SSM - Qualitative Research in Health 2 (2022) 100108

Contents lists available at ScienceDirect

SSM - Qualitative Research in Health

journal homepage: www.journals.elsevier.com/ssm-qualitative-research-in-health

Inducing labour in the United Kingdom: A feminist critical discourse analysis of policy and guidance

Cassandra Yuill [a,*], Mairi Harkness [b], Chlorice Wallace [a], Christine McCourt [a], Helen Cheyne [b], Lia Litosseliti [c]

[a] Centre for Maternal & Child Health Research, School of Health Sciences, City University of London, London, UK
[b] Nursing, Midwifery and Allied Health Professions Research Unit, University of Stirling, Stirling, UK
[c] Centre for Language and Communication Science Research, School of Health Sciences, City, University of London, London, UK

ARTICLE INFO

Keywords:
Induction of labour
Health policy
Feminist epistemology
Critical discourse analysis
United Kingdom

ABSTRACT

Induction of labour (IOL), the process of starting labour artificially, is one of the most commonly performed procedures in maternity care in the United Kingdom (UK), yet there is debate whether inducing labour at 'term', in the absence of specific medical indication, is beneficial and reduces risk of stillbirth. Moreover, rates of routine IOL are rapidly rising in the UK, despite uncertainty about the evidence base and parents reporting receiving a lack of balanced information about the process. As a contested area of maternity care, the language used to debate, describe and discuss IOL takes on added significance and requires in-depth examination and analysis. To address this, we conducted a feminist critical discourse analysis on policy and professional writing about IOL in the UK, focusing on how these both reflect and construct social practices of pregnancy and birth. Our analysis identified a double discourse about IOL, which we term 'explicit-implicit discourse of care', revealing the differences between what is expected to be said and what is really said. Though most texts displayed an explicit discourse of care, which espoused women-centred care and informed choice, they also conveyed an implicit discourse of care, primarily composed of three key dimensions: women as absent actors, disembodiment, and evidence as a primary actor. We argue that this explicit-implicit discourse functions to preserve healthcare professionals' control over maternity care and further alienate women from their own bodies while maintaining a discursive position of women-centred care and informed choice.

1. Introduction

Induction of labour (IOL), the process of starting labour artificially, is one of the most commonly performed procedures in maternity care in the United Kingdom (UK). Around 30.6% of women and pregnant people[1] experience IOL (NHS Digital, 2020; Public Health Scotland, 2020), although in some maternity units the rate is now over 50% (Harkness, Yuill, Cheyne, Stock, & McCourt, 2021). IOL is offered in circumstances where "it is believed that the outcome of the pregnancy will be better if it is artificially interrupted rather than being left to follow its natural course" (NICE, 2008b, p. 1), or in situations where there are specific concerns about the health or wellbeing of the parent or the foetus. It is most often associated with prolonged pregnancy, a situation where the risks and benefits of inducing labour are less clear (Cheyne, Abhyankar, & Williams, 2012). However, the concept of prolonged pregnancy is not universally agreed, and the exact nature of the circumstances in which IOL is appropriate are the subject of debate.

Much of the current debate centres around IOL to initiate labour at 'term', in the absence of specific medical indication, ostensibly because pregnancy is viewed as prolonged. 'Term' is the period between 37 and 42 weeks of pregnancy, with a pregnancy lasting longer than 42 weeks considered 'post-term'. The National Institute for Health and Care Excellence (NICE) guidance recommends that IOL is offered to women and pregnant people from 41 weeks of pregnancy, on the basis that waiting beyond 42 weeks increases the risk of stillbirth or early neonatal death (NICE, 2008a, 2021). Some argue that inducing labour at 'term' is

* Corresponding author. University of London, Northampton Square, London, ECV1 0HB, UK.
E-mail address: Cassandra.Yuill.2@city.ac.uk (C. Yuill).

[1] We use 'pregnant women and people' when speaking more generally about maternity and care in recognition of the diverse gender identities of those who become pregnant, experience IOL and give birth. However, the language in most of the texts we analysed used 'woman', 'women' and 'mothers' exclusively, so our reporting on these specific texts reflects this usage.

https://doi.org/10.1016/j.ssmqr.2022.100108
Received 18 March 2022; Received in revised form 13 May 2022; Accepted 17 May 2022
Available online 22 May 2022

beneficial and reduces stillbirth rates (Lightly & Weeks, 2019, p. 1598), yet because 'term' includes a five-week period, the literature around IOL remains imprecise and contradictory. Others question the interpretation and application of the evidence used to support clinical practice, as well as the safety and efficacy of inducing labour earlier and earlier into pregnancy (Cheyne et al., 2012; Seijmonsbergen-Schermers, Scherjon, & de Jonge, 2019). This debate is not mere semantics; there is emerging evidence that early term birth at 37–38 weeks of pregnancy may be linked to a range of adverse outcomes for infants in the longer term (Boyle et al., 2012; Coathup et al., 2020; MacKay, Smith, Dobbie, & Pell, 2010), and research on women's experiences suggests that they find IOL challenging (Coates, Cupples, Scamell, & McCourt, 2019). Further, in contrast with some prior retrospective cohort studies (Stock et al., 2013), a recent population-based data study including almost 500,000 births in Australia from 2001 to 2016 found associations of IOL at term in uncomplicated pregnancies with increased operative births, neonatal birth trauma, resuscitation, respiratory disorders and child hospital admissions for infections up to the age of 16 (Dahlen et al., 2021). The diversity of findings and interpretations across different studies indicate that greater analysis and understanding of context and indications for IOL is needed.

The range of perspectives on which 'better outcomes' should be considered and how they are achieved, combined with evolving evidence around risks and benefits, make this an area where informed decision-making, for pregnant women and people and clinicians, is particularly complex. Person-centred care and informed choice are at the forefront of the UK maternal policy agenda; however, qualitative research suggests decision-making for IOL may not be as 'informed' as it could or should be. Women have reported gaps between their needs and the reality of information giving and support within maternity services, with many feeling that IOL decisions were made for, not with them (Coates et al., 2019), or that only the risks of continuing with the pregnancy were presented (Cheyne, McCourt, & Semple, 2013). If there is a slippage between policy or guidelines and experience, it is important to explore how this unfolds discursively in terms of both policy and people's experience. Moreover, because IOL is such a contested area of maternity care, the language used to convey, debate, and persuade takes on added significance. In the context of high and rapidly rising rates of routine IOL, uncertainty and debate about the evidence base and parents' experience of receiving a lack of balanced information about IOL, the language used to describe and discuss IOL is crucial and requires in-depth examination and analysis.

Critical discourse analysis (CDA) is a research approach that allows the exploration of text and talk with a focus on language and the explicit and implicit relations of power that exist within texts (van Dijk, 1993), the aim being to look beyond what text is saying toward what it is doing (Lazar, 2007). CDA takes a particular socio-political position and given the strongly gendered nature of maternity services and the historical use of obstetrics as a means of controlling women's bodies (Jordan, 1997), a feminist CDA approach offers an important and appropriate framework for understanding what is really being said about IOL in current professional and policy writing. We conducted a feminist CDA on the language around IOL in the UK, focusing particularly on key discourses related to women's experiences and how these both reflect and construct social practices of pregnancy and birth.

2. Methodology and approach

A systematic literature search was completed (Table 1), and identified literature was then analysed using a CDA approach. Our analytical focus was primarily the ways in which IOL is written about and discussed in policy, guideline, debates and academic commentary texts. Because CDA is concerned with the way in which power and inequality are enacted and reiterated in texts and talk, it is an appropriate framework for researchers wishing to scrutinise the notion that professional and policy texts are passive and unproblematically "well-intentioned" (Evans-Agnew, Johnson, Liu, & Boutain, 2016; van Dijk, 1993). Our analysis aimed to explore how IOL has discursively evolved over time in these texts order to gain insight into the knowledge of society concerning pregnancy and birth care. We recognised social practices, like care, are not neutral but gendered; in fact, the "omni-relevant category" of gender is subtle, oppressive and pervasive (Lazar, 2007) and that when it comes to knowledge, particularly of reproduction, pregnancy and birth, gender influences our relations with this knowledge and how it is accessed and experienced. The power asymmetries therein are reflected in its discourse. In this sense, our review and analysis are aligned with 'feminist critical discourse studies', which aim to reveal the nuanced ways in which "taken-for-granted gendered assumptions and hegemonic power relations are discursively produced, sustained, negotiated, and challenged in different contexts and communities" (Lazar, 2007, p. 142). This analysis is situated in the emancipatory agenda of feminist critical discourse studies, with the intention of mobilising critical insights and theorisation for social transformation. Our stance was not neutral; we started from the position that the dominant discourse of our texts was one that disadvantages and disempowers women.

Table 1
Example of the search strategy used for Academic Search Complete.

Health care practice AB or TI	("induction of labour" OR "induction" OR "iol" OR "augmentation of labour" OR "cervical ripening" OR "cervical priming") outpatient N5 ("induction of labour" OR induction OR iol OR "augmentation of labour" OR "cervical ripening" OR "cervical priming")
Relevant Mesh or subject heading terms	"Induced labor" OR "Labor, induced" or "Cervical Ripening"
Document type AB or TI	(polic* OR guideline OR protocol OR "practice guideline" OR "clinical guideline" OR regulation OR "action plan'' OR strateg* OR commentar* OR debate)
Relevant Mesh or subject heading terms	"Medical Policy" OR "Health Policy" OR "Guidelines" OR "Practice Guidelines" OR "Government Regulation"
Service user AB or TI	(pregnan* OR "pregnant women" OR gravid* OR expecting OR expectant OR postdates OR postterm OR "prolonged pregnancy")
Relevant Mesh or subject heading terms	"Pregnant Women" OR "Pregnancy, Prolonged"
Location AB or TI	(England OR Scotland OR "Great Britain" OR "United Kingdom")
Relevant Mesh or subject heading terms	"England" OR "Scotland" OR "Great Britain" OR "United Kingdom"
Years – 1980 to Present	
English	

2.1. Literature search and selection

We used EBSCO (Academic Search Complete, CINAHL, Health Policy Reference Centre, MEDLINE), Scopus, Citations & References, King's Fund and Open Grey for references related to IOL, cervical ripening or priming and prolonged pregnancy (Table 1).

The searches produced 472 sources, which were then screened by title and abstract. National policy documents, national clinical practice or clinical guidelines, reviews of practice or policy in academic journals, debates or commentaries in academic journals published after 1980 about IOL policy, practice and services based in the United Kingdom were included. Research studies, systematic reviews, theses or dissertations, book chapters, books, conference proceedings, practice or guidelines aimed at pregnant women and people were excluded. While all of these texts contribute to the wider discourses of IOL, care and women's experiences, these criteria were applied in order to focus the analysis on documents intrinsically linked to the production, construction and discussion of IOL policy and practice for professionals. Following our systematic search 21 relevant texts were identified for inclusion in our analysis (Table 2).

Initially, each included text was read and analysed independently by two members of the team, and relevant information entered into bespoke analysis tables, covering first content and then language as described

Table 2
Numbered list of the texts included in the analysis.

No.	Reference	Text type
1	Cheyne et al. (2012)	Commentary
2	Chippington Derrick & Higson, 2019	Review of practice
3	Downe (2013)	Commentary
4	Edozien (1999)	Commentary
5	Harrison, Read, and Woodman (2003)	Review of practice
6	Jowitt (2012)	Commentary
7	Lehman (2016)	Commentary
8	Lightly and Weeks (2019)	Debate
9	NICE (2008a)	Clinical guideline
10	NICE (2008b)	Clinical guideline
11	NICE (2013)	Review of practice
12	NICE (2014)	Policy guideline
13	NICE (2019a)	Clinical guideline
14	NICE (2019b)	Clinical practice guideline
15	Ramsay (1993)	Commentary
16	RCM (2019)	Clinical practice guideline
17	RCM (2020)	Clinical practice guideline
18	Seijmonsbergen-Schermers et al., 2019	Debate
19	Seijmonsbergen-Schermers et al., 2020	Commentary
20	Sharp, Stock, and Alfirevic (2016)	Review of practice
21	Spillane (2020)	Commentary

below. The tables were then compared, and areas of commonality or difference were discussed.

2.2. Methods

A range of approaches and methods fall under the CDA umbrella, and those applied here are based on a dispositive analysis approach (Jäger, 2001; Jäger & Maier, 2009). This approach operationalises Foucault's concept of 'the dispositive', a heterogenous ensemble of discursive and non-discursive elements, such as discourse, institutions and scientific statements and a system of relations established by the connection of these elements (Foucault, 1980). As a method of CDA, dispositive analysis aims to identify the knowledge of discourses, exploring the context of power therein and subjecting it to critique. The focus is specifically on what valid knowledge consists of, how it evolves and is passed on, what role it has in constituting subjects and what impact it has on the shaping and development of society (Jäger, 2001, p. 32). Because this approach is rooted in the dispositive, it recognises that the societal discourse, in which knowledge is situated, is composed a variety of themes, which Jäger terms "discourse strands", that overlap and change over time. In our case, IOL was the primary object, or discourse strand, of analysis, which was conducted in two stages (Jäger, 2001). First, a content analysis of each text identified sub-topics related to IOL, noting any other overlapping discourse strands that appeared in the texts; and second, a language analysis focused on context, rhetoric and ideological statements (e.g. notions of choice, maternity, medicine, risk and safety). Bringing these different elements together, the content and language analyses aim to determine the position of a text in regard to the primary object of analysis and locate its argument or message. The content analysis was conducted on all the texts included in our study, while the language analysis was conducted on 'discourse fragments', or specific portions, of the texts, unless the text was short enough to analyse in full. Selection was based on the content analysis stage, by identifying discourse fragments that were typical of a certain category of text or discourse position.

Both stages of analysis were undertaken by CY, MH, CW, CM and HC, with theoretical and methodological support from LL. Together, we have decades of social science, midwifery and maternal health research expertise that enabled us to analyse the breadth of texts included. MH, CW and HC are midwives and healthcare researchers, while CY and CM are medical anthropologists who specialise in maternal health but do not have any clinical training. LL is a linguist, whose research focuses on gender, language and discourse analysis. This feminist CDA was undertaken as part of the CHOICE Study, a prospective cohort study and process evaluation of inpatient versus outpatient cervical ripening (Stock et al., 2021).

3. Findings

3.1. Content and language analysis

The majority of the texts we analysed were authored by obstetricians or midwives, and published in health sciences or services journals, or by NICE, a non-departmental public body of the Department of Health in England. Most were published in the last 10 years, following the trend of increased professional and academic attention on IOL. The NICE clinical guideline, 'Inducing labour', was published in 2008, an update to a 2001 clinical guideline (NICE, 2008a; 2008b). NICE provided an update of evidence (2013), and recently released a new version of their 'Inducing labour' guideline (2021), after this search and analysis was conducted. Leading up to the 2008 guidance, IOL does not appear as prominently in the wider discourse of maternity services in the UK; very few reviews of practice, commentaries or debates were found.

Our analytical approach entailed clarifying the primary positions of the texts, specifically their positioning regarding IOL and its use, efficacy, risks and benefits. The primary position of the majority of text analysed was that IOL is a safe, common procedure that reduces certain risks when used optimally, and that it is a woman's choice to undergo an induction. There was, however, divergence between texts on the extent to which IOL is represented as protective when it comes to CS and stillbirth, and whether any protective function outweighs the risks it also carries as a medical intervention if implemented routinely. This split in position is mediated by authors' perspectives on the sufficiency of the evidence base, its interpretation and how some evidence was centred over others. Those who interpret the evidence base as still underdeveloped tended to also include discussions of the risks of performing a medical procedure on those who do not need it[1-3,6, 16-19]:

> *Where medical complications … are present the dangers are relatively clear and thus the balancing of risks is reasonably straightforward. However, around 50% of labour inductions are performed in the absence of recognised medical complications (Grivell* et al.*, 2011; Stock et al., 2012). In these situations uncertainty persists about the appropriate timing, risks and benefits of induction, leaving significant room for both professional debate and maternal concern.* (Cheyne et al., 2012, p.1)

The texts in which the current IOL evidence base is seen to be sufficient to define clinical guidelines and practice tend to downplay the risks of unnecessary intervention[8-10,13,20]:

> *The evidence shows that induction at term improves outcomes, reduces costs and improves a woman's sense of control. Therefore, it is our role as advocates for women to create system change and to reconfigure services to deliver more low-risk inductions. (Lightly & Weeks, 2019*, p. 1598[2]

IOL practice was not only mediated by women's perceived suitability but also by adherence to guidelines. The importance of this adherence revealed the anxieties of providing care in the UK, where risk management, governance and litigation lurk heavily in the background[4,5,8-10,12]:

> *"However, in view of the increasing importance of guidelines and protocols in relation to risk management, litigation and the advent of clinical governance, it would seem wise to review policies critically and to work*

[2] Coates, Cupples, Scamell and McCourt have highlighted that their systematic review (Coates, Cupples, Scamell, & McCourt, Women's experiences of induction of labour: Qualitative systematic review and thematic synthesis, 2019) was inaccurately quoted by Lightly and Weeks in their *BJOG* debate (Coates, Cupples, Scamell, & McCourt, Re: BJOG Debate. Induction of labour should be offered to all women at term. FOR: Induction of labour should be offered at term, 2021).

within the recommended guidelines unless there are unambiguous reasons for departing from them." (Harrison et al., 2003, p.141)

There was also a distinction in positions whether offering IOL *routinely* and *at term* is beneficial, which emerged as the evidence base has developed over the past three decades. The texts revealed a consensus that IOL should and will be used for those who need it, but less agreement on how this is delineated, who gets to decide this and when it should be done.

Our analysis sought to identify the extent to which conceptions, practices and justifications of knowledge within texts disadvantaged and disempowered women. Texts were more likely to be upholding a discourse of gender asymmetry than challenging[4,5,7,8-10,12,13,15-17,19,20]. There was a frequent presence of an authoritative tone originating from policymakers and clinicians, aimed at demonstrating their ability to dictate women's care based on their expert knowledge of the IOL evidence:

"Few would deny" (Ramsay, 1993, p.858)

"[R]egimens can surely be modified for the induction of low risk births" (Lightly & Weeks, 2019, p. 1598)

NICE-authored documents had a particularly strong authoritative voice. Part of our analysis noted argumentation style, which was markedly absent in NICE documents because the information was presented as fact. Coupled with this assumed authoritative position over clinical information and women's care was a tone of paternalism:

"Women only have their labour induced as outpatients if safety and support procedures, including audit, are in place … women who are induced as outpatients who are given instructions" (NICE, 2014, pp.8, 13)

Women are rarely afforded an authoritative position, despite ostensibly being the centre of this care:

"Inductions planned to suit the convenience of the obstetrician are now uncommon but there is still pressure from some women who are 'fed up' and reluctant to await spontaneous onset of labour but without obstetric indications for intervention." (Edozien, 1999, p.343)

Yet, as Jowitt (2012, p.11) points out, women can also be "easily persuaded to accept induction if it is presented as a safe option, particularly if they are becoming weary of a long pregnancy", suggesting that this authoritative and paternalistic positioning extends beyond text and into practice.

We identified a double discourse in the texts, particularly around decision-making, choice and women's roles in their care, which we have termed 'explicit-implicit discourse of care'. There are often the two conversations about women's choice at play in the texts: one in which they are centred; and another in which they are peripheral. This explicit-implicit discourse demonstrates the differences between what is expected to be said (women-centred, informed choice, support for decisions) and what is really said (healthcare professionals control information, decision-making and choice) about IOL. Further, we identified a consistently narrow concept of choice in the NICE-authored guidelines and policy documents, in which clinicians are in control of what choice is offered and how it is presented, and women are merely involved in decision-making in a more passive fashion and restricted to reaching a decision:

"In making that judgment, it is necessary to factor in the attitude and wishes of the woman in response to her understanding of the actual risk of continuing the pregnancy" (NICE, 2008b, p.2)

In this sense, choice appears to be more ostensible rather than actualised. There are two concepts of choice existing simultaneously in the texts, one which follows policy rhetoric around choice ("fully informed choice", women have the right to refuse IOL); and other which reduces their capacity to make this choice (women have "attitudes and wishes"). Although the surface rhetoric is one of women's choice, significant control is imposed over how the decision-making process unfolds, specifically what information and options are given to women and when choices are offered:

"[A]llow the woman time to discuss the information with her partner … invite the woman to ask questions … The application of the recommendations in this interactive flowchart … do not override the responsibility of healthcare professionals to make decisions appropriate to the circumstances of the individual patient, in consultation with the patient and/or their carer or guardian." (NICE, 2019a, pp.4, 6)

While this rhetoric appears to centre women in the decision-making process about IOL, they are the more passive participants and have no action words attached to them. Healthcare professionals "allow" and "invite", while women have "involvement". Induction is "well tolerated by patients" (Lightly & Weeks, 2019, p. 1598), and evidence of its safety and tolerability are used to justify increasing rates and offering it earlier and earlier in pregnancy. The following sections will explore this double discourse further, suggesting that the explicit discourse of care is a composite of 'women-centred care' and 'informed choice', while the implicit discourse of care is one of 'women as absent actors', 'disembodiment' and 'evidence as the primary actor'.

3.2. Explicit discourse of care

Most texts displayed an explicit discourse, which espoused women-centred care and informed choice. Authors often describe women as central and vital to decision-making about their care; however, conceptualisations and descriptions of 'women-centred' varied. One version of the NICE CG70 (2008a) features a section entitled 'Women-centred care' after the 'Introduction' section, describing the concept as:

"Treatment and care should take into account women's individual needs and preferences. Women who are having or being offered induction of labour should have the opportunity to make informed decisions about their care and treatment, in partnership with their healthcare professionals." (2008a, p.4)

The RCOG published version does not feature this section, and 'woman-centred' only appears once: "The GDG agrees with and supports the generic principles of women-centred care" (NICE, 2008b, p.22). What is at the centre are individual "needs and "preferences" (NICE, 2008a), "feelings and considerations" (Spillane, 2020, p. 143), as information is provided and understandings of risks are shaped by healthcare professionals. Effective communication and individualised understanding of risk were seen to form the basis of decision-making that takes place in partnership with professionals:

"[P]roviding the actual and relative risks of each option so parents can make a fully informed decision about the path they wish to take" (Spillane, 2020, p.143).

Through shared decision-making, women are offered a choice and are required to balance the risks of IOL and the risk of stillbirth. Yet, shared decision-making is not "offered consistently" (Seijmonsbergen--Schermers et al., 2020), and balancing risks is enmeshed in the moral responsibilities of motherhood. These are assigned over the course of pregnant women's care, particularly during decision-making situations involving the well-being of the foetus, and take shape from the deeply-rooted notion that "mothers must protect their babies from harm" (Brauer, 2016).

Most texts described choice as integral to women's experiences during labour and birth, and fundamental to good quality care and outcomes. Decision-making was not viewed as limited to healthcare professionals, rather women were discursively placed at the centre of it. As such, women required high quality information to make individual decisions, support to make truly 'informed' choices and freedom to make choices

about their bodies, even if these went against clinical guidelines and recommendations[2,10,21]:

> *"If, after discussion of the relevant issues, the woman chooses to decline the offer of induction of labour, she must not be made to feel alienated."* (NICE, 2008b, p.2)

However, there were indications in the texts that shaping the framework of a choice and achieving an informed one were ultimately the responsibility of healthcare professionals. The RCM-authored texts make clear the duty of midwives to provide information and support, and this is assumed to result in informed choice. Though women's choice was presented as central and unequivocal, they still must be "helped" to make an informed one:

> *"Unless the clinical situation changes, midwives should not make frequent offers of this intervention."* (RCM, 2019, p.7)

> *"It is critical that women are helped to make an informed choice"* (RCM, 2020, p.1)

There was a tension between whether the choice was "real" or not, and the extent to which IOL choices were truly informed:

> *"Women have to know the likely consequences of induction of labour I don't think they do, I still don't … Women do still seem to have a real choice in week 41 and there seems to be little reason to deny them choice."* (Jowitt, 2012, pp.9, 11)

Notably, not a single text describes the concept of choice as one that is based on human rights, which policy rhetoric is assumed to be predicated on. Instead, it was depicted as a straightforward, if not vague, event, one that is easily achieved and that should fall to the woman. However, what a woman's role truly is, outside of being a passive receiver and consumer of information, during this event was largely unclear. Thus, championing informed choice emerges as more of a performative stance, one which is required by policy and deployed regardless of texts' relationship to the dominant discourse and its own positioning in relation to IOL.

3.3. Implicit discourse of care

The implicit discourse of care was composed of three key dimensions: women as absent actors, disembodiment, and evidence as a primary actor. Our analysis traced when and how different actors appeared in texts, whether they were present (active) or mentioned (passive), revealing how they are viewed and spoken about. Women were more likely to be mentioned[1,4,7-15,18-20] than be present[2,16,17,21]. In our analysis, women recurrently were identified as absent actors[5,8-17,19,20], particularly when choice was discussed[3,4,7,10,12,13,15,19,20]. This suggests that while, as discussed above, women-centred care and informed choice were central in the discourse, closer analysis reveals a more passive and peripheral positioning. For instance, women have "*involvement in decisions* about IOL" (NICE, 2019a, p. 4) rather than *make decisions* about IOL; "[a]ll women need to *feel* in control" (RCM, 2019, p. 10) rather than *be* in control (authors' emphasis). One of the more visually striking examples appears in the text 'Induction of labour overview', which is a hyper-condensed version of the guideline bringing "together everything NICE says on a topic in an interactive flowchart" (NICE, 2019a, p. 3). The seven topic sections all point to further sources of information except the section 'Pregnant woman who may need induction', which reads: "No additional information" (Fig. 1).

When it comes to IOL, women appear as a part of its process and defined by their risk status in relation to that process: "women locally determined to be low risk at term" (Sharp et al., 2016, p. 22). Texts often presented a concept of medicine and maternity where women are on the periphery[4,6-8,10,12,13,15,19-21], reflecting how they are being acted-upon during their IOL care rather than active participants in it: "it is our role as advocates for women to create system change and to reconfigure services to deliver more low-risk inductions" (Lightly & Weeks, 2019, p. 1598). Within this implicit discourse of care, women are either absent as actors, on the periphery or a process to be managed but never centred, in the manner the explicit discourse of 'women-centred' care suggests.

Illuminating women's marginalisation and absence further, we identified a rhetoric of disembodiment[4,5,8,10,13,15,17], present beneath an implicit discourse of care and often overlapping with the texts' positioning on the concept of medicine and maternity:

> *"Given that labour will be induced in one-fifth of pregnancies carried to viability,"* (Edozien, 1999, p.344)

> *"[F]urther discussion is required regarding the measures needed for ongoing monitoring of the pregnancy … Precipitate labour is defined as expulsion of the fetus within less than 3 hours of commencement of contractions."* (NICE, 2008b, pp.2, 40)

> *"It is reassuring to observe … relatively low risk pregnancies and that a degree of fetal assessment and risk stratification appears to happen prior to initiating OP IOL"* (Sharp et al., 2016, p.23)

> *"[M]embrane sweeping involves the examining finger passing through the cervix to rotate against the wall of the uterus, to separate the chorionic membrane* (NICE, 2019a, p.5)

The separation of women from their bodies – *the* pregnancy as opposed to *her* pregnancy – has been prevalent in medical texts for decades (Martin, 1987), meaning this disembodiment is widely normalised and so may appear unremarkable. When it comes to IOL, women are especially disembodied from their cervix and uterus. The cervix and uterus were present actors in four texts, most significantly the NICE-authored texts:

> *"The continuation of a woman's pregnancy requires that her cervix remains closed and rigid and that her uterus quiet and not contracting … A woman's cervix … must undergo a process called ripening, where it becomes soft and pliable … In parallel with this, the uterus … must begin to respond to the stimuli which cause these cells to contract in the waves that characterise labour.* (NICE, 2008b, p.1)

> *"[A] score of eight or more generally indicates that the cervix is ripe, or 'favourable'"* (NICE, 2019a, p.5)

Aspects of a woman's reproductive physiology are not only separate actors from herself, but also given more personification ("quiet" uterus). The cervix and uterus are portrayed as prone to unfavorability ("unripe" cervix), echoing Martin's writing on the use of function and dysfunction metaphors in medical text descriptions of women's reproduction (1987).

The "cervix" plays a key role in IOL, guiding the course of labour and

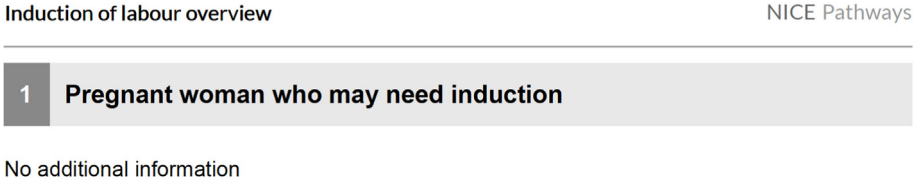

Fig. 1. The section from NICE's 'Induction of labour overview' reading "No additional information" (2019a).

birth, but because its "state" is prone to unfavorability, its role is one of constant uncertainty. Women's bodies, more generally, were also portrayed as sites of uncertainty, where outcomes can vary[1,2,7,8,9,12,20]. Risk is pervasive in management and representation of pregnancy and birth and some commentators argue has come to define women's experiences (Chadwick & Foster, 2014; Smith, Devane, & Murphy-Lawless, 2012). Unsurprisingly, risk appears often in the IOL discourse, particularly around the women's bodies:

> *"[T]hese differences are in part attributable to the higher risk profile of women for whom induction is indicated"* (Edozien, 1999, p.343)

> *"Research is needed into racial differences in the UK to identify the possible differences in the distribution of perinatal risk specific to gestational weeks and possible benefits of intervention before 41 weeks."* (NICE, 2008b, p.16)

> *"The trial was done with the aim of reducing stillbirth, which tends to happen more in women who give birth for the first time at the age of 35 or older. The presumption is that induction at term will reduce the stillbirth rate, but critics have said it would increase the rate of caesarean delivery"* (Lehman, 2016, p.395)

If women are not the primary actors in the discourse about their own care, then who or what is? We found that evidence was the most present actor in the texts[1,2,6-8,17,21], a phenomenon that appears in other texts related to maternity care, particularly the *Myles Textbook for Midwives* (Harkness & Cheyne, 2019). Evidence is recurrently centred within the authors' discussions of IOL:

> "*If the findings are trustworthy"* (Cheyne et al., 2012, p.3)

> *"[T]his trial did not use stillbirth as an endpoint"* (Lehman, 2016, p.395)

> *"[T]he data still tells the same story"* (Chippington Derrick & Higson, 2019, p.5)

> *"The evidence from the AFFIRM trial suggests that there would be no change in the stillbirth/perinatal death rate, when compared to an alternative policy of expectant management"* (RCM, 2020, p.1)

> *"[C]ohort studies cannot give a conclusive verification of a link between the intervention and risk."* (Spillane, 2020, p.142)

Aligning with the evidence base and following policy and clinical guidelines were described as the primary ways to manage risk, promote safety and even save lives[5,8,12,16,17,18]:

> *"There is an urgent need to translate these research findings into clinical practice and* save *the lives of more babies"* (Lightly & Weeks, 2019, p. 1598)

> *"Induction of labour has been associated with reduced caesarean section (CS) rates in some randomised controlled trials (RCTs) but not in cohort studies (Rydahl* et al. *JBI Database System Rev Implement RCM, 2019;17:170–208). The study population in these RCTs is often rather different than the general population."* (Seijmonsbergen-Schermers et al., 2019, p.1599)

However, not all the IOL evidence and research holds the same weight in the discourse, so some evidence should be considered as more active as an actor than others. The AFFIRM trial, a randomised controlled trial (RCT) evaluating whether the introduction of a reduced foetal movements care package would impact incidence of stillbirth (Norman et al., 2018, p. P1629), was frequently a subject of discussion in the texts. It appears to have significantly affected current IOL practices in the UK, even though this was not the focus of the intervention nor did the care package reduce risk of stillbirth. The NICE clinical guideline itself operates according to a methodological and ontological hierarchy, which includes some evidence but not others, ranks that which is included and does not consider lateral forms of evidence:

> *"[T]he highest possible evidence level (EL) is a well conducted systematic review or meta-analysis of randomised controlled trials (RCTs; EL = 1++) or an individual RCT (EL = 1+) … For each clinical question, the highest available level of evidence was selected. Where appropriate, for example, if a systematic review, meta-analysis or RCT existed in relation to a question, studies of a weaker design were not included."* (NICE, 2008b, p.5)

This falls in line with the standard hierarchy of research designs for evidence-based medicine, which is often depicted as a pyramid of decreasing bias and increasing quality (Murad, Asi, Alsawas, & Alahdab, 2016). While 'expert opinion' is included at the bottom of the pyramid, qualitative and survey-based research is almost entirely excluded and epidemiological studies which may provide insight into longer-term consequences of interventions are not considered within remit.

Though evidence was a primary actor, it was also often used as a tool [1,4,8,10,13,16-18,20,21], deployed in aid of a language of safety, by authors, namely healthcare professionals. There were a variety of standpoints on its "trustworthiness" situated around which language of safety was being used; for example, whether it was safety from the harms of unnecessary intervention or safety from increased stillbirth risk. The texts authored by midwives tended to be more sceptical of the way that evidence is used to support IOL as a widespread intervention, while obstetric-authored texts presented the evidence as unquestionably in support of IOL's benefits. The latter often reveals an endorsement of obstetric knowledge as uncontested fact. For instance, Sharp et al. (2016, p.21) state: "the growing clinical indications for labour induction have led some units to induce up to 38% of pregnancies," with no further critical exploration of how knowledge of these clinical indications is produced. This is indicative of two overarching narratives of evidence that emerged from our analysis. First, that the evidence points towards IOL as vital in saving babies' lives; and conversely, the IOL rate is unnecessarily high because evidence is misinterpreted and exaggerates the risk of stillbirth over any other risk, or because certain areas of evidence are not present. These narratives are interconnected through who is seen as the focus of care, where risk and safety are located and how women's bodies are perceived as sites of uncertainty.

4. Discussion

Our analysis of IOL policy and practice language reveals a complex discourse, with polarising narratives regarding use, risk and safety, reflecting the growing but contested evidence base on the procedure. Since the 1990s, the discourse relating to IOL, like many others in maternity care, has assumed the choice rhetoric of UK maternal health policy, making reference to it and eventually centralising it. The UK maternal health policy landscape was significantly altered in the early 1990s, when *Changing Childbirth* was published, a document that placed the principle of women's choice at the centre of maternity care policy (Department of Health, 1993). This was shift from the 1970 policy recommending complete hospitalisation for labour and birth care, which marked a period of over-medicalisation and high intervention, including an IOL rate of 56% nationally (MacKenzie, 2006).

One of the reasons that IOL may not have garnered as much attention in the 1990s and early 2000s is because measures for policy success were focused elsewhere: providing choice, expanding continuity of carer and reducing interventions, particularly caesarean sections (Department of Health, 2005). Moreover, the induction rate was more or less stable during this period, hovering around 20% until the early 2010s when it began to rise (Macfarlane, 1998; MacKenzie, 2006; NHS Digital, 2020). The increasing attention on induction then may be connected to the growing range of 'clinical indications' for and rising rates of IOL, but also the shift in the measures of policy success. Providing choice still remains central, but decreasing perinatal mortality and stillbirth rates is more prominent. The UK currently has one of the highest stillbirth rates in Europe, and lowering perinatal mortality further has become a key

measure of maternity service safety and improvement (Department of Health, 2017). This has led to increased monitoring of foetal movements (NHS England, 2019) which, along with "timely delivery", is associated with reduced stillbirth risk (Norman et al., 2018, p. P1629). Because inducing labour is often deemed necessary for "timely delivery", IOL and stillbirth have become enmeshed, despite the complexity of perinatal mortality, which involves social determinants of health, factors are IOL alone cannot address (Douglass & Lokugamage, 2021; Draper et al., 2021).

As we have shown, there is a broader double, or 'explicit-implicit', discourse of care about IOL. Informed choice, along with women-centred care, sits within the explicit discourse, or at the surface level of what is expected to said. This double discourse is reminiscent of the "double-talk" Lazar identified in Singapore fertility-campaigning ads, which on the surface equalised gender relations while in fact reaffirming existing gender inequalities (Lazar, 1993). Ads operated on two levels, one overt and the other covert, which, when mixed, created "resolution-through-contradiction" that served to protect men's power and dominance and to engender "consent among women to police themselves" (Lazar, 1993, p. 463). Lazar highlights the functionality of "double-talk" in maintaining a status quo of gender asymmetry. In the case of IOL, the explicit-implicit discourse functions to preserve healthcare professionals' control over maternity care and further alienate women from their own bodies while maintaining a discursive position of women-centred care.

The superficiality of choice language in IOL texts furthers the arguments that there is an "illusion of choice" in maternity care (Sherwin, 1998, p. 28), as well as a "hollowed-out practice of autonomy" that is primarily rhetorical (Newnham & Kirkham, 2019, p. 2147). Informed choice does not simply happen; it must be *made* (MacDonald, 2018). Maternity is a field in which agency is warped, contributing to a care environment in which consent to procedures becomes murky and autonomy either an illusory goal or nullified all together (Dixon-Woods et al., 2006; Newnham & Kirkham, 2019). Foucault's well-known work on prisons has also established that an "illusion of choice" can operate to control behaviour through self-disciplinary mechanisms (1979), and Sherwin brings this idea out further in her discussion on how choice can be used "to mask the normalizing powers of medicine":

> *[I]nformed consent procedures aimed simply at protecting autonomy in the narrow sense of specific choice among preselected options may ultimately serve to secure the compliance of docile patients who operate under the illusion of autonomy by virtue of being invited to consent to procedures they are socially encouraged to choose.* (Sherwin, 1998, pp.28–9)

Moreover, 'women-centred care', as part of this explicit discourse, may shift the responsibility of care to women, and we would argue that there is a difference between having a responsibility over care and having authority over it. The consistent authoritative and paternalistic tone across the texts displays how these diverge, in that women are given responsibility for using information about IOL to make the 'good' decision but rarely afforded the authoritative knowledge (Jordan, 1997) that produces and shapes it.

Women-centred care rhetoric in IOL is also highly focused on 'the individual', and such a view tends to centre any health issues on that particular person (Sherwin, 1998). Thus, perinatal mortality is not understood as situated within wider social and physical environments or life course but caused by an individual body which healthcare professionals can intervene upon. Throughout the texts, women's bodies are written about as disembodied parts that pose problems – such as of deficiency – and must be managed ("the state of the woman's cervix"), and as sites of uncertainty potentially controlled through IOL. A prominent aspect of this disembodied rhetoric is personifying the cervix as an actor, one usually needing assistance to become "ripe" or "favourable". The cervix as a location of tension and anxiety has been overlooked in scholarly work on reproduction. Martin, for example, focused more on the uterus as "an involuntary muscle" but disregarded the characterisation of the cervix as a potential impediment to labour: "'The forces involved in labor … must overcome the resistance offered by the cervix to dilatation'" (1987, p.58). Whether the cervix is 'ripe' or not has implications for IOL practice and signifies whether a woman can move forward on the care pathway or not. In some of the texts analysed, the locus of uncertainty was placed on women's bodies, rather than situated in the contested evidence base.

In our analysis it was apparent how little women's *experiences* or maternal outcomes factored into the discussions of IOL policy and practice. Women were not only absent in the texts but their experiences were peripheralized. This could be due to the relationship that healthcare policy, professionals and journals have to the qualitative body of IOL evidence, where these experiences are elaborated on in-depth but it may also reflect discursive positions which lead some questions or outcomes to be prioritised or overlooked in research. The standard hierarchy of evidence-based medicine used to justify and implement perinatal interventions centres policy and guidance around research deemed to be of "high quality" (NICE, 2008a; 2008b). Within this rigid hierarchy, RCTs and meta-analyses of RCTs are considered the best sources of evidence, effectively disregarding evidence on women's experiences, but also presenting the evaluation of evidence quality as linear and uncomplicated (Greenhalgh & Papoutsi, 2018). This is crucial in IOL because the qualitative evidence counters the narrative that it is a process "well tolerated" by women (Coates et al., 2019). Moreover, lateral evidence, particularly on continuity of care and place of birth, is equally unconsidered, despite each being associated with improved maternal and perinatal outcomes and reduced caesarean section rates via evidence classified as 'gold standard' (Birthplace in England Collaborative Group, 2011; Sandall, Soltani, Gates, Shennan, & Devane, 2016; Scarf et al., 2018).

Evidence was discursively reproduced as such a meaningful, primary actor because texts and authors increasingly deployed it as a signifier of their ownership. Confidence and authority in claiming ownership over this language of safety was stratified professionally, intersecting with gender. Texts authored by obstetricians and policymakers often used evidence fluency as a rhetorical strategy to build this ownership and solidify their authority over policy and practice, whereas this was less apparent in those authored by midwives, academics and service users. Authority over policy and practice also impacted texts' position in the IOL debate itself. While the NICE documents do have a position, that the IOL evidence is sufficient to define clinical guidelines, it is limited in the debate because the information they produce is discursively shaped as beyond contestation. This was rhetorically achieved through employing a strong authoritative voice but no argumentation style and presenting information as fact. This authoritative position, one that is beyond reproach, allows NICE guidelines to serve as an important resource for risk management and against litigation, as mentioned by Harrison et al. (2003).

The language of safety often precluded the wellbeing of the woman, both physical and emotional, despite the explicit discourse of women-centred care. In some texts, there was an assumption that women will accept and tolerate IOL, which is unsurprising given the deeply-embedded, socio-cultural expectation of 'maternal sacrifice' requiring women to put their child first even when it is not in her best interest to do so (Lowe, 2016) and protecting babies from harm (Brauer, 2016). The rhetorical vagueness of the IOL choice process in texts emphasises the extent to which women's roles are marginalised and indistinct. The oversimplification of the complexity of decision-making about pregnancy and birth obscures how the responsibility of choosing care is steeped in moral imperatives of enacting what it means to be a 'good' mother (Yuill, McCourt, Cheyne, & Leister, 2020). For IOL, being a 'good' mother involves deciding between the risks of an intervention and the risks of continuing pregnancy, and downplaying the potential physical and emotional weight of such a care decision is a disservice to women. They should not appear in policy and practice as just a feature but should actually be there, active and autonomous, as an equal focus of care.

Funding

This work was supported by the National Institute of Health and Care Research (NIHR) Health Technology and Assessment (NIHR 127569).

Declarations of interest

None.

Ethical statement

No ethics approval was sought for this work. CHOICE has National Research Ethics Service Committee approval (York and Humber—Sheffield Research Ethics Committee, REC reference: 20/YH/0145) and National R&D approval in Scotland (NHS Research Scotland Permissions) and England (Health Research Authority).

Acknowledgements

We would like to thank the CHOICE Study team and co-applicant group for supporting this research.

References

Birthplace in England Collaborative Group. (2011). Perinatal and maternal outcomes by planned place of birth for healthy women with low risk pregnancies: The birthplace in England national prospective cohort study. *BMJ, 343*, d7400.

Boyle, E., Poulsen, G., Field, D., Kurinczuk, J., Wolke, D., Alfirevic, Z., et al. (2012). Effects of gestational age at birth on health outcomes at 3 and 5 years of age: Population based cohort study. *BMJ, 344*, Article e896.

Brauer, S. (2016). Moral implications of obstetric technologies for pregnancy and motherhood. *Medicine, Healthcare & Philosophy, 19*, 45–54, 2016.

Chadwick, R., & Foster, D. (2014). Negotiating risky bodies: Childbirth and constructions of risk. *Health, Risk & Society, 16*(1), 68–83.

Cheyne, H., Abhyankar, P., & Williams, B. (2012). Elective induction of labour:The problem of interpretation and communication of risks. *Midwifery*, 1–4, 2012.

Cheyne, H., McCourt, C., & Semple, K. (2013). Mother knows best: Developing a consumer led, evidence informed, research agenda for maternity care. *Midwifery, 29*(6), 705–712.

Chippington Derrick, D., & Higson, N. (2019). Labour Induction at Term - how great is the risk of refusing it? *AIMS Journal, 31*(1), 1–13.

Coates, R., Cupples, G., Scamell, A., & McCourt, C. (2019). Women's experiences of induction of labour: Qualitative systematic review and thematic synthesis. *Midwifery, 69*, 17–28.

Coathup, V., Boyle, E., Carson, C., Johnson, S., Kurinzcuk, J., Macfarlane, A., et al. (2020). Gestational age and hospital admissions during childhood: Population based, record linkage study in England (TIGAR study). *BMJ, 371*, Article m4075.

Dahlen, H., Thornton, C., Downe, S., de Jonge, A., Seijmonsbergen-Schermers, A., Tracy, S., … Peters, L. (2021). Intrapartum interventions and outcomes for women and children following induction of labour at term in uncomplicated pregnancies: A 16-year population-based linked data study. *BMJ Open, 11*(6), Article e047040.

Department of Health. (1993). *Changing childbirth. Part I. Report of the expert maternity group*. London: HMSO.

Department of Health. (2005). *Maternity Matters: Choice, access and continuity of care in a safe service*. London: NHS.

Department of Health. (2017). *Safer maternity care - the national maternity safety strategy - progress and next steps*. London: Department of Health.

van Dijk, T. A. (1993). Principles of critical discourse analysis. *Discourse & Society, 4*(2), 249–283.

Dixon-Woods, M., Williams, S., Jackson, C., Akkad, A., Kenyon, S., & Habiba, M. (2006). Why do women consent to surgery, even when they do not want to? An interactionist and bourdieusian analysis. *Social Science & Medicine, 62*(11), 2742–2753.

Douglass, C., & Lokugamage, A. (2021). Racial profiling for induction of labour: Improving safety or perpetuating racism? *BMJ, 375*, n2562.

Downe, S. (2013). Commentary on 'does induction of labour increase the risk of caesarean section? A systematic review and meta-analysis of trials in women with intact membranes. *BJOG*, 1, 2013.

Draper, E., Gallimore, I., Smith, L., Fenton, A., Kurinczuk, J., & Smith, P. . . . Collaboration, o. b.-U. (2021). *MBRRACE-UK perinatal mortality surveillance report, UK perinatal Deaths for Births from January to december 2019. Leicester: The infant mortality and morbidity studies*. Department of Health Sciences, University of Leicester.

Edozien, L. (1999). What do maternity statistics tell us about induction of labour? *Journal of Obstetrics and Gynaecology, 19*(4), 343–344.

Evans-Agnew, R. A., Johnson, S., Liu, F., & Boutain, D. M. (2016). Applying critical discourse analysis in health policy research: Case studies in regional, organizational, and global health. *Policy, Politics, & Nursing Practice, 17*(3), 136–146.

Foucault, M. (1979). In T. A. Sheridan (Ed.), *Discipline and punish: The birth of the prison*. New York: Vintage.

Foucault, M. (1980). The confessions of the flesh. In M. Foucault (Ed.), *Power/Knowledge: Selected interviews and other writings* (pp. 194–229). New York: Pantheon Books.

Greenhalgh, T., & Papoutsi, C. (2018). Studying complexity in health services research: Desperately seeking an overdue paradigm shift. *BMC Medicine, 16*, 95.

Harkness, M., & Cheyne, H. (2019). Myles Textbooks for Midwives 1953 and 2014, a feminist critical discourse analysis. *Midwifery, 76*, 1–7.

Harkness, M., Yuill, C., Cheyne, H., Stock, S., & McCourt, C. (2021). Induction of labour during the COVID-19 pandemic: A national survey of impact on practice in the UK. *BMC Pregnancy and Childbirth, 21*(310), 2021.

Harrison, K., Read, M., & Woodman, N. (2003). Current practice for induction of labour in the United Kingdom: Time for a review? *Journal of Obstetrics and Gynaecology, 23*(2), 138–142.

Jäger, S. (2001). Discourse and knowledge: Theoretical and methodological aspects of a critical discourse and dispositive analysis. In R. Wodak, & M. Meyer (Eds.), *Methods of critical discourse analysis* (pp. 32–62). London: SAGE.

Jäger, S., & Maier, F. (2009). Theoretical and methodological aspects of foucauldian critical discourse analysis and dispositive analysis. In R. Wodak, & M. Meyer (Eds.), *Methods of critical discourse analysis* (pp. 34–61). London: SAGE.

Jordan, B. (1997). Authoritative knowledge and its construction. In R. Davis-Floyd, & C. Sargent (Eds.), *Childbirth and authoritative knowledge: Cross-cultural perspectives* (pp. 56–79). Berkeley: University of California Press.

Jowitt, M. (2012). Should labour be induced for prolonged pregnancy? *Midwifery Matters, 2012*(134), 7–13.

Lazar, M. M. (1993). Equalizing gender relations: A case of double-talk. *Discourse & Society, 4*(4), 443–465.

Lazar, M. M. (2007). Feminist critical discourse analysis: Articulating a feminist discourse praxis. *Critical Discourse Studies, 4*(2), 141–164.

Lehman, R. (2016). *March 12). Research update - inducing for better outcomes? BMJ* (p. 395).

Lightly, K., & Weeks, A. D. (2019). *Induction of labour should be offered to all women at term - for: Induction of labour should be offered at term*. BJOG.

Lowe, P. (2016). *Reproductive health and maternal sacrifice - women, choice and responsibility*. London: Palgrave Macmillan.

Macfarlane, A. (1998). At last—maternity statistics for England. *BMJ, 316*(7131), 566–567.

MacKay, D., Smith, G., Dobbie, R., & Pell, J. (2010). Gestational age at delivery and special educational need: Retrospective cohort study of 407,503 schoolchildren. *PLoS Medicine, 7*(6), Article e1000289.

MacKenzie, I. Z. (2006). Induction of labour at the start of the new millennium. *Reproduction, 131*(6), 989–998.

Martin, E. (1987). *The woman in the body: A cultural analysis of reproduction*. Ann Arbor: Beacon Press.

Murad, M., Asi, N., Alsawas, M., & Alahdab, F. (2016). New evidence pyramid. *BMJ Evidence-Based Medicine, 21*, 125–127.

Newnham, E., & Kirkham, M. (2019). Beyond autonomy: Care ethics for midwifery and the humanization of birth. *Nursing Ethics, 26*(7–8), 2147–2157.

NHS Digital. (2020). *NHS maternity statistics, England 2019-20*. Leeds: NHS Digital.

NHS England. (2019). *Saving Babies' Lives Version Two A care bundle for reducing perinatal mortality*. Leeds: NHS England.

NICE. (2008a). *Clinical guideline 70 - induction of labour*. London: National Institute for Health and Clinical Excellence.

NICE. (2008b). *Clinical guideline 70 - induction of labour*. London: RCOG Press.

NICE. (2013). *Induction of labour - evidence update july 2013*. London: National Institute for Health and Care Excellence.

NICE. (2014). *Inducing labour - quality standard 60*. London: National Institute for Health and Care Excellence.

NICE. (2019a). *NICE Pathway - induction of labour overview*. London: National Institute for Health and Care Excellence.

NICE. (2019b). *NICE Pathways - performing induction of labour*. London: National Institute for Health and Care Excellence.

NICE. (2021). *Inducing labour - NICE guideline [NG207]*. London: National Institute for Health and Care Excellence.

Norman, J. E., Heazell, A. E., Rodriguez, A., Weir, C. J., Stock, S. J., Calderwood, C., et al. (2018). Awareness of fetal movements and care package to reduce fetal mortality (AFFIRM): A stepped wedge, cluster-randomised trial. *The Lancet, 392*(10158), P1629–P1638.

Public Health Scotland. (2020). *Births in scottish hospitals - year ending 31 march 2020*. Edinburgh: National Statistics.

Ramsay, S. (1993, October 2). Costs of labour induction. *The Lancet*, 858.

RCM. (2019). *Midwifery care for induction of labour*. London: Royal College of Midwives.

RCM. (2020). *Rationalisation of interventions such as induction of labour during COVID-19*. London: Royal College of Midwives.

Sandall, J., Soltani, H., Gates, S., Shennan, A., & Devane, D. (2016). Midwife-led continuity models of care compared with other models of care for women during pregnancy, birth and early parenting. *Cochrane Database of Systematic Reviews, 4*, CD004667.

Scarf, V., Rossiter, C., Vedam, S., Dahlen, H., Ellwood, D., Forster, D., & Homer, C. (2018). Maternal and perinatal outcomes by planned place of birth among women with low-risk pregnancies in high-income countries: A systematic review and meta-analysis. *Midwifery, 62*, 240–255, 2018.

Seijmonsbergen-Schermers, A. E., Peters, L. L., Goodarzi, B., Bekker, M., Prins, M., Stapert, M., … de Jonge, A. (2020). Which level of risk justifies routine induction of labor for healthy women? *Sexual & Reproductive Healthcare, 23*, 1–4, 2020.

Seijmonsbergen-Schermers, A. E., Scherjon, S., & de Jonge, A. (2019). *Induction of labour should be offered to all women at term - against: Induction of labour should not be offered to all women at term: First, do no harm* (p. 1599). BJOG.

Sharp, A. N., Stock, S. J., & Alfirevic, Z. (2016). Outpatient induction of labour in the UK: A survey of practice. *European Journal of Obstetrics & Gynecology and Reproductive Biology, 204*, 21–23, 2016.

Sherwin, S. (1998). A relational approach to autonomy in health care. In S. Sherwin (Ed.), *The politics of women's health - exploring agency and autonomy* (pp. 19–47). Philadelphia: Temple University Press.

Smith, V., Devane, D., & Murphy-Lawless, J. (2012). Risk in maternity care: A concept analysis. *International Journal of Childbirth, 2*(2), 126–135.

Spillane, E. (2020). Induction of labour—the debate. *British Journal of Midwifery, 28*(3), 142–143.

Stock, S., Bhide, A., Richardson, H., Black, M., Yuill, C., Harkness, M., … Norrie, J. (2021). Cervical ripening at home or in-hospital—prospective cohort study and process evaluation (CHOICE) study: A protocol. *BMJ Open, 11*(2021), Article e050452.

Stock, S., Ferguson, E., Duffy, A., Ford, I., Chalmers, J., & Norman, J. (2013). Outcomes of induction of labour in women with previous caesarean delivery: A retrospective cohort study using a population database. *PLoS One, 8*(4), Article e60404.

Yuill, C., McCourt, C., Cheyne, H., & Leister, N. (2020). Women's experiences of decision-making and informed choice about pregnancy and birth care: A systematic review and meta-synthesis of qualitative research. *BMC Pregnancy and Childbirth, 20*(1).