Introduction

Where to give birth is one of the key decisions women face during pregnancy. Homebirth is widely recognised as a safe option for women with low risk pregnancies (Birthplace in England Collaborative Group 2011) but some women with risks associated with their pregnancies also choose to give birth at home, even though this is associated with an increased risk of adverse perinatal outcomes (Hollowell et al 2011). Reasons women choose for giving birth at home include previous negative experiences in hospital, organisational factors affecting the type of care provided, and perceptions of the care, healthcare professionals and locations available (McCourt et al 2011).

Women with pregnancy-associated risks who plan to give birth at home may face potentially difficult discussions with the professionals involved in their maternity care as their plans are likely to go against the recommended advice. There is no consensus in the wider literature on the definition of high risk pregnancy (ref removed for blind review), however guidelines from the National Institute for Health and Care Excellence, which inform much of healthcare practice in the UK, provide parameters for straightforward pregnancy and labour (NICE 2008; NICE 2014). It is usual practice in the UK for women with straightforward pregnancies to receive only midwifery-led care during pregnancy and childbirth and for women with pregnancy complications to received shared care from obstetricians and midwives (NICE 2008). Thus pregnant women discuss their choice of place of birth with their midwives and, in cases of pregnancies deemed to be at higher risk, with obstetricians as well.

How women perceive communication with healthcare professionals affects their satisfaction with care (Harrison et al 2003). Zandbelt et al (2004) found there was no correlation between professionals' degree of satisfaction following a consultation and how satisfied patients reported feeling. Professionals may also be poor at predicting which

patients are satisfied with care (McKinstry et al 2006). A positive experience of communication increases women's perception of competence in professionals (Pozzo et al 2010). This is important as a negative perception of interactions may lead to a loss of confidence in the service (Sjoblom et al 2012). Research into women's experiences of communication regarding planned place of birth is therefore relevant to any professionals involved in the provision of their care.

Professionals' views regarding the most appropriate place to give birth may differ from those of women. Sjoblom et al (2012) found women planning homebirths could be met with intimidating and emotional arguments to try to change their minds. Women believed professionals perceived the birth process as fraught with risk, whereas they found it an empowering process and focussed on the positive potential. Healthcare professionals may believe homebirth to be more risky than it actually is (Cheyney 2009). There may be differences between professional groups regarding women's care (Kruske et al 2013).

Research suggests there is little association between the risk perception of healthcare professionals and that of pregnant women (ref removed for blind review – study by authors). Perceptions of risk are constructed from meanings and impressions formed over the course of time (Coxon et al 2014) and are highly individual. However, within healthcare settings, the definition of risk becomes linked to power dynamics within relationships so that professionals' definitions and assessments of risk are prioritised and regarded as more authoritative and objective than those of patients (Lupton 1999). Pregnant women who do not follow advice from healthcare professionals may therefore be regarded as exacerbating their degree of risk and so face censure (Lupton 1993).

Women are concerned about the wellbeing of their babies and will do what they believe best to promote a healthy outcome for their pregnancy. This may not include following all recommended medical advice (Corbin 1987) including advice concerning place

of birth. Some women, including those with risks associated with their pregnancies, may perceive a hospital environment as increasing risk (Jackson et al 2012). Women actively interpret advice from professionals rather than accepting it at face value (Browner and Press 1996). It is therefore important to establish how women regard the advice they are given and the factors which influence their response to it.

This paper forms part of a larger study exploring risk perception and decision making processes in women with risks associated with their pregnancies regarding their planned place of birth. The aim of this paper is to investigate women's perceptions of their interactions with obstetricians and midwives in discussions regarding place of birth and pregnancy associated risks. Many social, cultural and individual considerations will influence where women choose to give birth and advice from professionals is only one potentially influencing factor. Understanding how women view these interactions is significant however for professionals to communicate in ways women find sensitive and respectful and work together with women to facilitate decisions about their healthcare (Levy 1999).

For the purposes of this study, the definition for high risk pregnancy was taken as women with obstetric or medical conditions which could affect the pregnancy and required referral to an obstetrician. Half the women in the study were planning to give birth in hospital and half were planning to give birth at home despite medical advice to the contrary. The intention was to consider differences and similarities between the groups and examine if perception of interaction with professionals relates to choice of place of birth.

Methods

Study design and population

This was a qualitative study using semi-structured interviews to examine risk perception and decision making processes in women with risks associated with their

pregnancies who were booked to give birth at home or in hospital. The interview schedule consisted of open-ended questions to explore (i) how women perceived the risks they were facing in pregnancy and (ii) their experiences of discussing their planned place of birth with healthcare professionals and other people. The interviewer also had the freedom to follow lines of enquiry introduced by participants. This paper reports the analysis and results of women's perceptions of interactions with professionals during pregnancies with associated risks (See Table 2 for interview questions concerning this topic). Other aspects of the study are reported elsewhere (reference removed for blind review). The aim of the study was to explore women's perceptions of communication with midwives and obstetricians and present and analyse their descriptions of their experiences.

Ethics approval for the study was obtained from the (removed for blind review) Research Ethics Committee.

The study was conducted in the United Kingdom and women were recruited via the maternity department of a National Health Service hospital which conducts approximately 3500 births a year. The department is broadly supportive of homebirths and the area has a homebirth rate higher than the national average. The department offers antenatal care to women according to National Institute for Health and Care Excellence guidelines so most women with pregnancies complicated by medical or obstetric conditions receive multidisciplinary care from obstetricians and midwives. The exception to this is women with up to two previous straightforward caesarean sections, who will only receive midwifery care in the absence of any other complications. In addition, women planning homebirths against medical advice will see a Supervisor of Midwives to discuss their plans. The aim of this appointment is to explore the reason for their choices and develop a plan of care for the births. The department does not operate a system of case-loading midwifery.

Women were eligible to participate if they were pregnant and had a medical or obstetric condition which meant their pregnancy was at higher risk and would therefore be advised against homebirth. Conditions defined as presenting risks included any that could potentially have an impact on the pregnancy and required referral to an obstetrician. Details of participants' medical and obstetric conditions are shown in Table 1 along with demographic data. Conditions of women varied across the groups but all meant women would be medically contraindicated for homebirths. Medical conditions and parity were not matched across the groups as qualitative research reports specific, detailed interpretations of participant's experiences rather than providing generalisable comparisons (Green et al 2014).

Information about the study was available in the antenatal clinic and women were also given information by obstetricians and midwives. Purposive sampling was used to recruit women planning to give birth at home. All potential participants were initially told about the study by their obstetrician or midwife when discussing their birth choices. Women planning to give birth in hospital, who were part of a larger population, were recruited randomly during antenatal clinics and were approached directly by the first author. Written consent to participate was obtained from all women.

Seventeen women planning hospital births and 14 women planning homebirths were approached to participate in the study. Thirteen women from each group agreed to participate. Ten of the women planning homebirths and eleven of the women planning hospital births had seen a midwife and an obstetrician in this pregnancy and two of the remaining women planning homebirths and one woman planning a hospital birth had seen an obstetrician in a previous pregnancy. Women were recruited after 30 weeks of pregnancy to ensure they had had some time to potentially consider their birth location. Interviews took place after 32 weeks of pregnancy and following discussions about place of birth with midwives and obstetricians. Following these discussions, the women were aware the

healthcare professionals would recommend they gave birth in hospital. Interviews were conducted in locations chosen by participants.

Interviews were carried out by the first author, an experienced midwife, under the supervision of the second author, a psychologist with experience of perinatal research. Women were aware the interviewer was connected with the hospital but were reassured about confidentiality. The study team was aware the interviewer's status as a midwife could influence the research and a process of reflexivity was undertaken to mitigate this (Lambert et al 2010). The interviewer reflected on her role both before and after interviews and the team held regular discussions on the potential impact of her values, perceptions and identity as a midwife on the interview process. Participants were encouraged to be open regarding their thoughts and feelings about their healthcare. The interviewer was not involved in the participants' healthcare. Interviews took place between April 2012 and November 2013.

Data analysis

Inductive systematic thematic analysis was used to analyse the transcripts. This is a systematic, data-driven approach to identifying, describing and organising themes and patterns within data and facilitates an in-depth exploration and understanding of it (Boyatzis 1998). This can be valuable for ensuring vivid descriptiveness in an exploratory study where participants may introduce new lines of enquiry (Burns 1989). The recorded interviews were transcribed with all identifying data removed. The transcripts were read several times to ensure familiarity with the data. Initial codes arising from the data were identified. These were refined and organised into potential themes. Initial codes included positive and negative experiences of communication with professionals and experiences of different communication styles between obstetricians and midwives. These eventually became the theme 'women's experiences of communication about risks in pregnancy'. The codes concerning ideas about how midwives and obstetricians perceive birth became the theme

'women's perceptions of professionals' beliefs about birth'. Codes related to overall faith in healthcare professionals and specifically midwives and obstetricians were amalgamated into the theme 'women's trust in professionals'. The theme 'women's attitude to professionals' advice' contains codes concerning the extent to which participants followed, personalised or rejected advice from midwives and obstetricians. The themes were reviewed in relation to the codes and the original data and finally were named and defined. NVivo 10 was used to organise the data.

Steps taken to ensure the method was rigorous and transparent included discussion between the study team of each stage of the process to ensure there was consensus regarding the themes and their supporting data. Inter-rater reliability was checked across themes to maintain quality in the coding process. Agreement was high (mean agreement was 97.6%, Kappa.97). Regular review of themes in relation to the original data ensured theoretical connectedness and an auditable process (Burns 1989). Heuristic relevance was preserved by relating findings to the existing literature in the field and to healthcare practice.

Findings

Four similar themes arose in both groups of women concerning perception of interactions with professionals. These were: women's experiences of communication about risks in pregnancy; women's perceptions of professionals' beliefs about birth; women's trust in professionals; and women's attitude to professionals' advice. Similarities or differences between the groups are discussed within each theme. Direct quotes supporting the themes are provided in italics, coded (Home1-13 and Hospital1-13) to maintain confidentiality.

Women's experiences of communication about risks in pregnancy

Women from both groups reported positive experiences with obstetricians and midwives. All the women appreciated professionals who acknowledged their concerns: *"they listen to you which I think is the main thing"* (Home13). Information giving was valued: *"if there was something I needed to know she would explain it and she would really try and give as much as she could"* (Hospital8) especially when the information did not appear to be biased: *"she explained all the facts and it was great in that I didn't feel any pressure either way"* (Hospital4).

Women from both groups also mentioned negative experiences. These included conversations when professionals personalised the discussion with comments like *"'if it was my wife she'd be having a c-section'"* (Home4). Feeling patronised was also a negative experience: *"when you try and talk to the doctors about some of the papers that I've read… you get dismissed… it's like I'm not capable of reading an academic paper"* (Hospital5).

Women planning homebirths reported feeling positively towards professionals who appreciated the care that had gone into their decisions: *"I wasn't a ten year old just doing a foolish thing but somebody who had understood the risks"* (Home11). Women planning homebirths also reported negative experiences with professionals who were perceived as exerting pressure to get them to change their minds through guilt or fear. They described being made to feel as though: *"you're being irresponsible and you're not thinking about the health of your baby or yourself"* (Home6).

Although women reported negative experiences with midwives and obstetricians, they generally spoke more positively of communication with midwives. This could be due to the approach taken to women: *"midwives just seem to be a lot more human about the whole thing… whereas doctors are very doctorly about things and you're just another patient*" (Home10), "*[the midwife] had that kind of empathy that I didn't find in the consultants"*

(Home13); or in the language used: *"I asked the nurse 'what did he say?' and she sort of explained it to me"* (Hospital10).

Women's perceptions of professionals' beliefs about birth

Women planning homebirths referred to obstetricians' perceptions of birth more frequently than women planning hospital births, and generally in a negative light. Obstetricians were believed to perceive birth as a risky process best managed with a medicalised approach: *"it's all a bit too risky and therefore they're not brave enough to look outside of that"* (Home3), *"[obstetricians] treat you like there is something wrong with you… they treat women like patients"* (Home10). This medicalised approach was seen as being at the expense of the woman's experience of the birth process and to reflect a balance of power: *"they are still doing the thing of delivering the baby [rather] than assisting the women to deliver the baby"* (Home11). Obstetricians were also believed to use caesareans for their own convenience: *"I honestly think it's easier for them it's scheduled, you can go in... it'll suit them…, you know, they've got a nice little schedule"* (Home2).

Women planning homebirths also made more reference to midwives' perceptions of birth. Midwives were seen as having greater faith in the natural birth process: *"with the midwives there's more of an understanding, more respect around the mother's intuition; the knowledge and the wisdom and the faith in the body to do what it needs to do"* (Home6). This approach was perceived as benefitting the woman: *"I just feel a lot more empowered by midwives cos they sort of trust you and trust your body"* (Home10). Women believed midwives perceived their role differently from obstetricians: *"[obstetricians] see themselves as delivering the baby more than the midwives, while the midwives maybe have the idea of helping the woman"* (Home11).

Women planning homebirths also mentioned fear of litigation as an influence on obstetricians' practice. The effect of this was perceived to be professional defensiveness resulting in unwillingness to support women's choices: *"it really feels like everybody's very worried about something coming back and biting them on the bum… that kind of fear is not conducive in itself for labouring and stuff"* (Home12).

Women's trust in professionals

Women planning to give birth at home often described a lack of trust in doctors: *"I think they're useless, most of them… they don't say anything that I don't know"* (Home13). These women often preferred to rely on alternative forms of healthcare: *"I think it's possible to be your own GP… I've self-diagnosed issues before and resolved my symptoms naturally through self-diagnosis"* (Home12).

Women planning homebirths frequently spoke of the trust they had in midwives. This enabled them to feel confident in the choice of a homebirth: *"I'm safer in that respect of having more consistency and more regular and more present care from a midwife who's experienced"* (Home6). They trusted midwives to monitor their wellbeing in labour: *"any midwife that comes out will be very much looking out for any problems"* (Home4), and to be able to remedy problems: *"I know that there's quite a few things that the midwives can do there and then without needing the equipment that is at the hospital"* (Home11).

In comparison, women planning hospital births more often referred to trusting the whole range of healthcare professionals: *"I think just having the reassurance like I mentioned before of having the professional people at hand. They've either had a baby themself or have delivered hundreds of babies... I just feel for myself I'm in the best hands"* (Hospital1). Professionals were seen as competent: *"I think I'd feel safe in the knowledge that if things started going a bit wrong they would know what to do"* (Hospital11); and well-motivated: *"I*

trust the medical profession and I trust that they want the best for me" (Hospital2). This trust was seen as warranted by professionals' expertise: *"They know best. They've done years of research and becoming a doctor. I've got no reason not to trust them"* (Hospital3). Among women who had given birth before, this trust was based on previous contact with midwives and obstetricians. Among primigravid women it stemmed from a more general faith in healthcare professionals.

Women planning hospital births spoke highly of midwives: *"these nice women are calm and they've been through it lots of times, which is exactly what you need"* (Hospital10), but they also felt there were limits to what midwives could do in emergency situations outside the hospital: *"it's within the limits of what a midwife can do and what people can do in your own home"* (Hospital7).

Women's attitude to professionals' advice

Women planning to give birth in hospital were generally willing to follow professionals' advice regarding their place of birth and in other aspects of their care. They mentioned having only brief discussions regarding place of birth: *"In the protocol obviously it says that if you're having twins then you should give birth in the hospital and I didn't really question that"* (Hospital5). They accepted their medical conditions would lead to hospital births: *"my expectations around birth and labour were very much driven by the medical profession… I hadn't gone through this huge thought process, decision making process, about the birth. And actually that's fine with me*" (Hospital2). Women regarded accepting professionals' advice as a means to achieving a healthy baby: *"[obstetricians should] do whatever you've got to do just to get her out, just to make sure she's safe"* (Hospital8).

Women planning homebirths more frequently described rejecting or adapting advice from professionals beyond that regarding place of birth. They questioned the blanket

application of hospital policies and pointed out the need to consider individual circumstances: *"these scales are based on white Caucasians of which I don't fit in, it might be that just my body reacts a bit differently than what this majority of people's tests have shown"* (Home8). They preferred to trust their instincts regarding their wellbeing if it contradicted advice: *"she said that I was bleeding too much, but I didn't feel that I was bleeding too much; and I was right, I was fine"* (Home1). When they did accept advice it was because it was perceived to be in their best interests rather than part of routine care: *"I've never said no but if there's a reason, if there is a necessity to do it then I will do it"* (Home2).

Women planning homebirths were willing to accept advice in emergency situations. They did not accept advice that they should give birth in hospital but if problems arose at home, they were willing to be transferred there: *"should we need to go into hospital, then we're not gonna argue, we're just gonna go with whatever needs to be done"* (Home8).

Discussion

The aim of this study was to examine women's perceptions of their interactions with midwives and obstetricians during pregnancies with associated risks in the context of where they were planning to give birth. It identified four themes: women's experiences of communication about risks in pregnancy; women's perceptions of professionals' beliefs about birth; women's trust in professionals; and women's attitude to professionals' advice. The study provides a rich insight into how women perceive interactions. It shows there are similarities and differences in attitude toward healthcare professionals between women who plan home and hospital births.

The study showed women from both groups described positive and negative experiences during interactions with both midwives and obstetricians. Women planning homebirths more frequently expressed the belief that obstetricians perceive birth as fraught

with risk whereas midwives have more faith in the natural birth process. They also more often questioned the applicability of advice to their personal circumstances and were more inclined to trust their own instincts when these contradicted professional advice. Women planning hospital births were more likely to express trust in obstetricians whereas women planning homebirths expressed more trust in the abilities of midwives. They more commonly followed professionals' advice and were less likely to question the advice. Parity did not appear to affect perception of healthcare professionals for women planning hospital births. The women from this group who had given birth before were generally more willing to trust professionals and regarded hospital care as the most likely source of safety. This suggests women may have an individual philosophy of risk and safety in childbirth already deeply held prior to, and not necessarily influenced by, their own experiences of birth (Regan et al 2013).

Women in the study perceived communication with professionals as positive when they believed their views were acknowledged. Negative experiences of communication included that which was dismissive, intimidating or believed to reflect clinicians' personal biases. This is supported by other research which has found women value professionals' expertise but also want to be acknowledged as experts regarding their particular circumstances (Van de Vusse 1999). If women's views are not acknowledged they are likely to feel frustrated and rejected (Berg and Dahlberg 1998). Women want to feel they are able to exercise a degree of control related to their healthcare and may be more willing to accept recommended medical interventions when this is the case (Van de Vusse 1999). They are also likely to detect latent communication from obstetricians reflecting personal biases if these contradict ostensibly unbiased recommendations (Goodall et al 2009).

Other factors which can affect communication include the extent to which healthcare advice is perceived as personally meaningful. Women are likely to regard communication

which does not take their cultural circumstances into account as irrelevant and so turn to alternative and more personally meaningful sources of information (Greenhalgh et al 2015). Time constraints are also cited as a barrier to improved communication (Pozzo et al 2010). Professionals perceive consultations which address women's psychological as well as physical needs may take longer. However research shows discussions with women by professionals who have received communication training to improve their skills do not take longer (Van Dulmen et al 2001).

Some women in our study perceived differences between interactions with obstetricians and midwives. Women planning homebirths described having more trust in midwives than obstetricians and being more questioning of obstetricians' beliefs about birth. They appeared to have quite fixed ideas about midwives' and obstetricians' approaches to birth. They did however refer to instances of positive communication with obstetricians which suggests holding generally unfavourable stereotypes of a profession do not impair women's ability to recognise and respond to individuals who do not conform to their negative expectations. Other studies have shown that women's perceptions of professionals involved in their maternity care can be altered and the therapeutic relationship strengthened (Van de Vusse 1999). Further research is required to establish what factors influence the degree to which perceptions of midwives and obstetricians is subject to change.

Obstetricians and midwives may have different perceptions of childbirth and their role in regard to women and this may well be communicated during consultations. Kruske et al (2013) found that although obstetricians and midwives believed the final decisions about care should rest with women, midwives agreed with this more strongly. Obstetricians were more likely to believe women's wishes should be overridden in the presence of safety concerns and midwives were more likely to disagree women having more control over decisions about care would compromise safety. Midwives caring for women with risks associated with their

pregnancies view their role as preserving as much of the natural birth process as possible for these women and believe this is best achieved through a sustained emotional connection with women (Berg and Dahlberg 2001). This connection includes giving of the self to form an authentic relationship. Midwives have also argued being too focussed on medico-legal risk concerns hampers the process of caregiving (Seibold et al 2010). This contrasts with research into the experiences of other professionals which found obstetricians caring for women with risks associated with their pregnancies may have anxieties around interacting with this group (Pozzo et al 2010). Obstetricians' philosophy of childbirth may also be at odds with that of midwives and pregnant women. Klein et al (2011) found obstetricians are increasingly less likely to believe caesarean section is qualitatively different to vaginal birth, or that vaginal birth can be empowering for women. This difference in philosophy may further hamper communication between obstetricians and women as Zandbelt et al (2004) found doctors expressed higher levels of satisfaction following consultations with patients who preferred to receive less information suggesting doctors may be less comfortable with women who question their care. This medicalised model of birth contrasts sharply with the social model in which professionals advocate for, and work in partnership with, women (Walsh et al 2002).

The study does not suggest that interactions with healthcare professionals had any influence on women's decisions to give birth at home. This may be due to the study design as there are potentially other women who would have chosen homebirth but changed their minds following discussion with healthcare professionals and who were not captured in the group of women choosing hospital births. Interactions with obstetricians and midwives also do not appear to have altered women's preconceived ideas about professionals' beliefs regarding birth. If women maintain deeply entrenched philosophies about childbirth, these may well not alter with only relatively limited contact with professionals with different

views. Women cite many reasons for choosing to give birth at home and, while safety is a consideration, advice from professionals is not described as a direct influence (Ashely et al 2012).

The study does however provide valuable insight into women's perceptions of interactions with midwives and obstetricians and how these could potentially be improved. Women value advice from professionals (Grimes et al 2014) but actively interpret its application to their individual circumstances. Faced with advice perceived as biased or unhelpful they will use a variety of strategies to avoid confrontation but still disregard the advice (Levy 1999). It is therefore an unproductive and inefficient use of time to attempt to engage women in discussions which are not respectful of their feelings and concerns. Women will avoid discussing subjects which they believe will elicit a negative response from professionals and may prefer to lie rather than engage in debate (Lindgren et al 2008). Respectful and sensitive discussion is more likely to elicit a positive, open response. Women expect to be treated as partners in the process of making decisions concerning their care during pregnancy and childbirth and are unlikely to cooperate with professionals they perceive as adversarial in their approach (Van de Vusse 1999).

If healthcare professionals are not able to communicate in ways which elicit a positive response from women, they risk being excluded from women's decision making processes regarding their plans for birth. This may have safety implications for women and babies. If professionals work in partnership with women and foster mutual respect for their knowledge and experience, safety can be enhanced and outcomes improved (Cannella et al 2014).

These findings have implications for professionals discussing place of birth with women. It is important to provide women with evidence based information but attempts to coerce women into certain decisions should be avoided. Behruzi et al (2010) believe it is

possible for high risk birth to be humanised, that is for the feelings, values and autonomy of women to be recognised, within a medicalised setting. If women are given high quality, unbiased advice, they can make robust decisions which suit their circumstances even if these do not agree with professionals' advice or available evidence (Say et al 2011). People often make decisions based on personal heuristic principles rather than professional advice (Tversky et al 1974). However, because these principles are based on a complete knowledge of the person's own circumstances, they may well lead to a successful decision for that person and so should not be discounted as a decision making tool (Gigerenzer 2014). Professionals' perception of risk has typically been seen as more reliable and objective than that of lay people (Chadwick et al 2014) but this view may need to be reconsidered if women with risks associated with their pregnancies are to be considered on equal terms during interactions with healthcare professionals. Healthcare professionals should therefore not expect their advice to be the most influential factor in women's decision making regarding place of birth. Time during consultations can be more profitably used to explore women's beliefs and feelings about birth to gain greater understanding of their motives and choices.

Limitations of the study include the fact that participants were aware the interviewer was connected with the hospital and therefore may have been reluctant to criticise care they received there. As with most qualitative research, the intention of the study was to create a nonthreatening and non-hierarchical environment so women felt comfortable voicing their thoughts and feelings. However women's awareness that the interviewer was a midwife may have had some impact on their answers. Any research within healthcare settings risks being affected by the power imbalance implicit in the system (Karnieli-Miller et al 2009). In order to mitigate this, women were given the opportunity to decline to participate in the study, and an assurance of confidentiality during the consent process. The interviewer was transparent about her role and the aims of the study and reflected on her potential impact. Participants

did generally describe midwives in more positive terms which may have been the result of them knowing the interviewer was a midwife. In addition, the women all came from a single city and were cared for by the staff of one hospital. The majority were white European and living with partners. Further research is therefore needed to address how women from different backgrounds perceive interactions with midwives and obstetricians. This study looked exclusively at women with risks associated with their pregnancies so further research should also examine perceptions of interactions by women with low risk pregnancies to see if these differ.

Professionals working with women with risks associated with their pregnancies should remember women are positive about communication which acknowledges their concerns and which imparts unbiased advice. If women choose not to follow this advice, including that regarding place of birth, this should not be considered a barrier to communication. Rather, professionals need to work with women to ensure they receive safe care which is suited to their individual circumstances and respectful of their values. Future research should examine how healthcare professionals' perception of risk shapes their communication with pregnant women and how they interact with women who are not following recommended advice. It could also address how differences in the perception of birth between midwives and obstetricians arise.

In summary, this study extends understanding of how women with risks associated with their pregnancies perceive interactions with healthcare professionals. It shows there are similarities and differences in feelings and beliefs between women who plan to give birth in hospital and those who plan homebirths. Professionals working with women with risks associated with their pregnancies should consider these factors when interacting with these women.

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Table 1. Women's obstetric and demographic details

Women's details	**Planning homebirth**	**Planning hospital birth**
	***n*=13 (%)**	***n*=13 (%)**
Medical/obstetric conditions		
Diabetes (inc Type 1 & gestational)	2 (15)	3 (23)
Previous caesarean section	7 (54)	6[a] (46)
Hypothyroidism	2 (15)	1[a] (8)
Von Willebrand's disease	1 (8)	-
Previous postpartum haemorrhage	1 (8)	-
Twin pregnancy	-	1 (8)
Osteoarthritis & hypermobility syndrome	-	1 (8)
Polycystic kidneys	-	1 (8)
Cardiac condition	-	1 (8)
Parity (no of prev births)		
0	-	7 (54)
1	8 (62)	6 (46)
2	2 (15)	-
3	-	-
4	3 (23)	-
Ethnicity		
White European	11 (84)	12 (92)
Hispanic	1 (8)	-
Mixed	1 (8)	1 (8)
Marital status		
Married/living with partner	13 (100)	12 (92)
Separated	-	1 (8)
Education (highest qualification achieved)		
None	1 (8)	-

GCSE	-	2 (15)
A level/Diploma/City & Guilds	3 (23)	3 (23)
Undergraduate	7 (54)	3 (23)
Postgraduate	2 (15)	5 (39)
Social class		
Class I	-	3 (23)
Class II	11 (84)	8 (62)
Class III	1 (8)	2 (15)
Unemployed	1 (8)	-

[a]One woman had a previous caesarean and hypothyroidism

Table 2. Interview questions

Information from professionals
Tell me about what happened when you talked to your midwife/doctor[a] about where you would like to give birth. What was helpful about talking to the midwife/doctor[a]? What was unhelpful?

[a]For the purpose of this study, 'doctor' refers to the woman's obstetrician.