*So I’m going to ask you some questions about outpatient induction of labour and take you step by step through the whole sort of process. So can you tell me a little bit about how you greet someone, how you assess their eligibility, you know, what happens right at the start?*

So at the very start, there’s, erm.. a process that I go through as I work in induction quite regularly. So, erm.. just the usual welcome to the induction suite, introduce yourself, do the usual antenatal checks. So I check, erm.. date of birth and you know, their address, go through the notes, make sure they’ve emptied their wee, then you know, do the usual palpation, erm.. almost just a bog-standard antenatal assessment. Then check their notes and check what they’re being induced for. So, for the outpatient inductions, they.. are just post-dates women. So just.. I always check with the woman.. that their understanding of why they’re being induced is the same as ours. ‘Are you here because you’re twelve days over?’ ‘Yeah.’ So, they say they are, so I say, ‘that’s great,’ then I say, ‘have you read the induction of labour leaflet?’ All the while, going through their notes.

*Yeah*.

And if they say they have and I can see that they’re eligible, so they’re completely low-risk, you know, no admissions to the hospital in their pregnancy, so they’ve had a good pregnancy, they’ve been straightforward etcetera. And if they say yes, then.. I will say if they’re aware that they can have [the pessary] as an outpatient, and, erm.. most of the time, they come knowing that they can, so when we first launched it there was actually a separate appointment time for those women so they came in with a clear understanding but now it’s all merged together, I will double-check that they’re eligible. And then you do the CTG, you know, so long as the CTG’s normal, you check their notes and you know, they’re still low risk, then I will explain to them they can have [the pessary] as an outpatient, as in.. they can go home with it, twenty-four hours, you know, dependent on their Bishop Score etc. And they will either agree to it or disagree, erm.. yeah and that’s about it really I guess.

*Yeah. So how do you know if they’re eligible?*

Erm.. they have to be completely low-risk. They have to have not had any admissions to hospital, and also once you’ve done the vaginal examination, that their Bishop Score needs to be.. I think it’s below four.. below four. So all of those things, so to be honest.. so the first bit of them being eligible is are they low-risk, are they post-dates, is it their first baby, do they.. there’s a.. there’s like a checklist, erm.. erm.. so a criteria.. some sort of criteria checklist, do they live, erm.. is their BMI normal, do they live within thirty minutes of the hospital, a few other things that I can’t remember off the top of my head. They fit all of that. I’ve spoken to them what [the pessary] does etc. and they’re happy to go ahead with it and you examine them. Is their cervix actually, you know, unfavourable enough to warrant going home with.. [the pessary].

*So you might get to the point where you’ve done the assessment and the cervix is favourable and it’s like ‘oh’.*

Or.. the CTG’s not normal. So the CTG has to be normal as well, as in, like, completely normal. Not oh they’ve had one decel but it’s fine but for the other thirty minutes.. no. It has to be completely normal, erm.. So yeah, they have to fulfil all those steps first before we can send them home.. or before we’d be happy to send them home with a [pessary].

*Yeah, sure, that’s fair enough. So the women who actually turn up, do you think there’s many from the start who are eligible?*

No. No.

*Why’s that?*

The criteria is too rigid, it’s too tight. Erm.. there’s not many women who are going to fall into that category out there today. Our population of high-risk women is just, surpasses all of that. So no, they just don’t. Erm..

*When you say it’s too rigid what do you think could be changed?*

I guess offering it to more than just women who are post-dates, erm.. you know so maybe the women.. I don’t know.. who are being induced for social reasons potentially. Erm.. er.. maybe multips. Bit hard with multips to be honest as very rarely is their Bishop scores below.. not that often, are they below four. But, erm.. VBACs potentially I guess.. that’s a bit of a tricky one. Erm.. I don’t know, it’s really hard. I think in the beginning I would’ve said a lot more women, but actually, as we’ve been using [the pessary] more, we’ve had incidences where I think actually maybe it was a good thing that it was.

*They were inpatients?*

Yeah, or.. the criteria’s so rigid. Not always had the best outcomes with them.

*Right OK. So, there’s a small group of women who are eligible. You said about antenatal admissions, what sort of things do you mean?*

So, say they’ve been into the Day Unit. So say they’re post-dates, first baby but post-dates, but they’ve been into the Day Unit two or three times with reduced fetal movements. Or they’ve been into the Day Unit with query SROM, query PET or something like that, then usually they’re not eligible. They need to be completely low-risk.

*So they’ve had admissions to the Day Unit, reduced movements. If they’d had a scan that was normal, would that still be a bit of a worry for you?*

It would and if they were still quite keen to go home with it, then I would run it by the Registrar, the senior Registrar at that actually, but it’s quite a decision to send someone home with a drug that you can’t monitor and then you then rely on the woman who is her first baby, this isn’t her second or third baby it’s her first baby, to recognise when things might not be quite right, which isn’t always easy when a woman’s never experienced contractions before. She won’t necessarily always know what’s normal, or what she should be looking out for. Does that make sense?

*Yeah. Yeah, that does make sense. So in terms of assessing the cervix, what are you looking for… in terms of it being the Bishop score low enough to give [the pessary]. What makes you decide to give [the pessary] versus say giving Prostin?*

So if I think.. so if the cervix is, erm.. rigid, firm, I should say firm, not rigid. So if the cervix is firm, closed, posterior, head is high, really unfavourable, then I think ok they’ll benefit from, erm.. [the pessary]. But if the cervix is, say, a centimetre, or what some people deem as one to two, which I don’t believe there really is a one to two. You’re either one or two. But I know what they mean when they say one to two. One and a little bit.. it’s beginning to soften, posterior, you could get, you know, you could probably do an ARM if you were desperate, then I wouldn’t. We’re talking, you know, sometimes you can have a one centimetre cervix but it’s super tight and long, got lots of length, posterior, then that would.. I’d still give a [pessary] over a prostin. If I think in six hours’ time I will be able to ARM this cervix but it just.. just needs a little bit of softening and some contractions, then I will give them a prostin. But if I think oh, this is going to need a bit more… and ↑that.. just comes with experience. If I think this is going to need a bit more than two prostins, you know, or more than one prostin then I think [pessary]. So that’s.. that’s where the Bishop score is a bit difficult sometimes because it doesn’t necessarily fit every cervix if that makes sense.

*Yeah, it’s quite hard to.. so it takes experience.*

It takes experience and the.. the cervixes that I probably would’ve ARM-ed four years ago when I started the role, I wouldn’t do now.

*Oh OK.*

I would give them a prostin. You know, those heroic.. I used to have this belief that well if you can, you know, if you can get a finger in or you can get two fingers in then you should ARM. And that’s actually not..

*It’s not doing them any favours.*

Absolutely not. I find they do far better by having a prostin, erm.. than just having a straight ARM and there’s still length and it’s still posterior. You know, you can easily bring their cervix forward sometimes but it will just go back and that doesn’t necessarily always mean that’s a good.. but you know, if that makes sense, a good reason to then break some waters because you can. Just because you can do something, doesn’t necessarily mean you should.

*Yeah. So there’s a lot of assessment going on during that vaginal examination, isn’t there? A lot of decision-making. So, you know, the woman’s waiting to hear if she’s eligible to hear if she’s eligible to go home I suppose isn’t she. So how does that go?*

Well essentially, I suppose in total, so long as there’s not too many disruptions it’s about an hour and a bit, an hour and a half. Erm.. but then I say to them, ‘right, you know, the induction process itself is quite long anyway. This isn’t, you know..’ I kind of set them up in the beginning before I’ve done the examination that everything that we do from.. in terms of facilitating the induction.. it pretty much depends on their cervix. Once you’ve assessed them, risk assessed, then based on what their cervix is. Because they might come in with the mind-set that they’re going to go home with the [pessary] but they’re two or three centimetres dilated. They’re not suitable to go home. You know, they just need to have their waters broken.

*Presumably.. how do they react to that news? You’re not going home, but..*

Oh, well, very recently, erm.. if they come in.. the thing is I think with a woman if they come in with an expectation and then it’s not fulfilled, like anything in life, then there will be disappointment. So very recently I had someone, erm.. come in with the expectation that she was going to have [the pessary] but then, ↑erm.. what was she? I think she was already ↑two centimetres? I’ve forgotten the lady’s name now. I think she was already two centimetres erm… not a lot of length. I think she might have been only one, one and a half centimetres, average consistency. So I think I said to her that she wasn’t really suitable. So she’d come in with the thought.. as in, she hadn’t brought, you know, brought her bags into the induction suite or anything. She was like ‘well I’m here to have my [pessary] and go home.’

*Oh gosh.*

So she hadn’t been properly counselled about the induction process prior which then leaves it up to you on the day which of course then causes disappointment. So, erm.. she was disappointed.

*Oh right.*

Erm.. and I believe, if I can remember rightly.. because I’ve induced a lot of women in the last few days.. that if I can remember correctly I think.. we gave her a membrane sweep.. She had a membrane sweep, I’m sure if I can remember correctly, she had a membrane sweep because she really didn’t want to stay in… and I think she was term plus twelve but was happy to delay it to term plus thirteen. And I believe she had a membrane sweep and when I came back in.. I think it was two days later.. it wasn’t just last weekend, it was the weekend before. When I came back, I’d seen that she’d come in in the early hours of the morning and had a normal vaginal delivery.

*Oh wow, that’s cool.*

So yes.. But she was unhappy because we weren’t meeting her expectations, because her expectations were I’m going to come in, have my [pessary] and then go home, and come back in twenty-four hours, rather than giving her all the different possible scenarios, she just had one fixed vision.. mindset.

*Isn’t that funny, because my assumption would be you tell them, ‘oh, great news, your cervix is favourable.’*

Yeah, that’s what I thought. I was quite surprised she was upset but having.. I think, like in anything, you have an expectation and then it’s not met, for some people, even if it’s.. you know the outcomes are going to be better or whatever you’re expecting is actually better, they’re so rigid or so, you know.. they’re so.. you know, I think for a lot of women, when they get their heads round induction, they expect it to go a certain way, and.. and not necessarily always aware of all the different eventualities, erm.. not always but..

*Do you ever have to work hard to sell it to them? The idea of going home? Or do they all come in, you know the ones who are eligible, come in with the expectation that they may go home and they’re quite happy with that?*

Probably only on one or two occasions I’ve had to sell it, and actually, when you do end up being like you have to sell it, they’re never quite.. keen. Erm.. I remember having one woman who could’ve gone home but had opted to stay. She said, ‘oh, could I just stay, I just feel safer staying.’ I think only one woman. I think the others were all quite happy to go home but I think they had already known about it before, as opposed to coming in on the day and being told about it because again, that didn’t meet their expectations. They were coming in to have the baby, not be sent home, does that make sense?

*Yeah, so that bunch probably don’t want to go home do they?*

No.

*Because they weren’t expecting it.*

Exactly.

*Yeah. There’s not a huge number who decline it from what I’ve seen. At least in the narrative, let’s say.*

No. I don’t think people ever really decline it and I think that’s because they’ve pretty much put their trust in you and they trust that you will do for them what you feel is best as opposed to them thinking oh you know, well I think this is best, you know, from.. from an induction perspective. Erm.. that’s never really talked about. Everyone talks about the birth experience and the labour experience and people don’t really have induction in their labour plan.

*No. And there’s so many that have induction!*

Yeah. When you see.. When you see birth plans, induction is never part of it, is it, ever really? So people don’t plan for it, so I guess when it comes to it, they very much put their trust in you because I think, we, the majority of the time are recommending it, they think ‘well if you’re recommending it, you tell me what’s best.’ Does that make sense?

*Yeah it does.*

As opposed to.. well we all know we have to go through labour so we can plan for that, but we don’t know if we’re gonna.. it’s like you can’t plan.. like almost.. for when you’re going to have an emergency section because most people don’t really think like that. ‘Oh, I’m going to end up in an emergency section, so if I do can I have x, y, z.’

*Yeah*.

You know, people don’t plan ‘oh, well I’m going to be induced’ when they’re having their birth talk at 36 weeks so they think ‘oh, well I’m going to be induced.’ And I might be inducing you, ‘so if I am, I’ll have x, y and z.’ So they.. people don’t really.. that’s why I think people, we don’t get people rejecting it or saying no because I think they just say, ‘oh, you know, whatever you think’s best.’

*Is it.. you’re very experienced working in induction. Is it.. does it require much training to put in [The pessary]? Is it tricky?*

Well.. the training, when it was launched [laughter].. when it was launched, the training we had was about an hour and that was it really. And yes, it is tricky. It’s trickier, it’s definitely.. it takes more skill than just putting a prostin in. Erm.. just I think because of the way, the.. the shape of it and the way it is. Erm.. so very recently I couldn’t put one.. I couldn’t get one in a lady.

*Why was that?*

Erm.. she found the VE very uncomfortable. Erm.. the cervix was incredibly posterior, and every time I got past a certain point in her.. in the.. in the vagina, she just clamped up. And I said to her it was really important that I could get it right behind the cervix and it actually stay there because twenty-four hours is a long time for it to be just sat in the vagina.

*Not doing anything.*

Not doing anything. And you.. once you’ve lost that twenty-four hours you can’t get it back. So.. for me, if I don’t feel confident that I can get it one hundred per cent.. and this was with gas and air, hibitane, lots of gel… She just.. I couldn’t.. I even struggled to get a prostin in to be honest. Almost like a bit of, erm.. borderline vaginismus. You know, just spasming, clamping down, anxious. Erm.. so for things like that I will just abandon it, I’m not going to put it in. I know midwives who have done that, although I could barely get it in, but I.. just put it in and hope for the best. Well, unsurp.. unsurprisingly, twenty-four hours later those women have done nothing. So I.. you know, I’ve made a point of saying if you can’t get it in, do not do it because it’s a waste of twenty-four hours that you just can’t back when it comes to induction. It’s not going to do anything if it’s just sat in the.. at the introitus, it’s not working where it should be.

*Do you think that’s a factor, when, you know, say it’s not you [or your colleague] doing inductions?*

One hundred per cent. One hundred per cent.

*So people aren’t familiar with the product.*

No. No. If they’re not.. confident at putting it in, erm.. or making sure it’s in the right place.. then yeah.. it will just..

*They’re not going to offer it. They’ll just go for..*

What’s easiest. Absolutely. Absolutely.

*So, when you put the [pessary] in, you’re doing your CTG, then what happens next?*

Erm.. so they’re on the CTG for an hour and as long as you’re happy with that, then I will tend to give them all the information as in, erm.. what to look out for when they go home, double check that they are going.. that they are just going home, that they’re not going to go for a little wander into the [local national park] or something. Erm.. so you know, I say to them, you know, ‘if it falls out, this is what you need to do. If you start contracting, strongly, frequently, regularly, this is what you need to do. If you start bleeding, if your waters go.. erm.. if you have reduced fetal movements erm.. if you become unwell or have any side effects, erm… then let us know.’ Well they’re.. they’re meant to ring [telephone triage] first, and.. for any of those things.. and then [telephone triage] will contact us and they’ll come back in.

*Yeah*.

Erm.. and once they’re happy with all that information, then I will discharge them.

*Off they go.*

Off they go home.

*Yeah. So for the women who don’t have any of those concerns, do [telephone triage] check in with them, or what happens?*

Yeap. [Telephone triage]’s role is to call them, usually in the evening. So if they came in in the morning and had their [pessary], and then went home, then [telephone triage] would call them in the evening, sort of like an evening call, like eight, nine o’clock. Kind of before.. bed, and then theoretically they would then just come back at the time that you’ve given them to come back when the [pessary].. So you.. so if the [pessary] went in at say eleven, you’d get them back in at ten, so just to monitor them first. Yeah, monitor baby first, take the [pessary] out and examine, see what change there is basically.

*Yeah. So what’s your, you know.. in your experience, do you see many coming back in the next day. I appreciate you might not be on induction the next day.*

Not a lot. Yeah. Not always on induction the next day to be honest but, erm.. I think the majority of the time you find that if it’s going to work, they’re usually back within the night or that evening. Erm.. if not they come back the next day, they come back twenty-four hours and there’s not a lot of change.

*Yeah. Fair enough. Ok. Erm.. oh yes. The rest of your workload, how does it impact on your workload, outpatient induction?*

Well, if.. they go.. if they’re all straightforward and they all go home then it makes my workload much lighter. Erm.. I think there was only one or two situations where I think they had.. the [pessary] but, erm.. I hadn’t sent her home straight away and I can’t remember why, it was a couple of years ago. I hadn’t sent her home straight away.. I think she’d just gone off to have a walk, have some lunch and when she came back she was contracting really strongly, really regularly and when I put her back on the trace, the CTG, it was suspicious. So then she ended up staying quite a while.. you know, she couldn’t cope with the pain. Oh that was it.. so quite quickly after I put the [pessary] in she was quite uncomfortable, so within the hour’s monitoring afterwards she was saying that she was getting a lot of period pains and a lot of back pain and I thought well this is a bit quick, this is a bit unusual. Erm.. so I said well rather than going home, go off.. go for a little walk for a couple of hours and we’ll see what happens. She went off and had some lunch and came back and was quite distressed. Erm.. I think I tried to sort of.. prolong it as long as I could. Well you know, try the birthing ball, let’s get you some paracetamol. And at that point I thought if she’s this uncomfortable, she’s definitely not suitable to go home, so maybe I might repeat the trace. And when I did repeat the trace it was.. it had become quite suspicious. Erm.. I think we removed the [pessary] at like four or six o’clock in the evening, she was already two centimetres by that point. Erm.. and I think they had given her terbutaline but the trace progressively got worse and she ended up with a cat one section. So, erm.. I think if it’s going to go bad, it tends to go bad fairly quickly. Usually, I think. So, erm.. that.. that rang alarm bells, the fact that within the hour of monitoring she was, you know, already that uncomfortable.

*Yeah. Does that happen for prostin?*

It can do. It can do. It doesn’t seem like it happens as much with the prostin. But it can do. It doesn’t feel like it happens as often.

*Yeah. OK. What do you think needs to change, to, you know, make it more popular do you think? Or do you think it’s just because there’s not many women who are eligible?*

I think it’s not many women eligible. I think if you really wanted to.. test how effective it is then we need to give it to more women. Erm.. you could argue probably give it to women with a higher Bishop score so say, if they are eligible for prostin they can be eligible for [the pessary]. I think there’s some belief that with the [pessary] you can’t control absorption. So whilst it’s only meant to release nought point three milligrams an hour, they could be absorbing the whole ten milligrams in one bit, in one hit, which is why they can hyperstimulate, or why we’ve had so many hyperstimulate. Erm.. I suppose that’s the only thing that I can think of that would make a difference, so you’d get a bigger group of women to truly understand how it works. Our group of women that we have is just so small. It’s just not..

*OK. Do you think there’s anything else you want to tell me, we’ve gone over quite a lot of the things. Just trying to think if there’s anything else that’s important factor about why there’s not many women having it.*

I think the biggest factor is just the.. the criteria. It’s just too small. That it’s too.. not many women in today’s day and age are going to fit that criteria, erm.. yeah, we just don’t have that many post-dates, low-risk. And whilst I think.. I think I looked at, erm.. reason for induction being, I think the biggest.. one of the biggest was post-dates, they’re usually, it’s very rare in this day and age for them to come in without having had any issues in their pregnancy. Erm.. I think if you just had the criteria as post-dates and then.. even if they’ve been in for different various things in their pregnancy, that they could still have it if it was OK-ed by a doctor, I think that would make it easier.

*So perhaps some sort of.. around reduced movements or that says OK they’ve had reduced movements but the scan was normal.*

Yeah. Or it was three weeks ago, or.. you know, what sort of reduced movements is it? Because the thing is they’ll come in, it’s documented.. it’s down on paper as reduced movements. Actually by the time they’ve come in, while they’re in the waiting room the baby’s moving again. So was it reduced movements or were they just anxious?

*Tricky*.

So you’ve got that as well. Are they just feeling a bit anxious, they’ve had a busy day. Sometimes, you can go.. go over all of this on the phone but they just want the reassurance of hearing that heartbeat. So is that really reduced movements or is that just anxiety we’re treating? So you know, when you have all this reduced movements, well is it really? I suppose you could get the doctor. But then that probably takes time I guess, and trying to get that.. and trying to unpick all those bits when the woman’s in.. with a doctor who hasn’t got a lot of time. Maybe, just.. I don’t know.

*It can be quicker just to get on with prostin. Inpatient management or whatever.*

Yeah. That’s what I say. That’s how I see it.

*OK. That’s been really good. Thank you very much.*