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Exploring trust within the midwife-mother relationship

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This paper is a personal reflection on the journey of trust within the midwife-mother relationship, highlighting its significance in modern maternity services and advocating for its continued cultivation and prioritisation. While in this article, 'woman', 'women', 'she' and 'her' are used to refer to the person giving birth, this is in no way meant to exclude birthing people who do not identify as women.

My perspective on relationship-based trust:

Relationship-based trust is a mutual confidence and reliance that develops between individuals over time within the context of their interactions and shared experiences. It is built on a foundation of honesty, integrity, and consistency, where each party believes in the other's competence, intentions, and commitment to the relationship.

Background:

In 2008, I embarked on a journey that would lead me to research one of the most fundamental yet intricate aspects of healthcare: trust within the midwife-mother relationship. Now, as I reflect on my research, published in 2017[1] I am struck by the profound impact it has had on my understanding of the dynamics between midwives and mothers during the birthing process. This reflective paper revisits the foundations, methodologies, findings, and implications of my study, shedding light on how the concept of

trust has evolved and remained relevant in the years since its publication. Join me as we delve into the complexities of trust in the midwifery realm, re-examining its significance and exploring the pathways it creates for nurturing a supportive and empowering environment for mothers and midwives alike.

Research summary:

My PhD research explored the concept of trust within the midwife-mother relationship, aiming to deepen our understanding of individual women's experiences of trust and its significance within the caring relationship. Employing a **hybrid model approach**,[2] underpinned by a **Heideggerian phenomenological perspective**,[3] the study seamlessly integrated theoretical concepts with **empirical data**.[4] Longitudinal semi-structured interviews were conducted with women navigating through the journey of becoming a mother at three key time points: early pregnancy, 37 weeks of pregnancy, and 8 weeks postnatal, with a **purposive sample**[5] of nine women experiencing uncomplicated pregnancies and receiving continuity of carer. **Thematic analysis**[6] revealed that trust evolved over time as a series of building blocks, influenced by the developing relationship between midwife and mother.

Initially, trust is associated with an expectation of midwife competence, but it becomes more nuanced as the relationship progresses. The study highlighted the importance of women's agency in developing a two-way trust, where the midwife also trusted the woman. Key themes identified included the need for trust, expectations, the nature of the midwife-mother relationship, the impact of continuity of care, and the significance of women's agency. This research provided valuable insights for clinical midwifery practice, emphasising the dynamic nature of trust and its pivotal role in fostering positive birthing experiences.

Trust within the context of today's maternity services:

In today's maternity services in the UK, trust within the midwife-mother relationship holds a central and dynamic position. Midwives play a crucial role not only in providing clinical care but also in facilitating emotional support and empowerment for mothers throughout their pregnancy, childbirth, and postnatal period. Trust is essential as it forms the bedrock of this relationship, fostering an environment where mothers feel safe, respected, and empowered to make informed decisions about their care. With the increasing emphasis on woman-centred care and continuity of midwifery support, the role of trust has become even more significant.

In 2013 Coxen et al published a study[7] about how discourses of risk, blame and responsibility influenced women's birth choices. They argued that planning the place of birth is mediated by cultural and historical associations between birth and safety, and further influenced by prominent contemporary narratives of risk, blame and responsibility. I believe that the growing number of reports of bad care, shared via social media, has damaged the reputation of maternity services in the UK and significantly impacted trust within the midwife-mother relationship. Negative publicity, whether through news reports or social media, can erode trust by creating doubt about the quality and safety of care provided. Mothers may feel anxious or hesitant to engage with midwives or maternity services, fearing that their

own care may be compromised. In 2018 there was a global call to action for respectful maternity care and Betron et al (2018)[8] examined the links between inequalities and unequal power dynamics and the quality of care and women's capacity to exercise their rights. The limited evidence available showed that pregnant and labouring women lacked information, voice, and agency to exercise their rights. Mistreatment of women inside and outside of the health facilities was normalised and accepted, including by women themselves.

I hear from midwifery colleagues' anecdotal evidence that a growing number of women today are choosing to freebirth or seek the services of doulas to ensure that they can remain in control of decisions surrounding their care. Ford, Crowther and Waller (2023)[9] wrote about midwives' experiences of personal and professional risk when providing care to women who declined recommendations, and their willingness to support such care. Their argument revolves around the violation of women's rights to bodily autonomy and choice in childbirth, and the restricted access to safe midwifery care for physiological birth, within maternity systems that are adversarial toward midwives providing the care women want. Midwives who offer such care often face risks including damage to their reputation, conflicts with colleagues, intimidating disciplinary processes, inner conflicts, and significant psychological strain. Despite these challenges, these midwives persist because they believe it is ethical and morally right, recognising that women depend on them. However, maternity systems and colleagues can pose significant risks for these midwives, particularly those who support women in declining recommendations. These risks can render it unsustainable for midwives to continue providing woman-centred care, contributing to workforce attrition, and limiting options for women, paradoxically increasing risks for both women and babies.

Literature is growing exploring the psychological and physical impact of birth trauma from the perspective of both those who experience poor care resulting in sad loss and those who have felt betrayed, bullied, and abused by a care pathway that was not of their choosing and a system that would not support their needs. Rebuilding trust in such circumstances requires transparency, accountability, and a commitment to addressing underlying issues, reassuring mothers that their concerns are being taken seriously and that steps are being taken to improve care standards.

Developing understanding as a cornerstone to building trust:

Recognising the significance of understanding and trusting women has been a valuable lesson for me since completing my PhD. National initiatives promoting greater cooperation and co-production with service users in the development of new care models have become a significant political priority. However, in practice, there seems to be a disconnect between the political push for user involvement and the prevailing culture, where reciprocal trust based on relationships and shared decision-making are often challenged. Crowther and Smythe (2016)[10] describe the importance of relationships in rural midwifery care; they suggest that relationships are built on mutual understanding attuned to trust and that trust culture builds healthy communities of practice[11] where collaborative learning, open respectful communication and acknowledgment of personal and professional differences enables focus on what matters most - safe positive childbirth.

I believe that 'understanding' is the cornerstone of the midwife-mother relationship. It appeared that the women in my study grasped this concept well, which is why it was crucial for the women that the midwife truly 'knows' them. It is possible that they need to establish this understanding so that trust can be an informed decision, rather than blind trust. The women in my study possessed an understanding of the system, the midwives, and how to collaborate with them and they often talked about trust as though it were a given, yet never described it as absolute. The thing that appeared to hold them back was believing that the midwife understood them and was able to trust them in return. As I reflect on the changes in maternity services since my PhD I wonder if this notion of reciprocal trust would be even more important today, where a reliance on intervention and technology over relationship building has changed women's experiences of maternity care.

While on holiday, I had a moment of reflection about trust as I went for a swim in the Mediterranean Sea. The day was beautiful, and the water was refreshing, but the waves were quite high. Despite being a good swimmer, I found the waves splashing over my head and in my face unpleasant. As I tried to stand firm on the bottom, the waves crashed harder around me, pushing me over. I realised that by floating instead of fighting, I could ride with the waves. As I relaxed, I noticed the waves gently bobbing me up and down near the shore, and I felt safe, comfortable, and trusted the water. It struck me as bizarre to trust the sea, but then I had a light bulb moment: it's not just about trust but understanding. Trust without understanding could be mere stupidity. Trust with understanding, on the other hand, could be comfortable. Trust isn't about blind faith in medical advances or an expectation of perfection within a service. It's about comprehending the options, possible outcomes, weighing risks and benefits, and truly 'knowing'. I knew what was happening in the sea, accepted it, and understood the potential outcomes. So, I was able to relax, be comfortable, and trust. If we are to maintain a culture of trust within maternity services and the midwife-mother relationship, we must prioritise systems that enable relationship building and understanding.

Benefits and challenges of building trust through the model of continuity of carer:

One of the advantages of continuity of carer models lies in the relationships that midwives can form with women and their families. Sandall (2017, updated 2024)[12] suggested that the advantage of relational

continuity was the development of a therapeutic relationship between the user and midwife, which over time positively impacts experiences and outcomes. Bradfield (2019)[13] described the trusting relationship as central to being 'with woman'.

In my postdoctoral research study, which delved into midwives' experiences of providing continuity of care (Lewis 2020),[14] midwives described continuity as a facilitator in getting to know women and developing understanding. The data highlighted the benefits of this acquaintance, including an increased understanding and empathy that fostered a buildup of trust, mirroring findings in Rayment-Jones et al.'s (2020) study[15] on continuity of care with vulnerable women.

In my study, the primary challenge in working with the new model was the on-call system, particularly the number of on-calls expected of midwives. The data illustrated times when this was particularly challenging, especially during periods of high activity or when the team experienced staff shortages. However, there was an acknowledgment that the new model had some advantages too. There was a perception among midwives that despite being on call for more days, they were called less frequently than in the standard model. This perception stemmed from the belief that women who were familiar with the midwives would only call out of hours when they truly needed to, rather than for less urgent inquiries. This phenomenon was linked to the establishment of relationships and mutual understanding. There is limited evidence in the literature on studies exploring this phenomenon, and I believe it warrants further investigation, particularly in relation to building trust.

Continuity of carer models, where women are supported by the same midwife or small team of midwives throughout their maternity journey, have been shown to enhance trust by promoting familiarity, consistency, and personalised care. However, in the context of today's maternity services, challenges such as staffing shortages, resource constraints, and institutional pressures have impacted the development and maintenance of trust. Therefore, it is crucial for maternity services to prioritise practices that nurture trust, including effective communication, shared decision-making, and supportive relationships between midwives, mothers, and other healthcare professionals, ensuring that trust remains at the heart of maternity care in the UK.

Closing remarks:

Relationship-based trust is a cornerstone of effective healthcare, fostering mutual confidence and reliance between individuals. Rooted in honesty, integrity, and consistency, it forms the basis for fruitful interactions and shared experiences. My PhD research aimed to deepen our understanding of trust within the midwife-mother relationship. The study revealed that trust evolves over time, influenced by the developing relationship between midwife and mother. It became apparent that trust is not a static concept but rather a dynamic process, shaped by understanding, empathy, and shared experiences.

I believe that building trust requires understanding and reciprocity. The women in my study emphasised the importance of being truly known and understood by their midwives. They sought mutual trust, not blind faith, in their caregivers. This notion of reciprocal trust is even more crucial today, amidst a

changing landscape of maternity care. Thus, it is imperative to prioritise practices that nurture trust, including effective communication, shared decision-making, and supportive relationships between midwives and mothers.

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[1] Lewis M, Jones A, Hunter B (2017) Women's Experience of Trust Within the Midwife–Mother Relationship. International journal of childbirth Volume 7 (1), 40-52.http://dx.doi.org/10.1891/2156-5287.7.1.40

[2] **Hybrid model approach:** Hybrid research is a combination of research techniques such as qualitative and quantitative. **Quantitative research** is numeric and objective, seeking to answer questions like how many, how often or how much. **Qualitative research** is concerned with subjective phenomena that can't be numerically measured, like how people experience an event, how they feel, or why they behave in a certain way.

[3] **Heideggerian phenomenological perspective:** Based on the ideas of Martin Heidegger, this approach provides the qualitative researcher with a structure for analysing the lived experience of study participants.

[4] **Empirical data:** Data collected from empirical research, which is simply any form of research based upon direct observation.

[5] **Purposive sample:** An intentionally selected group of study participants based on their characteristics, knowledge, experiences, or some other criteria.

[6] **Thematic analysis:** A method of analysing qualitative data. A set of texts, such as an interview or transcripts are closely examined to identify common themes – topics, ideas and patterns of meaning that come up repeatedly.

[7] Coxon, K., Sandall, J., & Fulop, N. J. (2014). To what extent are women free to choose where to give birth? How discourses of risk, blame and responsibility influence birth place decisions. Health, Risk & Society, 16(1), 51–67. https://doi.org/10.1080/13698575.2013.859231

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[11] Editor's footnote: "Communities of practice are formed by people who engage in a process of collective learning in a shared domain of human endeavor"www.wenger-trayner.com/introduction-to-communities-of-practice

[12] Sandall J, Fernandez Turienzo C, Devane D, Soltani H, Gillespie P, Gates S, Jones LV, Shennan AH, Rayment-Jones H. (2024) Midwife continuity of care models versus other models of care for childbearing women. Cochrane Database of Systematic Reviews 2024, Issue 4. Art. No.: CD004667. DOI: 10.1002/14651858.CD004667.pub6. Accessed 11 May 2024.

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[15] Rayment-Jones, H. Silverio, S. Harris, J. Harden, A. Sandall, J. (2020) Project 20: Midwives' insight into continuity of care models for women with social risk factors: what works, for whom, in what circumstances, and how. Midwifery, Volume 84, 102654, ISSN 0266-6138, https://doi.org/10.1016/j.midw.2020.102654.