

Abstract

Objectives

To explore the lived experience of midwives in facilitating care for women with complex needs who choose to birth at home.

Methods

A qualitative design was employed, utilising interpretative phenomenological analysis, informed by hermeneutic principles. Purposive sampling was used to recruit Midwives (n=6) through social media and JiscMail. Data collection was via audio recorded semi- structured interviews transcribed by the researcher to allow full immersion in the data.

Ethics

Ethical approval was granted by the University of Oxford Medical Sciences Interdivisional Research Ethics Committee (IDREC) on 22nd February 2018 reference number R55585/RE00.

Findings

Two interpretative themes arose. The Radical Midwife embraces 'radical' in its purest form by positioning midwives between the traditional belief and practices, the physiological process, midwife knowing and skill, applying current evidence and professional context. The Conflicted Midwife arose out of this dichotomy and exposed the realities of striving for radicality whilst the negotiating the 'system', biased risk discourse and conflict.

Implications for practice

It is no longer acceptable to assume home-birth for women with complex needs is exceptional. This must be the catalyst to move towards a constructive discourse with midwives, women and the wider multidisciplinary team to address and expand the evidence base and pathways to support those who are already facilitating this care and those who inevitably, will continue to provide care 'outside of guideline'.

Introduction

The landscape of women presenting for care in pregnancy now compared to the 1970s is vastly different thanks in part to the development of technologies which support women with comorbidities, significant and complex mental health, obstetric, social and physical needs. Women who present with complex needs remain well informed and with the rise of social media, are finding that their voice is strong - as individuals and as a collective. Better Births (NMR, 2016) expounds a vision for maternity care which firmly places the woman and her family at the centre of care, supporting choice, control and autonomy and ensuring that midwives deliver responsive care, allowing informed decision making and choice, exemplifying this as a fundamentally embedded concept and cornerstone in modern maternity service provision.

An evidence base exploring women's reasons for birth choices outside of conventional advice is growing, with a view to contributing not only a deeper understanding of these motivations, but also informing how health care professionals can support such women. What is less understood is the experiences of Midwives who support women with complex needs who choose to birth at home.

Recent studies have explored how traumatic events and psychological distress arising out of midwifery practice affects the midwifery practitioner (Pezaro et al, 2015; Pezaro, Clyne and Fulton, 2017), as well as the experiences of providing generic 'out of criteria' care within a wider maternity context (Feeley et al, 2019). The aim of this study is to explore the experiences of midwives who specifically facilitate home birth for women with complex needs.

Methods

Qualitative interpretative phenomenological analysis (IPA) is a method used to facilitate a deeper understanding of a phenomenon as it relates to the individual, by examining the participant's experience and the meaning they attach to it rather than simply arranging data into descriptive themes (Smith, 2004; Giorgi, 2005).

Sampling and Setting

Purposive sampling was used (Yardley, 2000) to recruit participants via JiscMail (JiscMail, 2018) and social media via a closed group for Midwives (The Midwifery Hub, 2018). Midwives who fulfilled the inclusion criteria (practicing midwives who have experience of providing intrapartum care for women with complex needs) who wished to participate made contact with the principal investigator and were sent participant information detailing the voluntary nature of the study, as well as assurance of anonymity and confidentiality.

Data Collection

The principal investigator collected data using audio recorded, semi structured interviews with open ended questions, undertaken either face to face or via telephone utilising a digital voice recorder. Consent was obtained prior to each interview and the right to withdraw from the study up until the point of anonymisation and analysis emphasised. Each interview commenced with an invitation for the participant to disclose their philosophical approach to midwifery in order to ground the participant in their own world view and context whilst identifying motifs for discussion and allowing the participant to lead the interview. It is acknowledged that there are limitations to the use of telephone interviews, particularly in relation to being unable to respond to non-verbal cues which may affect interpretation.

Data Analysis

Interviews were transcribed verbatim by the author as soon as possible after the interview allowing full immersion and familiarity within the data. Entries into the reflexive diary informed the development of exploratory comments on the transcript and aided subsequent identification of initial emergent themes. This process was completed 'in-vivo' -line by line and word by word. Once transcriptions were completed, these were uploaded to NVivo 12 (NVivo QDAS, 2018). Iterative analysis reflecting the nature of the hermeneutic cycle began by the author simultaneously replaying the recording, and rereading the transcript, to capture linguistic emphasis and nuance (Larkin et al ; 2006. Eatough and Smith, 2008). Code assignment was guided by three areas (descriptive, linguistic and conceptual) and continued until data saturation was reached and a lack of further codes emerged. The author then considered and sought any relationships, commonalities or divergence between subordinate themes

and grouped them into 5 superordinate themes (Table 1) which were then further refined and distilled into 2 final interpretative themes throughout the analysis and writing process. The iterative process of writing and rewriting continued until interpretation could be articulated (van Manen, 1997 and 2014; Larkin, Watts and Clifton, 2006; Pietkiewicz and Smith, 2012).

Researcher Characteristics and Reflexivity

The researcher reflexively diarised in order to identify underlying assumptions and presuppositions. However, it was soon clear that this approach provided little personal insight as it was limited to those elements of which the researcher was aware. In order to amplify the researcher's reflexive capability (Rolls and Relf, 2006; de Cruz, 2017) the use of a reflexive interview technique was employed with the aim of exposing any unconscious views, assumptions and agendas. An unstructured interview was undertaken by a third party, with knowledge of the subject matter both from midwifery and social sciences perspective.

Ethics

Ethical approval was granted by the University of Oxford Medical Sciences Interdivisional Research Ethics Committee (IDREC) on 22nd February 2018 reference number R55585/RE00.

Results

Participant Characteristics

Six interviews were conducted between April and July 2018 with each interview lasting between 30 and 58 minutes. Each participant was allocated a unique identification number for use during transcription and subsequent analysis and a pseudonym was assigned prior to write up but after coding to protect anonymity. Two interviews were conducted face to face and four were conducted as telephone interviews. As is the nature of qualitative research, the findings are not intended to be generalisable but to seek meaning therefore the sample size is not considered a limitation (Smith, 2018)

Findings

Within the narratives two discrete accounts emerged relating to facilitation of home birth for women with complex needs - experiences of supporting women *planning* to birth at home and experiences of *intrapartum episodes of care* which often supported the discussion around antenatal care. This distinction was wholly organic and led by the participants and is presented here within the final interpretative themes - The Radical Clinician and The Conflicted Midwife.

The Radical Clinician

The Association of Radical Midwives (ARM, 2018) utilise the term 'radical' to define those practitioners who utilise their skills and knowledge whilst seeking and striving for improvement in care and practice through the application of evidence and modern technologies in the best interests of the pregnant women, the fetus and her family. The use of the term 'radical' within this context, aims to ground midwifery in its origins of being 'with woman'. Many of the midwives described their philosophy related to how they felt in providing and advocating for complex needs home birth. This demonstrated a clear sense of identity as a midwife and the prevailing sense of belonging to a cohort of professionals who shared an ethos of women at the centre of their decision making despite the complexity of the issues being presented and regardless of whether health professionals would agree with those choices or not. All participants were at pains to emphasise that they did not support 'normality at all costs' or lack recognition of events that have gone outside of what is considered normal. In order to provide *true* informed choice, there needs to be a full and frank discussion of risk and benefit but also an appreciation that women lead their own care and should be supported in their decisions:

This sense of identity and belonging to a cohort of midwives who felt only a little anxiety around facilitating care for women with complex needs was particularly compelling especially when there was

a demonstrable sense that rather than these episodes of care being the exception and presenting unease and apprehension within the team, they appreciated the opportunity to provide such care:

“everybody in the team has the same ethos, and actually, quite what we quite enjoy is looking after a woman with complex needs at home, erm, but that’s quite an exciting part of the job I think.”

[Dawn]

This multidisciplinary team working approach not only strengthened the unity within the immediate team at the home birth but within the cultural context of the Trust. Erin also described an episode of care that, whilst not at home, influences her practice around supporting women with complex needs at home, acknowledging the power of such experiences in challenging pre-conceptions and fear:

“... this lady came in, and she was having...a VBAC, (in the) pool in the high-risk side and two of the midwives on the labour ward were like ‘oh no, I don’t want to look after her, ...this is risky’ and um I was like ‘I’ll do it! I’ll look after her’ . (I was) really, really proud of her afterwards because (she didn’t) realise what she’d just done, she’d had a normal birth in the pool, in an environment where people ... didn’t think she could do it, so she wasn’t just empowering herself she was empowering the midwives...”

[Erin]

The ‘Deviant Obstetrician’ figure emerged from all participants, outside of their immediate team but within the wider maternity service in which they worked. This figure was usually represented by participants as being an individual, demonstrating a robust patient-midwife-obstetrician relationship, fostering trust, mutual appreciation and respect for each other’s knowledge. They worked together with the woman and within the wider multidisciplinary team towards a common goal:

“we have a link consultant in the hospital... we meet with him regularly to discuss cases or email or phone him about women ... because where women might be a bit dubious about an appointment or ... don't feel like they particularly need to go into hospital... we can kind of chat to him and he might say, 'oh fine, if you've talked to her about that then I don't think there is any reason to see her necessarily, I'd agree with your recommendations, whatever, if you need any further input then refer her to me'...”

[Dawn]

Many participants revealed how they would attempt to have the women assigned under the care of this particular obstetrician in order to facilitate fair and balanced discussion, “protecting” the women from biased discussions in order to navigate the wider maternity system

“we have one fantastic obstetrician that supports us, and we try to have all of our women under her care if they need obstetric led care...[she will say] it's your decision to make and while we can't recommend a home birth we will still support you and I think that's quite refreshing in an obstetrician”

[Megan]

This ‘deviancy’ was explored as it relates to midwifery care being provided to traditionally complex women, having the potential to appear somewhat extreme and outside the scope of midwifery practice, particularly where midwives demonstrated a clear lack of fear or anxiety around complex home birth. This was rebuked by all of the participants, many explaining that the ease with which they provided care to women was grounded in their extensive clinical experience allowing for instinctual decision making. Participants trusted that a demonstrable lack of fear and anxiety around facilitating women’s choices and providing high risk intrapartum care at home enhanced women’s experiences of birth, supporting the notion that despite the risk of adverse outcome, women felt listened to, supported and above all trusted the physiological process of birth. Megan describing this phenomenon as ‘unconscious knowing’:

“we don’t transfer many women actually, I don’t...if someone accuses me of being blasé or over confident, I might think then, am I? Is that what I am? Or is it that I’ve seen enough births now to know, you just I don’t want to call it intuition or sixth sense, but you just recognise a pattern of something happening and you think “right, ok, we might need to do something here”

[Megan]

“(it is) quite strange ... I kind of feel like... particularly hospital based [midwives] can’t quite get this point of view...generally things don’t just go wrong out of the blue, so you are kind of kind of coming at it with that faith and positivity ... for the most part, for the women with complex needs theres a bit of planning and thinking about a breech or twins or whatever you tend to do your little skills and drills through as a team”

[Dawn]

Dawn explained succinctly that intuition and knowing arises out of experience and a firm understanding of the physiology of birth and parturition contributing to the success and safety of complex needs homebirth. She again identified the team around her as well as a trust between the women and the midwife providing safe care at that time:

“it’s a confidence in women’s bodies and their ability to make an assessment for themselves, there’s an, unrealistic thought that emergencies happen frequently and unpredicted (sic), out of the blue when most emergencies you can see coming...”

[Dawn]

Hospital-based midwifery and obstetric colleagues often perceived the participants with a degree of suspicion. This suspicion manifested in many forms ranging from inquisitive curiosity, subtle

undermining behaviour to outright hostility, both to midwives facilitating complex needs births at home and the women under their care, with the former seen in some way encouraging women to birth outside of what would be considered acceptable in within the traditional midwifery model:

“talking to other midwives, we do things that they don’t do, and they’re amazed that we do certain things and support certain women ... they find that quite surprising...”

[Megan]

All emphatically denied this, but acknowledged that this perpetuated their being seen as ‘deviant’ in practice, challenging the tenet of radical midwifery the participants so vehemently strive for:

“that can be difficult for us professionally, there’s this idea ...that we are always encouraging women to do something out of the guideline, or something strange, and, that we’re...mavericks in our practice ...”

[Dawn]

“...it’s always the home birth teams (that) get this tainted brush ... one of the Consultants used to call my team the ‘Radicals’... in a really negative context...it shouldn’t be them and us, it should be really good joined up working...”

[Erin]

Experiences as they relate to supporting and advocating for women’s informed choices, regardless of whether health professionals would agree with those choices or not was explored at length. Most participants were at pains to emphasise that they did not support ‘normality at all costs’ or lack recognition of events that have gone outside of what is considered normal. In order to provide *true* informed choice, there needs to be a full and frank discussion of risk and benefit (see the Conflicted

Midwife), but also an appreciation that women lead their own care and should be supported in their decisions:

“That’s the overarching thing...let’s try and support her and let’s hope we can help her achieve what she wants to achieve...”

[Gwen]

For many women with complex needs that existed prior to accessing maternity care, who may have been within medical or mental health services for years this may be the first time a healthcare professional has handed back control and offered choice, autonomy and agency:

“all of a sudden they’ve got this person who’s looking after them saying, “well tell me what YOU want to do”, and we’ll just go with that really and we’ll support you in what you want. I think the women really kind of respond well to that and perhaps the [medics] aren’t so, ofey with that and how being at home [can result in] having a really empowering experience”

[Dawn]

Megan rationalised the story of a birth that, despite going well, could have ended poorly, due to the nature of the complexities of the woman she was caring for:

*“I’ve also been accused of being too encouraging to these women.... I was clear it could have not ended well for that woman and her baby, but **she** made those decisions, **she** was given the information, **she** didn’t want to do the things I was asking her to do. I could have gone, all aggressive, but I don’t think that would have helped any more than, the way that I was with her, I don’t think she would have responded to that”*

[Megan]

The Conflicted Midwife

The Conflicted Midwife is one who whilst working within the constraints of a modern healthcare system and society, her position as a radical midwife is challenged. The complexities of the conflicted midwife are multifaceted and intrinsically linked to the radical midwife ideology as well as extrinsic factors including the wider multidisciplinary team, workplace culture and nature of the women presenting for care. They therefore cannot be made discrete from one another.

A keen sense of responsibility and obligation to support women with complex needs who choose to birth at home was evident, largely as a recognition that “*we broke them in the first place*” (Megan) and that ‘*the system*’ had let them down exposing intense feelings of frustration, angst and dissatisfaction with “*the ‘system’*”. The acknowledgment that as midwives within the NHS, they are *part* of the system means that participants held a strong sense of responsibility and obligation. Yet participants felt criticised and viewed with suspicion for attempting to remedy this dichotomy by supporting women’s choices:

“they are either coming to us because they are broken from their first experience so they either had a traumatic birth or multiple intervention, or a caesarean section because of failed induction because sometimes the bizarre reason that they have been induced in the first place, can sometimes just because the whole system has failed them”

[Megan]

Tara explained how some women made particular choices that would not be facilitated within the ‘system’ and by eliminating the element of choice, the resultant ‘push back’ meant that women sought alternatives, usually within the community setting, which often resulted in women choosing to birth at home as means of seizing back control:

“...you know all she wants is a pool birth, she doesn’t necessarily want a home birth, you know she is opting for a home birth because they won’t let her in hospital. So, I think we should be asking what do they want? why are they choosing to birth at home? is it because

they are not getting what they want?... are they opting for homebirths because we are not facilitating the appropriate care?..."

[Tara]

The conflicted midwife axiom therefore demonstrates an ideology of midwifery, the philosophy held by these individuals and the quality of the care they strive to provide for women with complex needs alongside the realities of providing this service. We must however recognise the exposure and vulnerability in providing care at home for women with complex needs, as Tara elucidates:

"the person that I am as a midwife providing care to women [at home] with complex needs, so obviously if somebody is doing something that professionally is dangerous, life threatening, anything like that then obviously, that impacts me as a person, professionally, emotionally, mentally, you know, I could get struck off is the worst-case scenario, professionally, financially that would impact me as I wouldn't have a job, you know, that kind of thing and then emotionally if a baby is lost or a mum is lost, you have to live with that"

[Tara]

Tara and Andrea succinctly illustrated how the lack of flexibility and compromise in providing 'out of guideline' care in hospital results in the 'push back' into community. With a little thought and planning, this could be negated:

"If a woman wants a VBAC waterbirth, that seems to be a hard thing to come by. However, they get them at home. I have facilitated a VBAC in the water, in the hospital and that woman fought hard for her rights to have that and demanded only community midwives to look after her as she felt they would provide that type of care...I had the privilege of being a part of that care on that day, but it shouldn't have been a fight in my world."

[Tara]

“... if they need continuous monitoring in hospital, use the telemetry. If they want a water birth, maybe labour in the pool and get out. Just a compromise really, most women are happy if they get some of what they want. It’s when they, sort of, walk in and people are just like, nah you can’t have any of it. That’s what really upsets me. People don’t try and think around it. You know, if the woman has got, Synto up and is on the CTG...how many of them are pinned to the bed? They don’t need to be...really, really makes me cross”

[Andrea]

There was also discussion around women requesting complex home birth not always being a ‘pushback’ against ‘the system’. Instead the choice is borne of a fully cognisant desire not to birth within a clinical environment. Overwhelmingly, participants understood this and did not necessarily see these requests as extreme or unusual; indeed, there was recognition that it was the woman’s right to choose, regardless of risk:

“...people that are not even necessarily looking for something wild and different... because there are some people who walk in saying they want to birth in the ocean or whatever and that’s fine, there’s people that will walk in and want to free birth – absolutely, that’s your choice”

[Tara]

“...women will make their decisions ...they will find that information out for themselves, most of them. But I think we need to give them all good, quality information, they will make their own decisions, they don’t need to be bullied, we just need to support them, and I think that will help practise as a whole. They know what they are doing...most of them.”

[Gwen]

The “us and them” conflict ran through the spectrum of care, with participants expressing dismay that a gulf exists between not only the Obstetric vs Midwifery paradigm, but between midwives working within differing models. Indeed, the recognition of that oppositional relationship was fervently argued, as well as a sense of loss of cohesive Midwifery philosophy. Tara presented an example of that dichotomy:

*“There’s a disparity between hospital and community anyway ... I’ve had a hospital midwife say to me that birth is **their** expertise, labour ward... it was their expertise and I’m like oh! What do you mean by that? She said well when things go wrong blah blah blah and I said well you try managing a PPH with two midwives on your own, in the countryside... that’s a different skill set altogether. If I go into the hospital at all, I find that emergencies in the hospital are chaotic and stressful ...I’ve been at an emergency at home, many emergencies actually, and sometimes women don’t even know there’s been an emergency because the two midwives have been so calm and quiet...If they’d been in the hospital and its more of a minor emergency, all hell would let loose and I think the woman would be more traumatised by that than the PPH that actually resolved after ergometrine... people are screaming for Synto ... we just systematically deal with it and transfer in...”*

[Tara]

There was also an overwhelming recognition that that the term ‘complex needs’ involves a continuum of obstetric risk and when planning care for these women the health professional’s perception of ‘risk’ may be at odds with the perception and acceptability of risk for women planning a complex home birth. As Erin explains:

“... even in a normal planned home birth, things can ... go wrong”

[Erin]

Risk discourse with women evoked passionate responses, often revealing frustration with risk assessment and communication, with an awareness of absence of consideration of a women's rationale and beliefs informing their choice:

“we treat them like naughty school girls sometimes, ‘well why would you want to do that, why would you want to risk your baby’s life’-you don’t talk to well-educated adults like that, give them information, they ... make a decision and they are allowed to make a decision that we wouldn’t make, because it’s not ours to make unless we are really concerned that they are making a choice, for not a sound reason, like mental health reasons, something like that, then why? Why should we interfere with that? We don’t know what their personal values are, because we don’t have the time most of the time to find out what they are, and understand why they are making the choices they make”

[Megan]

Andrea identified how women had an expectation of the reaction they are likely to receive when requesting a complex homebirth and that the reality is generally that midwives wish to foster an empowering relationship. Tara explained how jointly empowering women to reach a fully informed decision provides an element of personal fulfilment:

“She used the word “allowed” a lot, and I don’t like that word. Yeah, I’m not in charge of her. You know I wish health professionals realised that we are not in charge. Full stop. But, what we did, what I aim for is that... together, we make a plan for her care...give her all the information, the good the bad, and the ugly and then she makes the decisions, I support her to get that regardless of whether I would do the same in her scenario...”

[Tara]

“I think women are quite rightly getting more empowered, ... women are ... doing more research for themselves, and they are not just talking what we as ... the doctors, the midwives, the GPS, the whole healthcare spectrum, not just taking what we are saying as verbatim, that’s it, that’s that and I LOVE that”

Discussion

The findings of this study demonstrate that the experiences of midwives facilitating homebirth for women with complex needs are intrinsically linked to and firmly embedded within the woman's experiences and the individual's midwife's philosophy of care despite the manifestation of both intrinsic and extrinsic conflict. This data supports existing research findings which explore supporting women making alternative choices (Symon et al, 2010; Feeley et al, 2019) demonstrating a commonality in experience. The celebration of maternal autonomy and an ability to synthesise available information to aid fully informed decision making was evident (Symon et al, 2010; Jenkinson et al.,2016) with a recognition that women are not necessarily accessing health care professionals as their sole source of information, a finding supporting Hinton et al (2018) study and that as midwives there is a limit to how they influence that decision making.

The data confirmed previous studies findings that midwives understand that woman's previous birth experiences may impact on their decision making with a resultant 'push back' into the community as a means of 'taking back control' and exercising influence over their childbirth experience and there was commonality in feeling responsibility as being part of 'the system' and consequently this drove the pursuit of individualism in care planning, risk assessment and support of choices (Symon et al, 2010; Keedle et al, 2015; Bernhard et al, 2014; Lee et al, 2016).

Satisfaction was expressed in supporting women with complex needs choosing to birth at home despite underlying frustrations, not only during intrapartum care, but through guidance and navigation of antenatal maternity systems. This frustration arose mostly due to inappropriate risk discourse with colleagues and the multidisciplinary team. (Hollander et al, 2017; Feeley et al, 2019) as well as when being disregarded as mavericks simply due to retaining core principles as radical midwives supporting

informed choice. This was evident in the constant assertions from all participants that they were not striving for 'normality at all costs' and emphasis on their ability and commitment to escalating concerns when they arise.

This study has shown that this perception of their practice is wholly inaccurate as they have not only established their appreciation of the multidisciplinary team when discourse around risk is unbiased, grounded in evidence and appropriately conveyed, but by reflecting on their own vulnerabilities, there is unanimity in a fundamental practise philosophy of providing safe, informed, supportive care.

There must be acknowledged however, the potential for dissonance where attendance at a complex home birth is not always through choice. This exposes vulnerabilities for some midwives both from a professional and psychological perspective (Pezaro, 2015; Jenkinson et al, 2016). As Feeley et al (2019) suggest, Midwives views on providing such care is dependent on context, underlying philosophy of care and values. This exposes a limitation of this study in that participants were, on the whole, supportive of women with complex needs making the choice to birth at home. This is therefore a need for research exploring the experiences of midwives with differing philosophy of care.

Conclusions

It is no longer acceptable to assume home-birth for women with complex needs is exceptional. Far from risk being ignored by women and midwives alike, risk remains foremost in their minds when collaboratively making decisions, both parties recognising that birth is not without risk but that that adverse events, on the whole do not occur out of the blue. The key therefore to providing a safe and effective service both for women and midwives facilitating care is pre-planning, preparation and honest, constructive discourse with midwives, women and the wider multidisciplinary team to address and expand the evidence base and pathways to support those who are already facilitating this care and those who inevitably, will continue to provide care 'outside of guideline'.

Key Words

- High-risk home birth
- Outside of guidelines
- Complex needs
- Interpretative Phenomenological Analysis
- Experience
- Midwives
- Labour
- Intrapartum

Key Points

- Women with complex needs will continue to exercise agency and autonomy in decision making which may include opting for birth at home.
- Midwives providing care and supporting women's choices to navigate maternity services face challenges which may expose vulnerabilities, frustrations and conflict, facing accusation of being maverick and radical in approach.
- Midwives facilitating and navigating care with women are skilled and hold strong core beliefs in women's autonomy, the physiology of birth whilst balancing the need for safety.
- The key to providing supportive and safe care for women who choose to birth at home despite complex medical, obstetric, social and health needs is communication, honest and unbiased risk discourse supported with robust evidence.

Reflective Questions

- How do you respond to a woman with complex needs that makes a request for a home birth?
What communication techniques might you employ to develop a trusting relationship?

- Do you have experience of supporting women and their families in their home birth request in the presence of complex needs? What do you consider to be complex in relation to your practise?
- What strategies might you as a midwife use to encourage effective multidisciplinary team working?
- What factors influence your personal and professional resilience in supporting women who may make choices that challenge your practice philosophy?

Tables

Interpretative Themes	Superordinate Themes
The Radical Midwife	The Craft
	Professional Integrity
The Conflicted Midwife	Frustration
	Conflict
	Risk Discourse

Table One: Superordinate Themes.

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