Providing maternity care from outside the system: perspectives of complementary medicine practitioners

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Abstract

One in two Australian women use complementary medicine during pregnancy including consulting with complementary medicine practitioners for pregnancy-related health concerns. Yet, very little is known about the everyday care and practice of this group of health professionals as it relates to the provision of care to childbearing women. As such, this study aims to examine the perceptions and experiences of complementary medicine (CM) practitioners who provide care to childbearing women. Semi-structured interviews were conducted with 23 practitioners from six CM professions (acupuncturists, doulas, chiropractors, massage therapists, naturopaths, and osteopaths) who identified as providing care to pregnant and birthing women in their clinical practice. The participants described professional issues affecting their provision of care to childbearing women including scope of practice, regulation and standards, and practice-specific issues, all of which they linked back to their profession and the reputation of their profession among other health professionals and the community. The study results draw attention to the importance complementary medicine maternity care providers place on interprofessional collaboration as well as the barriers they face to achieving this collaboration. The insights afforded by this study have the capacity to inform new policy and practice initiatives to support improved interprofessional maternity care.

Keywords: complementary therapies, maternity care, pregnancy, interprofessional, regulation

Introduction

The use of complementary medicine (CM) – products and practices not commonly associated with mainstream medical practice or curriculum (Adams, Andrews, Barnes, Broom, & Magin, 2012) –is increasingly popular through many life-stages, including pregnancy (Frawley et al., 2013; Hall, Griffiths, & McKenna, 2011; Steel et al., 2012). A study of 1835 Australian women found that 52% used a CM product (herbal medicine, homeopathic medicine, essential oil, but excluding vitamins and minerals), and 48% visited a CM practitioner (chiropractor, osteopath, naturopath, acupuncturist, massage therapist) during their most recent pregnancy (Frawley et al., 2013). These figures align with global rates of CM use which primarily fall between 20 and 60% of pregnant women (Adams et al., 2009). A desire for more personal control (Frawley et al., 2015), a holistic approach to health, and to increase wellbeing during pregnancy (Warriner, Bryan, & Brown, 2014) are often associated with the use of CM. However, an absence of rigorous clinical research for many CM products and practices underscores concern by many conventional maternity health care professionals regarding CM use in pregnancy (Adams et al., 2011).

Background

In Australia, national statutory registration exists for osteopaths, chiropractors and acupuncturists offering protection of title, but not defining their scope of practice (Jon Wardle, 2010). The Australian government has been hesitant to extend professional regulation to new health professions (J Wardle, Sibbritt, Broom, Steel, & Adams, 2016) and as such there is currently no statutory registration for other CM professions such as naturopathy, homeopathy, massage therapy and doula practice (Steel, Frawley, Adams, & Diezel, 2015; J Wardle, Adams, Magalhaes, & Sibbritt, 2011). In the absence of registration, peak bodies (for example professional associations) set standards for the profession such as minimum

qualifications, continuing education and practice standards (J Wardle, Steel, & McIntyre, 2013). This has resulted in significant heterogeneity and variability in practitioner training, with many different professional associations supporting varying education and practice standards (J Wardle, Steel, & Adams, 2012). Moreover, it remains possible to practice these unregistered CM professions without adequate training, without being a member of an association, or without completing any formal training (McCabe, 2008; J Wardle, 2015).

Most Australian women birth in hospitals (96.7%) while 2.4% attend birth centres and 0.3% birth at home (Australian Institute of Health and Welfare, 2015). Women are encouraged to make their first contact with the maternity care system with a GP to confirm their pregnancy (Victorian Government Department of Health, 2011). Following this, the majority of antenatal care is managed through consultations or visits by a midwife, obstetrician or GP (Commonwealth of Australia, 2009). However, many women also consult CM practitioners during pregnancy for pregnancy related health concerns (Steel et al., 2012). Very little is known about the everyday care and practice behaviours of CM practitioners, either registered or unregistered, particularly within the context of maternity care (Steel & Adams, 2011). Beyond preliminary work from a small sample of CM practitioners (n=31) and midwives (n=53) (Diezel, Steel, Wardle, & Johnstone, 2013; Steel, Diezel, Wardle, & Johnstone, 2013), there is also an absence of information describing inter-professional communication between different CM practitioners who support women during pregnancy and/or birth, as well as a lack of insight into trans-disciplinary communication across conventional maternity care providers and CM practitioners. In response, the research presented in this paper examines the perceptions and experiences of CM practitioners who provide care to pregnant and birthing women without being formally integrated into the conventional maternity system.

Methods

Methodology/Research design

Semi-structured interviews were conducted with CM practitioners who identified as specialising in maternity care.

Data collection

CM practitioners in current clinical practice in south-east Queensland who identified as having a special clinical interest in providing care to pregnant women were recruited via relevant practitioner associations, through an 'expression of interest' email. Interested practitioners contacted the researcher and were sent an information letter outlining the study in further detail, including a guarantee of confidentiality and ethical considerations. Twenty-three interested practitioners responded, all of whom were included in the study (see Table 1). Thematic saturation (whereby no new or relevant material was produced from subsequent fieldwork) was attained with 18 participants, however all interested practitioners were interviewed to ensure a balance in the data collected across the different professions represented in the study. While a semi-structured approach was employed, the fieldwork was also conducted in a manner which remained sensitive to participants' own tellings and concerns. Participants were encouraged to respond in their own terms and to introduce new and additional issues as they deemed appropriate.

[Insert Table 1 here]

Semi-structured interviews were conducted for between 45 and 75 minutes using an interview guide developed from the literature and pilot work with a small group of CM practitioners. Interviews were employed for data collection as they prioritise data which captures participants' experience and perceptions rather than exploring group interactions as is the case in focus groups (Britten, 2000; Kitzinger, 2000). In addition, interviews enabled

involvement of practising clinicians within proximity to their clinical tasks and within the time constraints of their clinical commitments (Britten, 2000). A time and location suitable to each participant was chosen for the interview. The interviewer was a qualified CM practitioner (naturopath) with no previous relationship with participants, female and held a Bachelor of Health Science (Naturopathy) and Master of Public Health with experience conducting qualitative interviews of health professionals. At the time of this study the interviewer was completing a PhD. The domains covered by the interview guide included identity as practitioner, inter-professional communication, and women in care. Interviews were recorded via a digital recorder and then transcribed by a professional transcription service. Transcriptions were checked against the original recordings to ensure accuracy.

Data analysis

Descriptive data analysis was undertaken from the interview transcripts, using a Framework approach (Pope & Mays, 2013), after importing into NVIVO qualitative data analysis program. The analysis followed an established process of *familiarisation*, *identifying a thematic framework*, *indexing*, *charting*, and *mapping and interpretation* (Pope & Mays, 2013). In line with the Framework approach we have chosen to adopt an implicit theoretical approach (whereby the theory is not made explicit), as utilised in applied health care research in many fields including general practice (Benson, Quince, Hibble, Fanshawe, & Emery, 2005; Burroughs et al., 2006; Fisher, Bhavnani, & Winfield, 2009), nursing (Jansink, Braspenning, van der Weijden, Elwyn, & Grol, 2010), and health promotion (Hesketh, Waters, Green, Salmon, & Williams, 2005). The Framework approach provides structure with which to analyse data within this applied tradition.

The researcher undertook immersion in the raw data by listening to recorded interviews and reading transcripts. Following this stage, the data were charted to identify themes, and

analysed for intersecting concepts. The interviewer initiated the data analysis and a second researcher coded and charted the de-identified transcripts. All differences in interpretation were discussed until consensus was achieved to triangulate results. Quotes were selected based upon the quality of the quote and the representativeness of the theme.

Ethical Considerations

Ethical clearance was granted by human research ethics committees from the University of Queensland (#2010000411), University of Newcastle (#H-2010-0031) and University of Technology Sydney (#2011-174).

Results/Findings

The study included a mix of acupuncturists (n=6), doulas (n=4), chiropractors (n=4), massage therapists (n=3), naturopaths (n=4) and osteopaths (n=2). The analysis identified X major themes: *Professional practice outside of the system* with subthemes of *scope of practice* and *practice isolation*; *Professional regulation and standards*; and *Working with maternity care providers*.

Professional practice outside of the system

The participants described professional issues affecting their practice including scope of practice, regulation and standards, and practice-specific issues, all of which they linked back to their profession and the reputation of their profession among other conventional and CM health professionals and the community.

Scope of practice

Practitioners discussed health topics and conditions in light of what they considered either within or outside their scope of practice (see Table 2). Across all responses, a tension between achieving and/or conducting collaborative care and a perceived sense that CM

practitioners are 'filling the gaps' in existing maternity care was apparent in participant responses.

> *"So if you're seeing the obstetrician, often it's just very physiological based, so they're not really looking at the emotional care of the woman, or how her fear of this pregnancy or birth's going to be…. I know it's very individualised, and some people wouldn't ask questions that I ask, but I very much address women's psychological health, I suppose, in that regard, and whereas no one else is doing that in standard maternity care" (Naturopath 2)*

Practice isolation

Over half of the study participants described a sense of practice isolation and identified issues related to this experience. One practitioner, for example, expressed an interest in being a part of a larger care team but considered the work involved in establishing or maintaining a network impractical:

> *"But I guess yeah, in a way I'm just sort of head-down tail-up, I haven't got that twenty years ago spare time, or whatever you want to call it! (laughs) spare energy to go and create it myself, but I'm happy to be part of it, yeah." (Massage 6)*

> *"I think it's mostly just that we [all health professionals providing care to the same woman] don't get together enough, and make the time to do it." (Acupuncturist 19)*

Other study participants described a lack of interest from other CM practitioners in being a part of a collaborative network:

> *"I like to, but I've found that I've tried to get into contact with other doulas, and acupressure people, and things like that. And they don't really want to, I don't know, I've found they want to stick to themselves" (Doula 10)*

The reason for this disinterest in collaboration from other CM practitioners was most commonly perceived by study participants as due to business competition:

> *"[I] think also there's probably a lot of competition going on there, competing for clients, maybe?" (Acupuncturist 14)*

Business competition was also described as a potential reason for not referring in the first place:

> *"I guess there's also maybe a competitiveness there between practitioners too so that you don't really want to lose them to another practitioner especially as I don't know other practitioners around here I don't want to want to send them off to someone if I don't know them [the practitioner] that well in case they don't come back. Then I maybe lose face because they've discredited me" (Massage 6)*

Whilst CM practitioners in this study reported isolation in their practice many also reported satisfaction with the level of autonomy they experienced. As most participants were in solo

practice or practising independently in a shared clinical space many participants felt their ability to be clinically effective was linked to this autonomy.

Professional regulation and standards

Participants identified professional issues that extended beyond their own practice to the larger profession and education standards were the most commonly discussed professional issue. Regulation of practice, due to a desire for increased respect from other professions and concerns about unethical financial practice such as profiteering by practitioners from within their own profession, was also a key theme. As illustrated by the following quote, education standards were identified as a concern by some participants due to a lack of consistency across institutions and qualifications:

> *"I think the lack of consistency in education is very important. I mean even looking at the College where I am you know, that quality of what the students leave with has changed, changes a lot over time, so even that isn't consistent you know? So it's not consistent in the one College, let alone across colleges, right? So there's just such a lack of consistency you know?... It's a terrible worry!" (Naturopath 3)*

Participants also suggested that due to a perceived overall sense of not personally having sufficient education in maternity care, many participants felt compelled to actively seek additional professional development and training:

> *"I personally don't think I'm as educated as I'd like to be, and that's after a five-year degree. And I'm now doing another three-year kind of postgrad, to be educated more into ah, I know that this*

year we do have a kind of a midwifery section and things like that. I think it's extremely important, in order to have a more balanced treatment approach." (Osteopath 4)

"I guess there is a bit of a concern that there is a very small amount done during massage courses into pregnancy massage and to specialise in pregnancy massage is to me appears to be quite significant thing… I do my own bits of study, personal study to learn more about pregnancy massage…" (Massage 5)

Education standards of CM practitioners were also perceived by some participants as impacting on the ability for maternity care providers from other (non-CM) health professions to work alongside CM practitioners. In part this perceived hesitance was thought to be related to a lack of education in the practice of allied and conventional maternity care providers:

"Like we know that most kind of have the check-up at 12 and 20 weeks with their ultrasounds, but why obstetricians, and particularly those that are under the private sector, why do they have more frequent ultrasounds? I don't know." (Osteopath 4)

Other participants perceived that the lack of consistency in education standards in some CM professions created a negative view of that profession amongst conventional maternity care providers. Some participants posited that these concerns were often valid:

"So they need to see that there is consistency [amongst education standards], in order for them [conventional practitioners] to start having confidence, definitely." (Naturopath 3)

A few participants described these concerns around CM practitioner training as being largely based on ignorance in the community of the content and quality of CM practitioner training:

"Their concerns are probably that they [naturopaths] are not qualified enough to be making decisions about care during pregnancy, I'd say, because it's just a lack of knowledge I guess. They don't know what our training is based around…they have no idea that we are trained to a higher standard, and that we are practising evidence based medicine" (Naturopath 1)

"Yeah. I think it does come down to them not realising how things have evolved over the years, I mean the training involved in becoming a chiropractor is a lot more than people think. Yeah it's just, I think it is a lack of understanding of what we're about really, and it is not just "crack, crack, there you go.""
(Chiropractor 21)

Participants who were from CM professions in which the practitioners are trained in university programs felt that although university training created a unified high standard of education this often did little to impact on the view of their profession from conventional care providers:

"I think it [university education] created a standard. I don't think it impresses anyone." (Chiropractor 22)

In contrast to concerns about CM practitioner training, several participants expressed unease with CM content within conventional health care courses. The stated reason for this unease by participants was described as due to other health professionals having insufficient exposure to the CM practitioner's profession to allow appropriate collaboration:

"But they [conventional health professionals] don't get any training…So there was nothing to say "this is what an osteopath does, this is their level of training, these are the sort of things they do. This is what a chiropractor does, this is what an acupuncturist does, this is what a physio does," nothing! So they've got to form their own opinion, or make that information from, they gather from different sources." (Osteopath 7)

Participants also perceived that there was insufficient training of conventional providers to support clinical application of CM treatments, which conventional maternity care providers may be employing:

"If they've got four years of training, I'm perfectly happy for them to do it… I just don't think that they've got the depth of understanding of how Chinese medicine works"
(Acupuncturist 12)

Although participants often disagreed on the impact statutory registration may have on perceptions among non-CM health professions of the legitimacy of CM, statutory regulation was raised by a few practitioners, both from regulated and unregulated professions, as being intrinsically tied to improved education standards:

> *"To move forward [with education standards])…I think there probably needs to be more regulation…of natural therapists."* (Naturopath 1)

> *"Well lack of regulation!...that very clearly has created that situation… and the lack of consistent education is very strong in that as well"* (Naturopath 2)

> *"I think probably because now, if people understand that you're a registered health professional, I guess it's regulated that you have to meet a minimum standard, so everyone's kind of met that minimum standard to get their registration, but not necessarily had as much experience*" (Osteopath 7)

However, regulation was not always viewed favourably by participants due to a perception that the imposition of further regulation may limit practice:

> "*just think yeah, there's a fine line there and at this point with the government regulations and all that, doulas are outside that. And I think if we [doulas] started attaching too much of a health professional label to it, then they're likely to start making*

rules and regulations that will prevent, well will just put the role of a doula in a certain box." (Doula 16)

Working with other maternity care providers

Participants described a complex relationship with maternity care providers practicing within the conventional maternity system. The need to collaborate with other health professionals providing care to the same woman was identified by all practitioners in this study. For some participants this importance was linked to clinical outcomes – and was explained by participants as essential to ensure women were receiving appropriate care when health problems fell outside of the practitioner's perceived scope of practice:

"*Yes actually because I had someone with pre-eclampsia. I just noticed when she came to see me… she had a lot of fluid retention and she had high blood pressure and so I said, "you need to go and see your midwife." And she got admitted to hospital*." (Naturopath 1)

However, for most participants collaboration was via informal referral pathways, either by word of mouth or through other health professionals:

"A lot of times it is word-of-mouth, they've heard that ah, that I'll have a pregnant lady and she'll talk to other pregnant women." – (Massage therapist 18)

"And you know it's just, people hear it from different places, but a lot of times it's word-of-mouth." (Osteopath 7)

> *"Medical people send me people, so it might be their doctor that has said "I think you would benefit from a massage," or a relative or a friend has said "this is what you need."* (Massage therapist 6)

Some participants also described relying on word-of-mouth themselves to identify other health professionals to collaborate with or refer the women in their care:

> *"I look for mums who've had good results from that practitioner I'd probably go through that rather than a web advert, I'd go word of mouth rather than that I'd be more trusting of that hearing of other women's experiences"* (Massage 5)

As a result of the informal communication patterns between CM and conventional maternity care providers, the pregnant woman was often identified by participants as being the conduit between practitioners for important clinical and health information:

> *"If the patient is really conscientious and I, whether I know their midwife, I'll be like, "I think you really need to call this person," and "you need to get in contact with them as soon as possible." That's often sufficient enough."* (Chiropractor 13)

> *"Usually you ask the women to bring in their results or, usually the women will end up being the go-between, rather than you calling."* (Acupuncturist 14)

Whilst the majority of participants identified the need to collaborate with other health professionals providing care to the same woman as being important, a range of challenges

associated with current shared care arrangements were also highlighted. Prime amongst these challenges was a concern for a perceived low level of knowledge regarding the CM practitioner's treatments by other providers, particularly where conventional medicine providers were considered by the CM practitioner to be giving contradictory advice or recommending that women reconsider their use of CM:

> *"some didn't want to know about it, and "oh no, you don't need supplements, you don't need this, you don't need that" you know, and then you sort of dig a bit further and go, "oh well how much training do they have in nutrition?""* (Naturopath 1)

> *"So people that don't really understand herbs, as in pharmacist-type people"* (Naturopath 3)

This perceived lack of knowledge of CM practices by conventional providers was thought to create some hesitancy amongst practitioners that referral to another practitioner with whom they do not have a pre-existing relationship may result in loss of that woman from their client base. Women's response to these recommendations not to continue consulting with their CM provider were reported to have varied between continuing CM care without informing the conventional care provider, discontinuing consultations with the conventional care provider whilst remaining with the CM provider and discontinuing consultations with the CM provider while remaining with the conventional provider.

> "*Yeah we have some good doctors, and some doctors that probably don't have as good an understanding. (laughs) So there probably are a couple of doctors in the area that will say*

"don't see an osteopath" to their patients, and I've had their patients say "well I'm just not telling my doctor I'm coming, because you know, they say don't see you, but I get benefit."' (Osteopath 7)

"We [osteopaths] certainly hear back from parents, especially if we've referred to a GP or to a paediatrician, feeling that further investigation is needed. Then they will then often back and say, "oh the paediatrician said not to come to you any longer, but we're getting such great results."" (Osteopath 4)

Participants remarked that interprofessional tensions were often heightened amongst practitioners who worked with maternity care providers in person.

"But in births, I find it's very mixed, there'll be some midwives who think doulas are great, because it is extra support for the woman…But I've had a little bit of eye rolling, or you can just tell that they're not that pleased that you're there, that they think that you're in the way." (Doula 10)

Discussion

Our study provides critical insights into the experiences and perceptions of CM practitioners involved in providing pregnancy and birthing care. In particular, the findings from this study highlight the potentially significant role of CM practitioners in the delivery of maternity care while also underscoring the tensions experienced by CM maternity care providers when playing this role. The study results also draw attention to the importance CM maternity care

providers place on interprofessional collaboration as well as several of the barriers they face to achieving this collaboration.

Participants perceived their role to be filling gaps in pregnancy and birthing care that were not adequately addressed by conventional providers. This finding suggests that CM practitioners view their involvement in pregnancy and birthing care as a complementary measure to existing services, rather than as a replacement for them. The CM practitioners in this study demonstrated a preference for their services to be used as part of an inter-professional approach to pregnancy and birthing care. This view also accords with patient preferences, which suggest that most users of CM practitioners and products use these in conjunction with, rather than as replacement of, conventional care (Steel et al., 2012). However, the notion that CM practitioners are meeting an unmet need does appear to be supported by research: CM practitioners are already playing a significant role in pregnancy and birthing care, with women consulting CM practitioners for conditions ranging from back pain and fatigue to gestational diabetes and pre-eclampsia during their antenatal care (Adams et al., 2009; A. Steel et al., 2014; Steel et al., 2012). As such, further work which critically examines the opportunities for appropriate integration of CM practitioners within maternity care is warranted.

Yet our findings highlight barriers to formal collaboration at both the patient and practitioner level and suggest tensions regarding the most appropriate response from CM practitioners when faced with a lack of interest in collaboration from conventional maternity care providers. Communication with other providers was usually mediated via the woman directly rather than via formal communication or referral pathways, an approach which was considered ad-hoc and in some cases conducive to inaccurate clinical

information being shared. CM practitioners in our study also perceived a resistance among conventional maternity care providers to work with CM practitioners: in some cases this was perceived as being due to ideological opposition or lack of respect for the CM practitioner's skills or beliefs, but also due to conventional maternity care providers who supported CM only extending this support if a conventional practitioner provided the CM. However, these perceptions may overlook the attraction of CM to some conventional maternity care providers (Adams et al., 2011). For example, research suggests that positive views towards CM may be the result of midwives adopting CM to help reinforce the holistic principles and partnership model of midwifery practice rather than driven by a desire to co-opt CM (Adams et al., 2011; Hall, Griffiths, & McKenna, 2015).

While both CM and conventional maternity providers in our study and previous research report perceiving the existence of professional barriers between CM and conventional maternity care communities, these perceptions can be broken down quickly with even minimal interprofessional initiatives. For example, interprofessional education workshops can be developed which promote awareness of the role of other professions and a shared understanding of maternity service delivery (Steel, Wardle, Diezel, Johnstone, & Adams, 2014). As such, barriers and facilitators of CM integration into conventional maternity care as well as factors which influence interprofessional relationships between CM and conventional maternity care providers warrant further examination. This additional research is needed to not only identify what CM practices or services are most appropriate (and most inappropriate) for integration, but also to examine how inter-professional tensions can be sustainably managed to ensure inter-professional approaches to maternity care provide maximum benefit – and minimum risk – to pregnant and birthing women.

CM participants view themselves as practising 'outside the system', and evidence would appear to support this being the case (Diezel et al., 2013; Steel et al., 2012; Steel et al., 2013). Yet there may be some advantages to incorporating CM practitioners in formal inter-professional collaborations related to pregnancy and birthing, particularly as this would enable improved interprofessional communication and coordination of maternity care across the entirety of the health care team. Most women who use CM during pregnancy or birthing do not disclose this use to their conventional provider (Hall et al., 2011), and participants in our study also identified that the informal nature of collaboration might be an exacerbating factor in non-disclosure as it relates to maternity care. Reasons for non-disclosure among general CM users are often passive (e.g. patients neglecting to report their use as the issue is not raised in conversation or deemed to be important), but more active factors can also be at play (Foley, Steel, Cramer, Wardle, & Adams, 2019). For example, non-disclosure of CM use for fear of negative attitudes from their conventional providers has been consistently observed in general settings (Foley et al., 2019), and has also been identified as a reason for CM non-disclosure in maternity care settings specifically (Holst, Wright, Haavik, & Nordeng, 2009). However, given that many CM have not been adequately researched, or that CM have research indicating potential risks if used improperly (Adams, 2011), appropriate disclosure is essential to ensuring the safety of women during pregnancy and birthing.

Maternity care providers have previously expressed that they lack confidence in their own CM knowledge and therefore their ability to appropriately inform women in their care on CM issues (Adams et al., 2011; Hall, McKenna, & Griffiths, 2013; Mitchell, Williams, Hobbs, & Pollard, 2006). This previous research suggests that the formal inclusion of CM content experts may help improve communication about CM between conventional maternity care

providers and pregnant women (Foley et al., 2019). Additionally, one of the primary motivations for using CM during pregnancy and birthing is to combat women's perceived medicalisation of birth (Gaffney & Smith, 2004; Holst et al., 2009). As such, there may be an additional cultural resistance to discussing CM use with conventional providers beyond the fear of a negative response to CM use. Therefore, CM practitioners may be well-placed to discuss CM use with pregnant women and relay this information to conventional providers as part of an inter-professional collaboration. Additionally, conventional maternity care providers may need to remain aware of the potential motivations driving CM use when discussing CM with pregnant women in the care.

Our study also shows that while competitive tensions with conventional maternity providers were significant to CM practitioners, it was also apparent that such tensions may also be observed *between* CM practitioners themselves. This finding has also been observed in general health settings outside maternity care (J Wardle, Adams, Lui, & Steel, 2013). Such intra-professional tensions may be the result of the status of CM existing wholly outside the mainstream health sector, and as such may be minimised via more formal integration into it. However, these tensions may also be suggestive of immature professional development within the CM professions. Some of the infrastructure usually associated with mature professional development – such as the development of consistent standards and an adequate regulatory structure – is notably absent in many CM professions. This absence of infrastructure can result not only in the significant heterogeneity of training and practice standards among practitioners but also varying levels of accountability and public protection (Sibbritt et al., 2016; J Wardle, 2014; J Wardle et al., 2016).

CM practitioners in our study suggested that the absence of regulation meant that it was difficult for them to identify appropriate CM colleagues for referral even within their peer groups. For conventional practitioners – or patients – unfamiliar with the CM practice environment such difficulties would be even more pronounced, leading to barriers to referral and integration even if they are supportive of such integration in principle (J Wardle, Sibbritt, & Adams, 2014). CM practitioner integration into maternity care should only occur if it can be managed in a safe and effective manner (Leach, Steel, & Adams, 2019). Issues associated with nascent professional development appear to be fully acknowledged by CM practitioners, who also appear willing to further development of their professions consistent with a level appropriate for integration (J Wardle, Steel, Casteleijn, & Bowman, 2019). However, CM professions may lack the capacity to discharge this process fully without external support, and further professional development within these professions should be both adequately supported and encouraged.

It is important to remain mindful of the limitations to this study. Selection bias is a study limitation, since non-responders may have a very different experience of providing care compared with responders. Furthermore, the study relied on self-reporting, and as such the findings can only be viewed as perspectives and experiences, rather than practice patterns and behaviours. The interviewer's personal attributes and characteristics may also have influenced the nature and content of the interviews. While the interviewer was a qualified CM practitioner, she is also experienced in conducting qualitative research and as such was conscious of minimising the influence of her other professional qualification on the dynamics with study participants. The qualitative nature of the methodology also means that the findings should not be seen as representative of CM maternity care providers, but

rather an opportunity to gain insight into a previously unexplored area of contemporary health care.

Concluding comments

This study identifies the potentially significant role played by CM practitioners in contemporary maternity care and the desire for improved interprofessional collaboration with other maternity care providers – a drive experienced by CM practitioners as limited by structural and regulatory isolation. The insights afforded by this study have the capacity to inform new policy and practice initiatives within maternity care to support improved interprofessional maternity care for the benefit of pregnant and birthing women. These findings also underscore the need for further research into the safety and effectiveness of not only specific CM treatments, but also CM systems of care. Equally, future research must include a closer examination of the factors impacting on effective CM and conventional maternity provider relationships to ensure any future steps to improve integration of CM into conventional maternity care are undertaken appropriately and have the best chance of success.

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Conflicts of Interest

No authors have a conflict of interest to declare.

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Table 1: Practitioner groups of participants

Practitioner group	Number of participants
Acupuncturist	6
Doula	4
Chiropractor	4
Massage therapist	3
Naturopath	4
Osteopaths	2

Table 2: Practitioner-defined scope of practice for maternity care amongst complementary medicine professions

	Chiropractor	Acupuncturist	Doula	Massage	Osteopath	Naturopath
Birth	I	-	I	-	-	-
Birth Education and information provision	I	I	I	O	I	I
Breech and induction	I	I	I	-	I	O
Fertility and preconception care	-	I	-	I	-	I
Nausea and vomiting	-	I	I	-	-	I
Nutrition/dietary counselling and support	I	I	I	-	-	I
Pain	I	I	I	I	I	-
Postpartum	-	-	I	I	-	I
Psychological support and	I	I/O*	I	I	O	I

stress management						
Wellness	I	I	I	I	-	I

I = included in their scope of practice; O = outside of their scope of practice

*some respondents considered within their scope of practice and others outside their scope of practice

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