*Fine, so can you tell me about your experience talking about outpatient induction of labour with women?*

Yeap, so I do it primarily in my clinic.

*Mmm..*

Erm.. So it would be mainly the primips because that’s really all we offer, erm and just trying to explain to them that we are trying to keep as many hormones going as possible to work with the induction, erm.. and just trying to explain how the induction works with being at home and how that’s a positive thing and actually being in hospital you don’t need to stay here, erm.. and just try and get.. draw back a bit of that normality for them, erm.. so I.. it tends to be just the women who are overdue I tend to talk about it at my term plus seven appointments, erm.. not to give them too much information when they have just got over their due date, erm.. yeah it tends to be the low risk primips that we talk to about it.

*Fine. So tell me a bit more about what you mean by working with their hormones?*

So because I am a, erm.. low risk midwife that tends to be what we concentrate most on so trying to explain to women that if they go home – which is generally where your labour starts, erm.. that actually, by being at home once they’ve had an induction, you’re more likely to get the better hormones to keep it going to be able to then carry that induction forward and have more of a natural start to your labour and therefore your birth. Erm.. I talk a lot about how, erm.. the light affects the oxytocin, erm.. and how if they keep their lights down low that then they’ll be in a more positive environment to.. to get their oxytocin going. Hospitals generally create adrenaline. A lot of the women that I look after, because they are middle class and they’re healthy, they’ve not actually been in hospital before. So, for a lot of them the idea of being in hospital is more stressful, erm.. because of the… because of the induction, because that’s really the only time they’ve come across a hospital, erm.. so just any ways to keep them low risk as much as much as possible I guess. Erm.. and trying to explain that that’s where their babies were made so that’s where their babies are more likely to be born. Erm.. and talking about Michel Odent and the.. the positive hormones that he talks about and things like that, erm and how [inaudible] that our birth centres are made to try and be a home away from home, erm.. so that when they hopefully come back in with their outpatient induction they can go to [the alongside birth centre] and then be able to keep that home away from home and therefore keep the hormones.

*Mmmhmm. So what kind of response do you get from women?*

Erm.. a lot of women thinks.. think it will be a quicker experience if they’re induced, erm.. and it’s just trying to explain to them that we’re trying to start something that your body hasn’t and actually we are slightly going against Mother Nature but we know you can’t stay pregnant forever, erm.. and try and explain the safety side of it. Erm.. a lot of women are up for being induced on their term plus twelve, erm.. again because of the dynamics of the women that I look after, they’re very intelligent women and they want to know the nitty gritty, the guidelines, they want to know the research and I will bring up the guideline and go through that with them, erm.. most women I think are happy that they don’t have to stay in hospital and that we’re almost giving everything we can a go to get them into labour without having to have them on labour ward, erm.. which a lot of them don’t want, erm.. don’t.. don’t want to do but I.. it’s really to explain to women that actually they are not eligible for outpatient induction, erm.. and I think just setting the expectations right when you’re in the community then means they’re not disappointed when they come in and then the poor induction midwife who is already busy enough has to then deal with their disappointment if they’ve said, ‘Oh ok actually no, we’re going to break your waters, we’re going to start things now’ erm.. so just making sure that every expectation is try.. is covered.

*So, er.. you mentioned safety, you know, what do you feel is important for women to know?*

What in terms of outpatient induction?

*Yeah*

Erm.. that it’s the right path of induction, because some women that’s what they want even if even if their body is trying to tell us something else. Erm.. the baby’s movements, try and make it really clear that actually… just clocking every hour has my baby moved, do I feel well, does this feel normal to me, can mean the difference between a low risk birth and a.. and a high risk birth and just try and encourage partners… to remind parents as well about baby’s movements, erm.. and just making sure that they know that they can call at any point, and the.. the telephones are twenty-four seven, and [the telephone triage] erm.. and just about looking after themselves at home because we are introducing a drug into their system, erm.. and it’s just making sure that they know that it’s.. it’s not.. it’s something to be.. be.. something to.. I’m looking for a word.. it is to take seriously but also at the same time we want them to be relaxed so it’s really, really difficult, erm.. but just giving them ideas for what to look out for, but I don’t think that’s any different from what we’d say normally in the pregnancy, you know, watch baby’s movements, make sure if your waters break let us know, that kind of thing. So yeah.

*You talked about expectation setting.*

Yeah

*So tell me a bit more situations you might have found difficult in that situation*.

Yeah. Erm.. I was present at a [birth debrief session] where the.. I think the woman had gone in with the expectation of erm.. of one thing with her induction but actually she was eligible for another thing erm.. and that’s what had played on her mind the most is that she’d gone in expecting this timeline of.. of events that was going to happen and then all of a sudden, it was completely different, erm.. and that really resonated to make sure because I’m almost at the frontline of women’s information, so I need to make sure that they have an open expectation as to what could happen. Erm.. Sometimes again women expect that their.. that their induction will mean that they will have a baby quicker and explaining to them actually it could be the next day. Explaining to the partners that they need to eat and drink and brush their teeth and all the normal things, erm.. and also the expectation that we’re, we’re the NHS, we’re a busy service and sometimes inductions don’t happen, erm.. and trying to cover that in a half an hour appointment is really, really challenging, erm.. but I would hate to think that one of my women would come to an induction and not be fully informed, erm.. because I think information is power so the more.. the more information we can give them, the more empowered they are to then make the decision that suits them best.

*That’s really good. So what do you think, erm.. you know, from the women you’ve spoken to, what, what are their main concerns about it?*

What about outpatient induction? Erm I think for.. for a woman I’ve just met is would be that it doesn’t work and that they’re then waiting a whole twenty-four hours, erm.. to then come in and potentially start the whole process again. Erm.. I think that would probably be the main concern that that the women have had that it won’t work. Erm.. but actually a lot of women are more positive about it than.. than negative about it. They.. they.. they want that form of induction more than they want the.. the form of the induction that we offer.. the prostin, the breaking the waters and the straight onto a drip. Erm.. I think it’s a very big jump, so they worry that they’re gonna go from a you could still come to [the alongside birth centre] and you could still go home’, to a you’re on labour ward all of a sudden, you’ve got a drip all of a sudden, you’re on.. on a CTG and there’s almost no middle ground erm.. so I think they worry about where they’re gonna sit and they.. they don’t know until they go and they start their induction process, erm.. so it’s the unknown potentially but that’s, erm.. that’s a part of being pregnant I think.

*So you’ve kind of prepared them for…*

For as many eventualities as possible yeah. But I think they all have their, you know, for them their idealistic view is that the [pessary] will make them go into labour they’ll come to [the alongside birth centre], it’ll be taken out, they’ll continue contracting, they’ll have a water birth and everything will be fine, erm.. and I think a lot of people think ‘What if?’. Erm.. and just kind of what path they could end up going down. Erm.. but I think it’s that twenty-four hour wait if nothing happens and starting the whole thing again.

*Do you have any concerns about outpatient induction?*

No, I love it. I wish we did it more. I.. I wish.. yeah, I wish we were able to facilitate.. erm.. I think women at the moment are getting a little bit disappointed that they can’t go to the [freestanding birth centre] because only.. because my.. my group of women [that locality] women so when you.. you’re all of a sudden, they’re going for an induction of labour and they’re changing their place of where they wanted to give birth so that’s quite a lot to put on them. Erm.. But yeah, no otherwise they’re.. they’re really excited by the fact that they get to go home. They love it.

*That’s really good. Yeah. And what about errm distance from the hospital? How do you talk about that?*

Erm.. in terms of what? In terms of like..

*In terms of getting back to hospital in time is that a concern for women at all?*

Erm.. it tends not to be because they’re first time mums erm.. but I do explain to them that if, you know, you’re ever concerned and, you know, you’re going past the [freestanding birth centre] it’s best that if actually, you think it is an emergency and your baby is coming, it’s best to stop where a midwife is and we’ll call an ambulance to you, we can’t get an ambulance to chase you, erm.. but just really, reassuring them that that’s very rare to happen, erm.. and that when they call 999 the midwives who are on [the telephone triage] are right there and that you’ll always have a team with you. Erm.. personally, I haven’t known any women from [the pessary] have a BBA [laughter]. But, you know, at least then we would know it was working. But yeah.

*OK and, erm.. have you had women who you thought would be really great candidates and then had any surprises. Perhaps it didn’t happen on the day or something like that.*

Erm.. I think the only woman I’ve had… was hoping for [the pessary] if she could go home and then when she went in she was ARMable. Erm.. and I think that was.. that was the only.. the only thing, you know, all of a sudden there was a complete change because they wanted to break her waters and start things. Erm.. but that was probably the only one, yeah.

*And in your.. in the group of midwives you sort of.. you know, do you think there are midwives who are... You seem quite enthusiastic about it from what you’ve described. Are there midwives with other views do you think?*

Erm… I don’t know. I’ve got to admit it’s not something that’s a debatable subject I think, erm.. I think when the guideline changed that they were offering it to multips everyone found that a really positive thing. Erm.. I think, I don’t know. I did discuss it with a labour ward midwife about why multips couldn’t go home, erm.. and we had a difference of opinion, erm.. but within my group of midwives in terms of low risk midwives it’s not really been a conversation that’s.. that’s kind of come up.. that some people saying ‘why don’t we do this, and why don’t we do that?’ Before the [pessary], there was a lot of preceptors that would come and say I don’t know why you’re not using it, erm.. and I even saw it at a conference and, erm.. said to our.. one of our labour ward coordinators ‘Why don’t we use it?’ And at the time I was told it was an expense thing, so the fact that it’s now worked its way into our system, I think it’s great because we’ve had so many people from other hospitals who have now come and said it’s so good that you’re using it, erm.. so I think it’s been met with positivity. I haven’t seen any negativity about it really.

*And for that woman you were talking about who ended up having an ARM and staying in. For women like that, what do you think their inpatient experience is like if you had to compare outpatient with inpatient induction.*

Erm… that’s a very good question. I think..

*You know as a midwife, from your perspective.*

Erm.. it’s challenging because if they were coming in for [the pessary], they’re low risk primips so they could’ve had anywhere from a homebirth to [the alongside birth centre, freestanding birth centre] and then I think it’s such a shock to the system to go to labour ward, erm.. and have very little time to give their body to work with the things that we’ve given them. It’s.. it’s as soon as your waters are broken you’re.. you’re on the drip, you’re on the CTG, erm.. instead of.. instead of almost giving them time and making them feel like they’ve given it the best shot that they could, erm.. it’s a very.. it’s not a rushed process, but it’s a very regimented process, and from working on labour ward with women with inductions, erm.. it’s not met with pos.. positivity when they want to change how their path of induction goes. Erm.. it’s saying ‘well we’ve started now, we’ve got to continue’ or the horrible phrase of ‘let’s get on with her’. I hate that phrase, erm.. because it’s trying to empower women that actually, it’s your body, you can have the drip when you want to have the drip. Erm.. a lady I looked after on Friday, she was contracting on her own.. when we did her waters, erm.. and by the time we.. we got the drip and I’d had a break, it had been three hours, erm.. and she wanted me to re-examine her and she… she’d gone on her own. She was doing fine.. so you then.. you put that to your colleagues and they go ‘No, still put it up, still put it up, she’s being induced, put it up’, and you struggle to see their reasoning. Erm.. and I think it’s a different culture if you’re used to the inductions constantly, of.. of just kind of.. of that getting on with them, but actually as a midwife from the [community], I want to give women more time, erm.. which is difficult, because at the end of the day, we’re running out of time because we know that they’re at more at risk of stillbirth and things like that. Erm.. but if they’re in a safe environment like labour ward is, why can’t we.. encourage their bodies to.. to work with us instead of working against their bodies.

*Why do you think we’re in such a rush then?*

Conveyor belt ↑system? A ‘We’ve started now, let’s continue, let’s.. let’s get her as far as we can get her’. Erm.. if.. if it’s busy, erm.. then I think they’re thinking about staffing, erm.. you know, will we have someone to look after her on a night shift if we’re not getting anywhere with the induction. Erm.. I don’t.. I guess it’s just personal opinion and what doctors are on and what midwives are on and how they work together as a team. Erm.. but when you do down as [a community] midwife you can sometimes feel like you’re fighting, just the way it’s done but I think that would be the same if.. if.. if someone came up and worked with us, it would just be a different way of working and it’s just adapting to that. Erm.. but it’s trying to empower women at the same time whilst trying to do your job, erm.. and letting them know they’re allowed to say no and that they’re allowed to question why are we doing this, why are we doing this now, can this wait? And that if they’re questioning it and changing what they want to do, it’s trying to advocate for them against.. people that.. who would think that their opinion is silly, because they think that they should just carry on with the induction. Erm.. so it’s trying to advocate, even when you know that it’s going against our guideline.

*Great. So you talked about place of birth being really important and you know… women’s choices during induction getting a bit squeezed. Can you tell me a bit more about, you know, how your women that you’ve looked after in community, your own women, how they’ve responded to changes in place of birth?*

Erm.. you just see it on their face as soon as you say this option is now off the table. Erm.. and like I’ve said before, a lot of women are really educated, and they go ‘Yeah but why? If you’re saying [the alongside birth centre and the freestanding birth centre] are the same, then why are you all of a sudden putting that change in place when I’ve got to this induction point?’ Erm.. so first, it’s complete disappointment. Some women go ‘OK, if that’s what you’re telling me, that’s what I’ll do’, and some women will.. will just keep asking ‘why?’ And ‘how can we change that?’ And ‘is there any, erm.. you know, let up on that?’ Again, the lady that I saw who’s for a [pessary] induction at the weekend, she wants a home birth. So, you know, I said to her 'if you’re coming to [the alongside birth centre] there’s no reason why you can’t have a home birth because we wouldn’t treat you any differently,' erm.. but she said, ‘Well, why can’t I go to [the freestanding birth centre]?’ And that was a really challenging part. Erm.. so I think you have to know all your reasoning and your guidelines and be willing to show them the guidelines as well. I often will bring up a guideline, erm.. a lot of my women are doctors and nurses so when I’m looking at the guidelines with them they’ll go ‘Well that’s weak evidence and that’s weak evidence’, and I go ‘I know, but this is the evidence we’ve got, we’ll use what we’ve got’. Erm.. but mainly it’s just disappointment – they feel like they’ve had something taken away from them.

*And what about groups of women who don’t currently have OPIOL, you know, is there.. what kind of appetite is there for outpatient induction?*

Erm…

*Do you get asked about it?*

I don’t.. I mean.. a very small majority of my women actually go to induction. Most of them will deliver by term plus twelve, erm.. the higher risk women, they’ve already had conversations with either [the consultant midwife] or consultants or just other team members about expecting induction towards the end of their pregnancy so I think they’ve had longer to process it. Erm.. so they.. they tend to not ask more questions in terms of ‘is this a choice, is this something we could do?’ I haven’t ever been asked ‘Can you come to my house and do the induction’, which I don’t.. don’t think is a bad idea but then you’ve got the monitoring issues and things like that so it’s logistics, erm.. but no, it tends.. I don’t think it tends to be an idea. Because women talk to each other when they’re pregnant to other women if it’s something.. if every other trust was doing it and we weren’t doing it, I think I would hear more women asking questions. Erm.. but because so many of the trusts are similar where we are, I don’t tend to get asked the questions of why don’t you do this here and they do that there. Erm.. so yeah.

*That’s good. Erm… is there anything else about outpatient induction you want to tell me about because we’ve talked quite a lot already.*

No. I just think we need to do it for more people. I think it’s just, I don’t know.

*What do you mean, like more groups?*

Yeah, more groups, yeah. And it’s just.. it’s just when you go down to the bare science, it’s just more conducive of a normal labour and a normal birth and just you know, bring down our epidural rate, bring down our caesarean rates and then bring down our infection rates, simply because we have encouraged women to go into labour in their own environments and I think it’s such a small thing that could make such a massive difference, does that make sense? But I think I think it’s still quite a new thing for [the Trust]. Erm… but exciting though.

*Cool thanks! Thank you very much!*