

“I’m ready for you. Why won’t you come, baby?”

**A narrative study of induction of labour for prolonged
pregnancy**

by

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A thesis

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Glossary of Abbreviations

ACTH.....	Adrenocorticotrophin Hormone
ARM.....	Artificial Rupture of Membranes
CRH.....	Corticotrophin Releasing Hormone
DHEA-S.....	Dehydroepiandrosterone Sulphate
DMW.....	Domino Midwife Wellington
EDD.....	Estimated Date of Delivery
FDLMP.....	First Day Last Menstrual Period
FIGO.....	International Federation of Gynaecologists and Obstetricians
GP.....	General Practitioner
HMSO.....	Her Majesty's Stationery Office
IOL.....	Induction Of Labour
IOLPP.....	Induction Of Labour for Prolonged Pregnancy
IPO.....	Independent Practitioners' Organisation
LMC.....	Lead Maternity Carer
LMP.....	Last Menstrual Period
MIDIRS.....	Midwifery Information and Research Service
NICHHDNMFDU.....	National Institute of Child Health and Human Development Network of Maternal-Fetal Medicine Units (United States of America)
NWH.....	National Women's Hospital
NZCOM.....	New Zealand College of Midwives
PP.....	Prolonged Pregnancy

RCT.....	Randomised Controlled Trial
SO.....	Synthetic Oxytocin
TMC.....	Total Midwifery Care
VE.....	Vaginal Examination
WHFAEC.....	Wellington Health Funding Authority Ethics Committee
WHO.....	World Health Organisation
WWH.....	Wellington Women's Hospital

ABSTRACT

The voice of women's experience of prolonged pregnancy and induction of labour is largely absent in the literature. This research relays and reflects upon the stories of four women who were induced because their pregnancies were overdue.

The date a woman's baby is due has assumed huge significance. However our methods for dating a pregnancy remain imprecise. Despite this, a very precise timing is recommended by some practitioners as to when to induce, since increasing length of pregnancy increases level of risk of morbidity or mortality to some babies.

For the women awaiting the onset of labour and their families, the undercurrents, which affect the milieu as the days pass, include powerful dichotomies. For example the best available research makes a clear recommendation to intervene but reinforces the woman's choice of management, suggesting that it is acceptable to choose to wait. Women experience emotional vulnerability due to apprehension both about continuing to wait, and about having the increasing likelihood of an induced labour. This is a decision that comes closer and closer, yet may not be necessary - a tense 'race' of sorts is in progress. Women experience mounting physical and social pressures, and a generalised, escalating frustration. Some of the common assumptions made about what it is like for women are that it is a struggle to accept the concept of the unreliability of the due date, to parry well meaning but unhelpful comments and the associated pressure, and to remain confident and phlegmatic when there is an alternative to waiting. An

increasing number of women go on to be induced. The primary indication cited is 'prolonged pregnancy'.

I have employed a narrative approach, using a feminist process and story telling, to convey the experience of being overdue and being induced, together with commentary informed by the literature and reflection on practice. Here women are speaking to women. The vivid detail and openness of the stories engrave messages to caregivers regarding women's needs for support while waiting, and for more information. The stories repeat messages documented in research carried out 25 years ago. Women require best available information, wish to be included in decision making, and should be encouraged to question their midwives and other caregivers on all aspects of pregnancy and proffered interventions.

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Victoria, Alister, Joseph, Paul and Emily Bridgman - dear friends - who took me in, and kept part of me in the real world, during my two years of study in Wellington. To them my admiration and gratitude always.

Chapter 1 - Introduction

Following the trial of the hapless Minnie Dean in 1895, her young and able lawyer, Alf Hanlon, excused himself from traveling from his home in Dunedin, New Zealand, to the capital Wellington, more than 550 miles distant, to plead her case for appeal (Hood,1994). Mrs. Dean was the notorious, so-called 'baby-farmer' from Southland. She had just been convicted of murdering one of the babies in her care, and was strongly suspected of having killed others for the money she was supposedly paid in advance, by their guardians or birth parents, for looking after them.

Hanlon excused himself because the birth of his first child was imminent. He engaged an alternative barrister. We shall never know whether or not his skill, which had provoked "a great burst of applause from the public gallery" (ibid, p.180) at the conclusion of his arguments in her defense, would have altered the course of events. Minnie Dean's fate was sealed by her status at birth and the times into which she was born. Hanlon's priority was his wife, the labour and the birth. There was a good chance apparently that the baby would come on the same date as his birthday and that of his father, the 1st of August. How confident he must have been of the midwife's or doctor's prediction. How enlightened, some of us will murmur. When time of travel and the reliability of the method then used to estimate the due date are taken into consideration, the decision was vindicated. Baby Hanlon did arrive on the 1st of August, 1895, four days after the hearing of the application for leave to appeal in Wellington.

More than a century later, on the 9th of April, 1999, a competition was held in this country, which would only be possible once in a millennium. Couples were actively

encouraged to win the status of conceiving the first baby born in the world in the new millennium, not to mention the cascade of fortune and dubious, voyeuristic fame that that bestows. Given the individuality of women's menstrual cycles and the imprecision of the methods used to predict the birthday of a baby,¹ this illustrates nicely the misconception the general public have about the accuracy of the method for dating a pregnancy.

Locating myself

The following summary helps position me in the New Zealand maternity care environment of the late 20th Century, which is the context of the study I present here. Not long after I qualified as a midwife in 1982, Joan Donley, a domiciliary midwife and researcher in Auckland, wrote "Save the Midwife" (Donley, 1986). An activist consumer organisation of the same name was formed. The combined efforts of midwives and women resulted in the formation of the New Zealand College of Midwives, the Nurses' Amendment Act of 1990, and the accrediting of direct entry midwifery courses. These events are superlatively documented elsewhere (e.g. McLauchlan, 1997; Guilliland & Pairman, 1995; Guilliland, 1998). Besides Donley's book, among other influences for me during this time was "*The "Know Your Midwife" Report*" published in 1988 by Caroline Flint and Polly Poulangeris. This provided strong evidence that continuity of care improved outcomes and satisfaction for women, and this could be organised within a hospital setting. Another influence was *Maternity in Dispute* written by Philippa Mein Smith in 1986. By researching the history of maternity politics in the 1920s and 1930s, Mein Smith elucidated the origins of the

¹ One well known estimate is that only 5% of babies arrive on the due date assigned (Resnik, 1999).

maternity politics of the day (i.e. of the 1980s), primarily the hegemony of the medical profession and the invisibility of midwives.

In August 1990, when I had been practising eight years, the Amendment to the Nurses Act (1977) was passed into law by the New Zealand Parliament. The right for midwives to practise autonomously and care for women throughout the course of normal pregnancy and birth without the supervision of a doctor, had been removed in 1972. This had been the culmination of a medical and nursing campaign to undermine independent midwives and reduce the status of hospital midwives to obstetric nurses (Donley, 1986; McLauchlan, 1997). The 1990 Amendment had restored this right. From that time conditions held greater potential for pregnancy and birth to be 'normalized'. It is difficult for many midwives to understand that the opposite is apparently happening. Pregnancy and birth are becoming increasingly medicalised.

I have been present when it has been discovered that a baby has died in her mother's uterus, in that case just a few days past the 'due date'. There was never any reason found. The baby did not appear to fit the postmature syndrome condition. The placenta appeared healthy. During the period of this research I was aware of a similar situation within a practice where I know the woman would have made an informed choice with regard to waiting or being induced. These are episodes that challenge my philosophical base. Over time, however, they serve to concentrate such attention on the multiple, complex issues around where our society is moving, reproduction, individual and societal expectations, and attitudes to dying. I find myself back on the original ground of the philosophy. This is a philosophy which believes above all in informed, empowered women/families making choices in which they are supported, come what

may. This is the wholly human arena of the everyday miracle and the reality of what is and what is not guaranteed in life.

Why this issue

A recent publication revealed that the national rate of induction of labour (IOL) in New Zealand is now 23%, compared to 7% in 1988/1989 (Ministry of Health, New Zealand [MOH,NZ], 1999). In 1997, at National Women's Hospital (NWH), New Zealand's largest women's hospital, a primiparous (first time pregnant) woman had a 1 in 3 chance of finding herself being induced (NWH Report, 1997). If this intervention is happening more and more, where is the study that informs us of the consequences for women? How can we learn what this trend means for the women both as a group and as individuals? How can we know it is their informed choice?

Having been a midwife in this country for 17 years, and in independent practice for seven of those years, I have worked often with women who find themselves in a situation where their bodies seem oblivious of any man-made calendar. They seem under an entirely different influence whose mystery continues to evade our science. Social and emotional pressures magnify with each passing completion of another 24 hours. Most times the baby is well and the waiting is appropriate. For a very small minority, waiting means the baby becomes compromised, does not cope well with labour, and sometimes dies (Gibb, 1984).

We have categorized this apparent anomaly of remaining pregnant as long as three or four weeks after the 'due' date, as 'prolonged' pregnancy (PP). PP has been saddled in

recent times with many varied definitions and this hampers efforts to produce clean, clear, conclusive research on the issue. PP remains a major indication for the intervention, IOL (Chua & Arulkumaran, 1999). There are signs that PP is being cited as the indication for IOL with increasing frequency. This presumably defies logic, or may reflect the influence of overseas trials. Just as a breastfeeding baby knows nothing of clocks, I believe a pregnancy operates to its own timetable. The concept of an exact or critical due *day* has assumed unreasonable significance. Sooner rather than later most women are asking their midwives: “How long do **they** let you go for?” This is the query (and all that it implies) that repeats in my mind like the scratched record.

Related to this is a continual consciousness of the effect of stories in helping midwives learn. We claim openly that we learn from the women. I believe it is possible to achieve a deeper understanding of what is affecting developments in maternity care by focusing on the women’s experience locally and studying the best evidence available to us globally. I decided to gather some stories of the experience of being overdue and having the labour induced because of that.

Overview of the Thesis

In this study women’s experience of issues concerning PP and IOL are examined. The two chapters that follow, present a literature review of topics closely related to prolonged pregnancy and induction of labour as background to my research. Chapter Two covers the dating of a pregnancy, the physiology of the onset of labour, and why prolonged pregnancy is an issue for pregnant women. Chapter Three provides a review

of prolonged pregnancy itself, and the intervention of induction, culminating in a literature review of women's experience of induction.

Whereas this current chapter has positioned me within maternity care in this country and the research issue, Chapter Four locates me within the midwifery model and the culture of story telling. It explains the research methodology of narrative enquiry and story telling, using a feminist process and informed by my position as working within the midwifery model. Chapter Five describes the research design, and sets out the methods used to obtain the stories and distil the messages. Chapters Six to Nine present the women's stories and the researcher's reflections. Finally, Chapter Ten provides in depth discussion, recommendations for further research, and concluding remarks.

To summarise: I aimed to explore in detail what it was like for four women who have recently encountered the current maternity care environment, and have undergone IOL for prolonged pregnancy (IOLPP). My research concerns itself with relating some women's actual experience of waiting and then undergoing an induction. More and more women in New Zealand are becoming IOLPP statistics, with rarely a loud voice to say: "Is this really necessary?"

Chapter 2 - The Dating of a Pregnancy - a Tale of Imprecision

In this chapter I will review the literature in relation to three concepts which are foundations to an understanding of women's experiences of going overdue. As the title suggests it is an account of imprecision, lack of consensus, uncertainty and incomplete knowledge. The tale begins with the confusion over how the estimated due date is calculated and the implications of that. I continue on to set out what our understanding is of what begins the process of labour. Then I turn to the third concept which is the significance of prolonged pregnancy, including what is, and what is not, reassuring.

Dating a pregnancy

Prior to the advent of ultrasonographic fetometry¹, women and their caregivers relied on calculation of the due date by reference to the first day of the last menstrual period. In 1836 Franz Carl Naegele (1777-1851) published *Lehrbuch der Geburtshilfe für Hebammen* (A Midwife's Midwifery Text) (cited in Gibb, 1984). In this text he reported, from his observations of French women, that a pregnancy lasted ten lunar months or 280 days. He suggested that the date when the baby could be expected to arrive, be calculated by adding nine (calendar) months and seven days to the date of the first day of the woman's last menstrual period (LMP). Alternatively, three calendar months could be subtracted from the first day of LMP and one year and seven days added. The belief then was that ovulation occurred soon after the last day of menstruation. We now know that ovulation, for a woman with a regular 28 day menstrual cycle takes place

¹ This is the measurement of crown-rump length, femur length, bi-parietal diameters, and abdominal circumference by ultrasound (sound waves) radiation to compare with tables of mean measurements of these lengths and therefore calculate an estimated gestation or age of the fetus.

around about day 14, conception occurs sometime in the next seven days. However, for practical purposes midwives and doctors have continued to apply Naegele's Rule. Inaccuracies occur as the occasional implantation bleed can resemble a light period. This event is erroneously reported as the LMP which results in the gestation period being over estimated.

The issue of the accuracy of Naegele's Rule came under review at least by the late 1960's (Guerrero & Florez, 1969, cited in Gardosi & Geirsson, 1998). More recently various studies, including large studies using routine second trimester ultrasound, sought to prove that a pregnancy was more accurately dated by adding (variously)

- 281 (Tunon, Eik-Nes & Gioltum, 1996, cited in Gardosi & Geirsson, 1998),
- 283 (Gardosi, Vanner & Francis, 1997; Bergsjö, Denman III, Hoffman, & Merik, 1990) and
- 288 days (Mittendorf, Williams, Berkey, & Cotter, 1990) to the LMP.

Cardozo, among others, emphasizes it is only an *estimated* date of delivery, that it is in fact uncommon for a baby to arrive on that date (Cardozo, 1993). The World Health Organization (WHO) define 'term' as in 'pregnancy at full term', or 'mature' (cf. premature, post-mature) as anywhere between 37 weeks (259 days) and 42 weeks (294 days) (Saunders & Paterson, 1991). A woman may have passed the estimated date but she is not considered post-term until the 295th day, or 15 days after the estimated date. This too applies only if her cycle is an average length and regular, i.e. 28 days, every time. Cardozo is daring enough to suggest: "Perhaps we should reconsider whether it is necessary to give a precise date on which they should expect their baby to arrive" (Cardozo, 1993, p.840). Others, in recent texts on maternity care, stress how important

it is to educate the woman with a clear explanation, and to underline the approximate nature of the date from the beginning (Chua & Arulkumaran, 1999; Roberts, 1993).

When obstetricians began to check on women's dates with ultrasound scanning in the first trimester, and to use the date provided by the scan rather than what the woman told them about LMP, they reported being able to reduce the incidence of prolonged pregnancy to as low as 1% (Boyd, 1988, cited in Cardozo, 1993; Romero, 1993, cited in Chervenak, Skupski, Romero, Myers, Smith-Levitin, Rosenwaks, & Thaler, 1998). Previously when relying on dates supplied by women's reporting of LMP, the incidence of prolonged pregnancy (agreed upon generally in those days as 42 weeks or more of gestation), was between 4 to 14% (Boisselier & Guettier, 1995). This implies that women overestimated the length of their pregnancy by providing a guessed LMP, or were unsure and their caregiver overestimated the pregnancy period from clinical signs. This in turn inflated the proportion of prolonged pregnancies. With the advent of ultrasound scanning, the date could be confirmed or 'corrected' by measuring the baby on ultrasound and working backwards to a more accurate probable LMP. Then the so-called 'true' incidence of prolonged pregnancy was hugely reduced. By deduction this would have had a domino effect of decreasing the morbidity that may have resulted from unnecessary IOL and increasing the rate of spontaneous onset of labour. However even scans done in the first trimester (the first three months of the pregnancy) have an 'accuracy' of prediction of the due date with an error margin of five days, second trimester (second three months) an error margin of seven days and third trimester (third three months) one of 10 days (Otto & Platt, 1991). The accuracy of ultrasound dating is dependent on age of gestation when first scanned, and which method to date the pregnancy continues to be hotly debated.

The detail of the debate regarding the implications of relying on scans to date pregnancies, their advantages and disadvantages will not be laid out in this study. But I would like briefly to summarise this on-going, high-level, controversy. The protagonists line up roughly along country borders : Americans, Swiss, Icelanders and some Britons, against Swedes and Danes and some other Britons. Simply put, the former argue passionately for the greater accuracy of the *routine* ultrasound scan in the second trimester and the latter reason with equal passion and greater logic, for not relying on the scan, instead for retaining the calendar method (Mongelli, Wilcox & Gardosi, 1995; Olsen & Clausen, 1997, and 1998; Zimmerman & Wisser, 1998; Gardosi & Geirsson, 1998; Hutcheon, 1999). The crux of the debate seems to be whether the calculations used to establish the accuracy of the technological method, the non-technological method or a combination, are made from the actual date of birth in retrospect or by using some inevitably arbitrary number, such as 280, to establish irrefutably the 'certain' LMP. Further trials are on-going, and a systematic, critical literature review is called for. I submit the Danish researchers' concluding words of their 1997 article: "... there is a limit to the precision of any method, since length of pregnancy is subject to biological variation and other factors. The current methods, corrected for bias, may well be close to this limit" (Olsen & Clausen, 1997, p. 1222).

Methods: menstrual, clinical, ultrasonographic

As has been said, midwives understand that a woman's estimated date of birth can be roughly calculated by assuming she will ovulate mid cycle and conceive shortly after. By convention the length of gestation from the date of conception is taken as roughly

266 days. As it is still unusual for a woman to know exactly when she conceived, a gestation length of 280 days is used (to include all possible conception days from day 7 to day 21). This is calculated from the first day of her last menstrual period (FDLMP).

Whichever way the date is decided on, in the clinical setting there are assessments of fundal height against which to compare the calculated gestation for confirmation. Measurements of increases in fundal height are made using finger widths from the landmarks of the mother's xiphisternum, umbilicus, and symphysis pubis; or by tape, measuring in centimeters distance from pubes to fundus. There is also the timing of feeling the first movement, or 'quickening' of the fetus, which for multiparous women would be around 16 weeks and for primiparous, about 20 weeks. There remains an approximate lining up of LMP, movements and fundal height to confirm the baby is appropriately grown.

The dating debate revealed that there is now a computer software program being used in some maternity units whereby head circumference, biparietal diameter, abdominal circumference and femur length are used to predict a customised due date without reference to LMP (Hutcheon, 1999). Everywhere else where ultrasound dating happens, these measurements are matched to a gestational age, the 'virtual' LMP calculated and *then* Naegele's 164 year old rule applied to supply the woman with an EDD (ibid; Weiner & Baschat, 1999).

Issues of ethnicity, sex of fetus, singleton or multiple pregnancy all impinge on the accuracy of dating by any method. These are researched and studied with little consensus as to how they impact on scan dating or calendar dating (ibid).

Irrespective of who is 'winning' the complex debate when it comes to allotting significance to a woman's knowledge of her individual cycle, the machine appears to be gaining ascendancy over woman's self-knowledge. In reality the power and glamour of the ultrasound scanning tool dominate over her unique and exclusive awareness of her body's subtle changes. The issue for a midwife and feminist centers around a strongly held conviction. This is that the implications of complete reliance upon high technology as being superior to a woman's self knowledge extracts too high a price.

Physiology of the onset of labour

Central to the issue of prolonged pregnancy and possibly basic to the woman's understanding and tolerance of 'waiting', is an understanding of what initiates labour. Currently there are researchers worldwide investigating just when and how labour is initiated, not, as it happens, because of the issue of apparent prolonged pregnancy but because of the incidence of *premature* labour. This entity is so costly in both human and fiscal terms, that it provokes keen interest in the physiology of the onset of labour, the better to know how to keep the pregnancy *going*.

What sets labour in motion? What is currently understood about the basic biochemistry and physiology of the initiation of labour? This is a complex topic. To provide even a limited grasp, there seems no alternative but to attempt the explanation in some depth. At base is the assumption that the baby's development has progressed to a level of maturity that she no longer needs to depend on the excretory and respiratory functions of the mother. A focus is needed on both the maternal and fetal hormonal state. The New Scientist in January, 1998 reported a summary of what is known to date as though

to herald a break through in our understanding, but this is yet to come (Hamilton, 1998).

Does a baby initiate labour? Does the mother? Is it a combined effort?

In a term pregnancy the baby has matured to the point of potential independence. The baby signals to the placenta her readiness. What is known is that the hypothalamus of the baby stimulates the pituitary to produce adrenocorticotrophic hormone (ACTH) which in turn effects the production of cortisol. Cortisol travels to the placenta to release enzymes capable of producing oestrogens. These act on the involuntary muscles of the uterus to provoke labour. So far there are only theories about the step before this specific activity in the hypothalamus. Is it a question of inevitable maturing of the hypothalamus? Is it a coincidence of maturing organs alerting the hypothalamus to act on the pituitary? Is the source of influence on the fetal hypothalamus hormones secreted from the maternal placenta?

Or, as the Australian physiologist, Caroline McMillen suggests, is it because of increased need for nutrients, especially sugar, beyond the capacity of the placenta to provide? Ordinarily cortisol has a self-regulatory ability so there are never excessive levels but it is known that in sheep fetuses prior to birth the cortisol level skyrockets despite an ACTH response designed to control cortisol levels. One possible answer is the stress of hunger (attributed to McMillen in Hamilton, 1998). Resulting low energy signals could trigger increases in adrenocorticotrophins. Cortisol releases fats and amino acids, as well as causing the release of an enzyme from the placenta to increase oestrogen and it's effect on the uterus.

For another part of the picture I draw on the recent summary published in the New

Zealand Midwifery Journal (Penny, 1999)². Penny begins by explaining that two to three weeks before the onset of labour, the level of prostaglandins, primarily of Prostin-E, rises, as does collagenase. This has the effect of steadily softening or ripening the cervix, an absolutely essential part of the process, often characterized by periods of mild contractions, maligned -undeservedly- as 'false' labour. It is oxytocin that switches on 'real' labour contractions only when it has specific protein receptors in the cell membranes to bind with. These receptors dramatically increase the sensitivity of the myometrium (muscle wall of the uterus) to oxytocin. Rising oestrogen levels dominate over the more or less static, previously dominant, progesterone presence (*step). Prostaglandins and other membrane factors are also increased. The placenta provides corticotrophin releasing hormone (CRH). The debate continues as to what provokes this development. McMillen argues that it is a naturally increasing stress felt by the fetus as the fetoplacental link becomes unable to meet the energy needs of the fetus (McMillen, 1995). The fetal hypothalamus is also releasing CRH but as a 'poor relation' to the placenta. In turn CRH provokes the release of ACTH (perhaps this is where the hunger stress is pivotal) from the fetal pituitary, and cortisol which usefully acts to complete the maturation of the fetus. Together they stimulate dehydroepiandrosterone sulphate (DHEA-S) in the fetal adrenal gland (a part of the adrenal unique to the fetal stage of our development). This DHEA-S is what pushes up the level of oestrogen and we are at the * step (see above).

Penny asks what trigger causes the placenta to suddenly begin making CRH? Also why do levels of CRH vary? Some say genetics, some say nutritional level of the woman.

² I choose not to draw the circular diagram that is generally used to illustrate the cycle of events that are thought to initiate labour. Instead I insert the symbol '*step' to indicate where the cycle begins again.

Once it has started fetal cortisol ensures that CRH production continues. *So* fetal input appears to initiate the onset of labour almost always *only* when the fetus is mature.

The oestrogens instruct the decidua to increase prostaglandin levels so the cervix is ripened. The oxytocin receptors and gap junctions multiply and uterine contractility rises. Ruptured membranes further increase the level of prostaglandins. Further research is looking at what triggers CRH production in the placenta (Penny, 1999).

As seemingly detailed as this trail is, it does *not* completely explain the triggering or physiology of the onset of labour (Miller, 1998). However what we do know could be paraphrased for most woman by saying when the fetus is mature (or, as some think, when the baby's need for energy exceeds the provisions of the uterine environment), a complex chain of hormonal reactions are set in motion that actually take an average of two to three weeks. This activity results in increased levels of natural prostaglandins that are necessary to slowly ripen the cervix when this is happening for the first time. This provides an insurance that the fetus is mature enough to survive extra-uterine life and supplies natural oxytocin which, together with the stretching effect of the baby's head on the cervix, eventually delivers the contractions which are active labour.

The issue of safety

Why not just wait until the labour begins by itself? I am using this question to conclude this chapter on the dating of a pregnancy and the physiology of onset as both topics lead naturally to this issue. The female body is designed to experience labour; the baby is mature; what is the twist in this tail?

Post term pregnancy, i.e. *longer than 42 weeks (294 days)*, is regarded as a concern because it is associated with increased perinatal mortality and morbidity (Crowley, 1999). Some of the increased mortality is due to congenital malformations. The other main cause of death is asphyxia. Neonatal seizures are between two and five times higher in infants born after 41 weeks. Meconium-stained fluid is a common feature among the babies who die (Enkin, Keirse, Renfrew & Neilson, 1995).

The incidence of post term pregnancy (referred to in this study as PP) when pregnancies are dated by first trimester ultrasound scanning is less than 5%; otherwise incidences are reported from 3 to 10%, or more (Chua & Arulkumaran, 1999). Women who have had one previous PP have a 30% chance of it recurring, and those with two PP have a 40 % chance they will again have a prolonged pregnancy with their third (ibid). It could be, of course, that the length of a pregnancy is individual to each woman. Experienced midwives have observed some women, in each of their pregnancies, always 'carry' for 36 to 38 weeks, some for 42 to 43 weeks.

Hilder, Costeloe & Thilaganathan (1998) retrospectively studied the gestation specific risks of fetal and infant mortality with prolonged pregnancy analyzing 71,527 births during 1989-1991. They concluded: "There is significant increase in the risk of still birth, neonatal and post neonatal mortality in prolonged pregnancy" (ibid, p.169). It is relevant to point out that many of these studies are on data collected prior to widespread first trimester scanning to regulate the dating. Also it is pertinent to repeat that even first trimester scans have an 'accuracy' of prediction of plus or minus five days (Otto & Platt, 1991). As has been said, this method of dating a pregnancy is widely touted to

reduce the true incidence of prolonged pregnancy dramatically (Romero, cited in Chervenak et al, 1993; Usher, Boyd, McLean, & Kramer, 1995; Chua & Arulkumaran, 1999). Unless all pregnancies were dated similarly, there must be a question mark over the inclusion criteria selected and logically over the conclusions formed by the study of the resulting data.

Frye (1996) on the other hand questions the true extent of the problem as it is propagated by the medical profession. She believes: “congenital anomalies, infection and intrauterine growth retardation account for much of the perinatal mortality generally lumped in to the post mature category” (ibid, p. 29). Goer (1995), in her review of the research with a stated aim of eliminating the myths, rebuts all the rationales put forward for evidence of younger and younger gestations being regarded as PP, and challenges the methodology of randomised controlled trials (RCTs) but does acknowledge there is risk.

Postdates pregnancy is far from cut and dried. Testing in order to induce selectively introduces risks. Routinely inducing creates more problems than it solves. Letting nature take its course is generally best, although that is not risk free either. No course of action (or inaction) guarantees good outcome. The result is you pay your money and you take your choice (ibid, p.183).

In 1995 the National (United States of America) Institute of Child Health and Human Development Network of Maternal-Fetal Medicine Units reported in the American Journal of Obstetrics and Gynecology on their RCT of 440 women who either underwent immediate induction at 41 weeks or had nonstress testing and amniotic fluid volume assessment twice a week until there was a concern or they laboured spontaneously (NICHD, 1995). They found that from the perspective of perinatal morbidity or mortality that either management approach was acceptable. Despite differences in protocols, their conclusions matched those of the Canadian trial of

Hannah, Hannah, Hellmann, Hewson, Milner & Willan (1992). Caesarian section rates were higher in the expectant (wait and monitor) group of the Canadian study. However these happened because of higher level of diagnosis of fetal distress, and criteria for fetal distress were not controlled.

The findings of the systematic review

The systematic review is regarded as the pinnacle in the hierarchy of scientific evidence (Greenhalgh, 1997). The conclusion of The Cochrane Library's systematic review *Interventions for preventing or improving the outcome of delivery at or beyond term*,³ after careful selection of 26 randomized and quasi-randomized trials, involving women with apparently certain dates, was: "...routine induction of labour after 41 weeks gestation appears to reduce perinatal mortality" (Crowley, 1999). It may be that fewer babies die. As a consequence of calculations made in the course of this review it was reported that for every 500 (at least this number but possibly as many as 1000) low risk women induced without need, one baby would be protected, i.e. not die as an unexplained stillbirth (odds ratio: 0.20; 95% confidence interval: 0.06 to 0.70). Crowley cautions that the number (500) of inductions required to prevent one perinatal death may be biased. The Henry trial held prior to 1969 reported a high perinatal mortality, so: "It may be that the number of inductions of labour required to prevent a single perinatal death may be higher in present day practice" (Crowley, 1999, p.4). In addition to the reference to the length in the period of history of the trials (18 out of 26 trials date prior to 1990), she also describes the methodological quality of the trials as variable.

Conclusion

³ The last substantive amendment to the review was made in October, 1996.

The above sections were designed to provide some background information to the primary subject of this study that is some women's experience of prolonged pregnancy and induction of labour. An understanding of the dating of a pregnancy, the onset of labour and why waiting is of concern, is useful to contextualise many of the issues raised by the women's stories. There are overlapping issues, however, regarding identification of higher risk, and the illusive nature of a solid definition of overdue/postmature that will be addressed in the next chapter. Chapter Three will review the literature on the issue of prolonged pregnancy per se. This, I will show, is still the most common indication for IOL in Western countries. It requires a chapter in its own right and only then can I turn to how the research was carried out, the descriptive analysis of some statistics, and the stories themselves.

Chapter 3 - The Issue of Prolonged Pregnancy and the Intervention of Induction of Labour

When the estimated due date passes and the baby has not arrived, anxiety begins to rise. For the woman there is exposure to the classic double bind situation. It may begin with the thought that something may be wrong. She may be aware that labours can be induced, that babies can be helped to come out if she 'goes overdue.' But what does that mean precisely? After how many days exactly? What would be done to her? What does this mean for the woman? Potentially anxiety inducing, as yet unknown but probably painful, procedures done to her body. Should she, can she, bear to wait still longer? What would the consequences be for her baby? It seems a dilemma either way. This chapter will explore the components of that dilemma for women and explore why it is also a dilemma for her caregivers. It will examine the large amount of what is known about prolonged pregnancy and inducing labour, and what little is known about women's experience of it. The following derives principally from the literature, with some contribution based on my own experience.

Definitions of Prolonged Pregnancy

Unilaterally, for the purposes of my research, I choose to define 'prolonged pregnancy' as a pregnancy simply lasting longer than 40 weeks, i.e. the woman is pregnant past her estimated due date. A synonym then clearly would be the term 'postdates'. In my definition 'prolonged pregnancy' includes postdates and post-term. It also includes women who are 40 weeks and one day pregnant. It is intended that this device serve two purposes. Firstly to underscore the issue of the imprecision with which the terms are used by arbitrarily defining prolonged pregnancy as merely

greater than forty weeks. Secondly to attempt simplification. I know paradoxically I in fact risk confusion and misinterpretation. I need to stress that this is not the official description but it is also designed to draw attention to the elasticity with which the definition has been applied.

The definitions supported by the International Federation of Obstetricians and Gynaecologists (FIGO) and the World Health Organization (WHO) imply that a pregnancy that is at *term* is one from 38 weeks through to 42 weeks, i.e. 266 days til 294. They define *post-term* as a pregnancy lasting 42 weeks or more. A *post dates* pregnancy is one lasting 40 weeks (i.e. at *dates*) and one day or more, and *prolonged pregnancy* is any pregnancy which exceeds 294 days from the first day of the last menstrual period, i.e. *after* 42 completed weeks (FIGO, 1982, & WHO, 1977, both cited in Cooke, 1997).

Also needing definition here is the term 'post mature' as it too is used loosely and interchangeably with the above terms. I believe this adds to the confusion, causes concern, and can be misleading to both woman and caregiver. 'Post mature' denotes a pathological condition relating to the pregnancy and the fetus, but not necessarily associated with gestation. Gibb¹(1984. p.111) lists the features as:

Absence of vernix caseosa (cheesy, creamy, white substance which coats the skin of fetuses, usually still evident on the skin of newborns, especially in body crevices)
 Absence of lanugo hair (thin layer of hair seen on the body of new born infants)
 Abundant scalp hair
 Long fingernails
 Dry, cracked, desquamated skin
 Body length increased in relation to body weight

¹ Gibb is a classic example of someone who inadvertently perpetuates the confusion. His chapter heading is 'Prolonged Pregnancy'; within the text he explains well the specific nature of the 'post-mature' syndrome which clearly does not necessarily relate to gestation, nor of being 'post dates' reliably. He comprehensively describes the syndrome, then he *continues* to use the term throughout the chapter to equate to 'prolonged pregnancy'.

Alert and apprehensive facies
 Meconium staining of skin and membranes.

Chua & Arulkumaran give a similar list of features of post maturity. They state also that this is a syndrome, only diagnosable after birth and not exclusively characteristic of 'prolonged pregnancy' (Chua & Arulkumaran, 1999). These authors of a modern obstetric textbook acknowledge that all of the above terms have been used to mean a pregnancy lasting longer than the 294 days, and state that all of the terms denote a risk situation. However, instead of devising a different, separate, neutral term, they then settle on the term 'prolonged pregnancy' to refer to the chronological entity so as to distinguish that from the pathological inferences of the other terms !

Lack of consensus is an issue

Before I proceed I would like to draw attention to the definition conundrum and other reservations that arise when reporting on the literature to do with prolonged pregnancy and induction. Olofsson and Saldeen seem to have grasped and articulated these better than most:

Variable definitions of postterm pregnancy, different patient selections, erroneous dating, different surveillance protocols, and loose indications and different methods of labour induction, are factors [further] confusing the attempts to establish a consensus on prolonged pregnancy (Olofsson & Saldeen, 1996, p.645).

It is precisely these difficulties which trickle down to the level of practitioners trying to inform women objectively.

More than once on my journey through the literature I encountered careful writers who took time out in their report to comment on the confounding aspect of the definitions associated with the phenomenon of being 'overdue'. There are a number

of terms which do actually have specific meanings, or did originally, but even well established researchers tend to use them interchangeably. Immediately confusion, ambiguity and imprecision rule. This factor, I believe, undermines any definitive accounting of the situation within first and second world countries, let alone world wide. It forestalls any accurate compounding of quantitative data. Despite FIGO's consensus definition of 'prolonged' it is evident from the Canadian Multicenter Study (Hannah et al, 1992), that these researchers considered forty weeks and ten days as the demarcation between term (lower risk) and post term (prolonged pregnancy) (higher risk).

The difficulty of determining the incidence and significance of post-term pregnancy is compounded by variations in the way that the condition is defined, which range from 41 to 43 weeks. Semantic problems also contribute to the confusion. The words 'post-term', 'prolonged', 'postdates' and 'post mature' are all used as synonyms, but are laden with different evaluative overtones (Enkin, Keirse, Renfrew & Neilson, 1995, p.180).

The Australian Council of Healthcare Standards together with the Royal Australian College of Obstetricians and Gynaecologists has lined up with the Canadians and defined prolonged pregnancy as greater than 40 weeks and 10 days, i.e. 41 weeks and 3 days from LMP (Robson, Pridmore & Dodd, 1997). As noted above, prolonged pregnancy is defined by the World Health Organization as greater than 42 weeks pregnant or synonymous with the term *post term*. This may appear to be hairsplitting. However there is a five day difference, quite a lengthy period during which many useful physical changes, necessary for labour to begin or be more prepared to begin could be underway. This is particularly so for first time mothers.

Thus generally in the literature I have found a rather loose adherence to any technical definition of these terms. There are numerous, scholarly reports and publications that blur the definitions and refer to due date plus ten days as post-term when, officially,

'term' is not 'over' til 294 days, 14 days after the 'due day' (Dyson, Miller & Armstrong, 1987; NICHDNMF MU, 1995; Augensen, Bergsjo, Eikeland, Askvik, & Carlsen, 1997; Divon, Haglund, Nisell, Otterbad & Westgren, 1998).

It is not easy to be more clear than this, with regard to defining the 'condition'. The terms are used interchangeably by some experts and healthcare researchers, so it is no wonder that health professionals feel able to use them loosely and erroneously. It is revealing to review the literature on the issue. Immediately one encounters the confusion and lack of consistency. No doubt I have added to the confusion, but the whole exercise has underscored the power that a label has.

Why should I be concerned at the shortening of the time span that formerly was agreed upon to be the length of a human pregnancy? This moving of the parameters that are used to define the accepted duration of a pregnancy? Clearly it was declared by fiat originally (Naegele, 1836, cited in Gibb, 1984). It is not impossible that the 'natural' timing is very occasionally wrong and the placenta may suddenly fail to support the fetus with fatal consequences or be unable to protect the fetus by some malfunctioning of the usual mechanisms to maintain good perfusion during labour. The pregnant woman's right is to know (in as objective form as possible) what is conjecture, what is actually *known*, and what the range of possibilities are. She also has a right to know what she may experience, or risk, should she choose the intervention. There needs to be a greater appreciation that it is the informed woman who is *doing the waiting*, or undergoing the intervention who makes the choice and, ipso facto, has the responsibility for the consequences. It may now be more clear how this issue encapsulates the juxtaposition of the two paradigms, the midwifery and the medical.

I argue that the issue of prolonged pregnancy, and the sometimes parallel, sometimes overlapping, sometimes opposing attitudes of different health professional groups towards it, provide an ongoing example of the tensions within the models currently straining to secure a position of influence in the maternity care scene. This applies not just within New Zealand, but world wide. The crux of the issue rests on the sad, uncomfortable fact that some babies die unexpectedly and some of the time we don't know exactly why. We expect ourselves to know and we expect to be able to eliminate that possibility. We arrive rather promptly at the sense of un-ease we feel with the whole issue of PP because there has been a death, or an imperfect child, and we may have been able to make it 'alright'.

The concluding comments from a Canadian study assessing fetal risk in postdate pregnancies are pertinent. This 1988 study found there was increased fetal distress and meconium aspiration in babies born *postterm* (defined in this study as 42 weeks or longer) but actually no increase in birth asphyxia nor fetal death:

...[T]here are, however, psychological and medicolegal reasons why postterm pregnancies will continue to engender anxiety. Even if it is true that the risks of fetal death and birth asphyxia are not increased postterm, as the results reported here would indicate; the loss of a fetus after the due date is more difficult to accept than one occurring earlier. The natural response is always to think of how unfortunate it is that the infant was not delivered earlier or followed more closely. No amount of scientific fact will change this reaction. (Usher, Boyd, McLean & Kramer, 1988, p.264).

I would hazard that sad personal experience provokes such words and these thoughtful, measured words would resonate with many carers. But what does this tell us *between the lines*?

Definitions of Induction of Labour.

In contrast to my search for references to women's experience of the 'condition' of being 'overdue' and women's response to induction of labour, there was no shortage of research relating to IOL per se, PP and IOLPP. Here I limited my search to studies published in the last 10 years.

I begin my report on the literature by offering a range of definitions of induction from some well known texts. "The decision to bring pregnancy to an end before the spontaneous onset of labour is one of the most drastic ways of intervening in the natural history of pregnancy and childbirth...The reasons given for elective delivery ... range from the life saving to the trivial" (Chalmers, Keirse & Van Oppen in Enkin et al, 1995, p. 297). These words open the chapter on 'Preparing for induction of labour' in *The Guide to Effective Care in Pregnancy* (ibid). They highlight the extreme nature of the intervention and hint at the broad disagreement amongst professionals as to which are reasonable indications to induce. The words in this midwifery text hint similarly at the writer's bias: "Induction of labour may be described as the deliberate attempt to pre-empt the spontaneous onset of labour by artificial means" (Cooke, in Sweet, 1997, p.610). A review of IOL by the British Medical Journal includes the definition: "Induction is the stimulation of the uterus with the aim of starting labour to ensure delivery of the fetus at an appropriate time when the baby is thought to be safer outside the uterus than in it" (Chamberlain & Zander, 1999).

A fourth definition of IOL written by an obstetrician neatly incorporates a clear understanding of 'term' or accepted length of a pregnancy also: "Termination of

pregnancy pre-term, i.e. < 37 weeks, at term (i.e. 37 to 41 weeks), or post-term (i.e. 42 completed weeks or more) when: (1) fetal survival is jeopardized if it remains in the uterus; or (2) if the mother's life, or health, is in danger (Llewellyn-Jones, 1990, p.384).

History of Induction of Labour

Ever since it's properties were known, it is believed that midwives utilized ergot to initiate labour. Why would they? Because the woman was ill? Or because the baby had died? And certainly midwives suggested the use of nipple stimulation, orgasm and sexual intercourse to induce or augment labour (Wagner, 1994). Amniotomy, artificially breaking the bag of water (liquor) surrounding the baby, was introduced as a method of induction by Thomas Denman of the Middlesex Hospital in 1756. (Calder, 1991). Throughout the 19th and during the early 20th centuries, obstetricians experimented with such compounds as: hot water, creosote and tar, quinine, castor oil and iodine. Attempts were made to hurry nature along by the insertion of various objects into the vagina (and uterus!) e.g. stomach tube, tampon, seaweed, balloon, wax and animal bladder (Wagner, 1994).

By the mid 1950's synthetic oxytocin (SO) had been manufactured. Where and how to insert it was much more of a challenge. Nasal, rectal and intra-amniotic routes were all explored. Intravenous use was settled on as by the late 1960's intravenous infusion pumps had been invented which could regulate the dosage given with sufficient accuracy to allow a safer, gradual titration against uterine contractions. In the same year (1968), the use of prostaglandins was introduced (Thiery, Baines and Keirse, 1989). These were able to be used systemically or locally.

The technology facilitated the intervention, it seemed, almost too well. There was a dramatic increase in IOL rates in some countries (Chalmers & Richards, 1977). Previous to this development induction would have been limited to obvious, clinically indicated, reasons, e.g. pregnancy with proven length of 44 weeks, and maternal illness. As is observed today, the pressure of available technology had a softening effect on the classification of indications. Then, in Marsden Wagner's words: "As the indications expand, the benefit weakens but the hazards remain constant. As a result the hazards outweigh the benefits" (Wagner, 1994, p. 146). The prospect of 'arranging' for the timing of labour and birth to be optimal for the institutions and the personnel (and some women) became too tempting. The IOL rate in England and Wales went from 13% in 1966 to 39% in 1974 (Chalmers & Richards, 1977). There was an outcry from the public and some health care professionals that resulted in rates halving thereafter in some centers. Convenience or 'daylight' obstetrics continued to be popular however. Concern rose regarding the side effects: increased incidence of neonatal hyperbilirubinemia; uterine hyperstimulation leading to fetal distress; an overall lowering of gestational age and birth weight. Over diagnosis of prolonged pregnancy as well as the occasional iatrogenic preterm birth were developments that discredited induction approaches in the 70's and 80's. These consequences were largely circumvented by the spreading use of ultrasonography to date pregnancies during the 1980s (Boyd, 1988, cited in Cardozo, 1993; Romero, 1993, cited in Chervenak, Skupski, Romero, Myers, Smith-Levitin, Rosenwaks & Thaler, 1998).

Methods also are reflective of the two models of care, medical and midwifery. The medical model approach favours mechanical and pharmacological methods. These

methods have been subjected to RCTs. The midwifery model, whilst clear in its philosophy that induction has a place only when medically indicated, is not averse to assisting nature, during the interval when such a medical indication is hovering and plans and times have been made for a mechanical induction. Methods range from the use of 'natural' herb or homeopathic remedies with ancient pedigrees such as oil of evening primrose (Muir, 1990), caulophyllum, castor oil and citrus; to advocating intercourse (semen is the richest, natural source of uterotonic prostin (Thiery et al, 1989)) and performing a vaginal examination or a series of examinations in order to stretch the cervix and sweep the examining finger between chorion and uterine wall just interior to the cervix in order to provoke the body's own release of prostaglandins (Auckland Homebirth Association, 1993; El Hatta, 1996; Frye, 1996). The latter is an increasingly orthodox approach used prior to, and sometimes instead of, application of prostaglandins (Boulvain & Irian, 1999; Grant, 1993; Berghella, Rogers & Lascale, 1996).

I was never involved in the use of the infamous SO spray but I have heard older women talk about being asked to sniff up a substance designed to provoke labour. Nowadays we shudder at the imprecision of such a method of administration. Breathe deeply and you could inhale many more times what was appropriate for you. There remain questions today about the relative imprecision of prostaglandin dosages.

I have been practising long enough to remember the artificial rupture of membranes (ARM) and SO intravenous infusion approach before there was an appreciation of the need to ripen the cervix. Or the means to do this. The woman would commonly be positioned in the lithotomy position. An elongated instrument with a hooked end

would be encouraged to pass through the cervix, ready (ripe) or not, the assistant midwife would be asked to apply pressure to the top of the uterus (fundus) to help ensure a 'bag of waters,' or the amniotic membrane filled with liquor, in front of the instrument and ahead of the fetal head, ready to be 'popped' or broken by the instrument. Some obstetricians favoured the Drew Smythe catheter, a long, shallow 'S' shaped instrument designed to be placed between fetal sac and uterine wall and puncture the waters to the fore of the fetus. This latter method was that chosen when there was excess liquor and the baby's head had not descended into the pelvis, but was 'floating'.

Coincidentally an intravenous infusion of isotonic fluid would be commenced. Added to the fluid would be an amount of SO. This would be administered via a pump which could be set to deliver a precise amount of the ecbolic so in theory the amounts could be slowly increased and ensure a gradual, progressive induction of the uterine activity. I am old enough to remember sometimes a 'double' bag, meaning a bag containing twice the original amount of SO, would be resorted to, administered but with still no sign of labour. In some cases, eventually, the attempt would be abandoned and an elective caesarian performed.

Around the mid 1980s the use of prostaglandin tablets designed to be swallowed, but instead sometimes inserted into the vagina, were used to ripen (soften) the cervix. Given in increments of 0.5mg, these tablets would at times drop out and sometimes not dissolve. Many, particularly first time mothers, were required to have such prostin insertions over many days, until the cervix was soft enough to allow ARM. Then SO infusions were used to continue to drive the labour. A few required only prostaglandins. In my area of practice prostin jel was introduced during the

early 1990s. This was injected into the anterior fornix in one or three mg dosages depending on an assessment of the degree of ripening already present. Gemeprost (a prostaglandins analogue) was used as an aggressive induction agent for second trimester labour in women with severely malformed fetuses. Nowadays the drug misoprostol seems to be increasingly used for this purpose.

Methods and up-to-date approach to IOL

A recent observational study on the experience of National Women's Hospital in Auckland, which provides care for approximately 9,000 women per year, may provide a reasonable representation of the methods used today and their relative popularity in this country (Parry, Parry & Pattison, 1998). Out of 36,025 births over a four and a half year period from 1992 to 1996, of those women who underwent IOLPP at 42 weeks, 79% had prostaglandins alone, 8.6% had ARM alone and 12.4% had syntocinon and ARM (ibid, p. 277).

Sequelae

Regardless of the increased confidence in accurately assessing the maturity of the fetus, there remain risks associated with this intervention. These are clearly reflected by the care taken to monitor both mother and baby closely, should an induction be in progress. Hazards of induction include: unexpected prematurity; neonatal hyperbilirubinemia; ruptured uterus; fetal compromise (inadequate placental blood flow) and death; increased operative delivery and episiotomy, and increased use of pain medication (cascade of intervention) (Yudkin, Frumar, Anderson & Turnbull, 1979; Boyd & Sims, 1988, cited in Almstrom, Granstrom & Ekman, 1995; Cole,

Howie & MacNaughton, 1975; Bramadat, 1990, cited in Bramadat, 1994; Alfievic & Walkinshaw, 1994). Precipitate labour can happen when the readiness of the uterus to labour is *underestimated* as when the ripeness of the woman's cervix with a digital examination is assessed too conservatively or the strength of the contractions the woman is already having is misjudged. Occasionally the amount of prostaglandins is then overestimated or, in retrospect, the woman is found to be more sensitive to artificially delivered prostaglandins than was anticipated. Sometimes this coincides with the often routine rupturing of the membranes. The cumulative effect of these is a tumultuous labour almost certainly resulting in a shocked baby and shocked mother.

This type of precipitate labour, or the intensity of these contractions, coupled with a natural anxiety magnified by the situation, often leads to increased demand for epidural pain relief, and increased diagnosis of possible fetal distress. Some research disagrees (Robson et al, 1997; Cucco, Osborne & Cibils, 1989; Hannah et al, 1992; Dyson et al, 1987) and some agrees, that the increased epidural rate generally leads to more apparent fetal distress and increased rate of Caesarian section (Parry et al, 1998; Yeast, Jones & Poskin, 1999; Saunders & Paterson, 1991; Soliman & Burrows, 1993). Some say no effect is found either way (Sue-A-Quan, Hannah, Cohen & Liston, 1999; Crowley, 1999). Ineffectual pushing can lead to increased need for operative or instrumental delivery that almost always requires an episiotomy to be cut. It is not easy to demonstrate clearly a relationship between epidural, SO (or prostaglandin) initiated contractions and the development of fetal distress, because of the factor of possible post maturity which classically declares itself by poor fetal response to contractions induced *or* spontaneous. To examine such a relationship it

would be necessary to study considerable numbers of clearly defined groups and the ethical implications may be insurmountable.

The range of sequelae then can go to the extreme of a failed induction. This means no method at all was successful in initiating the onset of active labour, leading to an inevitable Caesarian section birth, which continues to be associated with higher morbidity and mortality (Bulger, Howden-Chapman, & Stone, 1998). All the above are theoretical possibilities even with today's understanding of cervical assessment and the properties of prostaglandins.

Incidentally, when conducting the Cochrane systematic review of the RCTs of IOL versus conservative or expectant management with monitoring, Crowley found no effect, contrary to perceptions referred to above, on instrumental delivery rate, use of analgesia or incidence of fetal distress. There was less risk of meconium staining of the amniotic fluid if the woman underwent IOL at 41 weeks, but no effect on meconium aspiration and rate of neonatal seizures (Crowley, 1999).

As part of a perceived progress towards even more technological management of otherwise low risk pregnancies, some of the more recent research is focusing on whether women can be induced close to their due date (i.e. 40 weeks exactly) with its benefits to attendants in convenience but *without* dire consequences (Robson et al, 1997; Roztocil, Koudelka, Husicka, Jelinek, & Pilka, 1996). Apart from the *deja vu* impression it creates (did history not discredit the practice of 'induce on the due date in the 70's?'), this 'ideal', paradoxically, tends to highlight those very dire consequences. Such intense care is required and such lengths and expense are gone to, to prove there are not any dangers, or none of consequence. Intensive measures

are taken to monitor the woman and baby when a labour is being induced, and these metaphorically proclaim to all participants, that this *is* a high risk intervention which could go awry at any time. Why else the close monitoring?

There is a convention which disguises these measures as mere precautions designed to reassure the woman and not proclaim the hazard of the intervention she is experiencing. And there are of course clear medical indications for non-PP inductions, but then in those cases there is no need to equivocate about the monitoring. The monitoring does reflect the seriousness of the situation. Ironically the woman is expected to find it all reassuring, not the opposite.

Finally with regard to sequelae, there remain concerns about hyperbilirubinaemia that was first reported in Cole et al (1975), and an effect on breast feeding (Rajan, 1994).

Indications of induction of labour

Clearly, prolonged pregnancy is not the only indication for IOL. In order to suggest the range of indications, and provide some examples of rates according to indication, in a small variety of settings, and the variation between settings and within a decade of time, I offer the table below (**Table 1**). This lists percentages for each of the indications given by National Women's Hospital (NWH) and Wellington Women's Hospital (WWH) for induction of labour, and compares these with rates attributed to a 'large' Australian hospital in 1986 by Beischer & Mackay. These latter indications are calculated from a sample of 9,938 consecutive inductions at a major teaching

hospital, an incidence of 24.2% (time period not indicated) (Beischer & Mackay, 1986).

Table 1: Comparison of indications for IOL amongst two New Zealand women's hospitals and an Australian women's hospital (NWH Report, 1997; WWH Report, 1997, Beischer & Mackay, 1986).

Indication	NWH in 1997	WWH between 1994 and 1997	Major Australian Hospital in 1986
Pregnancy induced hypertension; Eclampsia; chronic hypertension	19.6%	26.9%	25.7%
Prolonged Pregnancy	25.3%	28.3%	20.3%
Placenta praevia; Accidental haemorrhage	1.6%	0.0%	1.2%
Fetal abnormality; Intrauterine death; hydramnios; intra-uterine growth retardation; fetal distress	19.2%	13.5%	9.2%
Rhesus iso-Immunisation	0.7%	0.0%	0.8%
Maternal disease/distress; diabetes; cardiac abnormality; tuberculosis; poor obstetric history	8.6%	3.0%	10.3%
Pre-labour ruptured membranes	12.3%	9.0%	0.0%
Other (?elective; miscellaneous; misclassified)	12.7%	19.3%	32.5%

As can be seen from the table, prolonged pregnancy is the most common indication in the New Zealand hospitals. If it is true that there are once more escalating rates of IOL then there is a natural tendency, when trying to understand why this would be so, to focus in on this indication because the majority of the women these figures represent are otherwise low risk. It is of note also that the table reveals sizable segments labeled 'other'. In the respective reports NWH documents 11.22% as 'miscellaneous'(NWH Report, 1997), and WWH has 15.18% and labels 4.21% as

'misclassified' (WWH Report, 1997). NWH openly includes the indication 'woman's choice' which I have included with 'other'.

Rates of Induction of Labour

In the United States, over the last decade, rates of IOL have been quoted as 9% in 1989, rising to 16 % in 1995 (Ventura, Martin, Curtin, & Mathews, 1995 cited in Prysak & Castronova, 1998). A WHO study carried out in 1992 cited in Wagner (1994) that admittedly (and misleadingly) combines induction with augmentation² of labour rates, reported variations between countries as wide as 12.0% in the United States of America and 80.0% in Greece. Hughes & Morrison reported an annual average IOL rate of 10.2% in the United Arab Emirates, between the years 1990 to 1993 (ibid, 1994). Although these figures are difficult to interpret without corresponding perinatal mortality and neonatal outcomes data, they do suggest caregiver manipulation of indications for IOL. In the Queen Elizabeth Hospital, Woodville, Australia the rate was 22.3% in 1997 (Robson et al, 1997)³. Pattison quotes 21.5% for Australia in 1995 (Pattison, 1995). There are variations between countries, and variations within countries, apparently related to rates within ethnic groupings, whether or not the hospital was teaching or private and model of care, i.e. doctor-led or midwife-led. Versi, Liu, Chia & Seddon, when studying a group of Indian (Bangladeshi) women in a European locale (East London), discovered these women experienced far fewer obstetrical interventions (including IOL) but had equal or better perinatal outcomes, compared to Caucasian Londoners (Versi et al, 1995).

² The acceleration of an established labour with the use of oxytocin intravenously.

³ Incidentally labour was induced here for defined indication in only 53.7% of cases, the other 46.3% had no indication recorded.

The same clear difference was discovered by researchers when comparing experiences of Vietnamese women with Caucasian Australian women in Sydney (Henry, Guaran, Petterson, & Walstab, 1992). The Vietnamese IOL rate was 7.1%, compared to 24.7% for the Caucasian women.

Induction of labour in New Zealand

IOL rates in New Zealand seem high compared to countries of a similar level of economic and social development and certainly compared to the WHO recommended maximum rate of 10% (WHO, 1985). These rates are also increasing (Pattison, 1999). In 1997 the rate of IOL at WWH was 26.5% and at NWH it was 32% (*Wellington Women's Hospital Women's Health & Newborn Service Report, 1997; National Women's Hospital Annual Report 1997, 1997*).

Figures quoted in Parry et al's study were of the 36,025 births at NWH from January 1992 to June 1996. 846 of these women (3.26%) were deemed postterm (defined in this study as greater than 42 weeks pregnant) with ultrasound confirmed dates. 360 of these (42.5%) were induced for postterm pregnancy, i.e. less than half of the cohort officially 42 weeks or more pregnant. The figure of 3.26% sits comfortably within Crowley's estimate of a *naturally* occurring rate of postterm incidence. "Post-term pregnancy, another indication for induction of labour, is a rare occurrence; its true incidence is only 4-6% of pregnancies of 28 weeks or more" (Crowley, 1991, cited in the WHO Report, 1992, by Wagner, 1994, p.147). Other estimates for comparisons are: Gibb et al, (1982) 6%; and Chua and Arulkumaran, (1999) 3-10%. The rate for IOLPP in 1996, at NWH was 7.1%, where n = 7651 (total number of women who did not have an elective Caesarian section) (NWH, 1997). The rate for

IOLPP at Wellington Women's Hospital over the years July, 1994 to June, 1996 was 7.8%, where $n = 8682$ (total number of women who booked at WWH in that time period and did not have an elective Caesarian section) (WWH Report, 1997). Setting aside the problems of inconsistency of definition, and the unknown volume of the PP cohort who would have laboured spontaneously and who may or may not have declined IOL, it is evident that PP includes women whose pregnancies were greater than 40 and less than 42 weeks. That is to say it includes many women who were not postterm by Parry et al's definition. Further research is required to establish the trend in rates of women at more than 40 but less than 42 weeks who have IOL only for the indication PP, together with trend in perinatal mortality rates for this group.

Speculations about the increasing rate

Is there more prolonged pregnancy than ever before? Is the definition of the 'condition' in New Zealand more elastic than the authoritative, internationally recognized definition? Further research is required to investigate this issue. Amongst the speculations that are offered to help explain the *overall* rising rate of IOL is one that more and more inductions are being done for the indication of 'prolonged pregnancy' and the finger has been pointed at the conclusions of a major overseas RCT as the primary influence on this trend. This study by Hannah et al involved 3407 low risk women. 1701 women were assigned to be induced at 40 weeks and ten days. The remainder were randomly assigned to serial antenatal monitoring and either went into spontaneous labour or, if there were signs of fetal or maternal compromise, had IOL or Caesarian section. The two approaches had similar rates of perinatal mortality and neonatal morbidity but the Caesarian section rate was lower for the induced group ($p=0.003$). Of greater influence possibly has been the

Cochrane Collaboration's Systematic Review of the evidence, which found: "Routine induction of labour after 41 weeks gestation appears to reduce perinatal mortality" (Crowley, 1999, p.1).

It is also suggested that the increase results from the growing perception that it is 'just another choice' in this era of options of care. This 1990s development could be interpreted as representing a virtual abdication of prudent obstetric judgment. Could this be one of the unwanted consequences triggered when the consumer can vote with her feet and she takes the Health Funding Authority (HFA) dollars with her?

Decision to induce and model of care

Examination of the statistics in the literature reveals a difference in IOL rates between different care models (Tilyard, Williams, Seddon, Oakley & Murdoch; 1989; Turnbull, Holmes, Shields, Cheyne, Twaddle, Gilmour, McGinley, Reid, Johnstone, Geer, McIlwaine & Lunan, 1996; Waldenstrom, Turnbull & Nillson, 1997). In this country there appears to be a scarcity of information regarding any association between IOL, other obstetric interventions and the maternity care arrangements made possible by the Nurses' Amendment Act 1990, and changes to Section 51 of the Health and Disability Services Act, 1996. In other countries there are data to suggest care arrangement plays a major role in the variation in rates of most major obstetric interventions. As an international comparative indicator, Turnbull et al studied 1299 women, with no adverse characteristics, and reported a rate of 33.3% for a shared care cohort in the Glasgow Royal Maternity Hospital and a 23.9% rate for midwifery-only-care women (Turnbull et al, 1996). The nature and location of the hospital, i.e. whether private or teaching, also appears to play a part.

For example the use of oxytocin for induction or augmentation at one tertiary level teaching hospital was between 29.1% and 31.9%. Whereas the rate was between 36.5% and 42.8% in primary metropolitan suburban hospitals (Lumley, 1988, cited in Bramadat, 1994). There is usually a clear association between complexity of the physical, maternal and fetal situation, and choice or assignment of caregiver. It could be expected therefore that women with more complex needs and therefore increased likelihood of requiring IOL would be found in a tertiary teaching hospital. Of interest would be the rates of IOL for those low risk women whose primary carer is an obstetrician.

As a further comparison between a total midwifery care model and shared care/ tertiary hospital, a report on the Domino midwifery practice in Wellington in 1992, gave their IOL rate as 13.7% (n = 205) (Scotney, 1992). In 1998 a further report comparing the IOL rate for Domino to other care models found the Domino IOL rate was 7.1% (n = 642), whereas other midwife-led care was 19.8% and shared care between midwife and general practitioner was 22.1 % (Sutton, McLauchlan & Virtue, 1998). This study was specifically adjusted to compare women of similar risk.

New Zealand is in a unique situation currently, of experiencing an increase of midwife-only care for a woman having a normal pregnancy and birth. In fact the majority of pregnant women in 1998 chose a midwife as their Lead Maternity Carer (LMC) (Guilliland, 1998; Pattison, 1999). Presumably it is the LMC who provides the information concerning prolonged pregnancy and induction of labour if the woman becomes 'overdue'. Therefore the potential for midwives to influence IOL choices is enormous. Midwives must be comprehensively informed on this issue.

Karen Guilliland in a presentation at the 10th National New Zealand College of Midwives (NZCOM) Conference provided some figures for comparison (Table 2, next page). Guilliland then commented: "...it appears induction rates are too high. The overall New Zealand induction rate of 33 % (# below) is alarming when 62% of women choose a midwife as their LMC. Midwives initiate consultation for induction and obstetricians decide its appropriateness so what are the dynamics influencing this highly unsatisfactory trend to induce?" (Guilliland, 1998, p. 6)⁴. Her call is echoed by Sutton et al: "There is [therefore] an identified need for New Zealand research that is focused on maternity care outcomes for different provider groups in different settings" (ibid, 1998, p.3). There is growing evidence that if continuity of midwifery care, i.e. when a woman knows her midwife and is cared for by that midwife throughout her pregnancy and birth, is in place, the woman is more likely to avoid induction for whatever indication, with quality of outcome at least not affected and usually better (Rowley, Hensley, Brinsmead & Wlodarczyk, 1995; Turnbull et al, 1996; Rosenblatt, Dobie, Hart, Schneeweiss, Gould, Raine, Benedetti, Pirani, & Perrin, 1997; Waldenstrom et al, 1997; Waldenstrom & Turnbull, 1998; Sutton et al, 1998; and Guilliland, 1998). There is the corollary, at least within New Zealand, that low risk women attending specialist obstetricians are at *greatest* risk of not only being induced, but also requiring an epidural and having an abnormal delivery (Tilyard, Williams, Seddon, Oakley & Murdoch, 1989; Pattison, 1999;

⁴ NB: Guilliland quotes a 1996 figure (33 %), in association with a 1998 figure (62%).

Table 2: Comparison of rates of IOL and caregiver (Guilliland, 1998).

Author/Source	Year	Caregiver	Rate of IOL
Guilliland, NZCOM Study Midwife Care	1996	Midwife	12.0%
Waldenstrom & Turnbull*	1998	Midwife	11.2%
As above	1998	Doctor	14.6%
AIHW National Perinatal Statistics Unit+	1995	Doctor	21.1%
NZMOH	1996	Shared	33.0%#

*This is a meta analysis of seven international controlled trials on continuity of midwifery care versus standard care. Clients were *low risk* in 5 out of the 7 trials, which calls into question how fair the comparison is. Ideally when the intervention being compared is IOL, and the model of care association is being scrutinized, all women should be low risk. *However* there remains a distinction between rates with regard to caregiver, despite the non-uniformity of risk. Also the risk status of the groups reported on by the other sources in the table are not indicated.

+Perinatal Society Newsletter, No. 41, February, 1998. Australian Institute of Health and Welfare National Perinatal Statistics Unit.

#Acknowledged by Guilliland to refer to IOL *and* augmentation; true IOL rate closer to 25% (Private communication).

National Women's Report, 1997; Wellington Women's Report 1994-1998). In Australia, Lumley, by comparing rates of induction and augmentation between tertiary level teaching hospitals and primary metropolitan suburban hospitals, was able to show that lower risk women had higher rates than high risk women (Lumley, 1988, cited in Wagner, 1994). The lower risk women in the suburban hospitals, from an obstetric and medical viewpoint, could be anticipated to have a lower rate of IOL and augmentation than the higher risk women who attended the tertiary level facility. Instead the reverse was true. It is possible only to speculate at this point that the time spent in information, explanation exchange, and affirmation of the woman's ability is more valued in such a non-medical model.

The debate regarding the approach to take when the pregnancy continues beyond the set date (but, confusingly for some women, continues to be, strictly speaking 'term')

still rages despite the apparent unequivocal conclusions of the Cochrane systematic review (Crowley, 1999, last substantive amendment October, 1996). The review takes a women-centered stance, however, recommending that the evidence should be explained to her, including the lack as yet, of reliable fetal surveillance methods, and then she decides (*ibid*). It is interesting to contrast the Cochrane Review with Boisselier and Guettier's narrative review of the literature (Boisselier & Guettier, 1995). The latter claim there is no definitive answer from RCTs. Overall they claim there is no advantage in systematic induction. Theirs is a narrative review that takes a lower place in the hierarchy of evidence to the systematic review. Some of course challenge the methodology of systematic reviews where the results of many carefully selected trials are combined for maximum power of analysis. Some question the sound basis of combining RCTs from different decades and different countries and, sometimes, with overall uneven methodological quality.

The debate, on whether or not to induce, and at how many days post dates to induce, seems to divide roughly along international lines. There is also division within some national medical communities. In the United Kingdom, Grant argues for induction and for this to happen shortly after 41 weeks always, whereas his countrywoman Cardozo sides with the view of the Scandinavians which is that the evidence does not support elective induction. This latter group argues that both approaches to management should be fully discussed with the women. (Grant, 1993; Cardozo, Fysh & Pearce, 1986; Cardozo, 1993; Almstrom et al, 1995). Some in the United States (Dyson et al, 1987; Votta & Cibils, 1992; Prysak & Castronova, 1998) clearly support induction at or just beyond term, whereas the American NICHHDNMFUDU disagrees. Their RCT, which involved women whose pregnancies were at 41 weeks, carried out about the same time as the Canadian multicentre trial (Hannah et

al,1992), came to similar conclusions despite several differences in how the studies were done: "...the major conclusion of the two studies was the same (i.e., perinatal outcome in postterm pregnancy is similar whether the pregnancy is managed by immediate induction or expectantly)" (NICHHDNMFDU, 1994, p.723). The Canadian trial was criticized by Crowley as having significant potential for performance bias because the researchers withheld prostaglandins from women in the control arm of the trial who required induction of labour following abnormal antenatal monitoring. Also, as Cardozo points out, these researchers did not define what they meant by 'fetal distress' although this was the indication for the Caesarian sections performed on those women in the spontaneously labouring group. This later group had a significantly higher Caesarian section rate than the induced group (Cardozo, 1993).

Aside from this, Hannah and her colleagues did carry out a most influential RCT presenting a strong argument for induction at 40 weeks and 10 days. Nevertheless they too line up behind the 'support the informed choice of the woman' approach advocated by Cardozo et al, 1986, and Almstrom et al, 1995. This is the conclusion of an article by the Canadians in *Birth*, which was based on their 1992 research:

Women should be informed of the benefits and risks associated with the policies of induction of labour and expectant management. Specifically, they should know that induction of labour, after pregnancy has reached 41 weeks' gestation, is associated with a lower risk of stillbirth or neonatal death and a lower caesarian section than expectant management. In addition, women should be informed that induced labour that occurs with expectant management is associated with a much higher rate of caesarian section than spontaneous labour. Despite these benefits from this policy, some women may perceive that induced labour is sufficiently unpleasant that they may prefer to pursue expectant management. Women's preferences should be respected (Hannah et al, 1996).

There is a different tenor to this concluding acknowledgment, than in the 1992 paper. Here they allow it is the women who take the responsibility and must make the ultimate decision.

Two Swedish researchers, Per Olofsson and Pia Saldeen, seem to represent those on the other end of the spectrum. They have studied outcomes for pregnancies *beyond* 43 weeks and concluded : “there seems to be no ‘right time’ to induce nor is there any conclusive data on which to base a rational decision” (Olofsson & Saldeen, 1996, p. 649).

In New Zealand, the recent observational study by Parry et al concluded that only multiparous women (having one child already) benefited from IOLPP, not first time mothers as the latter had adverse outcomes including an operative delivery rate of 57% (Parry et al, 1998).

Women’s Experience

A search for references to women’s experience of prolonged pregnancy, and the experience subsequently of being induced, at least within the English language category of the published scientific reports, was a disappointing exercise. There is very little in the literature that primarily reports on women’s experience of either prolonged pregnancy or induction of labour for that indication. Many review and commentary writers remark on the lack of focus on women’s views, whether it be on IOLPP or on induction per se (Bramadat, 1994; Alfievic & Walkinshaw, 1994; Hodnett, Hannah, Weston, Ohlsson, Myhr, Wang, Hewson, Willen & Farine, 1997; *Drugs and Therapeutics Bulletin*, 1997; and Parry et al, 1998). My search uncovered

just ten primary sources published in the last 25 years, which wholly concerned, or made any reference to, the opinions or views of the participants in the study. Only three of them appeared in the last decade, and three of the ten were based on brief adjunct questionnaires designed to elicit quite simplistic responses.

A study by Out, Vierhout, Verhage, Duiivenvoorden, & Wallenburg looked at characteristics and motives of women choosing elective induction of labour (Out et al, 1986). They were the first to study prospectively the attitudes and preferences of a group of women who were to be given the choice of waiting, or of being induced when they got to their due dates. The researchers assessed the personal characteristics of these women and the motives they had for choosing either spontaneous onset of labour or elective induction. Of the 237 women at full term in their pregnancies 46% chose induction. It appears these women had more complaints, both during the pregnancy and about menstruation, more complications with previous pregnancies, and greater anxiety, than the group who chose to await spontaneous onset. The former felt they needed the pregnancy over and were concerned for the safety of their baby. This was a study aimed at evaluating an approach to management rather than assessing the effects of the intervention itself. It studied a group at term not a group who were considered by all the criteria to be post term or with a prolonged pregnancy. Once more you encounter the semantic difficulty. This aside it is clear such an approach to management reinforces the attitudes or empathizes with a considerable proportion of the pregnant population whichever viewpoint you wish to take.

These researchers hint at the biases of the authors of the retrospective studies. There is also the problem of blurring of the indications. Was it elective? Was it medically

indicated? This confuses the issue of the effect of the procedure. These women attended an antenatal clinic at a teaching hospital in Rotterdam. The Dutch are known for their basic trust in the normalcy of pregnancy and usually signal a clear endorsement of midwife-led care. Apparently contradictory to this impression, 23 of the originally selected group of healthy women were strongly recommended by their attending obstetrician to *be* induced. For this reason they were excluded from the study. This may be an indication that a more medical, interventionist approach dominated the management in this particular hospital.

The women were selected at 36 weeks pregnant. Data were collected on age, marital status, education, occupation and husband's occupation. They answered a self-rating questionnaire of 91 statements about pregnancy, expectations about the delivery and motherhood. Amongst the topics were: information seeking behaviour and self-esteem. The statements required the response: 'yes', 'no', or 'don't know'. The women were supplied with a booklet containing information about the procedures, described as 'positive information.' It is acknowledged by the researchers that to ask a woman to make such a choice in the last four weeks, a time of optimal stress, has the potential to skew the response.

On day four or five following the birth, if the woman was accessible, she was interviewed about her motivation for making the choice she did. This resulted in 172 responses (72.6%). The questionnaire responses were chi-square tested. An optimal distinction between the two groups was searched for with a linear discriminant analysis. Clusters were identified. Motives that surfaced in the interviews were counted and grouped according to similarity.

Significantly more primiparous women chose spontaneous onset. Significantly more women with previous complications chose elective induction. Significantly more of the lesser educated and non-religious women chose elective induction. Parity paid a major role in the decision. Those with more confidence in themselves as carers of babies chose elective induction, which is consistent with the perception that the baby is easier to deal with outside, rather than inside, the womb. It was also a factor in that with induction there was more certainty about the start time of labour. If that was known then it is more likely the partner would be present, child care would be easier to arrange, and there would be no chance of the humiliation of arriving at hospital only to find it was 'false' labour. Induction gets the pregnancy over sooner and perceptions of ensuring optimal safety by having an induction are satisfied. There was a group who laboured spontaneously even though they had chosen induction. There were no significant differences found with respect to reported motives for this group. The general feeling was that the group choosing IOL expressed less trust in their physical reproductive functions.

Those that chose spontaneous onset valued the 'naturalness' of this process, the "doing it all by myself". They rejected obstetric procedures. They wanted to be active and not be confined by monitoring and induction equipment. They had had a smooth pregnancy and had abstained from intervention. They were conscious of the possible harm involved in the induction procedures, and had feelings of stress if a precise moment of onset is known. You wonder how the study would have gone if they had restricted the group of participants to primiparous women. Because this study deals with 'term' pregnancies and although that is not defined, it is inferred that this is 40 weeks, and it is not possible to relate it directly to women who also experience prolonged pregnancy.

Roberts and Young's study was also prospective and questionnaire based (ibid, 1991). This research does address attitudes to PP. A group of 500 women were enrolled at 37 weeks gestation. These women were told by their medical advisors that their health status indicated they could await spontaneous onset of labour. Only 45% at that gestation however would agree to wait. Of that 45%, who were still pregnant at 41 weeks, less than a third wished to continue to wait. There was no connection between making the choice to wait and parity (whether or not the woman had children already) or being certain of the accuracy of the due date. This study took place in a military hospital in Britain. There had been a change of attitude towards the management of prolonged pregnancy. Previously IOL at 42 weeks had been the policy. Low risk women now were invited to choose, and an audit of the effect of this change was done, including this study of women's attitudes. These researchers give the text of the information sheet they provided the woman. This includes the statistic (unreferenced) that in only six in 1000 pregnancies that extend beyond 42 weeks is it medically indicated that the labour should be induced. Induction was however recommended at 44 weeks. The final paragraph of the three paragraph sheet states: "If unnecessary induction of labour can be avoided, we think the forceps delivery and caesarian section rates will be reduced. In addition, a spontaneous labour is likely to be shorter and less painful than an induced labour. Although nothing in medicine and particularly in obstetrics is 100% guaranteed, we feel that our current attitude towards postmaturity⁵ allows women to await the spontaneous onset of natural labour between 42 and 44 weeks with no greater risk than that faced prior to 42 weeks" (Roberts & Young, 1991, p. 1103). These frank

⁵ This seems to me to be another inadvertently erroneous and misleading use of the term 'postmaturity,' which is not a synonym for 'prolonged pregnancy' but continues to appear as such.

words encourage informed choice although brevity is favoured in place of detail of the intervention procedures and actual chances of operative outcomes. This research predates the Hannah trial and the systematic review.

The questionnaire results were chi-square tested. They found that attitudes changed significantly between 37 and 41 weeks. Of the 60 women at 37 weeks who declined to wait to 42 weeks and beyond, 34 “could not stand the thought of being pregnant for more than 42 weeks” (ibid, p. 1105). Faced with this together with the logistic hurdles of complying with the extra visits required for increased surveillance of the baby, they balked. It was interesting to note that irrespective of the education (the information sheet and time spent on explanation with their advisor) 66% of the women gave reasons for not waiting which were contradictory to the gist of the information and counseling.

These researchers identify the ‘stumbling block’ as being the intense focus on *one* due date or day. They call for greater efforts at education, repetition of the critical issues, inclusion of the woman’s partner in the information sharing and decision making, and an awareness of the need for consistency of advice from other health workers.

Sarka (1997) also used a prospective, questionnaire based study to compare the current and general anxiety felt by women at term with that felt by women who were still pregnant at 42 weeks and longer. He asked 51 women with low risk, post-dates pregnancies to complete questionnaires aimed at revealing level of anxiety, and compared these to a control group of 54 woman having antenatal assessment just at 40 weeks. Not unexpectedly, those at 42 weeks or longer scored significantly higher

($p < 0.0001$), but there was no evidence of depression. For these women it was the thought of medical intervention that seemed to be causing the anxiety. As Judith Bibby points out in her review, the study lacked detail, e.g. the socio-economic status of the women is not known and the sample was small (Bibby, in MIDIRS, 1997). There is a need for research to examine whether such increased anxiety has significant impact on incidence of postnatal depression. Sarka's research was complimented by Bibby, as well constructed and well referenced, but her summation noted "This article, despite providing readers with the unsurprising conclusion [that] there is greater general anxiety in post date pregnancies, provides little insight into the emotional aspects." And "From a midwives' (sic) point of view this piece of research reinforces the need for individualistic, holistic care and the awareness that increasing emotional stress antenatally may lead to postnatal depression but there is really the need for a longer, broader prospective study before any conclusions can be drawn from the evidence" (MIDIRS, 1997, p. 443).

Cardozo et al (1986) carried out a prospective trial aiming to compare "effects" of conservative (expectant) management with routine induction for prolonged pregnancy at 42 weeks. 207 low risk women waited for spontaneous onset and 195 had IOL. Age, parity and smoking rates were similar. As an adjunct to the trial, these researchers assessed the women's satisfaction with the management by a simple questionnaire administered by the staff midwives on the day after the birth. The questionnaire offered the choice of comments as 'pleased'; 'no comment'; 'disappointed' and 'no response'. These were matched with whether the outcome was a spontaneous delivery or 'other'. They concluded: "...there were no significant differences in the women's comments regarding management, and analysis of the

data showed that satisfaction was related to the mode of delivery and outcome rather than to induced or spontaneous labour” (Cardozo et al, 1986, p. 1061).

Twenty-five years ago a survey by Lewis, Rana and Crook (ibid, 1975) investigated women’s knowledge of induction. Responses varied depending on whether or not the woman had attended antenatal classes. Not an unexpected discovery was that an explanation of the procedure can radically alter the acceptability of it, all of which hinges on the objectivity or balanced nature of the explanation. It is germane that there was a distinct shortfall between the expectation of the ‘informed’ group and the reality of the experience for them. Far more in the informed group expected shorter labours than they had (and found labour more painful than they expected) than was the case in the uninformed group.

A study by Kitzinger (1975, cited in Bramadat, 1992) also showed women were not equipped during pregnancy with sufficient information to make an informed choice about type of labour. She reviewed self-composed reports from middle-class women who had attended National Childbirth Trust antenatal classes, 614 of whom had pharmacologically induced labours and 224 had spontaneous labours. Although her sample was non-representative, her findings were confirmed by Yudkin et al’s study (1979) with regard to incidence of medical interventions and the physiological outcomes. Both studies found that preference for spontaneous labour was significant and that perception of pain with IOL was increased. The interventions in the 1970s often meant the partner had to leave the room, which impacted negatively on psychoemotional health.

The findings of a third study in the 1970s were that the majority of women would avoid IOL for their second and subsequent pregnancies (Ounsted & Simons, 1979). These women were all primiparous and were interviewed just one day after delivery. 17% of women were undecided about whether they wanted an induction or not next time, 34% would have induction and 49% would prefer spontaneous onset. 93% of the induction group in this study had had epidural anaesthesia

Differences amongst the studies related to parity, amount of formal information, attendance at antenatal classes, incidence of epidural use, and timing of the administration of the questionnaires. All of these factors preclude simple interpretation of the findings or any overall conclusion.

The 137 women in Stewart's study (ibid, 1977) were interviewed in the 24 hours before the induction, during the labour, and at 12 and 48 hours after the birth. They were asked just half a dozen questions by midwives related to knowledge of IOL, immediate reaction to the induction, had they agreed 'gladly', 'indifferently', 'reluctantly', or whether they had initially refused. There were also questions related to assessment of length of labour, amount of pain and pain relief requirements comparing actual experience with expectation. These were IOL for all indications, not just PP, and in the days before prostaglandins, when amniotomy was performed regardless of readiness of cervix causing significantly greater discomfort to the women with unripe cervixes. Just 24% would have preferred natural onset; a high proportion did not get enough information, and nearly half considered labour more painful than they had expected. This was a small survey administered whilst the women were inpatients of the institution, subject to the service of the institution, and virtually directly after the event.

Finally, the pre-eminent source in the literature of research regarding women's experience is Ann Cartwright's 1979 book *The Dignity of Labour?* (Cartwright, 1979). Cartwright addressed the gap that existed up until that point because no one had surveyed a large enough, nor representative enough, sample of women who had experienced induction. Her book details her research into the experiences of a total of 2182 mothers who were selected at random from births registered in July and August, 1975. The women came from twenty-four randomly selected areas of England and Wales. They were intensively interviewed about their experience of childbearing. This took place for the majority (95%) at between three and five months after the birth.

In Cartwright's study, five hundred and twenty seven women experienced IOL. In contrast to the Ounsted and Simon study, Cartwright's group included multiparous women and only 9% had had an epidural. There was no separation out of the various indications for the induction so there is no specific data on experience of IOLPP.

Among the questions asked of the IOL group were how had they felt about induction before they had the survey baby, why they felt like that, and what their views were based on. One third said their views were based on other women's experiences and another third on a television or radio programme. When comparing the views of the women who experienced induction with those whose labours began spontaneously, there were clear differences between those for and those against induction matched with whether they had an induction or not. Those who were induced were half and half against and in favour. Those whose labour started spontaneously were five times more likely to be against inductions. Two of the possible explanations given by Cartwright for this difference: women's experience of induction coloured their

description of their feelings in the past, and in general the experience made them less antagonistic towards induction; and doctors are less likely to induce women who are antagonistic towards induction. Can we deduce from this that there is not always a clear obstetric rationale, accepted by the woman for each and every induction?

The current views of the women towards induction were found by asking them how they would like the labour to begin with the next pregnancy. This produced the most outstanding finding on the survey. This was that they rejected IOL as a way of beginning in labour in subsequent pregnancies because it was *unnatural*. Interestingly, speculation that the women would experience a sense of failure if their labours were induced was something that originated from caregivers rather than from the women themselves. Women were not given the information they would have liked. Also in line with Kitzinger's findings was the likelihood that their expectations of their labour experience were inaccurate. Consistent with the conclusion of Ounsted and Simons (1979), the majority (78%) of women stated they would prefer to avoid induction with subsequent pregnancies.

The most clear-cut verdict was that the great majority of women on the survey would not want an induction if they were having another baby. Although a higher proportion of those whose labour was induced this time than of those whose labour started spontaneously would prefer an induction next time, the fact that among those with experience of the procedure over three-quarters would prefer *not* to have an induction contrasts markedly with their preferences for a home or hospital confinement or for having or not having an epidural. For these types of care, between 63 per cent and 91 per cent voted for the same arrangement as last time. And this vote against induction was in response to a question that stressed the positive sides of induction and in spite of the evidence that the majority of women find the latter part of their pregnancy an uncomfortable and frustrating time (Cartwright, 1979, pp 159-160).

Her findings replicated several from Kitzinger's 1975 study, but Cartwright's are with a far more representative sample, and thus are generalisable.

The phenomenon of the radicalization of women acutely dissatisfied with their childbirth experience is often encountered by midwives. It was especially noticeable in the early 1990s in New Zealand, as the environment was changing. During that time it provided fertile ground for the taking root and flourishing of the beginning independent midwifery practices. Even prior to that development, it was the motivating force of some of the women who braved so much more to choose a birth at home.

As a recommendation arising from her research, Cartwright strongly urged that women should learn to ask questions about the management plan and related issues if not satisfied. They should make their wishes and preferences known. They should insist on being involved in important decisions. They should rebel against what she called "... the paternalism of the doctor who refuses explanation and simply insists he knows best" (Cartwright, 1979, p.164). However her research also showed her how far yet the woman's movement needed to go to empower women to challenge actively instead of passively accepting what was happening, finding excuses for it, accepting and impotent.

Amongst the secondary sources I discovered "Induction of Labor: An Integrated Review" by Ina J. Bramadat, published in 1994 by Health Care for Women International. Dr. Bramadat is a member of the Faculty of Nursing of the University of Manitoba in Winnipeg, Canada. In 1992 she reviewed both the research and anecdotal literature related to IOL. She was struck by the lack of attention paid in the literature to women's response to induction and augmentation, at least in North America. She referred to Arney's work where he attributes the difference in response between the States and the United Kingdom as directly related to the fact that normal

birth is midwife-managed in Britain (Arney, 1982, in Bramadat, 1992). The implication was that obstetricians found inductions convenient and easily moulded this into an argument that such intervention was safer than awaiting a spontaneous onset. Perhaps it was provocative comments such as these that precipitated RCT after RCT attempting to vindicate this claim. Bramadat summed up Arney's theory regarding the first IOL 'era' of controversy: "Arney conjectured that the British public reacted strongly to an increase in inductions because the justification for *moving the boundary of the normal region of childbirth further into high technology* was not based strictly on medical criteria" (Bramadat, 1994, p.136). Some writers attribute the backlash against rapidly rising rates of induction in the United Kingdom to a media campaign decrying the expanded scope of obstetrics. Whilst the American issue with medical intervention focused on the Caesarian section rate, there were some studies (partly as a result of strong media attention) in the United Kingdom which wanted to explore women's response to induction.

At a satellite symposium on IOL during the 2nd European Congress on Prostaglandins in Reproduction, Calder reported on maternal attitudes. (Calder, 1991, in Keirse & Elder, Eds, 1991). She gave an historical overview, argued strongly for the involvement of women in the decision making, referred to only two primary studies (Stewart, 1977, and Fleissig, 1991, cited in Calder, 1991), summarising them as concluding women given the choice would prefer natural onset. She also speculated on the connection between private care and increased rate of IOLPP: "...the interference may be considered justified for the convenience of her (the woman's) obstetrician. The extent to which a mother who has arranged private obstetric care will tolerate all manner of interference and indignity simply to ensure that her chosen obstetrician is available, is a matter of some surprise" (Calder, 1991, p.45). This adds

to the sense of the broad spectrum of responses women seem to have as they navigate the system at this vulnerable time, but also raises questions of adequate information, socio-economic factors, dependency and self confidence, contingent to the study of women's experience but unable to be fully explored in this context.

How different is the system now, the impact now at the end of the century in New Zealand as opposed to the scene she reflected in the United Kingdom in the mid 1970s? This uniquely female predicament becomes subsequently a real live scenario for some, a story they certainly may tell for years later and their children will always know as the beginning of the *mythology* of their own lives. It is also significant in its potential to influence greatly emotional health subsequent to the birth and attitudes to subsequent pregnancies.⁶

There has been little written in the literature, especially in recent years, that informs us of the response or feelings of women who experience induction of labour. In what little there is comes a clear message emphasizing a need for realistic expectations, balanced objective information, and the feeling of being prepared. I could find nothing in the literature that related to the experience of waiting, the state of being 'overdue'. It is clear the means available to us to date a pregnancy can only give the woman an *estimated* date; that it is at best accurate to within five days either side,

⁶ As a foot note I would like to refer to a passionately written submission by Gail Dahl of the Canadian Childbirth Association to the Alberta Medical Association, arguing for signed informed consent to IOL. This arrived via my midwives e-group mail late July, 1999. Referenced only by Goer's Chapter on Postdates Pregnancy (Goer, 1985), this submission reflects the extreme viewpoint of a woman catapulted to political activity by her induction experience. To quote from the submission: "...by reducing our ever-increasing rate of birth induction we will lower our medical costs for birth, reduce the need for cesarean birth, and we will have healthier babies and mothers.we are inviting you to regulate that written informed consent including the risks, side effects and natural alternatives to induced birth be made available to all women in Alberta....Many women report an induced birth is similar to a rape experience in regard to the trauma a mother feels when her childbirth is forced" (Submission, 23rd July, 1999). How many others does this woman represent ?

that is an imprecise calculation which nevertheless conveys an illusion of precision and assumes huge significance for the woman.

Conclusion

This chapter has relayed the many aspects of prolonged pregnancy and the intervention IOL that are to be found in the published literature. It is reasonable to conclude that rates of IOL and reasons for IOL vary from country to country, between geographical areas within countries, and from decade to decade. The variations are so great as to suggest no consistency in underlying rationale or pathology but some more arbitrary and political process at work.

Clearly there is a wealth of information on almost all aspects. What remain unheard are the voices of the women, who wait and who experience induction because a decision is taken that their risk status has changed because a day in the calendar has flipped over. The woman's social circumstances, self esteem and life experiences inform her attitude. Education, counseling and information are critical. What are the ways we can uncover both her response to the wait and the experience of the intervention? How best can her individuality be valued and considered when advising her in this 'condition'? The decision is reached in an environment where the current best evidence supports IOL at 40 weeks and 10 days but practitioners are urged to respect the woman's informed choice. Practitioners take up contradictory attitudes and approaches despite the non-equivocation of the evidence.

Midwives can derive reassurance from the fact that there is a debate regarding the 'best' approach to management of prolonged pregnancy amongst the medical and

scientific communities. Lack of consensus implies room for apparently non-women-focused practices to be challenged. There is a lack of literature that conveys the experience of a woman still pregnant past the time when her pregnancy was supposed to be over. For many, going 'over' by more and more days begins to become a nightmare. There is a way through; a rational approach which supports her and her family for them to grasp the situation, empathize, maintain or increase her confidence and support her choice. My challenge was to investigate the women's experience with maximum emphasis and focus on *their* voices, as opposed to their view filtered through a questionnaire composed by others, an interview survey where individuality is blurred as answers need to be grouped and themes allowed to emerge. The contradictions that arise when women are being interviewed by a woman in the area of childbearing are well described by Oakley (ibid, 1992). Time, finances and logistics; being outside my usual locale for the period of my study, together with a fascination regarding the potential for narrative to impact on learning and shaping practice, encouraged me to design a small, simple, narrative study. This research addresses the experience of the wait and of the intervention. IOL is explored in four unique, but also, paradoxically, universal stories, which form the major part of my study. In the process of telling, some of the women make better sense of their experience; the documented history of women's experience of pregnancy is added to; and we listen again to what we, as midwives, just 'know' perhaps, but yet are wise to *hear* again, and again.

Chapter 4 - Methodology

There is no binding theory of narrative, no standard set of procedures comparable to those used in experimental social psychology, opinion survey or psychophysical measurement. Investigators usually reach for narrative methods because of their evident power with respect to the topic at hand (Rosenwald & Ochberg, 1992, p.16).

Introduction

The methodology that I have chosen for this study is narrative inquiry using story telling informed by my position as midwife working within the midwifery model, together with the approach that this is an issue of empowerment. This chapter must explain the basis upon which these stories fit into the store of midwifery research and why they are to be taken with the seriousness the issue, and the commitment of the women, demand. In keeping with this approach I begin by discussing my midwifery position and where I stand with regard to prolonged pregnancy and the intervention, induction of labour.

My position as midwife

In my work as an independent midwife I encounter concern related to 'the date the baby is due'; 'what happens if the baby doesn't come'; 'what happens if I don't go into labour'; 'how long do they let you go'; and, 'why doesn't the baby come'. Women are aware that labour can be induced. I have been conscious of apparently higher intervention rates over the past decade. I have been aware of the research which reportedly influences intervention rates in this country because my approach is

to provide up-to-date information and whatever evidence exists regarding management to guide a woman faced with a decision to wait or not.

I have worked more and more in a total midwifery care (TMC) arrangement where the midwife works autonomously; can offer sole care for the woman and her baby provided there is no abnormal development. Should the woman or baby develop a problem the TMC midwife gives the woman the range of choices for specialist care and continues as her midwife but with the responsibility transferred to the specialist until the problem is resolved. I have also experience of working in shared care arrangements with general practitioners who have a six month Obstetrics and Gynaecology Post Graduate Diploma, and with fully qualified private obstetricians and partially qualified registrars who operate as part of a hospital based obstetric team with an obstetrician in overall charge. As such I have been exposed to a variety of approaches to the management of prolonged pregnancy. Part of my practice has been to supply and discuss the information given so clearly in the Chapter 26 of *Effective Care in Pregnancy* which deals with the best evidence on management of post term pregnancy (Enkin,1995, pp.179-182). This summary of best practice has been updated more recently by the systematic review on the issue available through the Cochrane Library. I spend time with the woman and her partner so they have an opportunity to discuss how this wait impacts, their understanding of the intervention, how they feel about the best information available, and what they prefer to do. We discuss what evidence there is to support the screening tests to detect whether the baby is one of those who could be compromised. There is much emphasis on the reassurance of knowing the characteristics which establish the fetus as an individual, known uniquely by the mother. Knowing what is and what is not usual can then guide the level of the woman's concern. This of course relies on the degree of self

esteem and confidence of the mother. If there is sufficient, testing but positive contact with her caregiver, then she learns that she will be heard and responded to positively, regardless of whether it is a 'false' alarm. In this supportive atmosphere she learns to discriminate amongst the plethora of advice from all around, and trust her own judgment. Feeling powerful on behalf of her baby needs constant effort for a new mother in this society. A midwife is challenged to know how to strengthen a mother's faith in herself so she does not require confirmation of her instinct from an other.

These are the aspects of the midwifery model that I apply: the midwife questions, informs, supports choice, provides actively a debrief outlet for the women as the relationship is closely and at crisis points as they pass; she practices reflectively to avoid sliding into a dogma in her turn as midwifery becomes a part of the establishment and all the associated narrowing of boundaries and protectionist mechanisms that accompany that development; the midwife empowers the woman to mother; promotes the normalcy of pregnancy, labour and birth; practices partnership; honours the Treaty of Waitangi; tends to the learning of students of midwifery and the lesser experienced midwife; values evidence-based practice; values stories.

An empowerment issue

This is a women's health and women's empowerment issue. The dominant discourse in maternity continues to be medical and patriarchal (McLauchlan, 1997; Donley, 1998; Davis, 1998; Papps & Olsen, 1997). The midwifery philosophy of the New Zealand College of Midwives (NZCOM) specifically mentions empowerment and partnership (NZCOM, 1993). It seems to me that there is a synchrony of method with

subject. So much of the power that women legitimately claim relates to their belief in the process of procreation happening ultimately perfectly through them as women, unaided. Both women and midwives have a need to combine energies and to question the nature of the assumptions which form the basis of the dominant worldview.

There are some characteristics of my research which align with a feminist position and more solidly with my position as midwife within midwifery model, using story telling. Berhard characterizes feminist research as: done by a woman; she (the researcher) uses feminist methodology (e.g. there is researcher-subject interaction, non-hierarchical research relationships are attempted, feelings are encouraged to be expressed and values are carefully guarded); the research potentially benefits the participants; it focuses on the experience of women; the text includes the words feminism and feminist; feminist literature is cited and the report uses non-sexist language (Berhard,1984, cited in Webb,1993). I also would include the concept of the subjects controlling the dissemination of any papers or articles based on the research in partnership with the researcher.

Another benchmark against which I have measured my approach is the summation of what feminist research constitutes for Patti Lather. She comes from the post-modern paradigm which pursues research intended to “empower the researched and contribute to the generation of change-enhancing social theory...” Feminist research should be “praxis-oriented ...critical and empowering...openly committed to critiquing the status quo and building a more just society” (Lather, 1988, p.569). This reference to ‘praxis’ for me links back to the use of my reflections to distill the messages within the stories.

Oppression lies in usurping of their (the women's) natural function by interfering *without necessarily their equal involvement in the decision* and whether they have always had access to all the information they need to participate in that decision, and the time they need to reach the right decision, which includes an appreciation at a deep level of the vagueness or imprecision of the dating of their pregnancy.

Narrative inquiry

The use of narrative pervades all cultures, from the beginning of human society. It's power has, I believe, always been recognized, but only recently has it been utilized as a formal means of inquiry (Riessman, 1993). Riessman quotes Todorov who first used the word narratology in 1969. More intense development of the methodology occurred in the late 1980s and early 1990s (ibid). We have an endless capacity to listen to, and tell, stories. What else is going on in this compulsive activity? How much respect is given it as a reflective learning tool? There is much casual acknowledgment amongst midwives of the power of stories.

Whilst continuing to value research and using it to inform our day to day work we should not underestimate how we question, learn and share an enormous amount of knowledge by listening to each other and the women we attend (Leap, 1998, p. 3).

I have chosen descriptive narrative because I am interested in how the women relate the story so as to make meaningful (or not) the experience to them and their significant others (Polkinghorne, 1988). Each woman's story presumably represents the accumulation of her individualized understanding and (permanent) impressions from a wide variety of sources resulting in residual feelings of comfort *or* discomfort. From this we can deduce her lasting impression, i.e., it is the ultimate consumer feedback. In an exposed, politically and economically vulnerable

midwifery profession, it is consciousness of quality care and consumer responsiveness, explicitly demonstrated by consumer involvement in its professional body, which are its cornerstones. This is one representation or reflection of quality or otherwise of maternity care with respect to immediate pre-labour care and support and to IOL at that historical point in time. *Her* last word.

Also I wanted to pursue this methodology because I realized that when researching a question of this nature, it is very difficult to eliminate bias. I suspected it would not be possible to remove the self from the outcome. My focus was on the truthfulness of the stories, taking care to establish the validity of the data and relevance of the 'results', clearly all the while facilitating the explicit participation of the co-researcher/subject/mother/woman in the generation of knowledge.

Swapping stories is fundamental to the culture of midwifery (Flint, 1986; James, 1995; Leap, 1998). I have set out to convey women's experience of induction in the form of four stories. This is a window of women's experience, not to my knowledge represented anywhere else in academic writing. There are examples of anecdotal accounts of induction for prolonged pregnancy in popular literature (e.g. Grayson, 1995; Bennett, Etherington & Hewson, 1993). These cast no more than a passing glance at the experience of being overdue: the waiting... waiting... waiting...As I indicated in the literature review, there was nothing that I found that dwells with intensity on this experience and the increasingly common, associated experience of induction of the seemingly dilatory labour.

What is assumed in the use of narrative? Intersubjectivity between researcher and participant and mutual creation of data. The participant is responsible for

constructing meanings that become data, opening these up to the presence of research; the opportunity of participating, and coincidentally minimizing potential for exploitation.

I do not want to confuse therapy with research but there is a sense in which one is pursued and the other is the result/partial result in the recording of narratives. Validity is best answered by the question: whose narratives are these? How holistic is the basis of the decision for the women? Where does midwife model differ from medical and where do they approach each other? Narrative, with its potential for detail, nuance and subtlety, seems well suited as a way to investigate practice issues within the midwifery model. Stories are about persons and about relationships. There is always an ethical element (consequence for the subject) explicit or implied. Judgments are always present. To become a 'narrative' a story must be conceptualised, restressed and completed. Narrative if it is ascribing a structure to certain events; containing a reflection or a theoretical component.

To summarize: the qualitative approach of narrative inquiry was chosen because I was conscious of the impossibility of eliminating bias. I was comfortable with making my position clear, with using active listening, if necessary, to facilitate the flow of the story and utilizing a memorized check list of key words to provide soft, approximate boundaries for the story; with recording how the women made sense of this episode in their lives. Finally there is the magnetic attraction and enduring impact of stories in themselves and the treasured place of stories in midwifery culture.

Rigour

How I influenced the content and process (construct validity) is explained in the methods section which follows. Michelle Fine urges researchers to articulate “how, how not and within what limits” voices are used (Fine, as cited in Webb, 1993). The voices are used to relay the stories. This may sound disingenuous however there is a legacy of story telling, recording of cases learning from women’s and midwives’ experiences. It fits well with the simplification of an approach for a broader audience. There were no preliminary assumptions or context set beyond: ‘tell the story to me as you would to a friend.’ However my midwifery persona breaks through that device, with minimal restraint and consciousness of a research setting. I slide into the knowledgeable or therapeutic(active) listening persona. I am conscious of the tension of what is implied by the prepared ‘prompts’ which shape my agenda and valuing what ‘prompts’ are operating for the woman. This immediately sets up contractions in power. All I can do is acknowledge the dynamics, trust in the integrity of the women and in the validation process I have put in place. The women have passed the stories as adequate representation of what was said, also that the story is the way it was. Questions were put to the women but largely the story flowed around the issues the women chose to emphasize/ reminisce with little resort to the prompts. The limits we agreed to were the exact topic, a time limit, the use of prompts if necessary, and the needs of the babies. The literary devices I have used to render the reflections more readable may have disguised the original form this data (the reflections) took when it was derived from the stories and sent for member checking to the women. Clearly, however, the stories are dialogic and verbatim. My voice is present, my opinions revealed directly and indirectly.

I have chosen not to analyse the conditions that have produced these experiences, although I acknowledge some aspects of the system surface with my reflections. I am looking for messages and otherwise to leave the stories intact for maximum impact and verisimilitude. I want thus to respect the ordinary along with the extraordinary to make the point that never is any of what we do and its ramifications to be taken for granted. I take no explicit stand with respect to the system in individual cases. I do not interpret economic, class, ethnic group influences. I present the experiences. I reflect. I distill messages. I link back up with the literature where this is relevant. I acknowledge the possibility of a self-selected, unconscious but inevitable discourse chosen by the women and a textuality which potentially undermines the integrity of the story as it can change from listener to listener. Hence my simplistic aim: the messages and the indelible imprint such detail and openness can leave. My discipline is midwifery. My agenda is how it can be strengthened by research, not transformed. A stronger midwifery profession has a greater impact in transforming the status of women. I know who my audience is.

Much more than 'swapping stories' however this forum allows me to draw attention to a topical issue in a most powerful way whilst also having the space, structure and time to ensure the validity of the data. The accompanying reflections can allow me to demonstrate possibilities, at least, of reflexivity. Reflective practice has the potential to keep us safe and strong as midwives as our profession enters the second decade of returned autonomy (Smythe, 1998).

Reflective practice

The task of my reflections is to uncover the deep seated but poorly recognized view on issues central to the research; to uncover the full account of the researcher's

views, thinking and conduct. Reflecting on practice is intimately linked with 'praxis'.

I am guided in how I present the stories by the concept of praxis. Praxis is the "self-creative activity through which we make the world. The central concept of a philosophy that did not want to remain a philosophy, philosophy becoming practical" (Bottomore, 1983, p.386, in *A Dictionary of Marxist Thought*, cited by Lather, 1991, p.11). The two requirements of praxis are: theory that is both relevant to the world and nurtured by the actions of it; and an action component in its own theorizing process that grows out of practical political grounding. As the postmodern equivalent of the dialectic (cf. Marx), deconstructivism provides a corrective moment, a safeguard against dogmatism, a continual displacement (ibid. p13). Reflexive practice is privileged as the site where we can learn how to turn critical thought into emancipatory action, learn to attend to the politics of what we do, and do not do, at a practical level.

The myths of universality, progress and the autonomy of science have been debunked. The mantle of objectivity has been irreparably rent. This suspicion of the intellectual who both objectifies and speaks for others, inveighs us to develop a kind of self-reflexivity that will enable us to look closely at our own practice in terms of how we contribute to dominance in spite of our liberatory intentions. It must work to oblige us to stand still and evaluate whether we do still have a mandate from women or whether we are of value to them in other ways than those we presume to be *before* we are too tightly locked in. Before we have replaced the subservient image with an equally rigid, ineffectual persona who spouts midwifery dogma.

Reflexivity

I like the way McLauchlan sums up 'reflexivity' from the viewpoint of the midwife researcher, in her thesis which explores current discourses on childbirth in the light of renewed autonomy for midwives in this country and how women negotiate the resulting medical model/ midwifery model paradigmatic turbulence: "As a midwife with a postmodern feminist perspective I expose my biases in an attempt to ensure that my account of discursive positioning (reflection on the stories of women's experiences) is viewed as one construction, influenced by my own positioning in the midwifery and feminist discourses" (McLauchlan, 1997, p.84). When reflecting on the women's stories, I selected issues which resonated with me after 17 years as a midwife. I was also influenced by the literature, by the selection of the women themselves, and by my individual *Weltanschauung* (worldview).

Reflexivity to me is a key concept protecting our profession from a mesmerizing reliance on one particular model, one viewpoint, one right way; of ensuring we sidestep the pull or tendency towards dogma. We argue we protect the normal in pregnancy and childbirth. We should continually demonstrate this, revising what we do, reviewing our actions, never taking our role as granted nor static. We need to cast a continual, deconstructive gaze on who we are and what we do. This will hold us with greater integrity on the journey to our women-centered goals.

Conclusion

The chapter which follows details the method of the study. This chapter sought to convey the theoretical framework I was working within to choose the method and shape the lens through which to view the data. Although the temptation was to

'trawl' the narrative for commonalities, parallel themes and significant conclusions, my challenge has been, given imperative respect for the methodology, to "...explore directly the storied (as opposed to actual sequencing) nature of human interpretation and place it at the centre of [the] analysis" (Sandelowski, 1991, p.479). Sandelowski characterizes narrative as a framework for understanding the human being (pregnant woman/new mother) as subject of nursing (midwifery) inquiry, for conceptualising the interview, where the rules and guidelines relate directly to the telling of a story, and finally, for analyzing and interpreting the interview data. The following chapter details the method This qualitative approach has the potential to speak to other women, to women pregnant for the first time, to mothers and to carers. In summary I pursue the unpacking of what is expected that a woman will live with in the final weeks of her pregnancy, how influential a quite imprecise day/date on the calendar is, and the tracing of the residue an intervention leaves on the memory of a birth.

Chapter 5 - How I Collected the Stories

This chapter treads the concrete path of how the study was done. Preparing for the fieldwork, I discovered a similar anticipation and challenge to what is felt by midwives when they approach a client for the first time, break the stranger barrier, and settle down to listen to the story, for example, of the previous birth, or the story of 'why a baby now,' or how the expectations of motherhood have formed for a first time mother. In order to reach potential participants, I found myself thinking along familiar lines. Referral happens; contact is made; a meeting is arranged; certain body language used. It is necessary to demonstrate an empathy and openness as well as be clear that a professional contract is being entered into. I plan to begin this chapter with a summary of how the research was carried out and move on to evaluate this approach 'from the other side', i.e. looking back from my destination, the fieldwork and the analysis complete.

Purpose and aims

There are nationally and internationally worrying trends of increasing intervention rates in the care of pregnant and labouring women (Bulger et al, 1998; Pattison, 1999; NWH, 1997; WWH, 1997; and WHO, 1992). It is timely to draw attention to both to the increase and the wide fluctuations. It may be that replicating a survey such as Cartwright achieved would best supply answers to the questions that I have flagged. However what is within my scope and how I can add to the scrutiny of this development is by investigating women's experience of PP, as a leading indication for IOL. I intended to focus on the intervention IOL, as one example which encompasses an issue

of practice and the importance of sound information. I wanted to add to the store of information and insight that is conveyed during the discussions and planning that take place between midwife and woman when the latter appears to be moving into this 'overdue' period in pregnancy.

My intention was to relay the stories of four women whose pregnancy experience included waiting after the due date and having their labour induced. I planned by reflecting on their issues, by analyzing how they have or have not made sense of this period in their lives as mothers, by inviting them to scrutinize the transcripts and the comments for validation, to begin to address the virtual void in the literature where the women's voices belong. Would there be something in the detailed stories of a small group which midwives needed to hear and/or would suggest what might require further investigation?

Research Design

This is a qualitative study using a narrative approach informed by feminism, to explore the experiences of four New Zealand women reflecting on going overdue and having their labours induced. Although there is a variety of ways in which to approach narrative presentation and analysis (Polkinghorne, D.E.,1988; Sandelowski, M., 1991; Rosenwald, G.C. & Ochberg, R.L.,1992 and Riessman, C. K., 1993), the method chosen has been straightforward selection of texts from each woman's story which relate to being overdue and the events as they recall them of the induction process. Where useful I have linked these texts to the literature. I have also commented and reflected from my perspective as an independent midwife. By positioning myself *in this way* (as I have

done in the previous chapter) which exposes my biases, and by describing and explaining my approach as listener and transcriber of the stories, I hope to demonstrate that my assessment of the women's experience can only ever be one individual construction. I have also sought to reinforce the validity of the approach by referring to the Field Diary and other reflections in my Journal. The stories were edited and scrutinized for accuracy by the women. The reflections, also sent to the women, have not been challenged by them.

Method

The intention was to advertise for volunteers who would be prepared to tell me their stories of going overdue and eventually experiencing IOL. I would record the stories, transcribe them, ask the women to audit the transcripts, write my reflections, which the women would also review. I would then summarise the messages, primarily for midwives, but also for pregnant women and mothers. A pilot narrative was originally planned. However it rapidly became clear that the uniqueness of each story and the individuality of its setting negated any benefit of modifying the design on the basis of one story. I required faith that the original design was simple and flexible enough to do justice to the stories and extract the required data without being pre-tested.

Participants

I envisaged recruiting a minimum of four, and a maximum of six, women who met the criteria. Inclusion criteria were women who experienced induction of labour because their pregnancies were prolonged, their babies were well and now 3 to 5 months old.

This was a similar time lapse from the birth to that chosen by Cartwright (ibid, 1979). From my side I chose to decline women who had any known medical problem or obstetric abnormality. I excluded women if their use of English was hesitant, because I required the woman's own words. I needed to comprehend these unaided.

I had prepared for widespread advertising for participants in newsletters and Plunket Rooms. Because of time constraints, some apprehension regarding manageable numbers of applicants, and after consultation with my supervisors, I amended the recruitment process. After clearing this modification with the Ethics Committee, instead of advertising, I personally approached a small number of midwives. I asked these midwives if they would pass on to former clients, who met the criteria, an awareness that this research was taking place and my tracer number should the woman wish to take part. The instructions were designed to forestall any perception of pressure. By coincidence, these midwives happen to work in a variety of demographic situations, and have a variety of styles of midwifery practice.

Midwives are busy people. I was asking them to remember clients who, four to six months previously, had gone past their due date and had had their labour induced primarily because of prolonged pregnancy, whose baby was well and who might be agreeable to having their story recorded. The purpose of the initial phone contact was to inform the woman of what was involved and to determine whether she wished to participate. If interest was expressed, the woman was sent an information sheet and two consent forms, one form to sign and return to me and one to keep for her own record (Appendix 2). As it happened, the woman usually declared no need to consider

these documents before agreeing to participate and arranging a time with me. I met ultimately with each woman in her own home.

By the recruitment method used it was possible that all four who contacted me could have had the same midwife. It was, I believe, chance that each midwife's practice, each locale, each medley of care was different. This was not a necessary criterion of the research, but adds a useful dimension of variety to the narratives. It was also chance that the support mechanisms, ethnic and socio-economic groupings varied.

The Women

Four women who had been induced, primarily for prolonged pregnancy, told me their stories. Three were primiparous, that is first time mothers, and one multiparous, having already one child. The women were put in contact with me by their midwife or another of the midwifery group to which their midwife belonged. The babies' ages ranged from 11 weeks to six months. Three of the women were in stable relationships; one was a health professional, two were student health professionals, and one owned her own business. There was one Maori woman and three European or Pakeha women. In one interview the partner was also present and very naturally added comments to the woman's story with both her and my encouragement.

One woman was cared for by an urban based midwife working in a level three hospital clinic as part of a team caring for high risk women. A second was cared for by a midwife in a semirural practice, offering the range of birth care and location choices. A third received care from a midwife who was part of a large urban, independent

practitioner organization (IPO), which offers a restricted range of care, for her labour and birth. She contracted another midwife, from a suburban practice, for her postpartum care. This latter practice was also affiliated to the IPO. The fourth woman was cared for by a midwife who belonged to a city-based independent midwifery practice. Similarly to the second midwife, this practice provided the full range of care choices and birth location.

Informed Consent

The women were given information on the study and invited to sign their consent and post this to me or allow me to collect this when we met. They were aware they could withdraw at any stage up until the time of the writing of the report. They were aware they could completely control what was said and how that was modified. They were also encouraged to comment on and criticize the reflections that I made on studying the stories. In addition they will control the dissemination of any subsequent modified reports suitable for public access.

Data collection

The sources of data were the transcriptions of the women's stories, my own notes and reflections. My own notes included: a field diary of all developments concerning the research which was kept from the first day of the project; notes taken of phone contacts, milieu details, decisions taken and reflections as they occurred. I tape-recorded the stories. Each story required sixty to seventy minutes. The shortest transcribed onto 34 pages, the longest onto 45 pages. I transcribed the stories myself; which intensified my

exposure to their words. The process happened over a five month period with the first story being recorded in June and the last in mid-October.

Field Notes

Documentation around the contact was intense. I kept a field diary to record general impressions, details of the environment, the other participants, a notebook recorded all phone conversations; reflections were noted both in the field diary and in my Journal. A confidential, detailed record of contact numbers and addresses of the participants and the midwives were also kept. Copies, both hard and electronic, were kept of all correspondence. I collected a file of signed consent forms and other related correspondence.

Prior to the recording sessions, a list of prompts was devised as a 'safety net' to ensure we stayed primarily on track, while also endeavouring to keep intrusive, directive comments and questions to a minimum. These were utilized selectively to ensure the stories touched on some of the key issues around the waiting and the induction decision. I wanted to allow the narrative to 'flow' and anticipated that the issues, I felt were in there, would arise, but I did not rely on this assumption. I checked over my list with my supervisors and then used my discretion in each situation.

Recording Stories as A Beginner: The Lessons

My experiences as a beginning recorder of narrative inevitably provided me with certain lessons to pass on.

- Regarding the avoidance of pressure on participants to take part, I would in future formalize the instructions to the midwives in writing to avoid any possible misunderstanding, and forestall the awkward note such formality can strike in the lower key, supportive, affirmative networks within New Zealand midwifery culture.
- There was no discussion beforehand regarding what to do if we should be interrupted. Formalities of this sort were deliberately kept to a minimum to help ensure the woman was at ease; however with hindsight, simple procedures agreed upon in certain contingencies would have been useful.
- Each time I would check the equipment was functioning prior to setting out but did not plan to interrupt the proceeding to playback and ensure the tape was actually recording. During the second session nothing of the first side of the tape, a total 45 minutes of the story, recorded. The woman was amused and sympathetic when I rang to confess. She herself spontaneously offered to repeat the narrative. For each subsequent session, I checked by recording the initial few minutes of our conversations. This was well tolerated by the women.
- I had not anticipated the difficulty I would have in setting aside my midwifery self and allowing the story to flow without any professional response to what I was hearing. Not only did I utilize elements of midwifery practice which relate to the typical “booking” interview or facilitated debriefing from previous birth experiences (which most midwives would employ as part of their care), I heard myself supplying information and clarifying issues. I endeavoured never to undermine any of the woman’s carers. I was constantly mindful that this was the story purely from the woman’s point of view. However, with the tacit support of my supervisors and in line with Oakley’s rationale for relaxing or modifying the masculine conventions of interviewing and recording stories laid down by sociologists in the 1960s and earlier,

I worked to establish rapport and limited formal direction of the sessions (Oakley, 1990). I feel this approach worked well although I was dismayed at what seemed like over frequent interruptions from an *over*-active listener.

- There was no construct by which to integrate the viewpoints of the other participants. This is the woman's side, the lens of the participant most vulnerable most susceptible to the potential political extremes.
- The intention was to allow largely what story may come to come, and be valued simply just as that. A window onto the life of a woman who has crossed from pregnancy to motherhood in a sense manipulated by a timing convention and the intervention by external means to occasion her labour. Such an account, to stand by itself, necessitates the risk of not uncovering all the details which are relevant to midwives and potentially valuable as future reference material for others.
- These women were talking to me at my behest. They did not necessarily sense a need to tell their stories. Originally I planned to advertise for participants. Perhaps this may have revealed the women who volunteered themselves as wanting to talk.
- There was, I found, an obvious flaw in the process of returning the reflections to the women for their feedback and agreement that these were acceptable statements to make regarding the lessons and insights the stories provoked. The form the reflections took when freshly written and dispatched to the women was different to the form they are, having undergone refinement and crafting. Now that the segments have been juggled into an order dictated by chronology and consistent with the key

issues I was targeting, and the reflections reordered and crafted to bridge the segments, who knows whether the women will recognize these thoughts as those they sanctioned?

- Conclusions from the four stories are hardly generalisable. This was never the aim. This is the deliberate use of a form of qualitative research to investigate experience to a depth not available by quantitative methods. It is a relatively new method, perhaps not perfectly exploited; perhaps insights will go unrecognized; perhaps riches will go unmined; perhaps justice to the stories will not be done. This is a chance the researcher takes. It is not her role to judge.

Limitations

This research recorded and reflected on the stories of four women. As they saw their experience, as they will tell their children, at times in fine detail with frankness, openness and humour. The conclusions were never intended to be generalisable. Neither was the method intended to be a formal interview with carefully crafted questions to fulfill the objectives of a scientific survey (cf. Cartwright, 1979). I do not offer even a demographic profile of each woman. I could give no complete, succinct, obstetric history of each woman's experience. Whatever details there are, are largely there because these are what the woman has chosen to include in the story. To whatever extent it fits with and extends the meagre evidence in the literature that reports on women's experience, it remains simply each woman's individual, unique, subjective story. It was told to a midwife researcher who is plainly allied to the midwifery model.

The researcher is clearly unable to detach herself from her midwifery persona and intrudes to support the story telling and interact with the participant.

Whatever similarities the reader may find between the experiences, whatever differences, these have no relevance in terms of establishing a comprehensive analysis of the experience of all women who were induced for PP in this country at that time. Consequently there is no expectation that policies will be influenced nor attitudes changed amongst caregivers in maternity care. There is no expectation that women who face this situation will feel different or better prepared on reading these stories. There is no expectation that women who have experienced the same sequence of events will read the stories and for the first time feel affirmed and validated in their reactions. It is enough that some may.

The women were approached by their midwives. This raises the possibility that their particular experience stood out as particularly worthy of telling, as opposed to 'typical' and this would tend to the conclusion that these stories were extraordinary and remarkable when the general run of such experiences were largely ordinary by comparison. It also raises the issue of whether that particular woman was selected because she would be complimentary of midwifery care. Were the midwives approaching women whose experience was particularly negative so as to weigh the stories to the negative side of the spectrum? I am confident again that careful reading of the stories refutes both questions. There is sufficient balance in comments made regarding all caregivers referred to. In each case attitudes reflected in comments about the intervention are mediated by the outcome (safe arrival of the baby, although one spent time in Neonatal Intensive Care, one was felt to require special monitoring, at

least two required resuscitation). This is in line with the published research. Although the detail and the possibilities raised by what was risked each time must draw the conclusion that induction is an intervention of considerable risk.

I did not involve primiparous women exclusively as my story tellers. This reduces the impact of reflecting the singular importance of a due date when it is your first baby. As I have indicated I exchanged this power for that of relaying and reflecting on the story of a woman who, quite unusually, had had to wait after a spontaneous labour before due date with her first pregnancy. Hers was a valuable, contrasting perspective.

Many of these limitations would be the greater if my aim had been to select a representative sample however small. Quite contrary to this I intended to showcase each story as unique and valuable for study in its own right, irrespective of how 'typical' the woman was, or if there was a spectrum of care practices.

The Story Telling Process

I needed the woman to feel not too differently from her previous condition. I was not a professional listener. I was not her midwife. I was the active listener to her story. We were working together to bring her experience to the attention of the wider community. I concentrated on how it may help others who are pregnant and certainly how it will help other midwives respond in similar situations.

Usually I began the session with the request: "Tell me the story of your experience of going overdue and having your labour induced." I usually added that perhaps it would

be helpful to imagine I was a visiting friend who had been overseas, and had asked about the pregnancy and the induction. It is very important to elicit the *oral narrative* as opposed to merely recording a commentary. Keeping in mind the contradiction that Oakley identifies¹, I approached the stories primarily with a focus on the issues the women chose to surface (Oakley, 1990, in Roberts, 1990).. I was intrigued to learn what aspects of the waiting and what issues of the intervention were significant to them.

There were however certain key concepts and issues I was alert for. For example: how had the women informed themselves? Did they appear to behave any differently from their counterparts in UK in the late 1970s? Induction is more prevalent than it ever was since that time. If necessary I would encourage the women to expand on these with minimal open-ended, 'interview' type questions. These concepts included: type of information, from whom, under which circumstances, previous knowledge, expectations, planning, understanding, choices, pressure, involvement, consultation, communication, priorities, support, attitudes, family, feelings (*then*, just after, and *now*), ideals, confidence, satisfaction, perception, dates, pain, outcome, and sense of own health.

The stories were recorded by tape-recording, transcribed by me and stored on both my hard disk and a floppy (back-up) disk, initially. The recordings and transcripts will be retained for a period of five years unless the woman requested them returned to her at the completion of the study. They will then be destroyed

¹ Following her experience when researching motherhood, Oakley became aware that, as a feminist interviewer intent on validating women's subjective experiences as women and as people, the traditional approach to the methodology (i.e. a one way process and information being extracted as 'data') is quite incongruous and unworkable for such a purpose.

Once her story was transcribed, I would contact the woman and advise her that the story was ready to be returned to her in a registered mail envelope, for her to check, correct and edit as she felt necessary. I sent an accompanying letter, to explain the conventions, the abbreviations, and to remind her of the purpose of the scrutiny. I included a return addressed registered envelope. Each time it was necessary to make another contact one or two months later, to see how it was going. Mostly they responded to this indirect reminder with an undertaking to return the story shortly. The corrections were minor. Nothing was deleted by any of the woman; likewise nobody took the opportunity to add further details. One indicated a lapse in anonymity and made her preference of abbreviations known.

Reflections on the transcripts

The modified stories were then written up in research report format together with reflections by the midwife researcher. These reflections were then sent to the woman for her to add to, if she so wished, and comment on, to accept or to challenge. I received replies from two out of the four women. Both felt satisfied with the comments and chose not to add or amend. 'Anna' commented: "We are very pleased with it and once again it brought back so many memories." 'Cath' wrote: "I have nothing more to add or change. It sounds/reads great and I'm extremely interested in reading the whole thing."

Data synthesis has taken place by scrutiny of the stories with the help of my supervisor. I have used the process of reflexivity to distill the messages and by selective use of sections of the text attempted to capture the essence and convey the power of the story,

in particular the subjects of waiting and experiencing the intervention, largely so it stands alone, for best effect.

My personal reflections

I noted that during the first story certain events were revisited and ‘fleshed’ out, or built upon, as we proceeded. One memory stimulated another of a related event, and so on.

This influenced my approach in subsequent sessions, encouraging me to revisit previous ground. There were clear themes which included: expectations; stressors (mental, emotional and physical) a graphic reflection of what it means to wait... and wait...and wait...; nature of available information and knowledge; individuality; uniqueness and intensity of the experience; perceptions and nature of support; the evolution of priorities. Themes were evident and arose informally as I wrote my personal reflections and inevitably there was some matching up amongst the women.

I have chosen sections which I feel best illustrate, for example, how the pregnancy was dated; the waiting period; prior knowledge of being overdue and induction; gathering of information; reaction of the people around her and the impact of this on her; the involvement of family; events around the decision; the intervention and the birth itself; how she would discuss her experience with others; whether there were any unresolved issues and feelings following this unexpected development, i.e. non-spontaneous labour.

In each of the narratives, I have chosen to include a ‘story-within-the-story’. The incidents chosen are not directly related to waiting nor to the experience of induction. They do however demonstrate one inevitable consequence of narrative recording,

subplots which underscore the individuality of the story teller and convey memorable insights of new motherhood and the current maternity care system.

Elevating the voice of women is certainly more complex than it appears on the surface. There is a suspicion that it may be treated more reverently than it has proven it should be treated. Again I feel the checks and balances to ensure validity mean no idealistic or falsely inflated assessment of their influence is possible.

Data Dissemination.

It is intended that the dissemination of the research outcome will happen firstly among the women participants themselves, and secondly with other women who may be planning pregnancy or who are pregnant for the first time. I would also hope to publish the stories through a medium suggested by the women themselves. This is in line with an approach to research which is informed by feminism.

Establishing Trustworthiness

Trustworthiness was established by careful use of reflexivity which requires note taking whenever in contact with the participants, and the keeping of a field diary. I shall use the points made by Lather to explain further how I worked to achieve validity within this methodology (Lather,1986). She advocates the use of triangulation, i.e. multiple sources of data. This for me was represented by the literature review of recent investigation into issues of PP and induction of labour, the field diary, comprehensive notes of phone calls and interview environs/impressions, and the transcripts of the

stories. This process helps to ensure counter patterns and convergences can be checked out.

Lather's construct validity is ensured by use of researcher *reflexivity* - the systematic reporting of how decisions were taken, and how the researcher influenced content and process. The means for doing this is the field diary and the documenting of phone conversations and notes taken of those aspects of the story not conveyed on tape or conveyed but not able to be transcribed. Face validity corresponds with feminist research requirement to return to the women and check out the story as it has emerged from the transcript. This is also known as member's check, i.e. having the women 'audit' the transcript. This is officially defined as having the research participants recycle the analysis and refine it according to their reaction. Much more difficult is ensuring or demonstrating catalytic validity. Has the research changed anything? Has it been successful in promoting greater understanding of women's experience of IOLPP? This thesis stands as a document which adds to that understanding.

Ethical Considerations

The proposal for this research was submitted to the Wellington Regional Health Authority Ethics Committee (now the Wellington Health Funding Authority Ethics Committee [WHFAEC]) (Appendix One). Once approved, a copy of the proposal and letter from WHFAEC was lodged with the Victoria University of Wellington Human Ethics Committee. I have previously recorded the minor alterations in the ethical approval process I followed. It was socially impossible to avoid the woman's midwife knowing whether she responded or not as the woman would immediately agree in the

midwife's presence to the student researcher approaching her. None of the women reported ethical concerns. Some even were unconcerned about disguising their identities to guarantee anonymity, which surprised me. It is me who has presumed a need for anonymity, so whose need? I asked the Maori woman whether there was a cultural safety/protection issue for her in my method. She was clear that she perceived none.

Conveying the Stories

There is not a clear guideline for transcribing conventions. As a footnote at the bottom of page 94 (Chapter Six) I have explained the devices I used. Each story occupies one chapter. Each chapter begins with a brief vignette to give the reader some sense of the background detail. This was not explicitly solicited from the woman, but was revealed gradually in the telling of events. The woman is identified by a pseudonym, all the other 'characters' are referred to by non-identifying capitals. Their roles are explained in the opening vignette. The researcher is denoted by 'R.' The woman's words are in bold type, other speakers' words in normal type. Brief interjections or replies are noted by brackets within the text of the main speech. All other longer sections of speech and response begin with a new line and the speaker's pseudonym or letter he/she is known by. The reflections are in normal text, separated by double spaced line from the story and relate to the previous segment of the narrative. Sometimes segments are linked by explanatory text or an abbreviated summary which supplies the missing events.

Conclusion

I have been guided by a feminist stance in my analysis and reflections on the stories. I have used a feminist process as consistently as possible in carrying out the study. I attempted a form of partnership with the women in the carrying out of this study. The women audited both the data and the response (reflections on the stories); they controlled the content and could challenge any conclusions formed from the content; I avoided traditionalist interview techniques which rely on a status gradient between the researcher in charge and the participant passively responding; I shared my background, viewpoints and understandings with the women; finally, they have the key role in deciding how the 'results' of the research, i.e. any articles based on the research, are to be disseminated.

Whilst incorporating the simple aim of presentation and reflection, it is still possible to identify themes by way of summary of the analysis without jeopardy to the integrity of each individual story. The women largely controlled the flow of the narrative. They have chosen the emphasis and the detail. Nevertheless there were common concerns relating pre-eminently to information needs, but also the need to *be* questioning, the perception of loss of control during active labour, the 'coming to terms' with the less than ideal progress because of the positive outcome. For this group this progress included: being induced rather than experiencing spontaneous labour; abnormal, i.e. accelerated progress and in one instance Caesarian section with fetal distress, in another forceps birth with fetal distress. Yet in terms of outcome three of the women had vaginal births (one instrumental), and all the babies were basically well. All of these concerns are echoed in the literature. Cardozo et al noted women's sense of satisfaction related to outcome rather than how the labour began, although their sample were responding just one day after the event, whereas these women were reflecting between

11 and 20 weeks after the birth of their baby. It seems at least for this small group the outcome continues over time to dictate the degree of satisfaction. This is a foretaste of how the literature and my reflections work with each story to distill the messages.

Chapter 6 - Anna's story: "...‘Oh, you are *sure* to go early.’..."

Anna is a first time mother and a student health professional. She had planned a homebirth. She has a close, supportive relationship with her baby's father, 'T' in the story. She lives in a regional town and for her midwifery care, approached a midwife group practice based in the town but practising also over a wide rural community. The couple did not attend the majority of their antenatal classes. Anna's labour was induced on the day she was 42 weeks pregnant. Her baby, a son, 'O', is now five months old. He was born normally, in hospital, and the family chose to return home shortly after. Her midwife is 'P' and the back up midwife, 'W'.

I visited this family on an autumn weekend afternoon. The flat was warm, comfortable, semidetached. The couple seemed unaffected by the presence of the recording machine. O played on the floor. I asked Anna to imagine I was a friend recently back from overseas who wanted to hear all about the pregnancy and the birth, and 'why was she induced?' She began with the crux for them of why the wait had seemed more than usually difficult. There had been a confident prediction she would have the baby before her due date. Everyone was primed to anticipate an early birth and all the preparation centered on that.

Together they moved quickly ahead with the story of the period spent waiting, then the induction, the labour, and what happened afterwards. I then asked some questions informally about prior knowledge of induction, including experience of family and how Anna had reacted to the scrutiny of the family when she was several days overdue. Soon

the bare bones of the story were more richly fleshed out. I used further questions to encourage Anna to go over previous ground on other issues, and elaborate on her long wait. This first excerpt actually comes from the beginning of the second side of the tape. The tape comes on when she is halfway through a sentence.

Anna¹: ... really hot days, then I just thought: ‘Oh I’m just going to die because I looked such a big fat whale and I just couldn’t *stand* the heat. And I just really felt miserable and...

T: I mean - your self image went downhill rapidly, didn’t it? I can remember you saying often: “ I just want this thing to come out !”

R: Wanted your body back, that sort of thing...?

Anna: Yeah. And just wanted to be able to fit clothes, that were cooler, and not look so big and frumpy... not... being able to go down to the school pool and not being able to worry about all these people looking at me in this big fat state. (L)

R: Were you sleeping OK at night ?

Anna: No, not at all . Not at all...Woke up all the time. Cos O was so active all the time. At night he would get really ‘kicky’ at nights and I slept on my stomach even through the last weeks...and so he’d kick around alot... It was so hot I just couldn’t get comfortable and it was actually quite awful. And I’d lie there thinking:‘Oh, was that a niggle? ’ (Yes [L]). And then I’d think: ‘ Oh no !’ And then we’d lie there and: “Ooh! was that something?”, “ No !!”

T: Then (inaud) you’d have to go to the loo.

Anna: Yes, I’d have to go to the loo about five times in the night. And the worst thing was I got quite a bit of swelling in my feet. I couldn’t fit any shoes at all not even like jandal type ones. And we decided that we would play cards at night and

¹ The transcribing conventions I have used are: (L) = laughter

... = pause

italics = emphasis

[] = gesture described

(inaud.) or (unclear) = recording too muffled to be sure of what was said.

cool down a bit with all of us ... Just having my legs down, they'd get so big and tight. I could hardly walk. My legs would get swollen.

R: You would have had an antenatal visit or two in that time after your due date so... what... did the way you were feeling come up during the visits ?

Anna: I told P that I wish it would just hurry up. And that I was really just sick of the whole thing. I think I had a couple and she would say to me: "Oh, well, you never know. This weekend might be a good time." And so I'd hope on that, and then it would come and go that's.. then -like- I'd see her -say- the Monday, and she'd say: "Oh, well, you know, we'll just keep hoping that it is coming soon." And then we had to go in on the Wednesday and they said that I had to be induced and by that stage I was thinking: 'Well - you know - I'm not going to *let* myself be induced, I'm just going to naturally go into labour and I'm going to do it all myself. I'm not going to let this thing happen.

R: So you were still feeling like that right up til the last moment: "The thing would be to go into labour myself ? It's really what I want to do."? (Yeah) In spite of all these horrible, uncomfortable ..you know..

Anna: I think the Friday morning that we actually went in, we were still hoping that I'd go naturally and so on Thursday night I was *really* wishing that it would just happen, 'cos I didn't want to have to go into hospital and fuss around with all this bits and pieces that they were going to do and ...

T: And we were taking all of the old wives' tales to heart about how to induce labour. We had the godmother and Anna's mum telling us: "You should just go and have sex..."!

R: Prostaglandins. Natural prostaglandins. Just use that ! (L)

Anna: And ohhh and everything...

R: And of course it's not...often it's the last thing you feel like doing.

Anna: And ...and they were saying (well they forgot it was so hot), and they were saying: "Go for a nice brisk walk" Great ! went up the road and then we went for a swim and ohhh...

T: We went for a ride on a four-wheel motor bike..

Anna: Ohhh went in the ute! That was the funniest ! (L) We went out of..’cos the godmother’s son had this thing about hares. He thought hares would be able to get in the window and stuff and so we had to go and show him what a hare looked like so he had to go (inaud.) So I said: “Right, go in the front of the ute. This might do it.” And climbed into the front of the ute. And no! and I got home and they said: “Ohhh, so are you feeling any niggles?” “ No.” “ Not even anything ?!?” “No.” And then that night still nothing.

R: It’s amazing, you know, that you still up until the last moment thinking that ... and then you’re thinking that the choices had come an end? ...remember that Friday you thought...? Did you feel that you could have made any other decision then or...?

Anna: I don’t know ...I think probably by the end of it I was so sick of it I just wanted it- him - to be out? and then to go back to being a bit more normal.

R: So you were reconciled to something happening to bring you on? (Yeah) that you had reached a point where you just...one more day would have been...

Anna: ..Yeah (L) I think ...’ cos from my due date was... that every night we’d say: “Oh I’ll see you in the middle of the night”, or “Tonight’s going to be the night!”, and we’d always say bits and pieces and then after - like - ten nights of doing that, (Absolutely) I just felt like - like that I had to have something happen. I was just so sick of the whole thing...

R: Your morale needed something.

Anna: Yeah. I was just sick of all these people ...‘maybe tonight..’

T: And then if Anna’d got up to go to the toilet during the night, quite often Anna’s Mum would hear her and sort of come racing out thinking that she’d gone into labour.

Anna: Or like I’d walk past and she’d say: “Are you alright? Any niggles?” “Nooo!!” I just couldn’t- like- understand why it wasn’t happening. I used to ask T: “Why me? Why is this happening to me? Why can’t it just happen? ” Yeah...

Reflections

Thinking about these comments of Anna and the other references she made to this period, I felt in all, for her, it was a seemingly endless, free falling wait, with the building feeling that something may be wrong. The confident words of her caregiver played and replayed. The irony they represented becoming the key trigger which launched the story of the labour and birth. Later when prompted she relates events concerning the dating of her pregnancy.

Anna: Well, we thought he was going to be due on the ninth and then my..

R: You based that on your period?

Anna: Yeah, yeah. We based that on my period and when I'd thought I'd conceived. And then the scan picked up the eighth, so it was very close. So it was definitely a certain date I was due on.

R: Can I ask you how many weeks you were when you had the scan?

Anna: The first one I think I was ..was I 18 weeks? Yeah. 18 weeks and then I had the last one when I was just over 41 weeks.

R: And when you thought of a date did you think in terms of that as 'my date' or that as 'my estimated..?'

Anna: Well, I thought that was my date. (That was your date.) Yeah, yeah. ('I should have had the baby by then. '?') Yeah ,well if not, it was going to be that day.

R: So, it's a huge psychological barrier to reach?

Anna: Yeah. I *never* ever thought that I was going to be over - like I wasn't going to go into labour or I wasn't going to have the baby on the due date. I just thought - you know - since I have seen it happen to other people, I was confident: "I'm going to have this baby out by the eighth of January !" and it just never happened. And you do feel - like.... I didn't feel let down by P saying that I'd go into labour beforehand, but I did have that in the back of my mind. Or I was thinking - you know - that I was going to go in before my due date and I'd got myself quite hyped up and we kind of planned everything and had the bag packed and then had the bag like three weeks it was! Yeah and then being told you come in on this day and

you'll have the baby this day or the next day, you know? It's - yeah - it doesn't really feel like nature's taking it's course. You're told you'll have your baby on this day.

R: It's more like a process you go through, rather than something that is spontaneously happening?

Anna: And I wish that I'd gone into labour only for the like to know what it was like to do it, but - hey - it didn't happen that way, and labour was the next thing we knew.

R: And your Mum's second child, how did that happen?

Anna: Oh, I've only got adopted brothers and sisters, and then me. So I was the only child my Mum and Dad conceived so... But my Auntie went into labour with her second, solet's hope this is...!!

R: Regardless of how we rationalise these things, you will keep that example in your head, and you'll think...maybe (L) ..It's just - only human nature...

Anna: During my pregnancy I never thought about my Mum not going into labour, and I'd said to P: "Would that make any difference? Would there be a chance that it could be hereditary?" And she'd said : " Well, [she] didn't think so. That she was pretty sure that I'd go before my due date." And so, yeah ...But it didn't happen that way. But you are here, now [addressing the baby].

T: But I think the biggest thing is, looking back on it now, we all, we had in our mind that, eventually, it had to be that he would come and, I mean, let's face it we weren't in that much of a rush. When it was sort of one or two days over, we thought: 'Oh yeah, not a problem.' But then with the pressures of the surroundings, like the family (And..) and the friends...

Anna: And like my Mum and O's godmum would say to me when I went to bed: "See you in the middle of the night!" and, I'd think like: 'Och, you know, tomorrow I'm going to wake up and I'll be in labour.' But in the end I had to start thinking: 'Well, maybe I've gone into labour and I just don't know what it feels like.'

R: The doubts set in and you wonder if you are going to recognise it? Because everybody's in attendance...

Anna: Yeah - I'd say to T: "Well, what do labour pains feel like? No one actually tells you what they feel like and - you know - what if I've gone into labour and I don't know?"

To elicit that part of the story which related to the dating of the pregnancy required an intrusion by the researcher. This is not usually *spontaneously* a feature of the story. This could be for many reasons. Possibly there was an assumption that that was what I was there for after all. There was no question in their minds whether they were overdue. It did not therefore need to be spelt out. Possibly there was a modern day perception of what is meant by 'prolonged pregnancy', i.e. anytime after the due date. Possibly the subject did not come up automatically because alongside this latter perception, there is confusion and an acknowledged vagueness of 'the dating' in the minds of some pregnant women. In Anna's mind, the date is the due date. The scan confirmed it. There was no sense of an 'estimated' day.

Paradoxically, or because they continually need to juggle confounding attitudes, there was no serious problem when she was overdue at first. The strain was more from the point of being affected by an *expectation of going early*. This was not the midwife's responsibility, but any length of wait was harder because of that expectation.

I probed from yet another angle about the pressures surrounding her after the date had passed.

R: How did you handle other people's reaction to that - you know - that you were... the due date was past?

Anna: Oh - it was awful 'cause we've both got quite a few relatives and we'd just have people ringing up - and friends -ringing up: "Oh has she had the baby yet?" and ...

T: I mean it got to the point where we'd answer the phone: "No, she hasn't had the baby."!

R: You'd say it before they could get the question out ?

Anna: And you felt....like in some way you felt a bit of a failure, really. Because here was your due date and you hadn't done anything. And all these people ringing up and ..

T: I mean most of the people that ring up have had kids themselves and: "Oh, well, I did this and I did that."

Anna: There were lots of people full of advice but nothing seemed to happen...like nothing seemed to work. And then when we went for this....oh that's why P decided to leave it til Friday because the day I went in for the scan when I hadn't had any movement, she had given me the homeopathy tablets and so we'd tried them that night and then in the morning and still nothing. And everybody in the families knew what was going on and so they'd ring up: "Has she had it yet? Has she gone into labour?" Ohhh! In the end I ended up saying to Mum: " I don't want to talk to anybody! I just am sick of the whole thing..."

T: And one of the worst phone calls we had, was from your grandparents.

Anna: Oh yes...I know people don't mean to be so nasty but my stepdad's mum rang up and I answered the phone and she said : "Oh, so you are still there!" And I said: "Yeah." And she said: "Oh, for God's sake!" or something (inaud) ! Ohh, my gosh! You just felt really terrible that you hadn't done something like it all depended upon you.

The effect of Anna's family, i.e. their presence, phone calls, consistent concerns and inquiry seems the most outstanding memory. Also marked is the feeling of responsibility to friends, who had put themselves out to be there and to whom Anna and T had been confident of producing a 'result'.

There was a relative decrease in fetal movements on the Monday of the 41st week, her midwife asked her to come into hospital for tests. There was the opportunity to use alternative techniques prior to the planned induction on the Friday when she was 42 weeks. However the use of 'low tech' intervention methods just exacerbated the feeling for the woman, of not being able to get 'off the ground', and no explanation in sight.

This was Anna's response when I probed about knowledge of induction:

Anna: Oh, I didn't really know anything. Just really what I'd...P had told me bits and pieces about ...it... But I don't think anyone can really prepare you for what's going to happen? Like everybody says: "Ooohh there are awful contractions!" And stuff. But until it actually happens to you and like specially being induced. I think it would be different if you naturally went into labour because you would get the slower ones and then they'd slowly build up...

R: There usually is a build up, yes.

Anna: Yeah but this ...to go straight from nothing into big, long contractions and... But I didn't really know a lot about being induced.

R: Did you know anybody who had been induced - you know - friends or family?

Anna: Not really, because my mum - when she didn't go into labour - she'd had a Caesarian and ... No, no one I knew had really been induced. And so I read the book but I don't know whether that scared me or not (L) telling you all these things that are going to happen to you! I thought: 'Oh, my gosh!' And - like- being a student nurse I'd read up about how the oxytocin starts off ... the uterus contracting and everything. So like I knew some of the stuff but like why it wasn't all happening and what was lacking. But when it came down to the actual being induced I didn't really know anything...

R: Did you want to know more? Did you feel at the time ...

Anna: Yeah. Yeah, cause it was like on the day she came in and she said: "Right, we are going to do this and this and this." And I really didn't know what she was

talking about? Which I found quite hard because it was quite frightening thinking that- you know- today was going to be the day, and you didn't know what was going to happen. 'Cause specially after I'd gone in and they'd said about the placenta break down. Then I thought: 'What if it's all broken away?' So, yeah, and 'cause he'd been - what do they call it when he'd been down? You know when his head's all....(Engaged.) Engaged, yeah, he'd been engaged for probably a month or so. Like P was saying: "Oh, your cervix is so soft and ready to go." And...Like *no one* could understand (L) why I hadn't gone into labour but I just hadn't! So it was really frightening. And with Mum not going into labour, I thought: 'Oh, no, it'll be easy. I'll go into labour.' And here was the midwife saying I'd go early.. as well as getting all excited. And it started getting hot, and I thought: 'Oh, well it will only be a day or two and I'll go into labour'. Then it never came...

She easily admits to limited knowledge about induction of labour. It was such an unlikely development after all. The use however of ambiguous terminology leads to a disturbing misunderstanding, e.g. 'breakdown' of placenta became the placenta 'broken away.' An innocent but unthinking use of a misleading metaphor. Inevitably in an apparent explanation vacuum, the mind makes up its own. Such discourse feeds the tension, erodes the woman's confidence. There was such a contrast between the feeling now, with when, during her pregnancy Anna had declared: "**Mum didn't go into labour but I'm going to.**"

" **I don't think anyone can prepare you for what's going to happen.**" This is an often repeated conclusion, implicit and/or explicit in all the stories, but no less a truth for that. Nevertheless there was clearly an issue of perceived lack of information. Cartwright (1979) identified this as the major issue through her extensive survey in 1975. Anna accepts partial responsibility (the couple did not attend the majority of the

antenatal classes they had enrolled for). So, would that need for more information, influence how she would advise and enlighten a friend? Would she reconcile her experience by using what she now knows to change the way it is for others? Would she try make a difference? So I asked what would Anna advise a friend:

R: Or, what's it like to be induced? Maybe she said to you: "What's it like to be induced? because I - I probably need to be induced."

Anna: Well, I'd tell her that it's quite frightening. Just explain, you know, the basics of what they are doing. That, you know, how the labour's going to start really fast and that to be prepared and, like, not let people get her down with saying: "Are you - have you had the baby yet?" and just to keep thinking positively and things will turn out for the best. They'll always keep a close eye on things. They'd never let anything go wrong.

T: Go in with a list of questions to ask your midwife, or whoever it is who's delivering the baby, about the procedures that's going to happen, so you can have them answer before the actual (inaud.)...

Anna: Or even [at] the next visit that you see the midwife to ask her about the induction and what happens, and if she's going to be induced.

R: So that there aren't quite so many surprises and ...(Yeah) - even shocks, for you, I would think.. Some of those things that happened to you, were shocks.

Anna: Yeah, [they] were a bit frightening... just to keep positive and that things will be alright. Just to find out about induction... and still be everything so it's a unique experience. You can't base what happens to somebody else on you, and be different (inaud.) people someone else...

R: It's hugely wise actually.. because although you can't avoid taking in other people's stories, you're not *them*? (Yeah) What's going to happen to you, is unique to you.

Anna: And people kept saying to me about their labours and I got a hundred and one stories about all these different people's labours and still nothing was *even near close* to what happened. (Yes) And no one had been induced. Or no one that I think had been induced. And so it was completely foreign from the start which was quite a shock and quite frightening and then to go into labour so fast it was... You

didn't really have much time to think about what was actually going on. What was going to be the end result, and how you were going to cope with things.

R: Yes, it's a whole different dimension, isn't it? Unexpected

...(Long pause)

Anna: Just to make sure you have support as well. Someone there to help you.

She entered hospital. Prostaglandin tablets were inserted, yet *still* no action. Then, Anna remembers unexpectedly, the membranes were ruptured by the midwife resulting in sudden, full labour. This section also touches on accessibility to information and feeling prepared.

Anna: Well, it was really afterwards that I thought about it and I thought: 'Hey, I really didn't understand what was going on.' But at the time I thought: 'Oh, well...' Like P said: "I'm just going to do an internal." And I said: "Oh, yeah." So T and Mum went out. And then next thing I knew she was rupturing my membranes and it really went so fast I didn't have time to say: "Look, I want to leave it" or "I want to go through with it." And so all kind of happened so fast I really didn't have time to think about it but then afterwards I thought: 'I really didn't understand what was going on.'

R: Did you find a time to talk to her about that?

Anna: Not really. Just thought: 'Oh, well, I'll leave it be.' I thought: 'Well, maybe it was just me.' I was so up in arms about what was going on any way. She probably *did* explain it all to me and I was probably thinking of something else. No, I didn't really...

Anna's enduring perception of feeling quite alone at that critical point. I looked for her to tell me those feelings of something like outrage. Were they still with her? Anna was clear that these were largely resolved. She agreed she felt strongly about it then, but has since let it go.

The power of what was happening led to a seeming character transformation. She felt in shock, not at all sure how to cope. She finds herself walking, silent (using the coping

mechanism of withdrawal, the better to concentrate). She relates using pure determination to stay with it. (Here she repeated: ‘**no one tells you**’, i.e. the unexpectedness of this intense labour). The power of the experience and the shock lead her to reverse her previous attitude to pain relief. Pain relief, however, was not an option, and Anna’s response is to internalize her focus. She walked, maintained silence, determined to ‘stay with it’. She was coping, but hostile and, knowingly or unknowingly, using the energy of that. Her memory is that she knew or was informed less than is ideal but has minimised this in the time that has now passed. Is this a ‘female’ response or at least the response of someone with the lesser power? It seems a perpetuation of “it’s me”, (it’s probably) “my fault” with the implication that the professional knows better...(than I do).

R: How does that feel now? Do you feel like you still need to know, or still need to **(Well, I wish that I had said something...)**...touch base with her, or have you let it go truly? Or is it sort of ...reconciled?

Anna: Yeah. I...really, it doesn’t bother me now. But looking back on it, I wish I had said something so she knew for other people. Because unless someone tells you, you don’t know what’s going on.

R: And even if as you say she may have said something to you “I just don’t remember...” **(Yeah)**. She would have got the feedback to ask...to come to you herself or come to the next woman, say..**(Yeah)** “I did all of that and we talked about it at the time but, you know, it was, you know, an overwhelming experience. Do you need to know again why we did that? The timing and...?”?

Anna: Yeah ... I just think now it doesn’t bother me so much. **(L)** I just think ... At the time, I was just a bit...

R: One of the reasons I’m talking to the women several months after the birth is to know that change, you know. About... immediately - what the burning sort of questions were, and then six months down the track...

**Anna: Yeah, now it doesn't bother me really at all...(The perspective is different.)
Yeah.**

R: You have other things that are preoccupying you. Not so much that...Although some women go through experiences that they never feel they understood, and that they always wonder, you know why a question keeps coming back at them...

Anna: Well I suppose I read quite a bit afterwards, and before, about being induced and so I knew the bits and pieces but it was just at the time of actually being induced I wished that I had known a bit more because it was quite frightening.

We move on to the appearance of the baby.

R: And when he was born did you look at him and say: "Yes, you do look as if you were due to come," or...?

Anna: Yes, he *definitely* was due to be born because afterwards he was so peel-y that he just shed a whole layer of skin.

R: Did you notice his hands and feet wrinkly as though they had been soaking in water...?

Anna: Yeah, and he had a big bruise on the back of his head where he had been engaged. Because he had been there so long ...

This couple may have had no choice about being in hospital for the birth, but were clear about where they would feel best once that was over. They spend time on the consequences of going straight home. They were establishing independence from both the family and institution, and demonstrating their faith in their health and that of their baby. Also faith in their ability to care for him where they would have been, given a successful homebirth. It was a powerful reclaiming of their philosophy.

The family thread continues. Within the main narrative, there is an episode concerning the step dad.

Anna: My stepdad, he's... you don't talk about 'girl's things' and he's very funny about that kind of thing. He came up to the hospital to see that everything was alright and he decided that he was going to stay but he wouldn't come into Delivery Suite. He sat in the lounge. Then Mum went to get him as soon as I had given birth and he was in there and he was trying to give O a hug and he was still attached! (L) "Granddad, you can't do that!" and he was going: "Why, why?" and he didn't understand that he was still attached!

R: He mightn't ever have probably seen a baby like that before - out of a woman like that..no way (L) - He'd still be thrilled.

Anna: Yeah. [Addressing the baby] He wanted to cuddle you. He really couldn't believe it. He was just so ...talkative.

T: ... So emotional. I think we all were at that stage.

Anna: They were all laughing because W (second midwife) was saying to T: "You can cut the cord now," and T was so emotional he couldn't cut and he dropped the scissors. They were all laughing and joking...

R: I think when you plan that (the cutting of the cord by the father), it sometimes seems like the easy thing to do, and yet what you're not contemplating is how you are going to feel right then and there. It's ...

Anna: And like what also made me laugh was after I had given birth and everybody knew what he was, except for me, and W said: "Do you know what sex he is?" to T, and T said: "Yeah!" and she said: "Well, tell her!" And here I was not knowing.

This is only one example of the 'offshoot' stories, which compliment the narrative, and which will forever be told in connection with O's birth. What it illustrates is something we rarely think about after 20 years of paternal involvement, i.e. the generational difference between now and our father's and grandfather's time. Men now attend births.

This is taken for granted. There are few examples nowadays, such as this, of the

awkwardness and uncertainty with which it was experienced when I first practised. Through this sub-story too, all the emotion of such an experience and occasion is fully acknowledged. There is a moving picture of the emotion (coincident with relief released, reminding us of the enduring image of the 'broken-down' placenta) that accompanies the birth of the baby safely. This was the first of four such superb, natural climaxes in each of these four narratives. All the elements are raised, i.e. the discovery of the gender of the baby, who said what, and where were the ironies, the humour, the pathos. Then the grandparents' stories are added and so the mythology is extended. All these stories were so rich, and told with insight and affection by this couple.

There is much justifiable pride. Anna used no pain relief and so there was no drug affected baby. However her sense of satisfaction is mixed issue. Cardozo's simple survey (ibid, 1986) indicated that satisfaction relates to outcome rather than to mode of labour onset. Anna felt a lack of information about IOL, and about how to push in second stage, self conscious as she was about discussing this. It's importance and it's legacy are evident. She has a feeling, however unwarranted, of foolishness. Again there is reference to ignorance, possibly due to not having attended classes and relying on knowledge gained as student nurses.

The couple's own reflection on the care from the midwives includes praise qualified by a referral again to information. The simple, vital, physical comfort measures and the willingness to respond to needs, are recalled with pure appreciation.

The intensity of the feelings evoked by these still recent events is again reflected with some most familiar words: "**I am never going to have children again**", together with a

readiness to discard inhibitions: **“something I’ll, I’ll never, ever, forget.”** Amazement still lingers in Anna over the intensity, the exhaustion, the falling in love with the baby, demonstrated by her instantly, repeating **“don’t think anyone can prepare you for it.”** and agreeing how quickly you forget the pain once the baby is there.

Concluding reflections:

“It doesn’t feel like nature’s taking it’s course.” “I wish that I had gone into labour only to know what it was like to do it.”

Anna’s own reflections on having her labour induced mirror exactly the conclusion of the majority of Cartwright’s women (Cartwright, 1979). For them induction was an inferior choice to spontaneous onset because it seemed ‘unnatural’.

Her story naturally surfaces a gamut of emotions - surprise; fear; humour; anger; bewilderment; love; pride. The self appraisal is full and frank. The maturation process from taken-by-surprise and first-time parents-to-be, to confident, committed mother and father (planning beyond/inclusive of the child] clearly depicted.

Two prominent impressions are: the woman’s powers of endurance and pragmatism; and the sense of family. The latter runs like a weaver’s strong, connective thread throughout and locates the pregnancy/labour journey in a complex, ‘living’, changing, *real*, context (more complex than we, as midwives, can ever definitively understand). Secondary issues e.g. care arrangements; modern obstetric procedures; the progress of the midwifery profession; politics of health professionals; questions of information, choice, power and control, certainly impinge but have all been now put into perspective.

What the couple found most difficult was the intrusion of the expectations of others, despite their usually consistent, rationalist, pragmatic approach to life. There is the unintended but real pressure of the scrutiny of the woman as about-to-become-mother by older family members. Then their monitoring of the couple as two people dealing with 'the big event', and as having chosen total midwifery care and a homebirth. This is such a radical system change from the experience of that generation. The 'rules' have changed. Is it comfortable? Is it secure enough? What are the risks? Even if these remain unspoken concerns, they add to the weight of the atmosphere nonetheless.

Then there are the mental factors. The tussle within the woman herself faced with the confounding illogic: 'Everything's in place.. 'they' keep telling me... why doesn't it kick in?' The pressure of time passing resembles a short lived, far more concentrated, biological clock ticking. This is a phenomenon not under her control, so the inevitable thought progresses to: 'Is there something wrong with me?' This threatens image, esteem, integrity of self. 'Am I to blame in some (unfathomable) way?' Self doubt builds. 'Am I not doing something right?' There is the allied feeling foolishness and incompetence, noted by Anna by these comments: "... **felt a bit of a failure...**"; "... **you just felt really terrible.**"

Overlying the psychoemotional effects are the physical discomforts which intensify with each day. For Anna these included heat, size, swelling, decreased sleep, and frequency of voiding. "**I was so sick of it.**" She felt such a yearning to feel normal.

The woman is concerned as time passes but not wishing to be alarmist. Her partner was more assertive, wanting her to act. Then there is finally an admission of emotional strain - “ **a bit of a mess.**”

T felt a sense of impotence, and still regrets not having option of being there at most intense point for Anna, i.e. the watershed when the ARM was performed. He has a sense of gap in his support which was and otherwise would be seamless.

This is an instance of a couple heading for a planned homebirth in New Zealand in the late 1990s. Their primary memory was the unexpectedness of finding themselves undergoing an induction. The concurrent discrepancy between expectation and reality leading to the immediate focus and the midwife’s words in hindsight are a mockery.

Again I am struck by, and acknowledge, such an imperative to be understood; to be listened to. Also a need for thwarted expectations to be acknowledged.

For Anna it was important that it is clear that she had waited the full fortnight. The assumption continues that due date has become the *expected* date rather than estimated. It is no longer explained that she is ‘due’ between a gestation of 38 weeks and 42 weeks and *only* thereafter overdue². In the face of the ultrasound scan, caregivers and couple worked out a compromise.

Later, almost overlooked comes the very understated, almost totally covered up, sense of achievement, and it is attributed to “we”. There is a repeated theme of “cannot be prepared” - the only certainty as first parents is the *unpredictability*. Somehow it - being overdue - becomes distorted, perversely as being the woman’s fault. This seems to me

² NB: this definition of continued period of low risk is not supported by recent research (Crowley, 1999).

a particularly female-centric implied/attracted accusation. It is a highly pressured time, more grueling than need be. Anna has arrived at a good humoured, pragmatic resolution of it. How much conditioning? How much the result of her own emotional work?

Chapter 7 - Bev's story: "...I just wanted it to come out and let me enjoy my life again."

Bev is a single parent, living temporarily with her extended family, working part time and caring for her five month old son, K. Their warm home is in a suburb of a large city. She no longer has regular contact with the baby's father, G. She refers to him as her 'ex-partner'. She has been a student health professional. For her care for her first pregnancy she approached a large urban based total midwifery care group practice which offers the full range of care and choices for childbirth. She secretly planned a home birth, keeping it in mind should all go spontaneously and felt it was a decision she could make in labour if necessary. She knew her parents might disapprove. She did not attend separate antenatal classes.

Her labour was induced 14 days after her due date by uncertain LMP, 21 days after her due date by ultrasound scan. She remembers her induction was booked for 40 weeks and eight days by LMP, but the hospital was too busy, and she was asked to come in six days later. K was delivered by emergency Caesarian section when Bev was in late first stage. Her midwives are H and T, and the back up midwife is U. The registrar is Y, and the student doctor, from the same culture as the couple, is S. The consultant is L. The paediatrician is F. Her story¹ begins following my prompt which was similar to that I used with Anna. She talks about memories of the pregnancy.

¹ This is the session where the first side of the first tape did not record. I feel that because she was kindly telling this for the second time, she exhibited the extra pressure to remember it as previously described. Hence the repetition of "what else was there?"

Bev: My pregnancy was really horrible, really, really horrible. I had full-on morning sickness. I couldn't eat. I couldn't do anything plus I had financial difficulties and that was a lot of stress. Plus I had a partner who ...very 'Jake Heke' type of the dominant type. Didn't work.. But the pregnancy itself was really horrible. Like everything I ate, everything I drunk, just came ...went in one way and came out through the same way it went in. I just about dehydrated and I was trying to drink heaps and heaps of water and my bowel movements were really bad. It was like having diarrhoea pains but nothing was coming out. They thought it was an infection but it wasn't. Thank God. That was at the beginning of the pregnancy. I was very tired. I had to give up work. Meaning I had to wait the stand-down for social welfare because social welfare said to me that I wasn't allowed to go on the dole. I wasn't allowed on the sickness benefit which was a bit more than the dole because they classify morning sickness only goes for three months. Which they really highly qualified, they really have a medical background to say that! But I got morning sickness right up to 7 to 8 months. As the months went by, it slowed down a bit but I was put off food and water and any fluids. The only thing I really loved was Ribena. Ribena juice. It was really amazing. I hardly ate and I didn't put on as much weight as I thought I would with K and I was a bit scared that K was underweight because I wasn't eating. I quit - when I got morning sickness - I quit smoking. As soon as I started getting better - but I was still stressed out because of other things around me - I started smoking up again, and that didn't help. Actually smoking was the one that relieved that morning sickness, strangely enough.

She relates all the associated strains of pregnancy itself, overlain with serious socio-economic concerns. She immediately recalled that the predominant stressors related to economic pressure, social stress, and physical discomfort. She knew she should stop smoking but she couldn't stay with this resolve. There are nice touches of irony, e.g. the

Department of Social Welfare's understanding of the effects of pregnancy . She suggests the query: how qualified are they to judge ?

The story moves on to relate the stress of waiting.

Bev: ...We waited for that day. My hormone levels were up then. Yeah real severely and because his hand was like this, when he kicked and he moved, it was really, really sore. It was real painful. There was electric pulses like right within the clitoris area ? There was electrical pulses and it was very, very sore and what else?

R: They weren't just him hiccupping? It wasn't him having the hiccoughs... It was something more regular and perhaps even faster than hiccoughs?

Bev: It just hit the vagina area and it was real painful and I used to just about shrivel up -like- pull my knees up. That happened from the last - end of the last two weeks and the beginning of the eighth month it started up. Very, very sore. But his movements were all right. He hadn't turned properly to where he was supposed to be. And on the due date he was in position and he was ready to come out but he wasn't coming out because nothing was happening .

The following excerpt relates to the dating of the pregnancy as well as more on what it was like to wait after that date had passed.

R: How certain were you about the date? Like was it like 'set in concrete' in your mind, or was it vaguely a date?

Bev: Well, what had happened is: I don't know my due date because I forgot when my last period was, you see. So when I went shopping one time, I bought this piece of meat that was packed that day and I knew my period was due up that week or the following week. And so we took it from there and then when I was scanned, the 11th of March was my due date on the scan and then H said: [counting] - 11, 12,13,14, - 15th, - the 15th, 16th, 17th, 18th was my other date.

R: Which date did you tell people?

Bev: I said the 11th of March. Because it was a scan? And apparently that should be accurate? Oh to me, it should be. Cos it's probably a machine and computerised. (L)

R: Its accurate to within five days. It can be out depending on when... You know. If you had it in the first say fourteen weeks of your pregnancy then that's within five days, and later on it's within ten days. So yeah, there is a margin of error - what they call a margin of error. But a lot of women are exactly like you. They think the scan must be spot on. (L)

Bev: Yes! Cos I thought: "Ah yes, they're the brainiest bunch."

Later I asked Bev: 'Did it ever enter your head that you would go past that day?'

Bev: No! I was hoping I was due on that day because I was actually dying for a real yummy meal, you know. I thought: 'Oh, I'll probably have stitches down below and I'll be probably full of (unclear) but I was dying for a decent, y'know, food and all that.

R: You had gone without all that time and ...

Bev: There was one more thing I had to say.. I wanted my temperature ...because I know that when you are pregnant your temperature goes up in your body, but as soon as you have had your baby, the temperature goes down and I was just worried that after the pregnancy, it was the stitches. Cos since I was constipated, I was thinking: 'Oh my God, I won't be able to handle those kind of things.' Cos my pain threshold's really bad. So I thought: 'God, I'm going to eat heaps of fibre so it's basically diarrhoea'! (L) So I didn't have to struggle and it wouldn't hurt. And then when the due date came, I was waiting... and waiting... and waiting... and I remember going downtown and going for a walk and trying to build it all up and I waited and I waited and my ex-partner keep on ringing up from work: "Has it come? Has it come?" and nothing happened.

R: Were you patient with him, or did you get short with him?

Bev: I got real short with him. Real short. I felt sorry for him cos I'm always 'snap!' I goes f'ing him.. ohhh, yes.. and that was the worst thing was my mouth was very

foul that two weeks. Actually two months before that. I weren't putting up with no hanky panky. I was working at the time and I finished two weeks before I was due. Cause I was getting really tired and I was tired in the groin area where the nerves are? Really, really tired and it's just I wanted to lower my stomach. And sleep on my stomach cos I sleep on my stomach. I wasn't comfortable on the sides. Then I had read in the book that usually if you sleep on the sides, the cords can go round the baby's head, so I always slept on my back. But I actually like sleeping on my back. (L) His movements.. His hands - cos this hand was by his face? (OK.) H and T had taken off to a hui so they were waiting- basically U said (that) usually the women wait for their own midwives to come.

R: They do. It's incredible . It needs to be researched because it is so - y'know - you can almost guarantee it !

Bev: Yeah, because U was a good midwife, but it's just that - they had seen my backside and I didn't want every Tom, Dick and Harry seeing my backside. Even though they work together, they're good midwives, but it's just that in the back of my mind, I thought: 'Oh I'll have to bend over and show someone else again.' I was very serious on how I wanted my birth. I actually wanted a homebirth? (OK) and I had it all planned. I wasn't going to say nothing when I went into labour and I wasn't going to say nothing to Mum but Mum said to go to hospital 'just in case.' Must have been her wise words, but I was so determined to have my baby at home. So my philosophy is I don't really mind having my babies at home - I mean - at the hospital, because there's 'buggerloos' [?destitutes masquerading as visitors to the hospital], and, not only that, I heard really horror stories about the 'wobs' [?drug addicts] going up there and raiding the place up, and asking for the drugs and they always go to the maternity area! And that's the one thing I didn't want to know about.

Reflections

Bev had a comprehensive list of symptoms which contributed to her discomfort throughout the pregnancy. All seemed to her magnified by the wait following the due date: nausea, no appetite, fatigue, thrush, constipation, varicose veins, back and leg pain, frequency of voiding, and mood swings. All are reasonably typical developments in pregnancy but, when happening together, represent a physical and mental ordeal. There is evidence that perceived difficult pregnancy intensifies the difficulty of waiting for labour even up until the due date (Out et al, 1986).

For Bev it was a very basic need that pushed her the farthest. For her the date was hugely important because she perceived her baby *would* be born by then and it signalled the time when she would be able to *eat* again. Also she would be able, she thought, to return to normal body temperature, and sleep on her stomach again. These are simple, basic but dominating needs or expectations. To her a reflection of her stress was hearing herself responding to G's queries by "foul" language.

Her midwives were absent at one point close to her 'time', but the wisdom was that she (her body) would wait for their return. A belief which may well be shown to be a coincidence. Even used jokingly however this sends a relaxed, but usefully clear message about the approximate nature of the due date.

Bev's private, personal birth plan included her choosing to birth at home. This she kept to herself as aware of her family's possible opposition. Through their Section 51 of the Health and Disabilities Act and various publications of the Health Funding Authority, the

New Zealand government has sanctioned the safety of homebirth for well women and having healthy pregnancies, but, although homebirth rates are increasing, it remains a minority choice of birth location for New Zealand women (New Zealand Yearbook, 1998). It does not yet have widespread public and medical support. When explaining the advantages to her of birthing at home, she revealed a fear of ‘buggerloos’; and of ‘wobs’ invading Delivery Suite and demanding drugs. I did not ask her to define what she meant. This rather alarming and even flamboyant perception of the hospital experience prior to her admission was not borne out by the actual events of her time there. A corollary for the inpatient postnatal ward stay, however, was the fear that her baby would be stolen, a sad reflection of our times.

The story of how the date was arrived at, i.e. remembering the ‘date packed’ on piece of supermarket meat in connection with knowing her period due that or the next week, seems an example of an apocalyptic memory, unique to women. *Only* menstruating women need to connect a physiological cycle with numbers on a calendar in such rudimentary way. Some women feel a continual need to be conscious or to have a low level awareness of a rhythm, an ebb and flow, which if different can have such far reaching implications. It is not uncommon that similar such incidental, almost accidental, reference points are used and assume such importance. These represent ‘toe-holes’ of potential, complete joy or total despair.

The scan said the 11th of the month; the uncertain LMP said the 18th of the month. Faith freely admitted by Bev in the scan as representative of ‘tested’, dependable, high

technology, therefore indisputably more accurate than any date based on LMP (inferior women's knowledge). Also she was not particularly clear about LMP which was potentially embarrassing. Others would expect that she should know.

Of all the women Bev was post term by the traditional definition (FIGO, 1977). She had been booked for IOL three weeks after her due date by scan at possibly 20 weeks. The accuracy of the date at this stage of pregnancy is within seven days. So one of the extreme possibilities is that she was 42 weeks on the 9th of the month (her scheduled IOL date) following her due month; the other extreme is that she was 44 weeks. The hospital, she understood, was too busy; the monitoring of the baby was satisfactory, and she was asked to come back on the following Tuesday, if she had not laboured spontaneously by then. This put her firmly in the post term category, one of the 1% who do reach this period of prolonged pregnancy. The issues of which dating method, which care model, how best to monitor her baby, and how these matters are prioritised, are all reflected in her story. Does her experience reflect the philosophy of her caregivers? Does it demonstrate the then current approach of the hospital medical staff, working with her caregivers? Or is it indicative of the contingencies of a large base hospital? Or the socio-economic and ethnic group minority status of the woman?

Bev's own knowledge of the nature and degree of pregnancy related complaints was a mix of very accurate, clearly understood, and not so clearly understood information.. For example: sleeping on your back whilst pregnant to protect baby from nuchal cord "**cord**

can go round the baby's head"; awareness of hazard of smoking, but still continued to smoke as it relieved the intolerable stress and seemed to ease the nausea.

Bev talked more about the stressors and her family's role:

Bev: It was the pain and the hormone levels that really got to me plus I was starving. I was really, really hungry. When I hadn't vomited up, There was some stages when I overindulged and felt like vomiting but I kept it in. That was in the last two months and then I ...

R: All these things made it harder to wait ? Once your date had gone ? And people were then asking you 'Have you had the baby yet ??'

Bev: Oh, that was another thing. All the aunties ringing me. I know that they were concerned and while I was having him. Friends were asking: "When is this baby coming?" Also all my girlfriends, we've all got boys. So basically we've got a rugby team. None of us have got girls. (L) See everyone thought I was going to have a girl and I just wanted to have a girl, cos I always liked to have a little girl. At the end I didn't give a s*. I just wanted it... oh sorry about the language! I just wanted it to come out and let me enjoy my life again. Yeah. Very tired.**

R: In terms of whether you were basically well and the baby was basically well, were you feeling fairly confident about that? Or were you feeling something might be wrong?

Bev: Well I was thinking something might be wrong because I smoked, you see? I was a heavy drinker before I got pregnant. A heavy, heavy drinker but I knew my limits. I just drunk heaps that's all and went out night clubbing and all that with all my mates. I must have had three beers.

Bev experienced pressure of the physical discomforts of waiting. She interpreted her baby's position and movements as contributing to her discomfort. "electrical pulses"; "pinching". On the due date he was 'in position' but nothing else was happening. She experienced a real and dominant sense of hunger. She also refers to 'hormone levels' which are causing mood swings. She felt considerable social pressure from her partner,

the aunties, and the friends, who were constantly ringing to inquire. She felt emotional stress, frustration and impatience, wanting to hold her baby and know whether 'it' was a boy or a girl. She represents a prevailing perception: that the pregnancy is the source of the discomfort, the problem, any problem. Life *has to* get easier once the baby is born, the baby being easier to deal with 'out' rather than 'in'. There are parallels here in the findings of Roberts and Young (1991) and in the conclusions of the Out et al study (1986). One predominant perception is that the baby is easier to deal with born than in the womb. At least this was the message from the multiparous women. Bev was primiparous,

As well as the pleasurable anticipation of the baby, is the apprehension of labour. This is building up unbearably. Because of her family history, she has a dread of having a Caesarian birth). Also she feels real support (special, personal - from a partner) is missing in that one important sense. There was anxiety because she smoked. She felt concern that the baby's condition may be jeopardised. There was also anxiety about drinking alcohol. She justified it in terms that it helped nerves, nervousness about pain, and about outcome.

Bev continues her story from the previous excerpt.

And in the last bit I started drinking quite a bit cos I was actually quite nervous. Even though I had read books on what to do before and after and I emphasised to Mum - because I knew Mum was coming in - "no epidural and no Caesarians whatsoever. There was to be no Caesarian unless it is an emergency and baby has to come out or I'll just bloody push." And the reason why I didn't want a Caesarian is

because of all the horror stories I've heard. Cos my nanna's got a cut down here (Oh yes, they used to do it that way.) Yeah, that's the old fashioned way.

R: Did your Mum also have a Caesarian ?

Bev: No. Her's were all natural, until the epidural came. Her story's quite good too. What else? Yeah, that's about it. And I was scared about the pain. The only thing was the pain. I think just the week before. I had to go in on a Thursday-Wednesday - to be induced on that Thursday and then they said: 'No' because the hospital was booked out. So the following week I had to be induced on the Tuesday and my midwife said ..meanwhile during that time that I was overdue I had to go get my baby monitored ...put on the puku and all that. (Was that OK?) Yep. He was alright. His heartbeat was well and I was well. There was slight contractions in the monitoring but I never felt them. And they were heavy ones too but I thought: "Ohh [dismissive]". So they reckoned that I was going to have my baby before - usually when the mother is told they are going to be induced, they have their baby before that time. But not me! I started getting shows on the Saturday and the Sunday but it was bit by bit so I didn't know. I thought it was just the typical discharge, (Sure) but it was actually the plug coming away bit by bit.

R: Had you been examined in the hospital like that before ?

Bev: Ooh yeah, I was... Ahh! I couldn't stand it! Yeah that's what they thought it was the gel that they used and I was thinking: 'Well, not *that* much gel he would have put on his hands.' I didn't like that either. It was quite embarrassing because, even though I had to go to the loo, I didn't actually wear pads because no one told me to wear pads when I leaked. And so my knickers were wet and the nurse went to grab them and they were wet and I went "Oohh! I'm sorry, but you know...?" She goes: "Oh no. I'm totally aware of that. I'm used to it." There was a student that came in and checked my son. She was actually becoming a doctor.

R: Did they ask you before hand if it was OK?

Bev: Yep. I don't mind students because I'm a student myself. I'd really appreciate it if they bought me in. Cos that's the only way they are going to learn. And their tutor came in too -

R: Still the principle that your permission is asked, because you might have been having an off-day. That we respect that you may not have wanted it that particular day.

Bev: Yeah. The only thing I didn't like when the student was put her piece of paper and her pen on my chest when there was a table there and a (L) (unclear)... and that's what I told her. (Good on you.) I told her: "Just don't put it on my chest. So it just - you know ?- you might as well go and write on my chest!" That's about it. She was aware of that. I think she was actually foreign, either Chinese or Japanese (OK) but ..she was really, really good actually, other than that. And she was asking me questions about the pregnancy. When I answered these questions I said: " Oh, we're not going to be put in a category of a mother who smokes." Cos I don't like that.-I don't want to be labelled as: '98: she smokes' cos basically -I know its a survey and all that- but I don't want to be put into categories. (Fair enough.) And then they monitored me and I was getting pissed off when they were monitoring me. Just got sick of it. And I hated lying in the hospital and I was thinking: "Ohh I hope they don't- I hope I don't bloody stay here all night!" And what else was there? When the doctor told me ... I wasn't going to let the doctor come near me cos *he* looked only 18 !!! (L) and I went: "No way, man!" when he walked into the room. He was going to examine me and I just turned around and I saw him and I went: "Now - how old are you?" and I didn't realise he was in his thirties and he had children of his own. I felt really slack. But he was actually complimentary and we had a bit of a laugh then. I was kinda: "That's alright. You just look like a graduate."

R: "You don't look experienced enough to know what you are doing !" (L)

Bev: Even though I give students a chance but when it comes to doing internals and touching me, going inside, just don't like students. Unless they have been doing it for years and years and when they are practised at it, I don't mind.

Bev discusses frankly and unselfconsciously issues of personal privacy, dignity and self consciousness and her sense of embarrassment. One example relates to student involvement with her care. I have included this 'sub-story' although it is only indirectly

related to the primary focus of the narrative overall. I do not necessarily want to draw attention to women's experience as 'clinical material', which is another area of research altogether. In addition to what this tells us about Bev and her survival skills (how she relates to others and manages life), the story of the student's inappropriate behaviour reveals so much of the incongruence of women's position or women's power in this situation which in many respects has changed little in 25 years. Bev has sufficient self esteem to chastise the student, but her nature and her sex puts her in the student's shoes and once told, the student is immediately forgiven and the positive side of the encounter emphasised. What this illustrates is Bev's nature, good will, kindness, and her strong dislike of being labelled. In this latter respect she is revealing insider (student nurse) knowledge that labels are used and they then are hard to escape. There's deference there, but also assertion. Between the lines I sense a continual feeling of being under siege from the system. A feeling is conveyed that the system is designed to deliver a service, to be benevolent and caring, but a person can never rely on this entirely. You have to be on your guard. She has already conveyed dramatic preconceptions of her possible experience, bases her views on what she knows of the experience of others and having seen the system from both sides. Therefore she employs a variety of approaches for her own sense of safety, e.g. to defer, assert, challenge, and to use humour.

She recalls the involvement of other health professionals. Firstly she gives her reaction to the youthfulness of the doctor. This became an ice breaking incident. Then, secondly, her fears of other strangers who may be involved, surface. Her sense of bodily integrity and privacy coming to the fore again ("...**touching me...going inside**"). Her comments

are also reflective of prior knowledge, prior expectation of the IOL process. An example is the following reference to her fantasy of an era when vaginal examinations would no longer be necessary.

When they induced me they put half in and I don't like internals. I just can't stand them and I was hoping that one day they would have got rid of it before I had my child cos my plan was to have a child at thirty. Because I thought there was no reason why they were poking their fingers up. There's no sense. You can actually feel the baby outside and it's quite accurate so poking a finger or hand up - urggh - it just puts me off!

I suggest this 'tape' (representing the memory, vision, or sense, of her distaste) we (midwives) would do well to rerun metaphorically every time we perform this ultimately invasive, in a sense, truly outrageous, procedure. Bev had fantasised to the extent of planning to have babies *only* after vaginal examinations had become redundant, or gone out of favour, believing only then could she cope with the whole process as she wouldn't have to face such an invasion. This is pure, even naive, fantasy, possibly *but* a measure of her horror of the vaginal examination. How many others silently endure, dread this procedure, the prospect of vaginal examination (VE) compounding their anxiety? How many midwives wait for a compelling reason before doing this? She even delivers a spirited, albeit inaccurate, argument for the lack of rationale for doing VEs "**...can find out all you need to know externally!**".

The following excerpt relates some of the story concerned with the issues of information and preparation:

R: Did you feel you knew what was going to happen to you with the induction process?

Bev: Yeah, I read it all in the book. All my nursing books and all that, went into more depth. There was one book- it must have been an old book dated back way in the seventies, and I didn't actually see it, but they said - cos you have the tablet form - well, when they had the tablet form that was alright and then they said they put a needle up and poked the waters. And I was going: "No way, man, No, no, no, no, no, no, no, no!" I wasn't going to have that and I was going to fight to say: "No, just put that pill up!" Hopefully that will do the thing. What else was there? And then I went in on the Tuesday and I had a bit of the show and it was the show and I was in labour for seventy-two hours but I didn't realise it. I was waltzing around. My plans were working out. (L) But because I was overdue I knew I had to go to hospital. I couldn't have my typical homebirth like I planned.

She could access books as a student but she found the information alarming concerning induction: tablets vs 'needle' (possible this referred to an amnihook which is a firm plastic instrument designed to tag the membrane around the baby, release the fluid around the baby a technique used to augment the labour) to break the waters.

Now the story moves on to the intervention and the birth:

Bev: When I started, I walked around and walked around and walked around and I was smoking. (L) I couldn't actually eat. I drunk heaps though. I must have drunk round about four or five galleons of water, man. Just drink, drink, drink, drink, drink. I was real tired and I just couldn't be bothered doing anything. I wanted to have a spa to massage. I was really sore. My shoulders were sore and my legs were sore. Basically I just wanted to sit down in a nice, warm bath and just relax. I just wanted... And G, my ex partner, he's good at foot massage. And I just like - if he could just do the foot massage. Cos I taught him. He knows how to massage but he doesn't know much about reflexology. Whereas I do. And I just explained it to him

and that was really nice and I like my head massaged. Just rubbing the (unclear) - that was relaxing. Then everything started coming up tense and all that. I didn't go to Lamaze classes. I didn't end up going to them, but I did read in a book how to do it. But that went in one ear and out the other (L) when the contractions came up. Mum was a good coach because she was trying to - you know? But I was getting fed up with her too! (L) And I was getting fed up with the midwives cos they disappeared for a while. I was wondering where everybody was and I was getting really patchy and I knew I was going to boil over soon. I hope this baby...I knew that - heaps of the women in there were being induced and heaps of them were having them in the hour or two hours afterwards and I was *still* going! And this lady who had just got off a plane or something, she was having her baby and she had her there and then and I was *still* going! And I could hear these women who were pushing and they were having their babies and you could hear the midwife going: "Oh, she's had a beautiful birth! Bla-ahh." And I was *still* going. And I really, really tried to have a rest and have a sleep.

Family support was manifested by her partner supplying massage and acupressure. As her labour moves into higher gear she noticed herself becoming irritated by all around her including her mother and her midwives. She found the pressure of 'waiting' for her pregnancy to end now transferred to pressure of the wait for the labour to get under way and the baby to be born. She couldn't avoid knowing she was 'behind' in the IOL 'race.' She could clearly hear the progress of the other women. She felt decreasing patience and decreasing energy; and was ill at ease because of the presence of her partner's family, adding to her irritation. It was not her choice that they be there. To her it was a serious transgression of her privacy. However she remained sure that the midwives would protect her, that they would not tolerate any nonsense ("hanky-panky"). She felt that she herself

had insufficient power to control who was in the room. Here complex family and social issues were magnifying her stress and undermining her control.

Bev: She explains what's happened. Usually it helps to break the waters. So that was alright. Giving information was really good. S (student doctor) was really good for G. My Mum doesn't have much time for G. Which is fair enough. She was trying to concentrate on me and H and T were explaining it to him, but *he* was actually good for G as a man. Plus they've still got the minds of us young people. Even though he looks like a young gun himself too. I walked around the place and then I started having contractions but the contractions were off in the timing and the cervix weren't open, they didn't even open, they only opened to six centimetres and that's about ...

R: You were about half way. You did get past half way.

Bev: Yeah, got past half way and then they did an internal and I had a water bath. Cos I tried to do everything natural but I wouldn't take the gas. There was something about it. I didn't want to suffocate. Felt like I was going to suffocate with this gas...

A short time later:

Bev: I said: "H, I want an epidural." When the anaesthetist come in he was pissing me off too ! When - cos we had to wait for him because they had called him up and he came in and he knocked on the door and I went: "Come on in !" I didn't know how this epidural would work even though I read in the book and some of it said sometimes one can still feel the pain. I was thinking: "I'll be one of those women."(L) He was telling me - cos it was hard to lean over - to do the crouch to get to the back. And he was going: "Bev, you *have* to, you *have* to lean over." and I was getting really pissed off, cos I said: "I *am* leaning over !" You know.

R: There's just a little something in the way, isn't there ?

Bev: Yeah, yeah ... What I tried to do was open my legs and I didn't want to open my legs wide. In the back of my mind, I said: "If I open my legs then they will see my vagina and then I..." I can lean forward if I open my legs a bit more.

R: But you were inhibited because...

Bev: Yeah, I think that's 'cos because H stood there, sat there and tried to help me, and I knew she wasn't - you know - it just was quite embarrassing. (Absolutely.) He gave it to me and the pain of the epidural -when they did the epidural, I mean - that was no sweat. That was actually quite good. I heard it was quite painful but it was really, really good And when he did give me the epidural, ohh, it was heaven! I was really, really in heaven and that's when G came back and I was happy-as. I was really, really happy-as. Cos I was just about to cry when he told me to "lean over a bit more, you *have* to lean over a bit more!" - just about to cry cos I know when I start to cry that's when the pot's boiling, and it explodes and that's when I was going to explode . Cos when (L) I explode...!

She has firm opinions on the role of her caregivers. For her midwives, she had chosen a pair who work very closely together, and found real support. "**I'd have those midwives any day**"; and "**giving information was really good.**" She found she could accept the breaking of the waters which previously had seemed to unnerve her. The role of the student doctor, who was of her culture, was hugely appreciated, and endorsed with typical warmth, generosity and good will. The age of the doctor relative to her age and her partner's age was very important. "...**they've still got the minds of us young people.**"

There is more evidence of the level of understanding. Another example of what she knows perfectly and what imperfectly is her belief that she had made no progress at all

even though she had been told her cervix was six centimetres dilated which puts her into the second half of first stage of labour.

There is freely given, rich detail too of what her feelings were. She was clearly acknowledging that concern over dignity goes. She was feeling a sense of betrayal from partner whose support was not what she expected, and she felt no sensitivity forthcoming from his family.

She remembers feelings of hot and cold, and escalating discomfort to point where she requested an epidural. She was aware of rising annoyance and predicting some climatic showdown as her usual pattern. Bev has ample self awareness and knew when she is reaching (for her) close to crisis point: “**just about to cry**” ; “**pot’s boiling..**”; “ **going to explode..**” This excerpt illustrates the interface with another health professional, the anaesthetist. Then what follows is a description of an inhibition so frankly and graphically explained she may have already shed all her clothes but her perception that she could expose her vagina is very real and resisted to the ultimate, in that even though she knows it may speed the relief from her pain, she declines. There is no impression however that she explained this at the time. So how do we sense what is preoccupying the women except with constantly vigilant empathy? All we can realistically expect of ourselves is to check out what might be going on with sensitivity and perseverance and consistency to ease the anxiety of such as Bev. She supplied examples of her very accurate background information (“**that’s olfactory**”); and feeling relieved when she recognised the odour of her bowel movement, having smelt similar when working in the surgery ward.

The story of the intervention continues:

Bev: The doctor was really good. Y - whatever his name was - he had a foreign language. He explained what he was doing and what they were doing and H was good because she explained it over again but to my terms. Because even though I have done nursing, I still don't understand some of the terms of the doctors.

R: And when it's in a foreign language - I mean the foreign accent- is often confusing?

Bev: Yeah. I was still naked! (L) Didn't care. And I knew something was happening even though I was in la-la land - it felt like I was in la-la land and I think I was over-, over- tired. Then I started getting a bit worried. H said "Have to go and see Mr. L", that's the Head of the Department. He came and checked it and they went back in and explained about the blood to me - oxygen in the blood. When they told me about the oxygen in the blood, the first thing that came to mind was: 'Oh, shit, he's brain damaged. Or he's handicapped.' And that would have buzzed me out full-on. I suppose if I was about 32 or 34 that's acceptable, but because I'm only young, I think: 'F***! I've got a deformed baby and that must be...' - you know - put me off severely. But that's the first thing and then they said they have to wait for another half hour. And that's when I started panicking because I was thinking: 'Oh, why don't we do the Caesarian now before that half hour comes up? Because the next thing you know, the bloody thing might, you know, my baby might die or he'll come out deformed.' Deformed was my worst nightmare. Not so much dying but deformed baby. Cos if he died, there was a reason why he died ...

R: You mean mentally damaged, don't you? You mean brain damaged rather than deformed?

Bev: Yeah. I would prefer him dying than being mentally damaged. That would be more acceptable. So after that half hour they said: "Caesarian" cos his heart rate was fully-on going down. But his blood count and oxygen was good. It was alright. So, the girl that came round with the consent form. Well, that went in one ear and out the other ! (L) I was real wasted .And then she explained everything - she was really good actually. Asked me questions and I was saying: "Yeah. Yeah. Yeah.

Yeah. Yeah.” Yeah. Everything was: “ Yeah.” I’m sure if she had said: “Have you got diabetes?” I probably would have said: “Yeah !” (L) I am sure. I was so wasted. What else was there? And then they were preparing it cos I know they were just having another Caesarian before that. So I was next up. So off I went to surgery. They explained what drugs they were giving and explained the epidural - how it can - people think they are suffocating - and it does feel like you’re suffocating but I didn’t - and they panic- but I didn’t panic, I was alright. And that morphine was going to be pumped into me and given to me for the next twenty-four hours, so I was quite happy then. I think I was -

R: This was your worst nightmare. You told your Mum: “I’m not having a Caesar.” unless it’s a real..but you have accepted it in your head, this was a real emergency?

Bev: Yeah. Cos as soon as I saw that monitor cos H put it on me and she walked away and I saw it go (indicates with hand) ...his heart beat go down and I know - cos I read it in the book- I know that if it goes down, it’s alright once or twice, but once it starts continuously going down, down, down, down...

Her fears for her baby are associated both with stories and examples in the community and her student nurse training (“ **he’s brain damaged, handicapped** ”). For her how you reacted to the reality of a brain damaged baby was related to your age. The older you were as a parent the more you would presumably reconcile the situation and care for such a baby. These thoughts increased her anxiety as the half hour wait in line for the required surgery stretched out. She felt she would better cope if the baby were to die. The rationale for the Caesar is confused in her mind. Why the Caesarian? This is an important question for Bev, and called, I thought, for more resolution during her recovery, than the induction. She had been told the baby was distressed but there was this delay and they had reassured her the oxygen level was ‘good’. Opinion varies in the literature regarding a possible link between IOLPP and the outcome of a Caesarian section. There is a

perception that Caesarians are increased in IOLPP, and the rate was 22.3% for IOLPP in 1998 at WWH, compared to 18.0 % for spontaneous onset labours (WWH Report, 1998). However, the Cochrane systematic review concludes there is no increase in Caesarian section rate for women induced electively at 40 weeks and 10 days post dates (Crowley, 1999). Examination of data from Statistics Canada between 1980 and 1995 discovered an increased IOLPP rate but deduced this had no convincing influence either way on the Caesarian section rate (Sua-A-Quan, Hannah, Cohen, & Liston, 1999). Our national rates are high and continue to increase (Bulger et al, 1998). It is observed that areas of low induction rates also have low Caesar rates. Areas, such as the hospital where Bev was induced, that apply scalp vein blood sample analysis to assess the degree of distress detected on the cardiotocograph monitoring the baby's heart rate, are known to diagnose fetal distress less frequently (Sua-A-Quan et al, 1999). Parry et al's study showed an overall significant increase in operative delivery for primiparous women but no difference in overall Caesarian section rate (Parry et al, 1998). It is by no means a clear picture as yet.

Bev is amused with how she is asked to give consent when she is feeling so 'wasted' by the drugs she has been given. When her baby arrived and her mother held him close to her for her to see she could see seven images of him. The drugs were affecting her ability to focus.

The story continues, telling of the birth and the appearance of the baby (a baby that by scan may have been 44 weeks):

Bev: When he had come out, he was a white baby but they said he had pooped in his waters. G said to me that when they were cleaning him, it was right up to his top. But when I saw him come out, the doctor pulled him right up and I didn't actually see the cord, and I wouldn't have minded just reaching over and snipping it. But I actually never saw the cord. And that was really sad. Because I have always wanted to see a baby with a cord. But he came out nice and clean. But he came out a flat rate baby, so nothing was happening. He was doing nothing. And then two midwives, theatre midwives, came, grabbed him, they took him over and they gave him a ruffle and a tuffle just to shake him up. And then I heard him starting crying. And I said: "That's alright, eh?" He only cried for a little while and I'm sure for just about half a minute, and that was it.

R: It's a good sound, isn't it.

Bev: Yeah, and then I said: "Is he away? Is he alright?" H brought over the placenta and she showed me the different spots where the smoking is. And I felt a bit guilty then. Like full-on guilt over smoking all that shit. Cos I know heaps of women who smoke and their kids are alright. And then when I saw that I thought: "Oh, next time before I have a child I might try to full-on give up smoking." Once the damage had been done so there was nothing much I could do.

R: Did he look 'over done'? Because sometimes you can say: "Gosh, he really needed to be born -you know- he was overdue, because his skin is peeling and his hands are wrinkled and he didn't have much fat on him."

Bev: He actually come out like this.

R: Yeah? Nice and clean? and firm - intact -skin ?

Bev: Yeah. But his little nails were awfully long and I was going to snip them, but the nurse said: "No, cos the skin's still attached." And lucky, because I would have just gone ahead and snipped them.

R: It's also easy to cut them too. I've seen a wee boy - the mother has cut the nails and each wee finger has got cuts?

Bev: Oh, have they? Mind you, I had to have a cut of them first even though - cause I bite my nails, any way - but even though I know how to cut nails, my nails, it's totally different on a baby.

R: Yeah, and they are moving all the time.

Bev: He came out quite nice - very hairy though ! (OK.) He had all his hair down here. It was real hairy! Mum showed me him but Mum put him right up to my face. (L) - and I said: "I can see seven of him!" I could see seven. (L) I can remember counting it ! (L)

Her regrets included not seeing the cord, nor being given the option of snipping it for her son. Described the resuscitation of her son as his being given a "ruffle and a tuffle" - down playing/moderating the seriousness with a metaphor from a game.

Bev continues to draw a link in her own mind between the epidural and her baby's distress:

Bev:....Because all of a sudden I had everything - everything was fine before then. As soon as I had that epidural - that's when everything started going down. And I thought it was because of that. And I was a bit pissed off with myself.

R: You'd naturally think... you'd naturally think it was because of the epidural. But they explained something differently to you, didn't they?

Bev: Yeah. Basically I was overdue and what else? Then I was a smoker. So that's understandable. Then I thought: 'Ohh well, that's alright then...'

R: So that made sense to you? All that was comfortable. You could handle that ? you could cope with that? Yeah? Does it mean you would do anything differently? If you were... If you have another baby and - would you feel differently about the due date? or would you feel "that's what I do - you know- I go past my dates" or "I won't really expect that baby until a couple of weeks later," Or would you still get the same....would you still feel that there might be something wrong? Would you feel differently? Or do you think this experience has changed the way you feel?

Bev: Well, I'd take it to the due date of the scan, if I have another baby. And that's when I'd decide to have a Caesarian, if it's within the five years. If I have another child. Cause I'm not going through that again. I'd rather have a Caesarian than actually go overdue, and then seeing the heart beat, because that did scare me when they told me that they were doing the blood count. I said: "The blood count of what?" And they said: "The oxygen." The first thing that came into my mind was: mental, mentally retarded? Cos that *is* scary, you know. This is our first child. I've seen the parents go down like that, just go full-on down. (Sure.) You know - they had all their lives ahead of them and they had a child that's mentally retarded, and the next thing you know... And it *is* horrible. I know for myself that I wouldn't have been able to handle it, but then I wouldn't have been able to handle it to give him up? ! To give him to a place...

R: It's a rock and a hard place, isn't it. (Yeah.) You can't possibly give away your own baby, and yet you know it's going to be an enormous struggle to look after that wee one.

Bev: And I was just thinking, you know... Mind you if I was 34 or a bit older I'd probably bloody accept it, eh? This is life. This is what happens ...

R: And you probably know of women who have Caesarian sections and still have babies that aren't quite 100%. There are just no guarantees. No, nothing can be totally guaranteed.

Bev: Cos I know this...

R: But you would take... what you are saying is that you would take charge of the next situation. If anybody was listening to you, this is what you would be saying..

Bev: I'd be more aware of it, like full-on aware of it. But I am scared for the next time because usually if you've first complications with your first one, usually the second one's just as bad.

For Bev a major issue was whether the baby had been affected by the epidural, as the relief of the epidural coincided with signs of fetal distress on the monitor. Her midwives were good she says because they explained it to her in terms of the fetal distress possibly

being because she was overdue and she smoked. This guilt being less than the guilt of having given way to the temptation of the epidural and baby's being distressed as a consequence. The message concerning the state of the placenta for her was linked to her smoking. She reacts pragmatically. There is no connection made with her own health; she is only influenced in how she cares for herself if what's at stake is her baby's health. She might try next time not to smoke but it is too late for this pregnancy. She has left it behind.

I had asked about the rationale for the Caesar wanting to know how she explained it. She had held fears it related to the epidural, but her midwives explained it to her in terms of the fetal distress possibly being because she was overdue, and she smoked. This experience was scary. 'Next time' she would choose repeat Caesarian section; has the understanding it would be recommended should she become pregnant again within five years². She again brings up the fear of dealing, too young, with a mentally retarded baby; yet would also find it impossible to "...give him to a place..." She is not affected by my suggestion that a Caesarian section on her due date was no guarantee of protection from that possibility. I am not sure if this is the place there is for any challenging of views; only sanction for recording and relating to vital, but so quickly routinised, areas of practice.

² Practice differs here amongst practitioners.

I attempt to sum up: "Important thing is you would take charge of the next situation in so far as making your view known." Bev agrees she would be "**full-on aware**" next time. There is anticipation of being better prepared.

Another excerpt illustrates further information sources and the issue of communication:

R: I'll just ask you one - probably one last question - and that's to do with the amount of information that you got. I've picked up several times that you read and read and read. And that seems to be your main information source. Plus your midwife. Is there still- are there still questions in your head like: you didn't completely understand or you didn't necessarily want to completely understand, but you wanted to understand a little bit more about things?

Bev: Yeah. It was actually when they were doing the scalp thing. When they put the tube in. Knew what they were after. To get a sample of blood and all that... That was a bit scary.

R: It could have been better explained at the time? or you had questions later?

Bev: It was later I wanted questions. (L) If I had asked questions (then), it would have gone in one ear and out the other! (L)

R: You knew you weren't paying attention! (L) (Yeah, I wasn't!)..very sensible. Of course not! of course not! You were in pain. You had an anaesthetic and you were about to have a Caesar so... it was

Bev: ...at the back of my mind ...

R: You could hardly have sat an exam, could you ?...

Bev: I was saying to my Mum and G: "Can you understand me?" Cause it felt like I was talking [makes distorted sound] - y'know ? That's how it was coming out to me. Everything was echo, real echo - that was a real effort, too!" (L)

As with Anna's example there are many stories within Bev's induction experience story. These ask to be told. One example concerns the breast feeding and is attached to her description of the immediate progress of her newborn son.

R: When you say 'sore' you are talking about the nipple, not the whole of the breast.

Bev: No, it was just the nipple. Man, oh, it was *so* painful, and by the third day, my breasts were like *rocks*. and the pump thing was alright. That was really, really good...

... He went into Neonates. They told me it was his heart. But when I went to go to Dr. F - cause I had to have a referral - after he was three months. He said to me it was his lungs. And I said: "Oh, I thought it was his heart cos it was his heart beat that was going down, not his lungs." He said it may be due cos of the lungs-something - working on the heart. But the respiratory system and the heart system are totally different even though they might... work together, but I didn't understand that bit. He was alright. Yeah, I was dying to get out. I was dying to come home actually on the third day. I could have gone home on that day too, but I didn't realise you have to stay there five days until you have a check up. Cos I wanted to get home before Easter. I didn't get home til Saturday - yeah - Saturday. I was very tired but not tired to go for a sleep. He only got up for two-three feeds. That's about it Then I got sick and tired of getting up cos I had got some formula. I didn't breast feed for three days when we were at the hospital and another day when I was at home. He had formula. The milk that was spurting out actually quite healed it up by itself. And then he was hungry, and I got sick and tired of getting up, making bottles, sterilizing it, doing all this crap, cooling down the water, and I thought: "Oh, I'll just lift my top up and pop him on..(L) Actually Mum just pushed his head up and he plonked over, and I crenched [clenched]. And that's it.

R: Well, he was older, and he could put his head in a better place ...

Bev: Yeah, and that was better. I liked that. My energy came back up, after I had him, like full-on up. I ate *heaps and heaps and heaps* and I was enjoying my food so much.

Concluding reflections:

Her return of appetite and ability to eat is an abiding memory. She is able both to be critical and to praise aspects of her care. She is uninhibited in how she made sense or explained her experience to herself. I have the feeling there are gaps in the explanation but nothing seems to linger deeply now. She got through it. Other priorities crowd into her life.

She demonstrated what seems an eclectic mix of beliefs. For example she wished to use natural remedies where possible, and to reject oral analgesia; she had a firm belief in exposing to sun and air to help heal wound, but was also enthusiastic for the epidural and morphine combination for pain relief. This pick and mix approach seems to work for many women today.

Bev's hypothetical counsel to others reflects considerable, mature reserve. She would not presume to offer advice. This is not her place. She would be reluctant to influence negatively by using her experience as a guide. Also she does not (naturally) want responsibility of giving advice. Maybe this was the reason birth stories were *not* told, especially in the past? The inference being that it was too horrific. If it is likely one would set up one's listener negatively, best remain silent. This could partly explain why

women don't learn as they once did, about pregnancy and birth, from generation to generation. Paradoxically, there is the phenomenon of the compulsive teller of pregnancy birth 'horror' stories. I am not sure whether these people are more prevalent today, or were prevalent in days gone by but had usually a inhibiting effect generally.

On the surface it seemed that Bev had had the cliché experience. Her labour was to be induced. She was three, possibly four, weeks past her due date by scan. She was in apparently early labour when she arrived She was induced nevertheless. Fetal distress developed and she found herself undergoing an emergency Caesarian. The baby did not appear post mature. Now she is convinced that is the way to do it, i.e. to give birth by Caesarian section. She does reflect a growing group in the community. Bulger et al in their study on the rising Caesarian section rate, commented on a survey of British women: "As almost all those having CS were satisfied and almost half said they would prefer an elective section next time, it may be that consumer choice is helping push up the CSR [Caesarian section rate]" (Bulger et al, 1998, p.32).

There are clues that she may change her mind. Typically, she juggles the orthodox advice with her own independent judgement. Her preoccupation is with understanding the larger issues for which the communication from her midwives was so important. The freshness and frankness of her narrative ensure it's impact. Her misapprehensions and her insights encourage me to feel it is in every woman to question where she does not understand, given the feeling from her carers that she is supported. Her stories stay with me and point emphatically to the individuality of each situation.

Chapter 8 - Cath's story: "...my expectation was probably way of the wall."

Cath, her partner D and their two daughters G, three years, and KM, 11 weeks, live in the outlying suburbs of a main center. This is the locale of their respective extended families. In contrast, during Cath's first pregnancy, they lived in a township five hours away from this 'home' town. Cath had had an elevated blood pressure through most of her first pregnancy, and was to have an induction at term. She had wanted to avoid the pharmacological induction, used alternative methods and, coincidentally or not, laboured at 39 weeks, just days prior to the scheduled induction. She needed to be transferred in labour by ambulance from one hospital to another but had a spontaneous normal birth. She had had continuity of care with her first midwife.

This second pregnancy her blood pressure was not concerning until 40 weeks. She had engaged a midwife for the birth who worked for an independent practitioner organisation in the main city area offering a modified range of care. Once the birth had taken place in the tertiary hospital, she planned transfer to a small level 0 maternity unit closer to her home and engaged postnatal midwifery care from another member of the IPA, who practised in her neighbourhood.

On a visit to her general practitioner on the Monday of the week after she was due, it was found that her blood pressure varied but some readings indicated that it was moderately elevated. Consultations took place between the GP and the hospital doctors. A plan was made to induce Cath's labour on the Friday if she hadn't gone into labour herself by then. Cath would then be eight days 'overdue'. Although it

appears the elevated blood pressure was driving the decision, it is unlikely this was of acute concern or sufficiently serious, if the intervention could be delayed five days. No arrangements were made for monitoring of the blood pressure in the interim, again signaling the blood pressure change was of lesser concern than that she would be overdue.

Cath is a qualified health professional. She works, but not as a midwife, in a women's hospital. Cath's midwife for her first child is K. Her birth midwife for her second child is S. Her G.P. is Z. A colleague of both Cath and S, whom she meets up with in Labour ward, is P. She was induced eight days after her due date.

Cath takes up the story, responding to my query about the experience of waiting:

Cath: It was actually really hard. I was a week early with G and I was actually going to be induced. I had HOP¹ with her, and blood pressure and had been hospitalized at 34 weeks for a week. So I was being assessed on a day by day basis from when I went home at 35 weeks with her. My midwife would come daily and check my blood pressure and urine. I felt I could be hospitalized (at any time) for an emergency Caesar and at that time we actually lived in X. So we were traveling to Y weekly, and oh it was just awful. When I look back. At the time you accept it because that's what you have to do. You know, it wasn't until now that I reflect on that pregnancy that I appreciate how stressful it was and with family away. So that was interesting. So I had her at 39 weeks and that was literally after coming home from the obstetrician and she said: "Well, if you don't have the baby by (the following Monday) you are to come into hospital to be induced." And so I rang K, my midwife, and said: "OK, we need to have this baby out. What can we do?" And so with KM I was expecting the same, that I would go early. So after the due date went past, it was very disappointing and I had other factors. D, my husband's at the M.S. at the moment and so we had:

¹ Hypertension of Pregnancy, formerly known as pre-eclamptic toxemia.

“Well, this date’d be good because -you know- I’ve got exams here.” (L) And all the rest of it and so I tried the “natural things” which I (had) tried with E, to initiate labour. Unfortunately they didn’t work. KM wasn’t going to budge.

As with the others’ stories, this story is told in basic detail firstly and then revisited. What emerges is a fuller, richer narrative which more completely reveals her ambivalence. The following is from page 25 of the transcript.

Cath: It was hard. KM was a lot bigger than what G was. I was a lot bigger with her and then having three year old to run around with. I remember it being a lot more physically painful and uncomfortable. I was -like- ‘I really need this baby to be born’ - and I don’t remember feeling that way with E. Every day (with her) was as exciting and it was like: ‘Wow! how exciting!’ but with KM it was almost like ‘I’m so desperate to have this baby.’ Which is another reason why I think I didn’t really question... And I remember thinking: ‘Oooh, that’s a bit naughty.’ (Because part of you is with, is behind the decision?) Exactly, and it was almost like - although I didn’t want to be induced, it was like a relief? As well, because it was getting to that stage where I was sort of “oh dear” you know. I couldn’t get comfortable - all that sort of thing and every little niggle you think: ‘Oh is this the baby? Is this it?’

R: Exactly, exactly. “Am I going into labour now? or will I go to bed and tomorrow I’ll be in labour? ”

Cath: Yeah, and you’d have the Braxton Hicks, or whatever, and they were all alot different with G. G’s were, you know, a lot more different, where KM was just like a period pain. Then when I went into labour, it was just like a period pain. So I read in my book. I thought: ‘No, no, no. that can’t be because the book says if it does this, then it’s not doing that.’ And so that was really different. So every little pain or little twinge you think: ‘Ohh, ohh, this could be it!’ (L) And the fear of going anywhere, that my waters are going to break and I just didn’t ...I was shopping on the Tuesday and rushing and thinking: ‘I have to rush just in case my waters break!’ (L) And it was really weird, trying to keep me normal and keep this living sort of, having this normality and thinking: ...

R: Cos you've got, you know, a husband and another child to keep on an even keel. I think all around seem to take their cue from you as well. Did you notice that? It's so important that you stay calm and then they stay calm.

Cath: Yes, you're right, actually. And my Mum because she was sort of staying here at the time, and it was like: "Ohh, maybe tonight, maybe tonight." And you'd joke and then it would be sort of like ohhhh.. with the pressure. And then it'd be like: "Oh, sorry, Mum, I'm still here!" the next day, and she'd just laugh: "Oh, for goodness sake, Cath !" But it was. It became sort of "Oh no !" All the times I'd be waking up and I'd be timing myself and thinking: 'Should I be ringing S? Or should I do this or should I do that?' And then I'd be asleep and the next thing I'd know it'd be morning again. So it was... Yeah. (You are asked to cope - to put up with a lot, isn't it.) It is. There is. If you didn't know the date or you didn't have that social expectation of people continually ringing... (Then it wouldn't be such a big thing.) It wouldn't be such a big thing if you went over, but I mean - so what? But you do, you're right, you have that date and that date suddenly becomes such a big thing. Such a big thing. (If you had a due fortnight which you can't have, I know, but I think it would take a little bit of the pressure off.) Yes. I know myself it's like... you can go two weeks either side...

R: But the complicating factor in your case was your blood pressure. Just how high was it going to go? What was your body telling you by sending that pressure up And with the experience that you had with E (unclear). And D's position through all this - he had an exam to sit?

Cath: Yeah. (He was obviously studying.) I think it was sort of hard for him from when he went to M. S. It must have been about 33 weeks and so for him I think he sort of felt a little bit detached and just sort of: "Well, it's your decision, Cath. and really..."- you know - as he said to me: "I don't feel I can have like I can have an input because I'm not here and it's your body and it's you and you basically have to deal with this." (Is that what you wanted him to say?) I don't know - No, I don't, because I think by that stage I wanted some one else to make that decision. I wanted someone else to say: "Hey it's OK." you know? And he did eventually say: "Well, look, obviously that's what they think is needed." He was really worried too after seeing E and the placenta last time. We would spend time you know ...The conversation would go: "Well, what would have happened? Why was it? " We never got to ask those questions. And he himself

said: "Well, personally, I'd rather that the baby be born now than suddenly the same thing happen. When you had that retained placenta. When you had this baby that perhaps was a bit compromised." But like you said, we didn't know anything like that was going to happen. So I think he was quite supportive and then it was also: "Oh, that's good (L) because it's happening at nine o'clock and my exams at eight!" (L) ("I can do two things here!") ! Yeah. So for us it was also quite - socially for him it was quite neat because it fell in between some pretty hectic sessions he was having to deal with. It gave us the opportunity of coming home and spending some time at home together. Which we wouldn't have got had our baby been born on (the following) Tuesday. So that was also nice, yes. And that gave E an opportunity as well to do it as a family, which wouldn't have happened. So that was the up side of being sort of being induced at that time.

Reflections

Quite naturally Cath focused on the differences between the two birth experiences. Inevitably points of contrast are drawn between care models, i.e. midwife/obstetrician sharing versus midwife/general practitioner sharing. Observations were made concerning the inevitable differences in style of practice, and the differences in location (small town vs city). She focused as well on the differences in the pregnancies. The first was complicated by elevated blood pressure emerging early in the pregnancy and the 'race' between the deteriorating condition and the spontaneous onset of her labour. This, she later conveyed in expanded detail, did impact on the condition of her baby. As often happens (according to anecdotal reports) with a pregnancy-induced-hypertension, the uterus was amenable to mild, alternative (dubbed 'low' technology) induction techniques and there was a 'spontaneous' onset prior to term for that first labour. She managed to preempt the scheduled induction of labour. In her second pregnancy her blood pressure was

mildly elevated toward the due date, this time, in retrospect, with no discernible effect on the baby's condition. The second baby, KM, was in good physical condition at birth. She was aware of social differences in the two circumstances also. The first time family and all the support represented by that were not present whereas during the second pregnancy family, including both grandmothers, were available. Cath perceptively saw the two sides of that. The first time less perceived pressure of the family's expectations. There was more of a chance for the young couple to surmount the difficulties and challenges of a first baby independently and entirely within their set of requirements alone. The second time there is that welcome cocoon of family sympathy and practical back-up, but whether or not real, the family's presence puts the pregnant woman under the strain of others' ideas and opinions, spoken or unspoken.

Among the elements which heighten theoretically the *strain of waiting* for subsequent babies is the usually reliable prediction that these babies come earlier than number one. This is borne out by research (Mittendorf et al, 1990). This research reported that for healthy, white, private care primiparas with well established dates, the pregnancy averaged 288 days, and for multiparas five days shorter.

The undercurrents include the physical symptoms of being overdue and the building desire to have the baby born. There is increased discomfort compared to first pregnancy. This aligns with what was revealed in the audit by Roberts & Young (1991) of a new policy in their hospital towards prolonged pregnancy. Multiparas were more likely *not* to choose to wait beyond their due date. This added to the general pool of influences and strains. Cath described the waiting and being alert to

any sign which may indicate labour, conscious (whether or not valid) of disappointing those around her. She had the common fear of her membranes rupturing in some inconvenient, conspicuous spot. There are feelings of doubt, uncertainty, of being unable to perform: “... **that date suddenly becomes such a big thing.**”

There is much discussion between the couple. Her partner is supportive of whatever she would choose, but under the influence of an array of conflicting feelings in her, she felt the need for a clear direction. Eventually he gave it. The convenience factor was not insignificant and she was honest and open about this. It finally convinced her. A mix of influences swirl and settle before a direction is seen.

But what else crowded in to confound her normal tolerance and equanimity? Her previous experience is a major factor. She had a feeling of being relatively in control with her first labour, which she valued highly. Her profession is also an influence. She works in the maternity care area, has assisted at Caesarian sections for failed inductions or for fetal distress during inductions. This means she has inside knowledge which was of mixed usefulness to her when she was trying to make the best decision. She had no doubts about the *date* her baby was due, but had also a clear appreciation of the imprecise nature of dating. In future she would judiciously conceal the actual day to forestall such as the “**constant barrage of phone calls.**”

This excerpt concerns the sources of information available to Cath.

R: ... all sorts of issues about information are coming out and there are gaps there and you are explaining these as possibly because of assumptions that your caregivers were making. Did you resort to any reading? Or did you talk to your friends?

Cath: I did. I ended up coming back and reading some of the text books that I had of... my own maternity book, which was when I did my training years ago. (L) And different books that I had. But it was really good ...(because you felt the need to understand) I felt the need to understand, and I just wanted to reassure myself, I think. I had this deep fear that ‘...she’s not going to come out. I going to have these forceps.’ So I went into forceps. So I was very particular and I spoke to M about the timing thing. When is that decision going to be made? And what choices do I have around that? And I’d also seen deliveries of babies with forceps and their doctors should have done a Caesar and I thought: ‘Well, I don’t want that to be me. If that baby’s not right there and just...If the forceps aren’t going to go in and just.... I don’t want forceps. I do not want this baby extracted from my body’, you know.

R: You played that scenario in your head. Just in case you were in that situation, and they were saying: “We’re going to do a forceps” then you would...

Cath: Yes. And I wasn’t in the state....

R: Yes, but you were preparing yourself for perhaps...perhaps asking D to say : Not necessarily that you don’t want ...(unclear)

Cath: Absolutely, and it was important that I let S know that these are what I wanted, and I would rather have a Caesarian section than have this high forceps where this baby was virtually going to be pulled out and left screaming in pain for the next few days, and that was coming from experience and having worked in that area. So I suppose from myself and from speaking to my friend who’s doing her training, my biggest fear is that I had come from seeing the horrible sides of inductions and that was my only experiences. So that was all I could sort of come from...

R: In a sense it gave you more control. (Yes, it did actually) Because it gave you that insight that most women don’t have and that they don’t know ahead of time that they may need to make those choices. Whereas you had a pretty good grasp of what (I suppose you are right) ...there would be critical decision points reached and you wanted your input there because...

Cath: I suppose you’re right, actually. And that’s the first time I sort of thought about that one. I always thought of it as a negative, rather than a positive but really it was a positive because I was able to explain, in a situation where I

wasn't in labour and I wasn't panicking or whatever, to say: these are what I want. Should this happen, these are the options...so, yeah.

What were her information sources? Cath read her own maternity nursing text book, and consulted her own internal store of knowledge gained from professional training and experience. She related her dread of forceps. She has witnessed too much. It was one potential decision point where she could reassert some control: **"...here's where I would draw the line..."** She would not agree to the use of these, preferring to undergo a Caesarian.

As it is about the decision to induce that Cath most wrestled with in her experience, she spoke with greater detail around that than the other participants.

And so I went to the doctor on the Monday for a routine check-up - we were due on the 17th, on the previous Friday, oh, no - on the Thursday. On the Monday I had an appointment with Z the G.P. My BP was up - my diastolic was 100, and so I sat there for an hour while his practice nurse rechecked my blood pressures and it kept going up and up and down. (L) And I said to him: "Well, this isn't helping!" And here we were talking induction and talking to Mr. U, the consultant, after ringing the team of the day at the hospital just to see whether or not - because of my history - whether I should be induced straight away. Which of course made my blood pressure go even higher. So ultimately what we decided to do was go from the Friday, if I hadn't delivered by Friday, then I would have an induction and I actually came away quite petrified, actually. At the thought of being induced. I sort of thought all of a sudden I had lost control and thought: 'Here we go ...' My experiences of inductions had been through friends who had been nightmares and as soon as you tell people that you are going for an induction, all the horrible stories are retold. There's never a good experience. (No).. (E.g.): "Well, this happened and it was a really positive experience!" (Unclear) I had worked in postnatal and I'd worked down in Caesar theatre scrubbing for Caesarian sections, so my experience of inductions were the worst ones, the failed ones basically, and so that was where I was

coming from. So I was actually *really* anxious, but also thinking: 'Hey, it's going to be neat to know that by the end of the week I'm going to have a baby.' So that was sort of quite nice. And it timed really well, which is awful! (L) Cause of the fact that my husband's home during the weekend! (It's a reality though, isn't it ?) So it was reality, so for us ...Which normally it wouldn't have been a problem had D not been away for five months and he's at home Friday night to Sunday morning sort of thing. So that was the fact, otherwise, I mean, usually I'm not into these sort of social inductions, social Caesars. It's not something that I personally would choose to have.

Later in the story she reflects more deeply on the issues underlying the decision for her:

...but I remember feeling when I came away from doctor's surgery and a friend of mine said to me - and she's doing her midy now, she said: "Why are you doing this?" And I thought: 'I don't know!' And she was really surprised. She said: "Well then, why didn't you ask him?" and I said: "Well, I don't know!"(L) She said: "If he had have said to you: "Cath, you have to go on antibiotics." And you would have asked him, you would have challenged him. What made you feel you couldn't challenge him?" and I said: "I really don't know." And then I felt quite let down with myself and quite sort of 'Am I being railroaded into this?' you know - because I didn't question at the time, and then I thought: 'Well, I'm assuming that it's because of my previous history and the fact that my diastolic was so high and all the rest of it.' And I know myself what those implications can mean, and when I was first pregnant with E, at 16 weeks til about 20 weeks, the diastolic was about 90-95, so I sort of knew that it had gone a lot better, the pregnancy and everything, than what I had first anticipated at the onset. I thought: 'Ohh, am I taking -like- the easy option? Am I sort of being rail roaded into something that perhaps isn't necessary?'

R: Did you feel you had options though? Did you feel that there was other choices? (Not at the time, no)... of how to proceed? At the time, you didn't? It was one way of going from here?

Cath: Yeah that was all. And I remember ringing S as I didn't even know what was going to be happening. I think there was an assumption there because I

worked in the area, that I would just know... the timing, and what I needed to do, and I didn't.

R: Yes, this is a occupational hazard - (L)..Midwives and nurses: it's assumed that: 'They will understand the consequences. We don't need to explain.' But of course you're not a nurse, at the time, in a ward situation. You are a pregnant woman (**and this is my body**) needing information and nothing can be relied upon on as to what you knew before.

Cath: Absolutely. And so when I did come home [and] spoke to my husband. I then rang my midwife again... I said to S: "Well, why is this?" and she said: "Oh, you know, your blood pressure is..." It was almost, I felt, "Well, it's been decided, and I wasn't there, and you've already discussed it with the doctor", sort of thing? and I don't know and I'd hate to say anything bad about people but whether or not she didn't feel she would be... There was no "I agree with this" , or "I don't agree with it" It was a very neutral: "This has been decided and this is what is happening and this is what - you know - you come in for the pessaries" and then she explained exactly what happens through the day; gave me my timings and I asked: "What will happen if I don't do this by this time? Where does this leave me...? When will the decision be made that I've made no progress? And even just the timing of: what time do I go in? and where do I go? When am I meant to be in the hospital?" So I actually... yeah, I think I personally wanted from my midwife to say: "Yep, it's what you need." Because I generally believe midwives and midwifery come from all that natural, holistic, 'let's not rush in here with the medical stuff first' whereas the doctors, that's what they tend to do. They tend to - or I feel - could be wrong - want to, you know, take charge.

R: There's a range of doctors, but on the whole they - their training is to act, to do something. The midwives' training is that this is mainly normal on the whole, and sit on your hands as long as you can but know when you need to do something.

Cath: Exactly, exactly - that's it. Have that balance, to have that: "No, we need help here" or whatever - "we need medical intervention", and I think I wanted from my midwife an assurance that yes, this was necessary. And I didn't. I just got this neutral: "We'll just do this. This has been decided."

R: You were left still wondering: is it strictly necessary?

Cath: - Is it strictly - yes and after I thought: 'Is it because of my background that she's assuming that I would have discussed this fully with the doctor? And it was a joint decision?' because I don't believe that it was. I think it was: "Cath, this is what we have to do." And although he said: "Are you happy with that?", I didn't *really* feel like I could say: "Well, no, not really." And I don't know whether it's...

R: Were you by yourself? Or was D with you ?

Cath: No, I was by myself. I did go away thinking: 'Is it because he knows? he knows that I know what can happen? and the seriousness of - you know - or whatever.'

R: Which in a sense would be paying respect to what you know to your training and so on and that's nice..

Cath:... and that's nice (L) and that's a compliment

R: ...but I go back to your being a pregnant woman, who - you know - those sorts of things (Exactly - it's that fine line) They're fine if they're checked out, directly checked out, then you can agree or disagree. But if it's a silent assumption then it's really (unclear) .

Cath: Yeah I think I was. Just from - "Would this have happened? Is this how it's always broached with women?" I remember saying to my friend: "Well, I wonder if he does this with everybody? or whether it's just me because he knows my background?"

R: And it's something you'll never know, isn't it? It's not as though you can be a fly on the wall at any other consultations.

Cath: That's it, exactly. So, I think this friend -she was very good. But I did. I did think: 'Well, there wasn't an option that I didn't say...' and once again you start talking to people. A friend popped into see me on the Thursday before my induction and shared her story of being induced and told me of how she delayed her induction by saying: "Well, I don't want it this week. Give me another week." And then she said to him the next week: "Well, can I have another few more days?" and I thought: 'Maybe I should have done that. Tried to delay it. But why didn't I do that?' Why did I suddenly think: 'Well, I need the baby out and I've only got this week, you know?'

R: And behind all of this is the best interests of the baby and that's, I think, what's the underlying assumption all along. "You've come to me for advice. My advice

is... and if anything should happen “- you know - (L) Yes, it’s such a huge responsibility, you know, and that’s why I think a lot of women are finding themselves in the same position you are. Going along with what.. and later finding out that there may have been other ways (**..other ways..**) of dealing with this which didn’t impact on the baby at all. You are still caring 100% perfectly for your baby ! and yet there is also a possibility that that experience may have been different. So it is a ..and you’ve got to be tough [unclear] (**I think so**) ... examining and information put forward so that you can ask a few key questions you know (**That’s it, yes, oh, it’s so true**) and feel more in charge of...

Cath: ...of what’s going on. Yeah, yes

R: And not feel that they are compromising the baby either.

Cath: Oh, exactly, and you do think that. With E there was - she was small for dates. She was only 6 -5, and very, very skinny. The placenta was incomplete.

Further confounding aspects for Cath included other people’s negative experiences, which rain down on you if they sense any similarity between their experience and yours. Also she was aware of having a different relationship with her midwife. Cath is aware in a complex, subtle way, and is also able to express with rare insight, the many layers of the response of her midwife. This section inevitably merges with the section reviewing the decision making. .

The decision had been taken without the midwife’s input and is presented as a *fait accompli*. The midwife is professional in responding to the situation as a plan has already been made. It is detrimental to challenge it when the woman’s anticipation has been set, but Cath is left with the impression that the midwife is noncommittal regarding the need for the procedure, or she responds with the apparently revealed medical indication if directly asked to. This impression of her midwife’s less than wholehearted endorsement causes Cath to reflect with greater uncertainty on the rationale for the induction. However she continues with the plan. It has more

momentum than she can affect. The subsequent manoeuvring seems to reveal more a passive compliance than an active collaboration. Refuge is taken in the practicalities.

The significance for Cath is how this illustrates the contrast between her relationship with her previous midwife (in another town) and how differently it feels now. Aside from that, however, she can read between the lines. Because she holds a concept that values the service, care and philosophy of a midwife in her head, she can sense quite accurately how the midwife may be feeling about the way in which the decision was made. There is no urgency to induce. A date and a time have been decided without the midwife's input. The implications for the midwife are major. No mind. It is decided.

There is a narrow line between too much of a compromise, when there is the possibility of more than one choice of management, and a situation that chances a conflict. The woman's best interests are to be maintained but what are they? And who decides? Where is the power here? The contrast between the first and second pregnancies is thereby only more sharply focused. The question also has to be asked: is there any preparation and/or information that could have forestalled this development?

The woman has mixed feelings. There is the paradox of relief (the convenience from the family's point of view is clear) combined with anxiety and even explicit fear ('petrified') of the intervention. Also her professional judgment makes her uneasy. In theory it is a route she would not normally endorse. As she talks, she treks so interestingly through the maze of conflicting feelings and messages. This is a

complex, many layered issue for Cath. There are universal reactions. Part of Cath wanted her baby to be born but not unless it was really necessary. Her unease stems from the feeling that this is what has not been firmly established, and that in some obtuse way she has let herself down. Few, who have not been in this state, would understand her feelings; the link between her self image, her beliefs, and her needs. Her friend, a midwifery student, was the catalyst of the debate within her. Her self reflection was honest, thorough, detailed; the conclusion she comes to despite her overall resolution, seemed wistful and regretful, as though she had failed some test she had put herself to. What happened was less than it had the potential to be; but her overall self-concept is strong and confident and she is well able to return to a basic resolution, a pragmatic satisfaction because this is in perspective in the priorities of life for her and her family. This is her making sense.

She was convinced her body was unready (which for her begs the question: was the baby ready?) or the “natural things” would have worked. She feels sure she is relinquishing vital control because methods of acceleration will be used and the monitoring of her and the baby will interfere with ways of dealing best with the contractions. Then in the last few hours before, she is aware of ‘niggles’. She gets “grumpy” with the baby. She is then reassured that the timing is close to the baby’s timing and the feared consequences that less likely.

Cath: ...For me the induction started with the prostaglandin pessary at 9 o'clock and then my midwife went away to do a home visit, and D had arrived in. I was wearing my monitoring equipment, as you do, and then I was able to wander around the hospital. We went for a walk which was quite nice. Labour - like the contractions - started, but as I said, I was already niggling anyway, leading up to it so it was sort of quite interesting. (Just the one pessary?) Just the one pessary,

so that was at nine and then I was checked again at midday by S and I was 3 - 3 to 4 centimetres at that stage. So it was good. So that's why I thought: 'Yay ! At least things are starting to happen.' Everything was progressing well. I was getting to that stage where you are needing to rock and all that sort of thing, so that was nice - reassuring. By one o'clock the doctor arrived back again, and examined me, and decided then that he would break the waters. Which wasn't as unpleasant as I imagined it to be. I was told it really hurts and all the rest of it. It wasn't as bad as I thought. But there was meconium in the liquor and stuff, so that's exactly what happened with G so that's what made me feel a bit sort of 'Gosh! This is familiar... What's going to happen here?' So we decided then as soon as I got to pushing stage, I'd go from that room into the theatre. Which wasn't an issue. I wasn't concerned about having to be transferred. That was fine. But then contractions came on really strong. By quarter past one, they were on top of each other and quite a lot worse than what I had remembered with G.

With G I had gone through that horrible transition stage in the back of an ambulance transferring from X to Y ...It was different. It was just me and my midwife and she massaged me. It was just different. I felt I was in control a lot more. I could remember sitting back, taking a sip of my water, regaining some sort of composure, and then it (the next contraction) would happen again.

With KM it just continued and I actually started to panic. I thought: 'Is this because I was being induced? Or is this how my second labour would have been anyway?' It was quite quick with G. Five hours. So it had all those sort of things going on. I remember joking to the doctor, saying: "Oh, you know, you're not going to make it to the car park." Cause he said: "Oh look, I'll check in later on this evening and see how you are going." And he made it home and had to come back again, (L) because by 2 o'clock I was ready to push. So it was good in that respect but it was also - quite scary. I panicked. It was actually really freaky and I remember I just kept saying: "This is happening so fast. This is not how I intended it to be." I mean, literally, it was two hours. KM was born at twenty-four minutes past two. It was hard and it was really painful (L) and it was a lot faster, and more intense than I ever imagined or remembered with G...I was

drug free with G as well, and I just remember feeling a bit more in control with G. (The intensity is just unbelievable.) It was amazing. It was amazing. And having that pushing - I remember S had gone out of the room to get a heat pack and I just suddenly needed to push and I remember Mum saying to me: "Look, it's fine. You know. You just have to breathe through it." I said: "No. I *need* to push." This is not like I could do a 'small' grunt. I had this uncontrollable urge to bear down with everything I had.

You know, cos with G, just out of Y, I said to them: "I think -you know - that I need to push." I was able just to give little puffs and I was able to get through it. But with KM I just... it was unbearably... this need was just... push... with everything...

R: The urgency, you know -your body wants to do it and there's no way your mind can turn it off.

Cath: No!! It wasn't. It was just - and that really, you know, sort of thinking.... but it was very good and just... yeah, I felt like I lost it. I thought: 'Gosh, yeah...' it was awful - not *awful* - because, y' know... well, it was awful actually (L) full on (unclear ? people said?) : "Ohh, you're so lucky having such a fast birth." And I said: "No. I just felt I lost complete control." (Railroaded - not railroaded, but ... but 'taken over' ?) I was. I was. I forgot how to breathe, and I forgot to relax, push, bear down...- all the things that you needed to do. S said: "Open your eyes and look at me and just..." you know, and that was really good. I needed to focus, regain myself. And it was just what I needed - someone to help me gain control to do this: a couple of slaps across the face and I'd be right back into it (L) I thought I'd know what I was supposed to do, being my second birth. All I could think was: '...this isn't what happened with G. This was just so - just overwhelming.' I kept comparing this to G's birth and I felt really out of control. Yeah. And I kept thinking too: 'I'm not usually that pathetic and I felt really pathetic.' (L) I just kept thinking that afterwards and I remember saying to S: "Was it because I was induced that the contractions came on being so incredibly strong, and I just sort of lost that control? Or would that have happened anyway?"

R: Its lovely that you had that chance to sit down with her.

Cath: Yeah. Well, it was actually really good.

R: Cause who else knows? She'd no way know as much as you do (**Well, that's it..**), but she's right there, hopefully, beside you. And she's the person you can say: "Oh (unclear)"(L)... responses and if there are more things left to resolve, then to resolve them.

Cath: **Exactly, which is really good. It was a few pushes and she came out and very shell shocked. Breathing wasn't established. It.. -the first breath - it says in the notes - after a minute, and properly established breathing after three. Blue - she was taken straight away, and that was quite freaky, because suddenly I had this baby and then - gone, and I think, too, I could know in my head that: 'Hey, this wasn't right. I've seen this before.'** Just the silence and I just thought: 'Oh hell!' you know, and I mean- just basically - S just put it down to her being sort of shocked, really. And just needing that time. Because the birth was so fast. Even myself, you know, I just remember thinking: 'My God - you know - don't give her back to me because I just needed a minute to get over everything.' I hadn't - you know - I remember I had the shakes, I felt nauseous, and I myself was shocked. I didn't have a huge blood loss - 200mls, but I just remember thinking: 'My God, it's over !'

Her tone and her words convey the power and the immediacy, even now, of that experience of both precipitate labour and stunned baby. The immediate consequence was that she needed to request that her husband continue to hold the baby, once revived, in the first few minutes ("**just needing that time**"). There are several echoes with the comments made by some of the participants in Kitzinger's 1975 survey of women's experience of induction. Although it is well accepted now (but not then) that mothers and babies should be in continual contact if feasible following birth, and fathers are no longer excluded from the birthing room, there is a eerie similarity between Cath's experience and this woman: "In one case the mother could not hold the baby because she was shaking and vomiting, and the baby was taken out and handed to the father in the corridor" (Kitzinger, 1976, p. 265).

Cath continues with more of the story of the induction of labour.

Cath: But, yeah, you do, you sort of think, it was this timing, and if this doesn't happen, then syntocinon, then what I didn't like about an induction definitely was being monitored? Didn't have that with G. Obviously I was in the back of an ambulance. But... and I hated that. I hated the thought of being stuck on this bed and having those contractions and thinking: 'Oh I just want to get up! And I can't !' You know? 'And I can't !' But then that also wasn't *as* bad as I had envisioned it, and I had been warned.

R: Did they allow you to walk around with the monitor on, or stand by the bed, or sit in a chair?

Cath: I actually ended up rocking. I actually just sort of sat cross legged and was able to rock on the bed and things, so that wasn't too bad. I honestly can't remember...I think the monitoring all came off because when I...I flipped over, when the labour got so intense and I can remember it being held there for a while, but I honestly can't remember whether I was actually wearing them.

R: We sometimes work around what the woman needs to do. We still get to listen to the baby as unobtrusively as we can, because we are in an induction situation but she hopefully can manoeuvre herself to where she's relatively comfortable. Which is a silly word to use I know!

Cath: Yes. No, no, but I remember it ...It was actually really interesting ... I had my Mum and my husband - and D - were right there and S sort of came in. It was actually very lovely the way it ended up being it was almost like: 'OK, this is medical, but we can still have some of your wishes and I can still be here and give you advice but stand back..' It was actually very well done. That sounds weird ... perhaps inappropriate but, yes, for an induction it was...

(Discrete. The care was discrete?) Yeah, it was discrete and it was along, I suppose, the lines it would have progressed, had it all gone naturally and over perhaps not so intense, not so being within two hours. So that was really good. Yeah...

The whole tenor of the scene is as it has always been. Women who have given birth under similar circumstances will recognize this state. Cath pays homage to the efforts of the midwife to salvage what she can of 'normal' amidst the medical.

The labour was precipitate, both mother and baby Cath. herself assessed as shocked. However she used no drugs. She received this accolade from both her colleague and her midwife:

Cath: ...I remember laughing and speaking with P who came into help S. She laughed and said: "How did you find that?" "Oh!" I said: "Next time I'm going for that epidural!" And she said: "You wouldn't have pushed so well, Cath." She said: "I haven't seen pushing like that for a long time." I thought: 'Oooh !ooh!' you know? And S came and she said: " I'm sorry," she said, " you've given me faith that we can have births like that again. This is what I trained for..." Cause she had an awful experience the day before, and I thought: 'It's so true.' And I sort of thought: 'Well, I did it last time with nothing,' you know. It was sort of... so that was quite nice, doing it that way.

In that moment Cath was affirmed in a way that will remain with her always.

As with the other woman I asked about the appearance of the baby. Cath's baby did not appear 'overcooked'. Meconium was present but this was a 'smooth skinned' baby, keen to suckle.

R: ... And when she was born, how did she look in terms being past her date, you know, looking 'post mature' ?

Cath: She wasn't that 'overcooked' look, not at all. A little bit sort of dry in her hands and feet but nothing ...just very lovely and chubby and things like that. Obviously quite a hungry baby. Yeah, but not looking very overcooked at all. (No wrinkly hands or anything?) No wrinkly hands or anything like that.

R: There was meconium. (There was meconium and...) Were you worried about that ? You were, weren't you ? you've said to me just before.

Cath: Yes, yeah. That was... and so the paed [baby doctor] was called down for that reason. Which ended up being good because of her breathing... She was fine. There was no sort of fear of her aspirating or anything like that which was really good.

R: It wasn't deeply stained in the skin ?

Cath: No, they explained afterwards, it was just a light green tinge in the - yeah so that wasn't too bad... Whereas (with) G it was thick and she was obviously in distress and she had aspirated some.

Cath is someone who clearly appreciates the nature of the midwifery model. She remains thoughtfully aware that if the outcome following this controversial medical intervention had been less positive, her resolution and emotional work would have been very different. This linked directly back to Cardozo et al's finding in their simple survey of maternal satisfaction (ibid, 1986). Satisfaction related to outcome, rather than whether the labour was induced or spontaneous. Despite the debriefing with her midwife, she testifies to some unfinished issues. Her baby was not yet three months. I asked her about any unresolved feelings.

R: Do you think you've had time? Any residual feelings about what went on? Have you resolved those feelings or do they still linger on?

Cath: No, I think... (Have they come up again?) No. Not really. I think I had a really good talk with my midwife after the baby was born - and I think once again because everything worked out so well, I wasn't left feeling guilty because something was wrong and she was endangered or anything like that. Yeah, so in that respect, no. But like I said whether I would do the same again without questioning I don't think I would. I think I would question the actual need.. (It's almost as though ..it's enlightened you. The whole thing...) Yeah, actually I think it has, yeah (And with each child there is more confidence?) Yes I think so (You grow as a mother?) Yeah, you do. I think and as a health professional having worked in the postnatal ward since or in-between G and KM - a lot more knowledgeable. Also I think that's another reason why I felt so: 'Oh my gosh, am I going overboard with this? Should I be asking these questions? What's happening?' because I have worked in that area and because I thought perhaps I felt I should know better. As well really but then I sort of think it's so different as a mum -you know? We had an experience where KM went blue. Now I've seen that and I've dealt with it many a time -well, not many a time but you know

- but when it's your own it's like: 'Wow! Where did that knowledge go?' Because you are caught up in that emotional -you know- (Exactly) and I sort of think maybe it's something that needs to be remembered when you're dealing as health professionals dealing with other health professionals. Just because they know that doesn't necessarily mean they're remembering it, or they are reacting (They are confusing their professional role with their mother role.) Exactly. It's completely different. (I'm really sure you knew exactly what to do but...) Yeah it was like: 'Gosh!' and then (You did it despite being so emotionally involved.) Exactly. (So there wasn't any problem.) Yeah, I mean you do, and you do click into it but you think: 'Oh -' because you usually are detached in these sorts of situations.

R: "Will I do it right because this is *my* baby? Not somebody else's baby." (Yes).

As we finish, I ask about advice she might give to another..

R: And if you were advising a friend in a similar situation perhaps with a blood pressure complication or not, what do you think you would say to her? "This is my experience and your's could be quite different"?

Cath: Yeah I think that's what I'd say. (Please don't model your's on me?) That's exactly what I would do, because I think it is so individual and I think I don't have that knowledge to say: "Well, gosh, I wouldn't do that. Don't have an induction again." I would just have to state: "Well, this is my experience and this is what happened for us but it worked out fine. Whether I would do it again... I may do it again, but I think I'd question..." And I suppose that's what I'd say. Maybe you just question. Ask again. (Give her the confidence..[unclear] Anything she couldn't quite understand that she would actually speak out.) And what are my options? If I decide I want to do this on Friday what will happen? And could we give it a couple of more days? Things like that. Maybe you couldn't, but I would have liked to now have asked those questions. Just to make sure in my own mind that it was actually imperative or necessary that I have this have this induction on the Friday and not the Monday. Yeah, definitely just to question. Just to double check that it's not a convenience thing. That it's not... there is an actual need to have it done...

Although Cath reflects that her fears transpired as exaggerated, if ever in this situation again, her questioning would change. This is a parallel 25 years later, of precisely Cartwright's conclusion: "...women should ask questions. We should encourage each other and steel ourselves to ask and we should rid ourselves of the habit of waiting and hoping that we will be told the things we want to know" (Cartwright, 1979, p.164).

Cath queries herself; she may have let herself down. She talks about the health professional/mother role distinctions; and I ask about her advice to a friend: "**I'd question the necessity [for me]... yes definitely just to question...**" She emphasizes how important it is that there be an actual need to have it done.

Concluding reflections

She was aware she was projecting her concerns onto others. She will portray her experience - or rather the outcome - positively as a counter balance. We exchange views about the compulsion to talk about these experiences. She compares the services of her two midwives, this is a educative possibility not available to women pregnant for the first time and trying to make a choice of caregiver which is right for them. It seems very much to me as though when she was wrestling with the decision, she was looking for a conversation between partners, equals, such as suggested best fits the midwifery model suggested by Pairman & Guilliland (1995). "**I was in limbo about the decision**" then her next contrasting experience. Women talk about midwives. I detect the respect, the fellow feeling, the loyalty and "**we work as a team.**" Women are involved; women have an opinion. The question arises: how much have things really changed? Cath has concern for other women, especially first

time mothers. “ **Gosh I’m pleased that it isn’t my first...**”, and “**It just comes down to the way things are run.**” Unintentionally this thought foreshadows one of the major themes of the *next* narrative. What better place to complete Cath’s story and move on the fourth and final story in the next chapter?

Chapter 9 - Donna's story: "...internally berserk..."

Donna lives with her partner, E and their six month old baby son, F, in another outlying suburban area of the same city. She owns her own business and our original arrangement to meet involved seeing her during a break in her day close to this business. It transpired that the environment was not suitable for recording and she obligingly rescheduled a time in her own home.

This was Donna's first full term pregnancy. She was referred, as is explained below, to the High Risk Clinic, where she was assigned a midwife, X, later replaced by B. The back-up midwife was A. The first consultant is V. The second consultant/clinic doctor is C. Donna's gynaecologist is S. The osteopath is referred to as N.

With her partner she attended regular antenatal classes. She was induced the day after she reached 42 weeks by sure dates, which had been confirmed by scan. Donna had a forceps delivery as staff were concerned about F being distressed, coincident with her reaching second stage.

My opening statement varies this time. Usually I have suggested the woman tell me the story as though to a friend returning from overseas who wants to know 'everything'. Because we have already met and spoken, this time I am not so keen to cast myself except as the student researcher. I settle for asking Donna to talk about the feeling of

being overdue, that there may be aspects of the pregnancy which relate to that, so she may wish to begin the story telling me about the pregnancy as a whole.

R: Can you explain why you were with the Clinic?

Donna: I had had two previous miscarriages with another partner before I had met my husband. Then I was diagnosed by S to have polycystic ovary syndrome and S had been my gynaecologist in private practice through all of my teenage years and it was kinda because S had said to my GP: "If any of my clients get pregnant and need to see me, I'm at the Clinic." My GP sort of thought that meant: "Refer them on and I'll see if they're OK." And it all sort of went through S and I ended up there. But Dr. V ascertained after about the fourth or fifth month and just put me into his antenatal clinic. But it just meant I got a bit stuck in the public health system. I didn't really need to be there...

This next section Donna related earlier than the above, but chronologically it fits here to explain her experience at the interface of woman and maternity care system.

Donna: I think being part of the high risk clinic had quite an impact on my pregnancy as a whole, and on reflection I won't be a part of the Clinic again. No criticism of any of the staff of the Clinic itself. It's just that I didn't have a very good understanding of the system. Like it's this big, and everyone's acknowledged that now. It's just this really dumb system that nobody understands and I didn't understand that I had a lot more choice than I was first given? At the same time I had a lot of reassurance being at the Clinic that perhaps I needed so ...and there I stumbled across B. I had a change of midwife....

Reflections

Donna has anticipated this session on two occasions now. I can envisage how she may have naturally pre-composed large segments. The story flows and is rich in detail. She also had confided during our phone contact that this was the first time since her baby's birth that she had sat down to tell anyone the whole her experience. It was a significant opportunity and one she was, by coincidence, now ready and willing to take.

She immediately identifies the major influencing factor (as she sees it) on the nature of her experience. It appears almost through a misunderstanding, her GP had directed her into a system hardly geared, she recognised now, for her individual needs nor designed to provide her necessarily with the required level of care for her low risk status. In ironic contrast to the maternity service as it is in theory available to women in this country since 1996, it appears Donna was no more in control than her counterpart ten years previously. In the current care arrangement, the health care provider who discusses the next step with any woman, who has a positive pregnancy test, and chooses to continue with the pregnancy, is obliged to explain to her the full range of care options and supply her with written information on a range of caregiver choices (Section 51, Health and Disabilities Act). In Donna's case, her GP does not care for the pregnant women in his practice but refers on to or identifies her situation as not completely normal from her medical history, and refers her to Clinic ("a room full of bellies"). The impersonal maternity clinic system takes over. A woman experiences the system and she and her baby emerge at the other end safe physically (usually), but possibly entwined in socio-emotional issues that

may have repercussions the rest of her life (Caroline Flint, 1986). She has a midwife of course but this person is assigned to her from a team.

She is aware now of being misled, though not by any person exactly but by the system in general. However she also concluded that the size of the system worked against her knowing her rights, and that being in this system was not *without* reassurance,. Her resolution of the less than ideal situation comes about because of her belief system. This didn't happen without a purpose.

Continuing her story: being 'overdue' Donna has an the enduring image of her aunt's experience:

Donna: Yeah, I never thought about being overdue. I think one thing: I had watched my aunt when I was eight years old, go four weeks overdue with her second daughter, and I had watched her decline and I remember her being in tears and crying, and then that night her water breaking and the baby coming and it was quite imprinted on me.

She became, as the story returned to earlier points with greater elaboration, saturated in the condition of being 'overdue'..'...' " what are *they* doing about it?"...'.

Donna: I think I was blown away about how some people who are parents still invaded our space. With our first baby. And people who had been overdue, who rung when I was overdue ?

R: What sort of things did they say, can I ask?

Donna: "What are they doing about it?" Well, it's none of your business. You get sort of sick of talking about it, really. I wished I had something else to talk about. I didn't feel I could go out anywhere.

R: It dominated everything. The fact that you were overdue.

Donna: Yeah. I made people quite nervous. (L) The man in the coffee shop down in the mall used to get very nervous about me having my lunch in there. One day I banged my knee as I was paying my money and I went “ohhawhh” and he turned green and white and pink and purple. And wanted to know if I was alright and should he call someone in? And I said: “Well, it’s just a bruise really.” But it also makes you nervous because every little thing that you plan, you know, -like- you have to plan things otherwise if you just sit at home you’re asking for it never to happen. But you can only plan things to a point. You can’t go too far away. Our friends who don’t have children didn’t have a conception of that, really: “Let’s go over to X. for the day and take your mind of it.” Well, what happens if I do go into labour? You know. I don’t want to sit in the car for an hour and a half to get home.

Donna’s memories of the waiting remain vivid. ‘I just wanted to see my baby. *Who* had been kicking me for nine months?’

The strain affected her well beyond frustration. This next excerpt came from the conversation when I asked about hypothetical advice to a friend when coping with the waiting

Donna: ...when you’ve mentally reached a point where you can’t go on any more, and you’re not sleeping. I just felt like every day I was declining into this big black hole that one day, when my baby came, was I even going to be able to deal with what was ahead of me. Then, go for it, because if you reached that point and everyone knows that you are just counting it down, it might be all that helps. I mean I don’t know medically what’s behind it. I’ll be more mentally ready the next time.

The degree of difference between expectation and reality, all in a void of reassurance.

She refers again later in the story to the “occasion” that it is when the due date has arrived, and yet nothing was geared to that. The implication being it is ‘no big deal’ but *it is*. What follows is a revolving door of expectations and disappointments. What is striking to me is the care taken by Donna. to balance the comments. She emphasises the advantages of the system she was in, when in reality its disadvantages and inappropriateness seemed overwhelming . That was *then* to her mind. However painful it is now behind her.

In Donna’s case there was a lengthy sequence of events which contributed to the escalating pressure of waiting. It was first suggested to her during the eighth month of the pregnancy that “... **baby not doing so well** (possibly concern about growth of the baby) **may need to be induced...**” This set up the expectation that it could all happen even before the due date. There was no further development regarding this. Then on the 7th of the month, two days before EDD, she is contracting so she has an encounter with a health professional (B’s back-up midwife). She was given the impression that she would have her baby over the next two days. However, the contractions, the process, halted. The 9th of the month comes and goes. The baby may have had the distinction of arriving on her mother’s (his grandmother’s) birthday, which also happened to be Mother’s Day. The 17th of the month comes. This was Donna’s birthday. Another auspicious day but no development. Externally she was managing well, as she could tell was expected by those around her. Internally it was quite a different picture. The real inner turmoil finally became overt on the 24th of the month, the day when she was empowered to ask for

action, by her GP. The couple were emboldened to take on the system. This is unorthodox, and indicative, as nothing else could be, of the level of her distress.

Donna: But everything went really smoothly and he was due - I was pretty certain when I got pregnant - and by me he was due on the 9th of May, which was my mother's birthday, and Mother's Day. The 9th of May came - no - I think on the 7th I had false labour, and I ended up in the hospital and I saw A, B's partner, and she said: "Yep. I think you're all underway, but it's all not established yet. So you just need to go home and relax and over the next couple of days you'll have a baby." And it didn't happen. The 9th of May came, the 9th of May went and everything was fine. I was being checked all the time and then my birthday was the 17th of May, and the 17th of May came and the 17th of May went. (L) I think the most awful thing about being overdue was all of the people ringing. Like people really need to be told to just back off and stay away and just not go ...

R: And did you think you were in any particular position to do that?

Donna: Oh absolutely not, no. I used to go out. Mum was really good. I said to Mum: "You can ring. You are the only one that can ring, and maybe my grandmother as well." I didn't mind her, but I was getting all sorts of: "Have you had the baby yet?" " No, you'll hear it when I've had the baby. I know I haven't had the baby. I live with this stomach every minute of the day. God, I know I haven't had the baby!" And then I became quite convinced that the baby was stuck. Because I kept having like two or three hours worth of false labour. Quite strong contractions, and then it would just come to nothing and I kept saying to Dr. V: "The baby's stuck." And Dr. V kept saying: "You don't know what you are talking about." And I kept saying: "The baby's stuck." And he kept saying: "It always happens like this. It's just your first baby. Everything's going really well."

And in the end I lost the plot. On the 24th of May, I completely lost the guts. And someone - and my GP - said to me: "You have every right to an elective induction now. Two weeks overdue. That's it. You can tell them." So my husband rang up, and

said: "Right, this is it. We are coming in." V said: "No, I don't have an Induction Clinic on in the morning, so you are out of luck." And E said: "Tough. Get her in!" And we just kind of asserted our - or my husband did - his authority on the health system, and in we went. Another man was happy to oversee it. I didn't care. Poor old B probably got caught on the back foot but you don't care. You couldn't give a shit about anybody else.

R: Had you been talking to her at all during...?

Donna: I had. I had tried to keep a really brave face, I think, I just sort of lost the guts on B. I went from being what looked to be - you know - 'getting a bit disgruntled with it all but coping pretty well', but really I was internally berserk, and not letting too many people know...

R: That's a fantastic term.

Donna: Yeah. Internally berserk. It comes from the hospitality industry, that one. When service is full on, you're internally berserk, but you've got to keep this calm outside. So... I had a fear of Caesarian and I kept being scaremongered with: "You are going end up having - you know - Caesarian's highly likely. Caesarian's highly likely..." and I think I reached a point where Caesarian was a better option than another day pregnant. And people kept saying: "As soon as that baby comes out, you will wish you were pregnant." And I never did. I've *never* wished pregnancy back on myself since. In fact I look at pregnant woman in the Mall, in my shop, and think: 'Thank God, I'm not that woman!' (L)

But I went in that afternoon to the assessment C. I met with the gynaecologist or obstetrician that was 'on' - going to be on duty that night, and who would be beginning my induction. And he said that I was perfectly safe. Felt that I was a good candidate for an induction. Had to kind of do some sticky business with V and kind of clear it a little a bit and people were sort of going... I was stepping... I was making people step on toes, but I just kept saying to people: "You tell V to come and talk to me, if he needs to talk to anybody." I don't think he was very happy. I saw him after F was born, and I think he was a bit offended, but tough... I think you have to be thick skinned in this. Yeah. He's old school. He's a great obstetrician. I

felt he knows his business. He just looked - he just looked at me - and he'd say: "You are alright. I know." And he did. He thoroughly knew what he was doing. He'd always find the position of the baby. He.. all that sort of thing... very experienced, but he's just old school. And he's a man, and I think sometimes ...

The information and the influences guiding her are in conflict. Her specialist and her midwife are maintaining the stance 'this is still within the bounds of normal, better to go spontaneously into labour.... you are overdue but still not yet at greater risk.'¹

However her specialist also has a group of 'private' clients', who are perceived to be receiving his more 'careful' attention and certainly to be given greater priority by him. On another side are the overt concerns of family and friends, perhaps more aware of how she is really dealing with it and unnerved too by an inconsistent attitude to the assessment of safety or danger for the baby, of this development. Then there is the approach of her GP, possibly influenced by conclusions of research, who clearly conveys that she/he feels there is some risk with the pregnancy continuing. Overriding all of this is the woman's personal conviction that (her baby's his position, his connection with her body; his 'behaviour' so far, his seeming to be 'stuck', her uterus contracting, then halting) something is amiss. She cannot shake this off, does not feel heard, is not able to, or chooses not to communicate the extent of her anxiety and '*fed-up-ness*'. Coincidentally she is battling with a dread of needing a Caesarian, which she has been given the impression is more likely with an induction of labour. As a result of these fulminating pressures, through the agency of her partner, she takes the situation into her own hands.

¹ My quotation marks *not* a quote by Donna.

Now we move on to the induction itself.

Donna: ...They gave me a pessary, and I requested a sleeping pill because I'd been getting really crappy sleep. And I slept quite well that night, and I woke up at five o'clock in the morning, having twinge-y contractions, but just like false labour.

(Which you were very familiar with.) Yeah. They weren't bothering me too much, but I thought I might get up for a walk around because they were keeping me awake. They got stronger and stronger and stronger. Then I had a bit of a show at about 6 or 7 o'clock and I said to the midwife then: "Can you ring my husband? Because we didn't expect that anything would be going by now and he's going to go swimming and going to be do things at work and he'd better come in." By the time he got in, I was really glad that he was there (L) and then B arrived and I got taken straight down to Delivery. And they broke my water. A young guy, C, a consultant called C - can't remember his last name. And that was quite painful. I didn't expect that to be as painful as it was. Having to lie on my back, and my Mum was there for that. I can remember that. She just got in my face basically and said: "Right, you're going to look at me and breathe really deep and you're going to keep really still because if they can't do this then it's *stopped* and this is what you wanted. Remember?" And she just kept me really focused.

E, my husband, spun out a bit. He's very soft sort of man. He's quite genteel, and caring, and affectionate, but he didn't cope with childbirth very well.

R: Seeing you uncomfortable, seeing you in pain.

Donna: He's too soft in a way. He didn't expect it to be quite so harsh. I sort of tried to cope for a while with the pain. And the only way I can describe it is like baby being ripped from your body. I kept a sense of humour. I surprised myself that I maintained my sense of humour through my labour and I didn't expect that. I just kinda thought I'd be a bit rattier. And the most frightening aspect of it is that you are out of control.

B was amazing because she kinda was there, and she... I saw her as the person who was controlling things from a technical level. Like - it was never going get that bad because she keeping such a close eye on me that I was allowed to run around and laugh if I had to laugh, and scream when I screamed, and moaned at E and did everything I did. But she intervened at all the times I needed her to intervene. But she didn't get in my face cos like there's this really fine line (L) and E kept swaying either side of it and I kept kinda: "Don't do that, don't do this!" I must admit I felt really let down, when I asked for pain relief. I just felt - it took me a long time. I probably went another hour longer than I needed to...

R: Can you explain what the response was when you said...

Donna: Oh, it was fine. Everyone was like: "Yep. Sure. OK. That's going take half an hour. If that's what you need, that's not a problem." I told E first and kinda got him on my side (L): "I'm not coping. I'm gong to need something." And he was like: "Yeah, you're not." I wasn't... I felt I could cope with the pain. That it was going to hurt and I'd spent weeks mentally preparing myself for pain, and I think I'd done a good job there. I didn't comprehend how physically exhausting the pain was going to be. And I was going from all fours during a contraction, swinging, to wanting - needing - to rest between contractions and my contractions were coming on - like - with maybe only 15 seconds in-between and I just kept jumping back on all fours. B keep saying: "Your labour's not established, Donna. You've really got to get a handle on this because you've got 15 to 20 hours to go." And that was- like 'I'm not going to cope.'

And what no one realised was that I was just dilating at this rate that no one expected me to. So they put an epidural in. That was the most pain I think I've ever had in my life was waiting for that to go in and having to sit still. But I just went quite internal. I wouldn't listen or speak to anybody. If anyone spoke to me I acted like I was three year old, and I just.. it was ... I was *not* in the room. And all of my pain was in my toes and all that I could do was wriggle my toes cos you are not allowed to move and I'm thinking 'I'm walking out of here. There's no way they are going go paralyse *me!*' And so everything was in my toes. I remember looking at

them and thinking: "They're just going to drop off if I don't... if I don't... if someone doesn't let me move, I'm going to explode my big toe or something like - that is going to happen!" And E was really good at that point. I think he was glad that it was soon going to be over in a pain sense. And it was. And then it was like you're all really out of it and high and the anaesthetist was god-like and everyone looked beautiful (L) and the pethidine was kicking in and, God, having a baby's so blissful and what was I moaning about before again?

Mum came down to see me because my mother works at X behind Z hospital, so she was sort of in and out with her boss, who's a really good friend of the family's who I'm quite close to. Because her boss is a nurse, she was kinda breaking her neck to come and have a look. And I was quite social. I'm aware that I was quite out of it during that point as far as my memory goes. Everything gets foggy from the time the epidural went in and I think that's why I'd like to try and do it without drugs next time. Just so that you could cherish it some more.

R : Every sense is awake and alert and feeling it..

Donna: Feeling it, yeah. There's some parts of the labour that, because I had an epidural in, disappoint me, but at the same time my son's alive now because I had an epidural in so... I didn't know that at the time. B hadn't examined - hadn't checked me for a long time. She said that was her style. She wasn't really into lots of examinations. It didn't do anyone any good. And I had to agree. I wasn't really into having to keep still or feel like this was some sort of medical thing if it didn't have to be? And to that point, even though I had this drip in my back and one in this hand and all this machinery on me in this tiny little labour room, which my mother had given birth to my brother in, the very same labour room. It was Labour Room [names a room number] and it's a box. It's got no windows. I'd had a fear of those labour rooms when I'd had my tour. I'd said: "No, I can't give birth in one of those. It won't happen."

But you don't really care where you are. And there was sort of a nice-ness ? B was quite quiet. It was very much about E and I. She laughed when I needed her to. Like I didn't need the whole thing to be very intense on me. I needed to have a bit of a

joke every now and again. And the epidural would wear off and it would be Mum who would say to me: "Come on, you've got to - If you're going to have the stuff, have it!" -you know?- "Don't... you've got it in you, take the pain killer. You tell them when you need more. You're silly not to do that. *That's* being stupid rather than grinning and bearing it." So Mum encouraged me there. Then Mum went back to work.

B was still quite convinced that the labour wasn't establishing. I think I must have had the iso [sic] drip in, because I did have isotocin [sic] but I don't know at what point that went in. And then I just kinda lost the plot a bit. I can remember that it hurt and I wanted more and it hurt a lot and I need more still and B was a bit surprised how much epidural was going into me. But then they got it quite a good amount and I felt better, but there was this sense of something ...of ..of.. ohh- it's the weirdest thing! It was transition but I didn't know cos I'd never had it and no one knew, and then I wanted to go to the toilet. "I need to go poos. I need to go poos! I'm *not* doing it in bed! I'm *not* doing that! I'm *out of* control! You've got to unhook me off this monitor. I'm going. I'm going." I could hardly walk. E gets me into the toilet. I sat there for *ages* and nothing happened. Got back into bed. "*Get* me a bed pan!" I started to throw up and I had nothing in me to throw up and I felt quite out of control.

B said to me: "I'm going to examine you, Donna." And she examined me and I was six centimetres dilated. When we talked a bit about what had happened at that point - cause this part's the bit I don't remember that much - she said it was only about five minutes... And I was vomiting and F's heart rate just dropped and it wasn't coming back up. B was pretty convinced that he was stuck. That there was something not quite right going on in there and she very ...cos she just left the room. E and I didn't really notice. She hadn't left the room often, and when she'd gone to have her lunch and a coffee and things, she'd actually got someone else to come in with us. Which surprised me cos I sort of thought: 'Oh, she'll cruise off, and everything's alright.' I didn't quite realise how intense it is. And she came back into the room, and she said to E and I: "Things are not going as we would like them to.

Everything's fine at this stage. It's all well within our control. But I have got some people coming into the room because I need to examine you but I don't want to do that when the obstetrician's not here otherwise you're just really going to get examined twice." Which I did appreciate at the time and then the young guy, that had broken my waters, rolled in and two more midwives rolled in. He examined me, and he said: "Push!" and I pushed, and that felt kinda quite good so I did it again. (L) And they just wheeled me straight out into a theatre. I was excited! I was just charged. I thought: 'My baby's coming out!' And at no time, even though it was quite like: 'We have to move on this', at no time were E or I frightened by anything. Everyone was smiling. Everyone was like: "Your baby's coming out. We're going to get him." I felt really motivated.

One criticism of X Hospital I've got, is: I'm standing in the theatre and I get off my bed with legs *filled* with epidural and the obstetrician said: "Right, you've got to get up on this bed." And it's about that high [indicates] (L) and I said: "You've got to let the bed down. You've got to let..." And I felt this sense of urgency about getting on this bed. I said: "You've got to let it down." And he said: "No, it doesn't go down," he said: "It's a design fault. The bed doesn't go down." Ahh! He said: "It's alright. You can give birth in the bed you're were in. That's not a problem. We'll sort that out." No, and I don't know where the energy came from but E said I, like, leapt-leap-frogged onto this bed! (How amazing!) Just this burst of endorphins, (Exactly, and adrenaline too, perhaps.) Got on the bed, and threw my legs in the stirrups, and then I screamed for a sick bucket. Being sick on myself was something I couldn't have tolerated. That was part of the control thing. So E found me a little cup thing. I threw up and I pushed, and I threw up and I pushed. They cut me and the baby came out. And I - I could feel him leaving my body from here [indicates upper abdomen] but it was all numb. And I just thought: 'That must be a much more amazing feeling when it's hurting and you can feel the baby coming out.' And I think I... - that's the only moment of my birth that I have grieved loosing, because of the way that everything went.

But everyone was really like they should be when a baby's being born. Everyone smiled and - and even though they do it every day, everyone seemed like they had somehow taken part in something that was never going to be again and E got.... I didn't want to know him. They put him up on me and I - (L) "No way! No! I'm so *not* mentally prepared for this. Didn't I have fifteen hours to go? Where's my fifteen hours? (L) I'm deprived of my fifteen hours ! (L) Look - where's my mother? She didn't make it to my birth." She was meant to be there and that was a bit sad. But Mum completely under..- you know- she was pleased that everything had just worked out well. That time was just.... I don't know... everything ..that whole afternoon's very... He was born at about 2 in the afternoon and the rest of the time was very mish mashy. I said to E very soon - obviously E dressed him - and they checked him and he was fine. E got his nappy and his gown on and brought him over. He cried for the first time and E and I laughed our heads off cos he sounded so funny. And E cried and I didn't and that's how I imagined it would be cos I'm not a very tearful person. But E is really tearful. Then I said to him: "You had better go and get Mum."

Here she reflects on the strange combination of feeling out of control (e.g.: vomiting, wanting to move bowel, just keeping up with the rapid changes of position to handle the pain.) and feeling safe and protected by her midwife from ever having to cope with more than she could be expected to. This is close to the essence of birthing and watchful midwifery care. She also felt sanctioned to be uninhibited; felt a specialness that they, as a couple, were the focus, and that there was universal awareness of just how momentous this occasion was.

She has no qualms in 'rating' the support of the various people around her. Her exhaustion and the underestimation of her progress appreciated only in hind sight, led her

to request an epidural. She ensured she had support from her partner, but there was no challenge to her decision. I am very moved still, every time I read her words which reflect her transition to motherhood, the exact time of which is reflected in the text (laughter and tears), and then the exponential growth in parenting confidence that came with an incident in the postnatal ward. I include this story although it is not directly concerning the issues of prolonged pregnancy and induction:

Donna: They requested that he have three lots of blood sugar taken through the night and I was to ring the midwife to come and get him to have that done. I did that the first time, and they brought him back and he'd stopped crying, but he was snivelling and I wasn't happy about that. I was a bit soft about the whole thing. The next time he'd woke up, and he was really doing well now -like- to me, he ...to me, it was like he had snapped out of it. He wanted to get on there. He wanted to feed. He was waking up every - he was making up for lost time and in my mind he was fine. So on the second one, I said I wasn't very happy and they said: "Well, there's nothing we can do. A paediatrician ordered that. We'd have to ring another one in the middle of the night and it would all be a very big hassle and you can't object at this point." They took the baby away and blood sugar-ed him again and brought him back. And the third time I said: "No." And a midwife came in and said: "Good girl!" Another lady. She was an older [names an ethnic group] lady and she said to me: "You know your baby better than anybody else here, and don't ever let..." She must have got wind of something. I don't know if I said to them: "But someone said I had to" and she said: "Absolutely not. He's yours. He doesn't feel like that yet but that will come one day where you won't hesitate to say 'no'." She said: "Start now, and you'll feel better." And- yeah- that was a big insight to mothering, you know? He is mine. She - like- gave me permission to own him, I think, and be the boss of him. And so I got a lot better from then on.

A paediatrician came in to examine him, after he had gone to sleep, and I said (that) no, she had to go away. She didn't like that very much. She said: "Why?" and I

said: "Cos he's not been very well and he's been feeding all night and he's tired and he needs to go to sleep." So she came back a bit huffy and then she said: "And I think he can have a bath," and I said: "No, he's not being bathed in hospital." So this midwife gave me all this power, (L) and I drove everyone up the wall so they let me go home, I think. Yeah. I wouldn't let them bath him. I had a thing. It had to be done at home. I felt quite, almost religious, about that, actually. He wasn't to have something like a bath in a hospital. That he had to have that by the fire with the lights down and the music on. I wanted him to enjoy his first bath. It didn't have to be a big, screaming, horrible experience, so...And he did. He loved it and he's loved the bath every since. So. Yeah. She was incredible to do that. To push me to stand up for him, and it's made- yeah -it's made me respond to things quicker than perhaps you otherwise would with your first. Because that little parenting instinct takes a wee while.

This next excerpt fits naturally following the section on the birth, yet closely relates back to her 'waiting' reflections also.

Donna: ... I think the most interesting thing was at the end of it, someone said to me: "You know, your baby was stuck, and that's what the problem was." And I was convinced of that for weeks before he was born. (Can you explain more about what you mean by 'stuck'?) I got a lot of pain in the side of my pelvis and when I was scanned, F was always pushed right over to that side for weeks... Ohh, just this constant pain I had in my hip. The way he moved in me was like he was battling something. And then when my false contractions would start, his movements were quite... I mean the reading I had done was that baby sleeps a lot during early labour. Like it's almost like the body tells them - gives them something to put them to sleep. Because they really need to rest up. And he wouldn't. He was fighting whatever was happening to him. While I would contract, he fought it. Then I had read that they don't know where the first lot of chemical comes from to start your contractions. That's a bit of a mystery but they do know that by putting pressure on

the cervix, somehow releases more of that chemical and to me it was like something was releasing in me all of the time to put me into labour, but then F's head wasn't reaching my cervix to bear down on it. His head just didn't feel like it was positioned right. I kept saying: "His head's all wrong. There's something not right. His head's not in the right place. I don't have these feelings that people tell me about and I read about..." ...although, you know, everyone's a doctor, aren't they? Everyone thinks (L) that they know what they're going on about, but there's very much a sixth sense inside you when you are pregnant. It's only on reflection now, that of all the things I knew that that was wrong.

R: And during the labour that somehow changed and he was no longer stuck? And he was able to come? Is that your..?

Donna: Yeah, although it's just these head problems that he has got. He's got some moderate skull abnormality. And we've had him to the osteopath since he was six weeks old, which has improved him out of sight. He did have a couple of vertebrae out in his back which improved all of his feeding.

He used to buck to be fed. Buck and wiggle and kick and squirm and that settled down as soon as N started working on him. He's also helped to straighten his face up which was very crooked and it ... I explained to N how I felt he was stuck, because N's quite... our osteopath's quite into how I felt about F's birth and how relevant that really is to F's diagnosis.

And he said to me that F was confined in me in a way that's made his skull grow into my pelvis. A lot of people don't believe that. But I really do...it is only on reflection I can tell you how strong that feeling was. Like at the time if someone had gone out on a limb and said to me: "So this is a big gut feeling and you reckon your baby's stuck." I'd have probably backed off a bit. And said: "What do I know? Aren't you the experts?" But, believe me, the next time round, I'll be a whole lot pushier about how I feel. But that's so easy to say. When you sit in the chair...

It is naturally hugely important to Donna that her impression, that her son was positioned inside in such a way as to hinder him from taking advantage of the periods of latent phase she experienced, was confirmed in her mind. Her instinct was vindicated. Looking back she found she had her fears confirmed (i.e. about baby being stuck), whilst acknowledging that she could have been completely wrong. What else had she to go on, to explain to herself the absence of any development (labour) except her instinct, the internal voice?

Then we move on to how things would change with the next pregnancy. From the beginning, with the opening assessment of the care arrangement she found herself in, then following on to sense of grief at what she may have missed out on because of the induction and the epidural, Donna tracks the transformation in her thinking and sense of self.

In response to my question: what would you tell others? she demonstrates the affirmation of her decision and experience under those particular conditions. For someone like her, the mentally and socially healthy thing, she believed, was the induction choice. Hers were revealing experiences and spoken of frankly. She displays an astute analysis of the politics. Despite the professional demeanor of her midwife, the woman is not entirely deceived. She demonstrates an extraordinary empathy with the other woman's (midwife's) position, whilst staying healthily clear about her own boundaries.

Similar to Anna's baby but in contrast to the other two babies, Donna's baby *did* have the some of the signs of a postmature baby. She reported the shape of the head was explained to her as being the result of his position inside and, as noted above, this was a confirming opinion for her, a validation of her intuition. The skin was peeling, the nails were long, there was an absence of fat, and a presence of meconium staining of the liquor. Nevertheless cord pH² was good.

This is how Donna responds to my regular interest in the appearance of the baby.

R: Do you remember his hands and feet being wrinkly like they'd been soaking water?

Donna: Yeah, and his skin just fell off in sheets. His fingernails were very long. I had to bite all his fingernails down. I think I did that that night but they were like paper and they just sort of came away in my teeth. His skin fell off in sheets. B looked at the placenta with me and said to me yes, that there was crystallising in the placenta (Calcification) He really wouldn't have been doing very well. That it was good for me to really push [for the induction]. That I predicted something in myself, perhaps.

R: Did the word 'meconium' come up ?

Donna: Apparently no, he hadn't lost his meconium. Cause I remember asking... I didn't know what had made B leave the room. I didn't know what had told her he was in trouble and I asked her a couple of weeks later and she said: "No, it was the monitor..."...had told her that, not meconium. Because I'd thought perhaps because she put me on a bedpan because I had screamed that she had to, that she had seen something coming through, but no. They had tested his blood or something and she had said to me: "Yeah, he was getting into his reserves there..."

² Cord pH: measurement of acidity/alkalinity of blood; indicates degree or otherwise of acidosis, can reflect level of hypoxia the baby has experienced. Usually tested for if there has been fetal distress suspected just prior to birth.

Donna's degree of resolution of the experience is remarkable in that she is telling this thoroughly for the first time. Her summation of the experience demonstrates that her perspective is restored.

Whilst discussing the resolution of feelings aroused by intervention experiences, we reviewed styles of care, the opinion that some health care professionals approach an adult patient on an adult level, some have a parental approach:

Donna: ... I think the young guy that I had, that actually delivered F had lost that. He had come through. B had said to me he's great to work with, because he remembers your name. And you're on his level and (You've got a mind. You've got an intellect.) Yeah! He treats the midwives very much like they know more than what he does about what's going on. As B, who's sat with me like for the last three of four hours, she's *much* more aware of what my situation is. And B had, after the labour was over, which was much more an appropriate time to talk about the politics of the system... You don't really need to be involved in that, I don't think. And I felt that she was very politically correct in the way that she went about that with me. She left it til the end. She didn't step on anyone's toes. She didn't upset me. She didn't send me running scared. But at the end of it she let me know why some things had possibly gone the way they had, and helped to counsel me as to how I could change that for my next birth. Which - yeah that really helps. And to hear that she's not happy with the system, you know. It's not her ideal. You need to know that cos...(At appropriate times, like, after it's over, you know) You don't need B coming to you when you are nine months, saying: "I've got no faith in the system. It's a load of rubbish!" Because you are about to give birth in it! (L) She handled that really well. I just take my hat off to people that work in any sort of medical care for anybody. I think it's really hard and that no-one's given enough credit for it.

R : There are compromises you have to make, you know. There's just compromises and trying for the best outcomes regardless of those.

Donna: Yeah. (unclear) B had so much empathy and she really shared in F's birth and she cried every time she came round here, she cried. (L) And that just made me feel really special and you do feel special when you've had a baby, and it's nice to be acknowledged, to feel that. (To feel that being reflected in someone else is just...) She told me about the Clinic, and about... it was very different to what I thought I was going into. I thought the Clinic as just full of women who had a few little difficulties here and there. That had diabetes and epilepsy and sort of disorders that were difficult to control and maintain a pregnancy in, and that I was just one of heaps of women that were going to be in this big Clinic where they just kept a bit of a special eye on you. And it's really not that at all. As B said, it's full of mentally ill people and drug addicts and the low lifes of society. I think Dr. V in some way has put me in that category. And it was only B who had come to my home and knew a little bit more about E and I. Knew that we were a rarer case that you didn't see a lot of in Clinic. I think when she explained that to me after F's birth, I understood why I had been treated the way I had been, by a few people. Like: "Oh, maybe she's a heroin addict? Maybe she's got a mental illness? I wonder what makes her a high risk patient?" And it also made me realise why people asked me a lot: "What are you doing in the Clinic?" Because I didn't quite look the type. (MmMm " Do you have a secret life ? A secret ...?" !) (L) Yeah, and in a way, I'm glad I went through the Clinic. I'm glad that they thought that and it wasn't true, and that they learnt to change their mind, because people who have mental illness or drug addictions have as much right to good maternity care as anybody. (And what they are at risk of, is being judged badly-) yeah (- by people, prematurely...) and you *so* don't need that.

There is a wealth of empathy and a maturing and extension of awareness within Donna, that seems to have partly flourishes since her experience that is palpable even though I have known her only after this. This may not have been her intention but seems to me to attest to her skill as narrator. We are reminded how transforming this process can be for a woman.

Elsewhere she comments on the differences in attitude she detects with the more recently graduated doctors. This connects with her observations of the doctor, C. In turn my speech about *being heard*, evokes a plea from Donna to her specialist: does he know the effect his approach seems to have on the clinic women in general?

Donna: I think V needs to stand in the car park sometimes and watch people leave antenatal clinic, and see how many women leave in tears. Cos I've watched lots of women leave in tears and I left in tears a lot of times, and I think it would be quite an eye opener for him to see how many of this patients burst into tears when they leave his consulting room. And I wouldn't be very happy about that. And it's not a big *faux pas* [sic] on him as a doctor. It's just a handling of the situation and a way to help keep someone's chin up because there are words that you can hear. There *are* words to help. It's not one of those situations where there's not words to help. It's not like someone's died and there's nothing you can say. There's heaps you can say to help someone along and when you use the wrong words you have the reverse effect of just crushing them to the ground and all of their...like- your self esteem just drips away. I would not go out! My body was not capable of expelling a child. I was not capable of socialising. How could I cook dinner? (L) How could I achieve anything?

Concluding reflections

Donna did go a long way to follow her doctor's expectations that she wait, to respect his opinion that all was well; but ultimately this falters on a classic challenge: how can *he* understand? She makes a telling link to her midwife's sense of the proper, and describes the apt, the acute sense of timing, the politically or gently (political), unavoidable consciousness raising of the debrief. This she translates into the affirmation of her own

impression of the system, while still able to acknowledge it's strengths. Is it timeless this archetypal female sense of needing to accommodate, to be fair, to foster harmony?

I am reminded of Cartwright's words yet again when she was focusing on women's voices: "It is apparent (from her survey results) that the large majority, four fifths, wanted to be involved in making decisions about their care. In the meantime, for the most part they accept, adapt to, and make the best of the information, the choices, and the conditions that are available" (Cartwright, 1979, p.163). She then lists some of the advances in maternity care which were becoming available to women in the mid 1970s, co-incident with the feminist movement, e.g. being 'given' their baby to hold immediately after the birth. Then she goes on to say:

But when these things do not happen few protest. The more common reaction is to try to view the situation from the other point of view, to explain the authoritarianism in terms of inadequate facilities, staff shortages, and other jobs and needs to be met. This prevents them from harbouring grievances and enables them to maintain a good relationship with the people and the organisation whose power they are in" (ibid, p 163).

It is interesting to use this summary of women's attitudes as a yardstick against which to measure the approaches of all four women and deduce advances - Anna's plan for a homebirth, Bev's rebuke of the student doctor and challenge to the registrar, Cath's clear concept that her doctor was certainly able to be challenged, and Donna's outright demand to be induced when her mental state was threatened.

Donna also sought affirmation of the unique nature of the event for *her*. She feels a sense of satisfaction in helping reveal the hypocrisy of people. Then she expresses the frank

view: it is (some) women who are themselves agents or promoters in the medicalisation of childbirth. But her enduring concern is that others less strong would not have 'survived' and feel able to escape the plan that the system had, as she was able. In this she echoes Cath's concern for first time mothers running the gauntlet of social and medical expectations that *she*, an experienced, confident, 'insider', found hard.

When choosing the segments of Donna's story to relate I overlooked the discussion of the dating of her pregnancy. I clearly remember however her 'suggestion': "**Midwives should lie about the due date!**" She could have been echoing Cardozo, the British obstetrician and researcher who made this provocative statement in her 1993 article in the *British Medical Journal*: "Perhaps we should reconsider whether it is necessary to give women a precise date on which they should expect their baby to arrive" (Cardozo, 1993). Perhaps informed women should not passively accept, or wait to be given, an exact date by anybody.

Our discussion winds down. There is empathy and counter empathy as we seek to demonstrate that we understand each other. Donna specifically comments on how differently she feels now about her mother, how much closer she feels to all women. There were parallel statements earlier about the spontaneous sympathy with *all* people. And she makes this second plea on behalf of all women: "**I've made a choice.. I'm feeling the guilt of that... Don't magnify it.**"

Her final remarks refer to her right to make decisions and hold the power over her own body: **“I’ve made my own calculated choice about my own health care..”** How representative of all other women, is this paradigm shift?

Chapter 10 - The Power and Place of Stories



Ros Asquith

Discussion

There is a solid link between stories and midwives. The rationale for choosing this method of studying women's experience, was two fold. There was the overt aim of recording for history their experiences accessible to them and the children as 'hard' copy. There was also the motive of supplying the most indelible, powerful images possible. Images that would stay with the midwife/reader and guide her practice. Only a story has that power. It is a phenomenon not unique to midwives but I feel midwives are relatively transparent, unrepentant and open about their use of stories as a professional tool. That is

the swapping of stories can result in a midwife knowing 'her way through' the care in a situation she has never faced before. Many challenges in midwifery can be unexpected. There may be no practised or automatic response. Stories are used both vocally and silently for learning and professional development (Leap,1998). Stories that are spoken and stories told by a series of photographs, slides or drawings. They effectively provide a trigger as to how to proceed in an otherwise unfamiliar situation.

The power of each story is both specific and non-specific. It begins identity - the baby ; it embellishes or extends existent identity - the mother. Non-specifically it has the potential to linger on the consciousness til it's origin may be forgotten but it's messages continue to engage our thinking. I come the least fresh of anyone to the effect of the stories. I spent many hours on each, transcribing. I heard each first in person and reheard each on many occasions. I reflected, wrote and rewrote, engrossed in their words. I believe they have been catalytic for me. Just one example concerns vaginal examinations. I can never approach vaginal examinations again as I did before, and yet I prided myself that my old way was sufficiently sensitive, and appropriate to College of Midwives' standards (NZCOM, 1993).

Implications of the study

For the reader the stories of these four women, and what reflections they conjured for the midwife listener/researcher, have already had their effect. The immediate impact is past,

once the preceding four chapters are read. Any consequences for practice are by now sparked and the fuse running.

There is much more within each story, of course, than it has been possible to convey in this report. Yet I believe what has been selected crystallizes the essence of the wait and the impact of the intervention. They are powerful stories which contribute significantly to the literature on women's experience of waiting past their due date and having IOLPP. The openness of the women and the intensity of the detail ensures the stories affect us dramatically more than the summaries of survey results. As far as I am aware the conclusions of surveys are the sum of the literature to date on women's experience of IOLPP. These narratives provide the richness of four recognizable, detailed, human contexts for this experience. Sufficient of each story has been reproduced verbatim for slow, more deliberate reflections from any interested reader to form. Apart from this, there is a sense in which further discussion and dissection here are redundant. The women's and the researcher's contribution to the pastiche of women's experience of IOLPP at this point in time could be taken as complete. Yet I need to repeat the messages to sound the requisite emphasis the women deserve.

First of all the messages that pour from the stories is how hard it is to wait, to not be anxious, to ignore the physical discomforts, and duck the intensity of the expectations of others. Then how entrenched and affected some women are within their immediate and extended families. How much information they need. Although they were clear that nothing can fully prepare a woman approaching her first labour, whatever can be

explained or talked through, must be, more than once if necessary, and later rather than never at all.. How intrusive are the expectations of others. This process is inherently unpredictable. How invasive are the procedures done to women that we so quickly treat as routine. Women compromise. And balance needs. And get through. Some do things differently 'next time'; some don't. There are instances of assertion; representation of more information or better education and knowledge but still no sense that fully informed choices were made where the women were genuinely included in decisions regarding care.

It is evident from the stories that, for the women, any time spent by their midwife with them on explanation, discussion, exchange of information and checking back on expectations is highly valued. It is also clear that time spent during the 'wait' is valuable in helping the women react constructively to the attitudes and stressors that they are subjected to. Time spent after the experience was critical in allowing the women the opportunity to cover ground possibly covered already but now needing to be revisited with the lens of hindsight, for more satisfactory resolution of feelings.

It is necessary for midwives to access their own feelings concerning developments in these situations in order to walk with the women through the events. Then we would not avoid discussing those incidences we all know which we would dearly like a chance to approach differently the second time. This is the gift of reflective practice.

This study is emancipatory in that through the goodwill of both the midwives who helped me to access these women, and the courage and openness of the women themselves, we can construct appropriate models to strengthen the principles of our practice and our advocacy role. Our understanding of the issues of IOLPP is expanded. The women all appear enlightened by their experiences and were often guided by their midwife to that understanding. Their motive in telling me their stories is clearly to inform and provoke thought, as opposed to instruct. They feel that there are messages for midwives; but also insights for others like them who may be feeling caught in a count down scenario.

For the women and the children: there are personal implications for the participants which gives me much satisfaction. They have the hard copy of 'their' story, to refer to, to hold, to put away for the child to read one day. They have had the experience of talking it through, albeit to a stranger, the arranged exercise to make sense (if necessary), resolve, reflect out loud and review in private. If they were 'held back' in some sense by their experience, now it is more likely that they may have moved on. They have the satisfaction of making a contribution to the written historical record of women's universal experience.

These women were consistently positive about the research and their direct benefit from it. More and more midwives are beginning to respect stories as therapy, and continue to acknowledge them at every opportunity, at whatever position on the negative-positive spectrum the story belongs. They can use the stories to unpack the events and review the

scenarios as critical incidences, or they can merely absorb the essence of each individual story and incorporate them in their future discussions with overdue women.

“Midwives should lie about the due date” (Donna’s story).

It is possible that pregnant women, should they better understand the imprecision of the dating of a pregnancy, would begin to accept and help others to accept, that they will have the baby in the two week period either side of the ‘due’ date they are given. It is possible that, when fully informed, they will be conscious of the risk of the syndrome ‘postmaturity’ and a compromised baby, but that this could occur whether or not they are still pregnant after that ‘due day’. It is possible they could choose to be screened, and monitored as to degree of risk, relinquishing the idea that one date is all important. And it is possible that they could feel supported in that choice by their maternity care providers.. Donna, as a person who has experienced the current approach, came up with the conclusion of the most influential research to date on the issue of the management of prolonged pregnancy. The research is clear that women should be given the information and then the opportunity to choose induction or not (Crowley, 1999).

I admit a fascination for the evidence of the effect of the changes in maternity care which have come about in the last decade. Despite our theories and ideals, we remain distant from our goal. Women continue to need to juggle the desirable ideals with the undesirable developments. They need to reconcile at great speed the mixed side effects of an encounter with institutions, care systems and frustrated expectations, and still get

on with being mothers. It is a disheartening reality that there are parallels to Cath's situation with the women who were subjects of Ann Cartwright's research in the United Kingdom in 1975. We are now a quarter of a century further on, in a quite different midwifery scene (or so we fondly imagine). Cartwright's major conclusion was that women must learn to question their caregivers and insist on being involved in the planning of their care in all aspects. Cath is shocked that she did not question the plan even though she did not feel completely convinced by the rationale implied by one caregiver. Anna felt she was uninvolved in the decision to break her waters. Bev was content to be guided by the midwives she knew, liked and trusted. However there are issues regarding the outcome for the baby and what will happen in future pregnancies and births that she is unable to explain entirely. Donna, who had had the strength to challenge the way things were done (through her partner she demanded her induction), asked her questions e.g. about the Clinic, about her antenatal care choices, and about her rights as a mother, *after* the event.

There are many aspects that most women ever pregnant will recognize in the stories of these women. Some may dismiss the experiences as 'to be expected when you are pregnant.' Yes, it is common. It is to be expected. Many feel these pressures and discomforts and consign them in the general 'basket' of what a woman has to tolerate if she wants a baby. The need simply to be heard about *how* it is to wait, how it is to have an induced labour, though, is compelling. Validation of feelings is likewise hugely important. What any aspect of pregnancy, labour and birth feels like and implies (especially for a first time mother) seems at once both 'everyday' and sensational. Doris

Lessing, pregnant with her first child in South Africa in the 1930's, describing in her autobiography how important the friendship with another pregnant woman was, comes closer to expressing my meaning:

There is a companionship of women who are having their first babies that is like no other. They share a journey through revelations, yet the stages of what is happening to them is (are) written in a book they have lying open on the table, for what they are doing every woman has done. Timidity, or a sense of proportion, stops them from claiming to be extraordinary, but that is what they feel they are, and only one other person can understand this. They ground each other in the commonplace, while what is going on in them threatens to dissolve them in its enormity (Lessing, 1994).

Evaluation

How might this study have been done differently? I believe the original intention to advertise in newsletters and journals commonly accessed by new mothers would have succeeded in the recruitment of a greater number with the disadvantage of having to be even more selective of the issues to illustrate, a more savage thinning out of the reflections and signals than has taken place here. The fewer the stories the more room for crucial, intimate, even shocking, detail.

These women were consistently positive about the research and their direct benefit from it. More and more midwives are beginning to respect stories as therapy, and continue to acknowledge them at every opportunity, at whatever position on the negative-positive spectrum the story belongs. They can use the stories to unpack the events and review the

scenarios as critical incidences, or they can merely absorb the essence of each individual story and incorporate them in their future discussions with overdue women.

I have worked to ensure the trustworthiness of the study by conscientious attention to a reflexive frame at all stages of the research. I have positioned myself openly. I have used key words but I have invited the women to take their story where they have viewed the issues and the priorities, although at times they have displayed the female empathy and needing to know they are supplying what I, the researcher, needs to know, to better pursue the answer to my question. I have not withheld information but have been equally apprehensive of intruding my stance when they may have already been familiar with a even slightly conflicting explanation.

For example not recording the first half of my encounter with Bev. meant that I had to make a second contract. Her response was entirely consistent with a willingness to help, to put her experience at the disposal of others. There was no clearer test of her commitment to the research. My declining to record in the area chosen by Donna could easily have had the opposite effect to what happened. With great good will she organised a time at her own house but entirely consistent with her intensity and eloquence she arranged to talk one to one without the distraction of her son, conditions she would have had had it been possible for me to record her during her day at work, in some quite corner. Each woman paid equal attention to what I needed and what they needed or felt best relaxed to allow the story to come, to gain the maximum benefit from the request to help.

I have drawn primarily upon the stories, but I have also been reminded by my field diary of the unspoken props and influences in each woman's surroundings. They were relaxed with feeding their babies before me; they were generous with refreshments. Any interruptions were unexpected so it was obvious they had planned to set aside this time for private talk.

The stories have an inherent power, but this is significantly magnified by securing their face validity. Each story was read by the teller to ensure her agreement that these were her words, and that my transcription accurately matched her memory of her story. The outstanding result is that despite having every opportunity to qualify the words, to remove or elaborate to explain, apart from minor alterations to clarify meaning, not one of these woman changed any part of her story following the audit. Only two of them responded to the reflections I made, and these were to reinforce my comments. I have assumed that no response is also an endorsement. Will these stories behave as a catalyst? Simply to transpose the stories from verbal to written, even in the form of academic writing that is a thesis implies, means they will contribute to our understanding of woman's experience.

Conclusion

This study adds hugely to our knowledge of the issues of IOLPP and of women's experience of waiting and IOLPP. It contributes verbatim accounts of an approach to the management of an aspect of pregnancy often encountered by midwives. Reading these

stories midwives will gain considerable insight into the complexities of the issue, and appreciate more deeply the individuality of each situation. They will gain increased knowledge of the issue, the better to inform and support women and her family, irrespective of the decision made. Their work involves providing solid information and encouraging the woman to question and re-question whoever is involved in their care.

Our understanding of the trigger or timing of the onset of labour remains far from complete. However this is a natural process at work here. As the pregnancy continues on past a date on which the woman has focused for at least seven months, stressors totally discordant with nature's concerns come into play.

Midwives do not survive nor continue in this women-focused way unless we continue learning, delving, investigating, auditing, supplying high quality information and best evidence to the women, in reader-friendly, accessible form. Our privileged position as professional friend (Pairman, 1998) sanctions a role as resource, conduit and sounding board with specialized knowledge, variable experience and (usually) compatible instinct, nothing more.

There is a place for induction of labour. There is a place for induction of labour for prolonged pregnancy. It is possible to combine good practice and supporting women for true IOLPP. Every woman has the right to an understanding of her 'due' date and the apparent normality of her situation. This may enable her to enlighten her family, grasp the implications of best evidence and apply her own self knowledge. This requires:the

midwife whose ethos is to be prepared to spend the necessary time, and to be fluent on the issue herself; the midwife to share clear, full, balanced information, for which she needs to be skilled in communication; the woman to have the right to express herself whenever, and to be heard always; that it is assumed she can be trusted to deal with both positive and negative consequences whichever arise; the woman to know how to balance all her needs to make the best possible decision or plan for her baby and herself; that the health professional would support her in that decision for optimal outcome.

However I would also support efforts to establish a 'woman-friendly', minimally invasive, way of discerning those very few pregnancies where there is serious risk of utero-placental insufficiency (Grant, 1994; Olofsson & Saldeen, 1996; Enkin et al, 1995). If this is detected with some accuracy then which approach to recommend is compellingly clear. However the principle of the woman's right to decline that advice must persist.

These narratives of women's experiences of prolonged pregnancy and being induced powerfully reiterate so much more than the strain of the wait and the roller coaster nature of an interventionist labour and delivery which culminates in the birth of a baby. They work on our imagination, our professional instincts, our belief systems and our own sense of our ability and skills. We are closer to understanding how our role impacts on our clients; what is supportive, what is not, how there is never 'adequate' information conveyed, just good, and not so good, communicators. Repercussions can be lifelong; information opportunities present endlessly. Affirmative responses to their informed

decisions mean women are positioned so much more securely to take care of themselves and their children.

Are critical numbers of women *not* choosing to wait? If so, what does this say about their expectations and knowledge of their bodies? Are critical numbers informed but anxious and thus choosing intervention? Informed in what way? By whom? Do they have the self esteem to question? Does the funding system influence their caregivers? Where does this momentum come from? Do the women get the rates of intervention and the subsequent morbidity that they consciously or unconsciously have, passively or actively 'allowed'? The refrain (question) "how long do *they* let you go?" seems to size up all the issues, much as it did 25 years ago. The stories imply the work of midwives is valued and critical in the turn of events and approaches for women who are waiting and exposed. As we listen to the detail of the experiences of these four women, many questions arise that need addressing by midwives if midwifery is going to continue to progress the safety and satisfaction of pregnancy and childbirth for women.

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Appendix 1



Central Health

Te Ihonga Hauora

~~XXXXXXXXXXXXXXXXXXXXXXXXXXXX~~

Health Funding Authority

WELLINGTON ETHICS COMMITTEE

Room 425
Fourth Floor
Community & Support Services
Wellington Hospital
Private Bag 7902
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New Zealand
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4 June, 1999

Ms Rhondda Davies
2 Bolton Street
PETONE

Dear Ms Davies

99/44 - The stories of 4 - 6 first time mothers whose pregnancies were overdue and whose labours were induced.

Thank you for your letter of 1 June, responding to my letter of 14 May and enclosing an amended information sheet and consent form for this study. As the additional information in your letter and the amendments you have made to the information sheet and consent form satisfactorily address the various points raised in my letter, final approval for the above study is granted by the Chairperson under delegated authority from the Wellington Ethics Committee.

It is a condition of Ethics Committee approval that you provide a brief progress report no later than June 2000 and at the completion of the study a copy of any report/publication for the Committee's records. Please notify the Committee if the study is abandoned or changed in any way.

I wish you every success with your research.

Yours sincerely

Sharron Cole
CHAIRPERSON

PP

Appendix 2

Project Title: **The Stories of 4 to 6 Mothers whose Pregnancies were Overdue and whose Labours were Induced.**

INFORMATION SHEET

What is this research all about ?

I am planning to do a research project which involves the collection of the stories from about half a dozen women who have had their baby following an induction of labour because the baby was overdue.

If you choose to become involved and send me one of the enclosed consent forms signed (please retain this information sheet and a copy of the consent form for your own record.) then I will contact you to arrange a time and a place convenient to you for us to meet and make a tape recording of your story. I will invite you to tell me the story of the experience of being past your due date and your subsequent labour induction experience. I imagine this may take a period of 60 to 90 minutes. Because of the time period involved and the demands of your role as a mother, I need your baby to be about six months old.

There may be a few queries from me to clarify or check out your meaning or relevant details but the majority of the talking input is yours. I shall be writing down your words from the tape to return to you so I need your English to be understandable to me !

What happens after I have told my story?

This research uses a feminist approach. A feminist approach requires me, the researcher, to consult with you, the participant, about the accuracy of the transcript (writing down on paper) of your story. This will involve returning your transcript to you, for you to make any changes to it that you wish. This means that you have the final say with what is in your transcripts. Once the content of your transcript is agreed to by you, you will then be provided with a written copy of my (the researcher's) reflections on your story, which you will also be able to comment on if you wish. A feminist approach also means

that you will be consulted regarding how best to share this research with other women and health professionals.

With the help of my supervisor I shall be writing 'the story of the stories' setting the stories in context, identifying themes, describing how your story makes sense of your experience, generally *reflecting* on the story.

How is my confidentiality ensured?

You and I will discuss how you are to be named in the story to protect your identity.

All data, recordings, notes, diary and other confidential documents are kept under close supervision or in locked storage throughout the project, and are destroyed or returned to you, whichever you request, five years after the completion of the project. If you choose the tape recording of your story can be returned to you at the completion of the research. You will be offered a copy of the final story or transcript of your words for your own use. If you would like, a summary of the research report will be forwarded to you.

Nobody will know of your involvement apart from me and my supervisor, including the midwife who may have put you in touch with me. Nothing will be published that can identify you. You can opt out of the research at any stage before the report is written, with no penalty of any sort and no need to give reasons.

How will the research be published?

The research report is published in the form of a thesis and a copy must be lodged at the V.U.W. Library.

As I have said above, it is intended that you will be consulted as to where subsequent publications of aspects of the resulting research is offered, to best meet the needs of pregnant women and their families.

What if I have further questions about the research?

If you have any further queries, please contact me by putting your 'phone number on my pager **08-68-35-72-8**.

Who is carrying out this research, and why? .

My name is Rhondda Davies and I am interested in studying women's experience of being overdue, and experiencing induction of labour.

I am a midwife and a full time post graduate student in the Department of Nursing and Midwifery at Victoria University of Wellington, contact number 04-471 5363 and address: P.O. Box 600, Wellington.

I am working towards a Masters degree in Midwifery. As part of the degree requirements I am completing a thesis based on original research. When completed the thesis will be available in book form at the V.U.W Library.

I am supervised by Dr Maralyn Rowley, of the Department , who may be contacted at 04-472 1000, ext: 8490

This research has been approved by the Wellington Health Funding Authority Ethics Committee, Private Bag 7902, Wellington South, Telephone 04-385 5999, ext: 5185, Facsimile 04-385 5840; Email: Sharonb@wec.org.nz

Thank you very much for your interest.

CONSENT FORM

VICTORIA UNIVERSITY OF WELLINGTON CONSENT TO PARTICIPATION IN RESEARCH

Title: The stories of 4 to 6 mothers whose pregnancies were overdue and whose labours were induced.

- I have been given and have understood an explanation of this research project.
- I have had an opportunity to ask questions and have them answered to my satisfaction.
- I understand that I may withdraw myself (or information that I have provided) from this project (before data collection and analysis are complete) without having to give reasons or without penalty of any sort.
- I understand that any information I provide will be kept confidential to the researcher and her supervisor, the published results will not use my name, and that no opinions will be attributed to me in any way that will identify me.
- I understand that the tape recording of interview will be wiped five years after the end of the project, unless I indicate that I would like it returned to me.
- I understand I shall have the opportunity to check the transcripts of the interview before publication.
- I understand that the data I provide will not be used for any other purpose or released to others without my written consent.

Over the page please tick whichever box(es) applies to you:

- I would like the tape recording of my story returned to me at the completion of the research
- I would like the tape recordings and associated notes taken by researcher returned to me five years after the conclusion of the project.
- I would like the tape recordings and/or associated notes destroyed after five years.
- I would like to receive a summary of the results of this research when it is completed.

I agree to take part in this research.

signed:-----

name of participant(please print clearly)-----DATE-----

Principal researcher: Rhondda Davies, BA, RCpN, RM, IBLCA, Masters Student, Department of Nursing and Midwifery, Victoria University of Wellington. Tel:(care of Nursing Department).