Each participant was interviewed once; all recruitment and interviews were conducted by
164 XX, who did not work directly with any of the HCPs and had no involvement in the women's
165 clinical care. XX is an experienced researcher and qualified midwife who led this research as
166 part of programme of work funded by an NIHR Knowledge Mobilisation Fellowship.
167 Interviews were arranged at a time, date, and location of the participant's choosing (all
168 women chose to be interviewed at home, all HCP chose to be interviewed in a private room
169 in their workplace). The women were interviewed between 3-8 weeks postnatal.

170 **Data Analysis**

171 All interviews were digitally audio-recorded with the consent of the participant and were
172 transcribed verbatim by a research secretary. The transcripts formed the dataset analysed.
173 An inductive thematic analysis of the data was conducted using the constant comparative
174 method (Braun and Clarke, 2006). This iterative technique involved initial descriptive data
175 coding (Saldaña, 2013), using Atlas.ti software (Friese, 2014). The codes were then
176 reviewed and overarching themes identified. The themes were reviewed for consistency
177 against the dataset and the themes refined accordingly. We chose to analyse the data from
178 HCPs and women together (as opposed to conducting two separate analyses) to take a
179 holistic approach that considered how knowledge flows (or does not flow) through the
180 maternity care system which includes both HCPs and women.

181 XX conducted the initial coding analysis using a descriptive coding technique (Saldaña,
182 2013). XX is a research midwife with professional and personal experience of IOL.
183 Development of the codes into themes was discussed in regular meetings with other
184 members of the research team who also reviewed a subset of the transcripts (YY, ZZ). YY
185 and ZZ (an obstetrician and a social scientist respectively) had different professional and
186 personal experiences of IOL which aided reflexivity. Disagreements were addressed via
187 discussion until consensus was reached. Furthermore, XX engaged in memo taking
188 throughout the data collection and analytic processes to outline and explore assumptions
189 and attitudes that might impact on the analysis (Tufford and Newman, 2012).

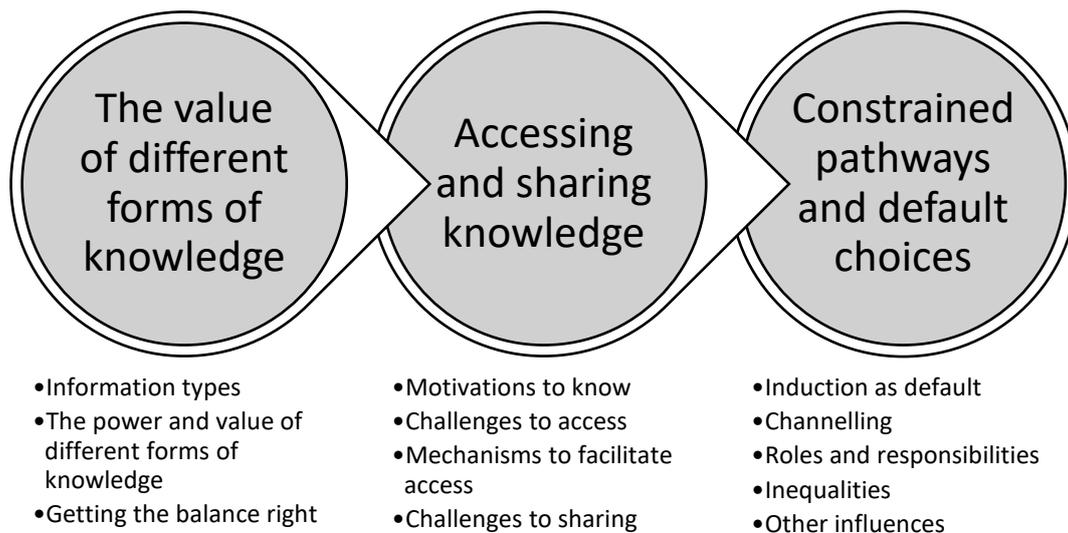
190 **Results**

191 **Participants**

192 Participant characteristics were collected directly from participants prior to interview (see
193 Appendix 1). Interviews lasted between 28-84 minutes; the median length of interviews
194 were 39 minutes for women and 52 minutes for HCP.

195 Three key themes were identified (Figure 1). The results section uses quotes to illustrate
196 key points; quotes from women indicate whether IOL was offered for medical reasons or
197 postdates, and quotes from HCPs indicate their professional background.

198 **Figure 2. Themes and subthemes**



199

200 **Theme 1: The value of different forms of knowledge**

201 This theme focuses on the types of knowledge participants described as influential in
202 decisions about IOL. The value of different knowledge types and the role they may play in
203 influencing care is explored in the subthemes.

204 **1.1 The power and value of different forms of knowledge**

205 Participants discussed the types of knowledge that influenced their thoughts about IOL; they
206 can be broadly conceptualised as formal evidence-based or experiential. Formal evidence-
207 based describes knowledge which is based on data (e.g. research, local audit). Experiential

208 describes knowledge gained via experience (e.g. women's experiences of undergoing IOL,
209 clinicians' experiences during training and working in a healthcare system). HCPs and
210 women drew from both types of knowledge (Figure 3).

211 **Figure 3. Information Types**

"your experience tells you things as well that you know research doesn't, you know about the different consultants, you know about different experiences that women have had, yeah, and I guess you know what women, 'cause you see them afterwards, women complain about with the inductions so you would know what to tell them beforehand" 087, HCP, medical

"I'd spoken to me friends who have had it done, they kind of give us a bit of an insight, and One Born Every Minute" 106, woman, postdates IOL

212

213 Most participants reported that they generally considered formal evidence-based knowledge
214 to be more reliable and objective than experiential knowledge. HCPs described their practice
215 and their organisational protocols as evidence-based, with one HCP participant (119) noting
216 that their organisation liked to be '*NICE compliant*' (referring to the National Institute of
217 Health and Care Excellence (NICE)). Several HCP participants mentioned concerns that
218 women can be overly influenced by experiential knowledge, however women participants
219 also described valuing formal evidence-based knowledge over experiential in terms of how
220 much it impacted on decisions about their care. Experiential knowledge was perceived to be
221 prone to being opinion-based with little way for women to judge how correct or credible the
222 information and its source was, and how much relevance it had to their own situation. The
223 internet was described by women as being particularly liable to hosting spurious facts and
224 commentary. Some women reported this experiential knowledge to be useful in prompting
225 further questions, which they could then explore further by accessing formal evidence-based
226 information from a more credible source (usually a health care professional or an NHS
227 endorsed website). (Figure 4).

228 **Figure 4. The power and value of different forms of knowledge**

“there is something intrinsic within us that recognises that erm, if you’ve read in a chat room about 5 women have tried this and 3 of them, it worked, that quality of evidence isn’t as good as if you’ve got 10,000 women and it worked in a different number. I think there’s something intuitive that tells you that one bit of evidence is probably higher quality than the other” 090, HCP, medical

“I go on the internet so, , I probably do more so now than I did when I was pregnant. Yeah I went on, I dunno you just do a search don’t you and it’s a bit frustrating I find with, with baby information because there’s a lot of stuff, like, is it Mumsnet? Which is just discussions, they’re just forum groups, so they always come up first, and I hate those because they’re not factual, they’re just people’s opinions about things” 096, woman, medical indication IOL

“I kind of just spoke to the doctors because sometimes you don’t get the right information on the net. I just thought I was seeing the same consultant so I just sat down and spoke to him, and I think, I can remember being given some leaflets and stuff so, and that was really helpful” 097, woman, medical indication IOL

229

230 Both groups of participants described basing care on formal evidence-based knowledge as a
231 way to achieve the best outcomes for women and babies, and indicated that knowledge of
232 the evidence-base is an expectation for HCPs (making it problematic for HCPs to admit to
233 uncertainty or lack of knowledge) (Figure 5). Several HCPs suggested evidence-based
234 practice also offers HCPs protection against litigation in the event of a poor outcome. There
235 was less consensus about the usefulness of experiential knowledge. Whilst some (most
236 HCPs and some women) saw experiential knowledge as unreliable, others felt it offered
237 useful adjunct information for women (e.g. about the reality of experiencing IOL).

238 HCPs also described using experiential knowledge. For example, NICE guidelines on IOL
239 offer clear guidance about when a membrane sweep should be offered as part of the
240 induction pathway, but community midwives described being often asked by pregnant
241 women to perform additional sweeps to instigate labour. In deciding whether to agree to this,
242 Figure 4 demonstrates that some midwifery participants agreed on the basis of their
243 experience of women finding this supportive, whereas others’ experiences were that multiple
244 sweeps did not work.

245

246 **Figure 5 Experiential knowledge guiding decision making**

“You feel like you’re giving them something to hope for cos the midwife’s going to do a sweep and that’s going to work, and not whether it does work or not, but it’s the fact that you’re doing something for that woman, whether that’s the right attitude or not I don’t know, but sometimes I think I’m walking up the garden path to knock at the door and I think she’s desperate for me to come ‘cause I’m gonna give her a sweep and I’m glad I’m doing it for her ‘cause she’s really fed up” 100, HCP, midwifery

“they’ve heard other women that have had one <sweep>, had more than one, but then you hear about people having like 2 or 3 and they still don’t work, so I just think it’s best just to stick to 1 to wait after 41 weeks” 114, HCP, midwifery

247

248 The data suggest that experiential knowledge can become so embedded that it becomes
249 understood and passed on as fact. This ‘embedded’ knowledge is particularly powerful as it
250 is associated with widespread acceptance by HCPs and women, and a lack of motivation to
251 question the validity of the knowledge or to accommodate alternative views. A clear
252 example was HCPs’ and women’s understandings that pregnancy should not advance
253 beyond 41-42 weeks gestation (Figure 6).

254 **Figure 6 IOL at 42 weeks as accepted routine**

“obviously all the way through pregnancy and kind of the latest you can go is 42 weeks, so I think I kind of knew at 42 he was coming out” 106, woman, postdates IOL

255

256 **1.2 Getting the balance right**

257 Knowledge was also described by HCPs and women as potentially burdensome. Many
258 HCPs were concerned about overwhelming women with information (particularly *‘facts and*

259 *figures'* or information relating to adverse outcomes). Some women described avoiding
260 information or limiting the amount they sought; importantly, such women still wanted care
261 based on best evidence, but trusted their HCPs to provide such care and to offer any
262 information they *needed* to know. Two women in particular, reflecting post-delivery, felt they
263 had had gaps in their knowledge that their HCPs could have identified (Figure 7). The
264 second quote is from a participant who was induced with a twin pregnancy and felt that had
265 the risk of requiring an emergency caesarean for the second twin (as happened to her) been
266 sufficiently explained she may have opted for an elective caesarean over IOL.

267 **Figure 7. Getting the balance right**

"I never look any further for research, you know, as I say, I trust what the doctors and that say, you know what I mean, the <hospital>, I'm more than comfortable, I trust what the doctors say, what they advise and, you know, and they're all, they know what they're talking about" 093, woman, medical indication IOL

"Maybe it's my fault, I could have asked about, my fault in a way of, like you say, if I had never asked what the, you know what the percentages are. But all I'm saying is, it might have been better if they'd sort of highlighted what they were, maybe it was one of the key things, instead of me having to ask for it. Maybe that would have been better to say, you know, 'Do you realise the likelihood of this is this?'. It would have changed my decision I think" 117, woman, medical indication IOL

"The lawyers want us to say a whole list of things, and really we should be telling women those things so they can make an informed decision but then I have had women who've turned up and said 'Oh that doctor that I saw in clinic last week just bombarded me with a set of statistics and I don't really want to know that'. I guess you can't get it right for everybody, and you've got to, to gauge it I guess in terms of how much people want to know and what their level of education and interest" 085, HCP, medical

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269 **Theme 2: Accessing and Sharing Knowledge**

270 This theme focuses on HCP and service user motivations for seeking knowledge, how they
271 accessed it, and how they mobilised knowledge to support decision-making around IOL.

272 **2.1 Motivations to know**

273 Participants discussed situations in which they were/were not motivated to seek formal
274 evidence-based information. Most women accepted IOL when offered, without seeking
275 information about the risks, benefits or alternative options. The few women who described
276 pursuing additional knowledge included those unclear about the need for IOL, those averse
277 to having the procedure, and women who were considering a choice between IOL and
278 elective caesarean section (i.e. the decision to deliver had been made and they were
279 considering the best option).

280 Many HCPs suggested that they relied on local and national clinical guidelines to inform their
281 practice regarding IOL and most had not engaged with the underpinning research evidence.
282 Those who anticipated their knowledge being questioned were more likely to report seeking
283 further information (e.g. in clinical assessments or where they perceived women in their
284 caseload to be particularly inquisitive). Participants holding more senior HCP positions were
285 more likely to report seeking further information, particularly to support clinical decision-
286 making in specific clinical scenarios (i.e. women with a particular medical condition) or to
287 inform their role in the development of local guidelines (Figure 8).

288 **Figure 8 Seeking further information to support decision-making or deliver care**

"I researched it while I was in hospital, just because I was thinking, I started researching thinking I'm gonna get induced, do I wanna go through the induction or do I wanna opt for a C section 'cause I knew the two options were available" 097, woman, medical indication IOL

"I'm probably my own worst enemy but I was aware from the NICE guidelines that you could wait 24 hours <after spontaneous rupture of membranes> so that was the suggestion in the NICE guidelines, but I know <the hospital> have a different policy, ... <the doctor>, again, was very kind of, not really, it was presented that it wasn't a choice, we need to be induced between 12 and 16 hours, and I said 'Well actually no, I want to be induced in line with the NICE guidelines'" 105, woman, postdates IOL

289

290 **2.2 Challenges to accessing knowledge**

291 Most HCP, and some women, participants described challenges associated with accessing
292 formal evidence-based knowledge. Four key challenges for HCPs were: (1) volume of
293 empirical information being produced, (2) sourcing, understanding and assimilating that
294 knowledge, (3) understanding how to communicate the information and incorporate it into
295 clinical care, and (4) finding time within busy clinical workloads. As shown in Figure 9, one
296 medical participant suggested that midwives may be more time constrained than their
297 medical counterparts, though midwifery participants did not note this as a phenomena limited
298 to their own discipline. For women, knowing what they needed to know, and sourcing
299 reliable, understandable information, were key issues.

300 Several women participants described having been given no, very limited, or superficial,
301 information in contrast to women who saw a medical consultant. When additional information
302 was requested it was not always provided, and some women went to on to seek further
303 knowledge independently, largely via internet searches or talking to friends/family. Some
304 participants felt that the internet offers women and HCPs equal access to evidence and
305 knowledge (Figure 9). .

“I think you know if you know where to look for the information then you know there’s nothing to stop you going and looking at it, but in the course of your working day, you’re working flat out, you know, I’m sure everybody else has got the same grumbles, you know, you start early, you finish late, you don’t get a lunch break, it is, it is hard, you’re just on the go all the time, you know, so yeah, it is hard, it is really difficult” 118, HCP, midwifery

“I had, again tried to, tried to look at the research studies in the NICE guidelines poring through the annexes to try and understand what the proportions were, and had misunderstood what the proportions were so it was useful to talk to <the consultant>” 105, woman, postdates IOL

“I don’t know, but erm, I’m not sure that erm, a busy midwife has maybe quite as much time to stay up to date with the evidence base as medical staff might have and I suspect a lot of the counselling is based on, you know, either information being given from the hospital or just past experience.” 090, HCP, medical

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308 In contrast, accessing experiential knowledge was described as unproblematic. Women felt
309 that other women were very willing to share their own birth/induction stories and opinions
310 directly or via internet forums. Motivations to access experiential knowledge were to
311 understand: (1) what induction is; and (2) what other women choose. Similarly, many HCPs
312 reported that sharing information between colleagues, and observing their practices, heavily
313 influenced their own care practices.

314 **2.3 Mechanisms to facilitate access to knowledge**

315 Some participants described mechanisms that facilitated access to formal evidence-based
316 knowledge for HCPs and women. The most frequently mentioned was national and local
317 guidelines, with all HCPs and many women mentioning NICE. Guidelines were described by
318 HCPs as a useful way to consolidate information and support the provision of consistent and
319 evidence-based care, though some had reservations about the quality of evidence
320 underpinning them. Whilst some women had accessed NICE guidelines directly, many were

321 content to accept their HCPs recommendations regarding IOL. In this respect both HCPs
322 and women described a '*cascade of knowledge*'; evidence is translated into national
323 guidelines, which are then translated into local guidelines, which are then interpreted and
324 translated by HCPs into the care offered to, and the information shared with, women. Trust
325 was a frequently mentioned concept, with each person trusting that those preceding them in
326 the '*cascade*' were qualified to source, interpret, and consolidate the information in an
327 accurate, unbiased way. Some senior HCPs however suggested that national guidelines are
328 not always based on the highest quality evidence and that the translation of national to local
329 guidelines could be influenced by a number of factors including personal beliefs, biases and
330 organisational resources (Figure 10).

331 **Figure 10 Trust and clinical guidelines**

"you have to have some form of trust that your leaders on research have gone through and will always do what is ethical, therefore your results would stand up in court if you like" 089, HCP, midwifery

"I think I felt quite comfortable to kind of trust, trust in away, not to question everything of them, so, but I guess in a way it would be good to, if, 'cause now I'm thinking did I, sort of, know everything exactly? Em, I'm not sure" 094, woman, postdates

"It used to be the case that you wouldn't find a recommendation in NICE that was based on just one RCT but today, most of NICE guidelines are, you find recommendations based on cases, so the NICE guidelines have been diluted to the point where clinicians now feel almost compelled to look at evidence and pick and choose, ..., so I think NICE is shooting itself in the foot by in essence, forcing clinicians to pick and choose which guidelines they do, and once you've allowed for them to pick and choose, they will pick and choose both the good bits and the bad bits" 088, HCP, medical

332

333 Most HCPs found guidelines a useful and appropriate mechanism of formal evidence-based
334 knowledge mobilisation, but some HCPs and women expressed concern that it left HCPs as
335 '*messengers*'; knowing when they should offer IOL but not fully understanding why.
336 Participants (from both groups) noted that this could result in HCPs treating guidelines as
337 rules or implementing them inappropriately. This was felt to be particularly problematic for

338 women with questions about how the guidelines related to their individual circumstances or
339 who queried why local guidelines differed between NHS Trusts (Figure 11).

340 **Figure 11 Clinical guidelines as a mechanism of knowledge mobilisation**

“I do think guideline policies sometimes gets confused and people might view them as being more rigid and you can’t deviate which clearly isn’t the case, , but I certainly, my view of a guideline is it’s a prompt, it’s a guide, as it suggests” 107, HCP, midwifery

“the midwives in the hospital were very much like, ‘well yes you should get induced at 42 weeks because there are risks’, and, but then when you say ‘Well actually, you know, there are risks with being induced and I’d, you know, I, kind of, I’m not sure I want that’ then they’d say ‘Oh, okay, fine, yeah that’s your choice” 105, woman, postdates IOL

341

342 For women, HCPs were generally reported as the most appropriate gateways to knowledge
343 and informed opinion (either directly or via signposting to NHS leaflets/websites). Other
344 mechanisms mentioned were antenatal classes (via NHS or independent companies like the
345 National Childbirth Trust), the internet (including NHS endorsed websites, internet chat
346 forums), friends and family, and non-NHS books and leaflets. For HCP participants, access
347 mechanisms included peer-to-peer, professional journals (especially systematic reviews),
348 Royal College of Obstetrics and Gynaecology (RCOG) guidelines, conferences, journal
349 clubs, in-house training and meetings, and training (clinical and continuing professional
350 development).

351 **2.4 Challenges to sharing knowledge**

352 HCP participants saw themselves as having a role in sharing formal evidence-based
353 knowledge with women but described challenges to achieving this. Being able to integrate
354 population level evidence with the circumstances and preferences of individual women was
355 described as important, requiring skill and time (not always feasible in a busy antenatal
356 clinic). Similarly, challenging inaccurate knowledge brought into consultations by women in a
357 non-dismissive, sensitive way was experienced as hard. Dealing with women with good
358 knowledge of the evidence-base also presented challenges to some HCPs who felt their own
359 knowledge may come under scrutiny. Senior level HCPs described their frustration at having

360 no time to observe more junior staff in consultations to guide them in developing these
361 important skills (Figure 12).

362 **Figure 12 Challenges to knowledge sharing**

“Hopefully it’ll help them to see where the guideline and the policy kind of side of things is coming from, but you’ve got to also have a human connection with the woman in front of you so you’ve got to go beyond that. I think if you just talk facts and figures and numbers that’s quite off-putting because that woman’s gonna go ‘Well I’m not just a statistic’. Well that’s how I would probably feel, so it is kind of relating population data, to individual women in their social context, which is much more challenging” 084, HCP, medical

“It would be nice to give them a bit more support because sometimes they don’t know what they need to know, em, but the way the NHS is just now with staffing and things, sometimes we just haven’t for the staff to offer loads of time where you can, which, I know, it sounds terrible, but it’s reality” 100, HCP, midwifery

363

364 **Theme 3. Constrained pathways and default choices**

365 This theme focuses on the environment within which knowledge is sourced, shared, and
366 interpreted. Several factors appear to influence the choices presented to women, and how
367 much information is shared and sought by both HCPs and women. This calls into question
368 the extent to which women ‘choose’ induction and the consequent impact on knowledge
369 seeking behaviours.

370 **3.1 Induction as default**

371 Participants in both groups felt it was important that women made informed choices about
372 their care, but one of the clearest themes evident in the data was women’s perceptions that
373 IOL was not presented to them as a choice, and HCP perceptions that women agree to have
374 IOL rather than actively choose it. The importance of this observation to the research
375 question relates to the concomitant observation that women do not ask questions (Figure
376 13).

377 **Figure 13. Induction as a non-choice**

“... it was very much like ‘well we will book you in for an induction then’, as opposed to ‘there are some choices, you could be continuously monitored’, and it was more that I was aware that that was a choice, than I was given that choice” 105, women, postdates

“I think that <women> do just say ‘Okay I’m being induced’, and they might be given some statistics about induction, but it’s given as ‘that’s the option’ rather than ‘this is one option, that’s the alternative option’, and so I think it is maybe sold as this is our routine, and only if it’s questioned do they then get the flip side of the coin” 101, HCP, midwifery

“Induction is done for a variety of reasons and therefore in circumstances where induction is clearly indicated, and one assumes the woman kind of knows that, then there isn’t a lot of discussion except to say ‘You are fully two weeks, you need to be induced’ and she says ‘Yes’. ‘Off you go, off you go to get induced’. So that’s a fair picture of the 30 second discussion.” 088, HCP, medical

378

379 Some explanatory factors for this phenomenon were evident. Firstly, language use in the
380 interviews suggested a power dynamic skewed towards the formal health care system, with
381 frequent references to what is ‘allowed’ and what HCPs will ‘let’ happen. Choosing expectant
382 management was often described as a ‘refusing’ IOL, suggesting that acceptance is the
383 default; this idea is strengthened by women who described concerns that declining IOL may
384 define them as awkward to HCPs (Figure 14).

385 **Figure 14. Language and ‘Choice’**

“We didn’t really talk about whether it was something I could refuse, or what the risks of not having an induction were” 111, woman, postdates IOL

“I mean often once they get to the point of their due date ‘cause you see them at the 40 week appointment, then they would normally be maybe ‘Well what happens from here on in? How long am I allowed to go over me dates?’ 118, HCP, midwifery

386

387 Some women described having feared that they would be blamed (either by others or
388 themselves) if they declined IOL and experienced a poor outcome; some HCPs described
389 wanting to protect women from this. Participants' discussions almost exclusively revolved
390 around blame in the event of a women declining IOL, although one woman blamed IOL and
391 her HCP for her instrumental birth. Some women described feeling a responsibility to avoid
392 any level of risk to their baby, although others felt that risk is unavoidable and that discussing
393 it in realistic, understandable, and non-sensational ways was important (Figure 15).

394 **Figure 15 Risk, responsibility and blame**

"... if you go against what people who are a lot more knowledgeable than you say, if anything went wrong who do you blame? You've been told the facts and if you ignore those facts and anything goes wrong, ultimately who is the person to blame? It would have been me" 117, woman, medical indication IOL

"When the doctor was getting my consent, or telling me I was having to go and have a high, a forceps delivery, I remember saying 'This is because you demanded that I come in at 42 weeks and he wasn't ready to come out and if I'd have had a few more days he would have turned his head'" 111, woman, postdates

"The risk element of it isn't communicated well, you're just told it's risky, but I don't remember anyone saying well how is it, and how risky in each case, how risky might it be because as a, a pregnant woman you make all sorts of decisions that may or may not be risky, like whether or not you're gonna have a glass of wine or eat some meat that isn't fully cooked. So I think women do make, are very well capable of making choices based on risk, but that isn't, I think sometimes you're fed a bit of like, you're a dumb person, so it's risky, don't do it" 111, woman, postdates IOL

395

396 **3.2 Channelling**

397 The data suggest that HCPs may use knowledge selectively to 'channel' women towards
398 options that align to professional norms and/or organisational guidelines. Some participants
399 suggested midwives and medical trainees may come under pressure from medical
400 consultants to restrict referrals of healthy women requesting early IOL (i.e. before 41 weeks).
401 Discussing such situations, HCPs described using strategies to encourage women to

402 continue their pregnancy (e.g. emphasizing the risks of IOL, offering an additional cervical
403 sweep with a follow up appointment (Figure 16)).

404 **Figure 16 Knowledge sharing in constrained systems**

“Someone says ‘I’m really fed up and I want to be induced’ so you’re saying ‘Well if your body’s not ready to go into labour you’re really increasing your chance of having a caesarean section if you got induced just now, so it’s not a good idea unless it’s really medically indicated, if you’re unwell, the baby’s unwell, but you know, not grown or whatever’ but, you really just have to try and support them” 100, HCP, midwifery

“... the other thing that we need to really look into is, what, what, that we have the capacity if you like, to be able to do all of what is recommended from the RCOG’s guidelines, so it’s not, it’s not always an easy thing to implement, though, you know, it’s recommended” 095, HCP, midwifery

405

406 **3.3 Roles and responsibilities**

407 The role of HCPs in their organisation in relation to IOL decision-making also appeared to
408 impact on their willingness to know and share formal evidence-based knowledge. Trainee
409 medical staff and midwives explained that women requesting care that did not align with
410 local guidelines had to be referred to a medical consultant to make further decisions. These
411 HCPs suggested they had awareness of the variable preferences of different consultants
412 and would sometimes adjust the knowledge they shared with women to manage women’s
413 expectations. They also suggested that they may transfer responsibility for information
414 provision to the consultant to avoid inconsistency or conflict. For example, the care pathway
415 in the hospital Trust required community midwives to (a) routinely offer IOL at 41-42 weeks
416 gestation to women with an otherwise low risk pregnancy, and (b) to refer on women who
417 declined this offer, or who requested IOL prior to this gestation, to a medical consultant.
418 Similarly, medical trainees referred on women who did not accept an offer of IOL.
419 Midwifery/trainee participants described that further discussion did not generally precede
420 that referral, suggesting that responsibility for further information sharing was seen to rest
421 with the decision-maker (the consultant). A number of women expressed dissatisfaction at
422 this system and felt it would be more appropriate to have an evidence-based discussion with
423 a known and trusted HCP (and that for many this would be a community midwife).

424 **Figure 17 Roles and responsibilities of healthcare professionals**

“If somebody refuses induction the midwife’s role would be to inform the medical staff who would then, it’s, because it’s outwith the norm, and because they become high risk, midwives are able to care for women at low risk. Anything out with that, it would be a medical review” 095, HCP, midwifery

“I think individual consultants get a reputation for what they want in their clinic and I think, the trainees often try and deliver what they perceive as being the right answer in that situation, and to some extent that’s, that is how medicine’s always worked” 091, HCP, medical

“It’s a social induction at 41 weeks and, I’m really sorry, but I think they shouldn’t have got as far as the clinic in the first place, or it’s often written in the notes by the community midwife you know, come to the antenatal clinic to discuss early induction, and they know as well as we do that that’s not appropriate, but it’s a way of passing it on and getting them out of their consultation room or whatever, and that’s not fair because the women then come to clinic with unrealistic expectations because they think they’re gonna get an early induction” 085, HCP, medical

425

426 **3.4 Inequality**

427 HCP participants suggested that access to choices and information about IOL may be
428 inequitable, and several gave women with symphysis pubic dysfunction (SPD) as an
429 example. Such women were reported to often request early IOL but to have their requests
430 declined without discussion. Conversely, women with a previous history of second/third
431 trimester pregnancy loss were reportedly given more information and choice about timing of
432 IOL. Some HCPs also explained their perceptions that some ‘types’ of women (educated,
433 middle class) were more likely to value detailed information than others (Figure 18).

434 **Figure 18 Inequality of knowledge sharing and access to IOL**

*“I think people who’ve got SPD are the most tricky characters because they have got very, very, painful, immobilising pregnancies that seem to get little sympathy from professionals, because they don’t live that life and I think there’s also a professional opinion that these people are trying to be induced, and there probably is a hard core of people who are trying to be induced, but there’s also some people who really are, they **need** to be induced, they really are in extreme pain, but still, we would try and get them as near to term as we can ‘cause we want them to have a spontaneous labour, just because it’s, it is better for them” 119, HCP, midwifery*

“I work in <two affluent towns> so I tend to get a lot of, my ladies are professional people who are well-educated and will question and will look up things so they understand what’s going on, where maybe other areas, you know, because of language difficulties or reading difficulties or, you know, in some of the socially deprived areas, they don’t always question, they just accept that that’s what’s gonna happen” 114, HCP, midwifery

435

436

437 **3.5 Other influences**

438 Some participants described societal and professional perceptions about pregnancy, birth
439 and the desirability (or not) of pursuing an intervention-free vaginal delivery. Some HCPs felt
440 that some women have fixed views about IOL and are selective in the knowledge they seek
441 and accept as legitimate, and that some HCPs may strive to avoid IOL. Finally, a number of
442 HCPs and women indicated that women have alternative motivations for seeking or
443 accepting IOL, namely that pregnancy can be tiring and uncomfortable so hastening its
444 completion becomes desirable. HCPs described their experience that this led some women
445 to have low motivation to understand the evidence-base (since they have already decided
446 that they want IOL) or to seek non-evidence-based interventions (e.g. more cervical sweeps
447 than are recommended by NICE guidance)(Figure 19).

448 **Figure 19 Additional influences on decisions about IOL**

“... people seem, almost seem to be a bit polarised into either wanting a birth experience, the most, a natural birth experience or being quite pro induction but there seems to be, people often seem to have very much made up their mind before they come” 091, HCP, medical

“At that point I would have done anything to get him out” 106, woman, postdates IOL

“It’s this instinct from clinicians who believe that a caesarean section is bad and insist to attempt a vaginal birth is good, this primary belief, and unless you kind of deal with that belief at the onset, then you face a much bigger challenge. But this is not just obstetricians, it’s midwives, it’s everyone in maternity care from the Government down. Everyone thinks that vaginal birth is good, caesarean section is bad” 088, HCP, medical

449

450 **4. DISCUSSION**

451 The results of this study suggest that whilst high quality research evidence was valued by
452 participants, and was viewed as a means to secure the best quality of care, evidence-based
453 knowledge was not always effectively mobilised to support decision making (e.g. it was not
454 always accessible and understandable to women and HCPs when the offer of IOL was
455 made).

456 The KM literature encourages us to think about use of knowledge as a social process that
457 occurs within social, political and organisational contexts that shape the way that different
458 forms of knowledge are accessed, shared, and used in every day care (Crilly et al., 2010).
459 Applying this lens to our research question led us to focus on the way high quality research
460 evidence is used in everyday interactions about IOL, and to consider the role of context
461 when interpreting the results. The results highlight the complexity of the context within which
462 choices about IOL are made, and highlight several influential factors (e.g. personal and
463 professional preferences, accessibility of knowledge, organisational constraints, experiential
464 knowledge, and societal norms).

465 Many of the findings echo similar work exploring women’s experiences of decision-making
466 about IOL; in particular, observations that women perceive that they are given limited
467 information and choice about IOL, and even less about alternatives (Coates et al., 2020;

468 Coates et al., 2019; Dupont et al., 2020; Jay et al., 2018; Lou et al., 2019; Moore et al.,
469 2014; Stevens and Miller, 2012). Descriptions of the use of directive language, maternal
470 feelings of moral obligation to avoid risk, and socially/medically constructed beliefs about
471 pregnancy contribute to that observation. These concepts have all been observed in
472 maternity care more broadly (Begley et al., 2019) and may explain why the '*non-choice*'
473 scenario regarding IOL appears to continue without much challenge.

474 Theme three suggests organisational factors that may influence how motivated HCPs are to
475 understand and use evidence in their clinical decision making and in their interactions with
476 pregnant women, for example the normalisation of IOL as a routine part of care or the known
477 preferences of senior clinicians leading to practices that we have labelled 'channelling'.
478 Care pathways that require women who wish to explore choices that deviate from routine
479 care (e.g. to decline postdates IOL, or to request IOL) to be referred to a medical consultant,
480 appeared to influence HCP perceptions about who has responsibility for knowledge sharing
481 to support decision-making. Several accounts suggested that that midwives and trainees felt
482 it was not appropriate for them to engage in discussions about options when they had no
483 ability to sanction deviations from clinical guidelines; it was unclear whether this was
484 because they felt they lacked knowledge or because they felt it was not their responsibility.
485 Only a proportion of women access medical consultant care (and thus access to these
486 evidence based discussions) and, for well women, midwives and trainees generally act as
487 gatekeepers to consultant care (Nippita et al., 2017). Additionally, some women found the
488 requirement to be referred to a consultant in these circumstances to be intimidating (as
489 compared to the '*easier*' option of compliance). Several women in this study noted
490 dissatisfaction with this arrangement, suggesting that it would be more appropriate to have a
491 well-informed discussion about IOL with HCPs who have already been involved in their care,
492 and community midwives were mentioned in particular.

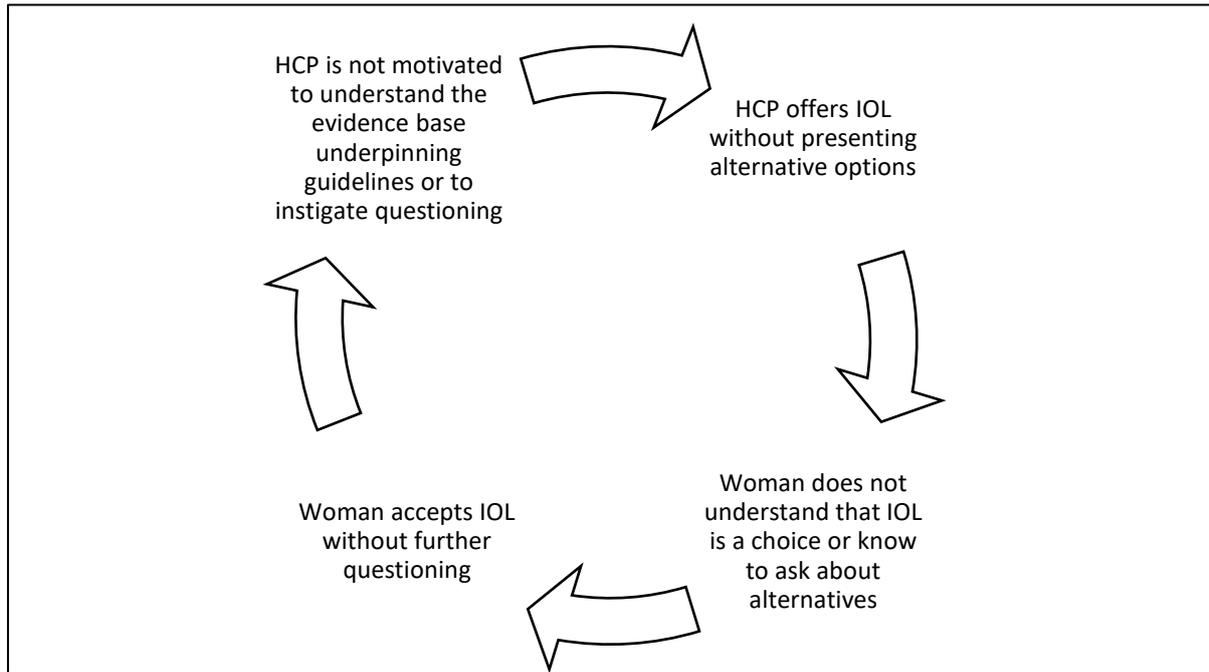
493 Clinical guidelines are a well-accepted and widely used tool that aim to increase evidence
494 based care and decrease unwarranted variation in NHS care (National Institute for Health
495 and Care Excellence). In light of the reported challenges of accessing, understanding, and
496 applying a rapidly expanding evidence base, they represent a familiar way to summarise and
497 share knowledge. In our study, the use of clinical guidelines represented a '*double-edged*
498 *sword*' in their role as a mechanism of knowledge mobilisation. They were undoubtedly well
499 recognised and widely trusted, and were referred to frequently by all HCPs (and several
500 women), but there were also suggestions that they were frequently applied in inflexible and
501 mechanistic ways. Conversely some of the senior HCP participants suggested that local
502 guidelines often do not completely reflect national guidelines because of concerns about the

503 quality of the evidence underpinning them or issues regarding the resources required to
504 deliver them; this has significant implications for the ability of guidelines to increase the use
505 of 'best practice' and decrease variation. This aspect of our findings resonates with other
506 literature on this subject (Shackelton et al., 2009; Woolf et al., 1999), as does the
507 observation that guidelines were applied inconsistently based on individual clinician
508 preferences, resource availability, or collective local understandings. Our study also
509 suggests that guidelines can reduce the motivation of HCPs to understand the evidence
510 base underpinning the guidelines, which then limits their abilities to deliver care
511 individualised to the needs and preferences of each woman or to engage in shared decision
512 making practices (Elwyn et al., 2012). Many women in this study indicated their passivity in
513 relation to knowledge seeking, instead indicating that they place trust in their HCPs to
514 actively provide them with appropriate options and explain information of importance; this
515 meant that HCPs were generally not challenged on their lack of detailed knowledge.

516 Widespread acceptance of IOL by women when offered may also lead to assumptions that
517 alternatives are risky or even subversive choices; these assumptions appear to have
518 translated into embedded or '*collective*' knowledge (Greenhalgh, 2010) which has the
519 potential to limit the extent to which HCPs and women are prepared to seek evidence to
520 support these embedded understandings or to challenge them. A belief that IOL is a routine
521 part of care, rather than a choice, encourages uniform acceptance and invokes discourses of
522 risk and blame when alternative options are considered or chosen by either HCPs or women
523 (Woolf et al., 1999). Furthermore, it may put pressure upon women to adhere to usual care
524 to avoid being labelled as difficult or reckless (MacKenzie Bryers and van Teijlingen, 2010).

525 We propose that the longstanding routinised and guideline driven offering of IOL by HCPs,
526 alongside almost uniform and unquestioned acceptance of the procedure by women, has
527 created a cycle of '*non-decision*'. Alternatives to IOL are not considered, thereby limiting
528 motivations on the part of HCPs and women to seek evidence to support decision-making
529 (because it is perceived that no decision is being made). Organisational pathways that
530 (deliberately or inadvertently) discourage women from accessing evidence-based
531 discussions or considering alternative choices, support this cycle further. This cycle
532 represents the easiest route for both women and HCPs to take and there is little incentive for
533 either to deviate from it (Figure 20).

534 **Figure 20. Cycle of non-decision-making**



535

536 The implications of this cycle, and the context within which it operates are significant for
537 anyone aiming to develop strategies to increase the use of high quality research evidence in
538 discussions and decisions about IOL (and perhaps around maternity care more generally).
539 Such strategies might aim to disrupt the status quo at any point in the cycle (for example by
540 aiming to make choices around IOL more explicit) but they might also consider the
541 implications of this for other parts of the cycle. For example, it could be hypothesised that
542 awareness of choice may lead to increased questioning by women, which may lead to an
543 increase in HCPs' motivation to understand the evidence base in order to engage in
544 discussions; it would then be important to think of ways to make that evidence available to
545 HCPs in an accessible and understandable way.

546 **Strengths and weaknesses**

547 Whilst this study was conducted in 2013/14, subsequent research strengthens the notion
548 that women continue to perceive shortcomings in the amount of information and choice they
549 are given about IOL (Begley et al., 2019; Coates et al., 2020; Jay et al., 2018; Lou et al.,
550 2019). National IOL guidelines have not changed since the study was conducted, and an
551 evidence update published by NICE in 2013 (The National Institute for Health and Care
552 Excellence, 2013) reported no changes to guidance around information and decision
553 making. Guidelines for care of women with specific circumstances (e.g. diabetes) have
554 contributed to an increase in the number of women being offered IOL (The National Institute

555 for Health and Care Excellence, 2015). We believe, therefore, that the results of this study
556 have continued relevance to an increasing number of women.

557 The key strengths of the study are the focus on how knowledge is understood in discussions
558 and decisions about IOL, the qualitative methodology (allowing an in-depth exploration of the
559 issue), and the inclusion of data from midwives, obstetricians and pregnant women. This
560 approach has offered the opportunity to explore the contexts within which decisions about
561 IOL are made, expanding understandings of the reasons why pregnant women persistently
562 report having limited choice and information about IOL.

563 The study weaknesses include the self-selected nature of the participants; those who chose
564 to take part may have had a particular interest in evidence-based care. The women who
565 participated were also more educated, older and less ethnically diverse than the general
566 population in England and there would be merit in exploring the experiences of women from
567 different backgrounds. Finally, this represents the experiences of individuals from one NHS
568 Trust and it is likely that Trusts with different processes (for example, those that refer women
569 requesting care outwith guidelines to consultant midwives) may have different experiences;
570 this would be interesting to explore in future research.

571 **5. Conclusion**

572 The results of this qualitative study offer a key contribution to our understandings of how
573 decisions about IOL are made by women and HCPs, and the value placed on different forms
574 of knowledge. It has identified some of the complex personal, professional, organisational,
575 societal, and cultural factors that have developed and coalesced to support a culture of '*non*
576 *decision-making*' about IOL. The findings have profound implications for understandings of
577 informed decision-making in maternity care, and for developing strategies to share
578 knowledge with women and support them to make informed choices about their care. This is
579 especially important for IOL, which is currently experienced by almost a third of the birthing
580 population in England. Transforming current patterns of care is likely to require complex
581 and multi-layered approaches that target behavioural and organisational changes, and that
582 engage women and healthcare professionals..

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Woman Participants n(%) Total 16		Healthcare Professional Participants n (%) Total 22	
Parity		Gender	
First child	12 (75)	Female	18 (82)
Educational level		Male	
GCSE or equivalent	1 (6)	Professional Background	
A level or equivalent	3 (19)	Medical (consultant)	5 (23)
Degree or above	12 (75)	Medical (Specialty Trainee)	4 (18)
Had an IOL		Senior midwife (e.g. matron, sister)	6 (27)
Yes*	10 (62)	Midwife (hospital)	2 (9)
Choice about IOL (as reported by participant)		Midwife (community)	5 (22)
Accepted IOL	14		
Declined IOL #	2		
Reason for IOL discussion (as reported by participant)			
IVF	1 (6)		
Multiple pregnancy	1 (6)		
Postdates	8 (50)		
Pre-existing medical problem	2 (12)		
Pregnancy related problem	2 (12)		
Previous obstetric history	1 (6)		
Requested IOL	1 (6)		
Age			
Median (range) Age	33 (27-43)		
Ethnicity			
White, British	14 (88)		
White, other	1 (6)		
Asian, Bangladeshi	1 (6)		

730 * 4 women went into labour spontaneously (of which 2 had previously declined IOL, and 2
731 had accepted IOL and had a date booked); 1 woman had an elective caesarean section; 1
732 woman had an emergency CS prior to labour.

733 # 1 women initially declined IOL but accepted a subsequent offer, 1 woman declined and
734 went into spontaneous labour