AIMS For a better birth...

Trust in maternity care – Going, going, gone?

AIMS Journal, 2024, Vol 36, No 3

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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.

What is trust?

Trust has been of interest to academics working in a variety of fields, including psychology, sociology, philosophy, theology and economics. There seems to be general agreement that:

> *Trust is the belief that another person will do what is expected. It brings with it a willingness for one party (the trustor) to become vulnerable to another party (the trustee) on the presumption that the trustee will act in ways that benefit the trustor.*[1]

For someone to trust another, she or he must be confident that the other person has good intentions. The trustor is willing to follow the advice of the other person (or group of people such as a profession) because she believes that this person knows 'the truth'; will tell the truth as they know it; and have the trustor's best interest at heart.

The key components of this definition are that the trustor is vulnerable, and that the trustee has integrity

and will act in such a way as to meet the expectations and needs of the trustor. Perhaps the most vulnerable of all people in our society are babies and young children, and this is why 1001 Days practitioners put so much effort into educating and supporting trustors not to let their tiny trustees down. Babies acquire an understanding of trust when their carers respond to their fears and distress consistently and lovingly. People whose earliest experiences lead them not to trust will struggle to form healthy, satisfying relationships over their life-course.

In the case of maternity services, we find another group of exceptionally vulnerable people, namely birthing mothers. First-time mothers in particular need to be able to trust their midwives to be confident in their ability to birth their babies and to convey that confidence strongly in the way they communicate with them, touch them and support them. Their midwives' confidence signals to the birthing mothers that they are strong women, able to make the transition to motherhood and to cope with the challenges motherhood brings. During pregnancy, women's self-concept undergoes radical reformulation including their understanding of who they are, of the key relationships in their lives and of how they want to conduct their lives. During labour, that self-concept undergoes further transformation so that by the time they have birthed – twelve hours, a day or two days later – they are literally different people from whom they were only a short while before. The confidence midwives demonstrate in their ability to make good decisions that are right for them is a powerful yeast in this transformation.

Until the mid-twentieth century, birthing mothers placed their trust in women whom they already knew. The trustees were their own mothers or female relatives, or community midwives who knew local families well and may have been at the birth of two or even three generations of the same families' babies. Today, birthing mothers are expected to place their trust in midwives whom they generally do not know. They do so because they trust the profession to which midwives belong; they trust that, as professionals, midwives adhere to codes of conduct and ethics that make placing trust in them a reasonable thing to do; they share in that confident expectation that midwives *'can be relied upon to act with good will and to secure what is best for the person seeking help'* (Carter, 2009:393).[2]

It is in many ways a leap of faith to place our trust in complete strangers. However, as citizens of an 'advanced' economy with a highly regulated, evidence-based health service, we have been programmed to trust that we will get excellent care when we encounter healthcare professionals.

The problem is, as we are all beginning to understand from the relentless exposure of failures in maternity services across the country (Morecambe Bay,[3] Shrewsbury and Telford,[4] East Kent,[5] Nottingham[6]), that the trustees are sadly conflicted. They may be relied upon to act with good will – instances of healthcare professionals acting with deliberate malice are fortunately rare - but they cannot be relied upon to 'secure what is best' for the birthing mother because the mother's concept of what is best may be at variance either with the trustee's, or with 'the system's' concept. The trustee's concept of what is best may be the same as the mother's or the same as the system's but either way, she may run into conflict in honouring the woman's trust.

'The system' is *not* a listening system. Even when forced to listen, for example when the subject of official

inquiries, its only means of demonstrating that it has done so is to amend its protocols. This does not necessarily increase confidence on the part of either the trustor or trustee because protocols are rigid whereas each birthing mother is unique. A situation thereby is perpetuated where, in order to act in the best interests of the birthing mother, the trustee who decides to listen to her rather than to the system may have to be prepared to face criticism, ostracism and possible disciplinary procedures. Understandably, most are fearful of the repercussions and aren't willing to run such a risk.

When even independent trustees can't be trusted

A young friend of mine – we'll call her Amy - has been recently pregnant with her second baby. Her local hospital is, as is so often the case, short of midwives and it was clear that they could not support the home birth she wanted. Although her friends had had good experiences at the hospital, Amy was concerned about high induction rates and the consequent cascade of interventions. The hospital was also associated in her mind with a tragedy that had occurred there involving a member of her family.

In order to give herself the best chance of having an uninterrupted, peaceful birth, she decided to employ an independent midwife. This was not an easy decision because the midwife's fees put a heavy strain on Amy's already tight domestic finances. Nevertheless, she went ahead and started to form a strong relationship with her midwife who gave her the time she needed to think through both her birth plan and how she could help her toddler daughter adjust to having a sibling.

Monthly, and then fortnightly, visits continued until Amy was 30 weeks. At this visit, the midwife measured the bump and was alarmed to find the measurement a lot less than she would have expected at this stage of pregnancy. The baby was lying transverse which probably explained the unexpected measurement but the midwife was clearly disturbed and strongly advised Amy to go to the hospital for an emergency scan.

An ironic reversal of roles then took place. Amy tried to reassure the midwife that the baby was kicking vigorously – keeping her awake most of the night! – and that she knew from having been pregnant before that this was *not* a small baby; in fact, the baby felt much larger than her daughter who had been born a very healthy 8lbs. Amy was confident that all was well. The midwife, however, wanted the reassurance of a scan and very reluctantly, Amy went to the hospital where she was told that her baby was thriving.

Of course, this incident led Amy to lose trust in her midwife. She felt that the midwife did not trust what she, the mother, knew about her own body and her unborn baby. She questioned the extent to which the midwife put her trust in a technological approach to pregnancy and birth. The relationship between the two was fractured.

Of course, the independent midwife was in a difficult position; she had to cover her back by exerting pressure on Amy to have a scan once the fundus/pubic measurement seemed to suggest the baby wasn't growing well. But Amy felt, as so many women who contributed to the recent Report on Birth Trauma felt,[7] that she was not listened to and was not respected. She felt forced to make a choice that was what her carer wanted, not what she wanted.

Amy hopes to have another baby but says that she will freebirth as she now doesn't trust either NHS-provided or private maternity care.

Where do we go from here?

The sad reality to emerge from this story is that once trust is lost it is very very hard to regain. This includes trust in a particular healthcare professional, or profession, or system of care. There is an asymmetry in relation to trust, namely: **It is much harder to build it than to destroy it.**

My feeling is that trust in the maternity service is at an all-time low. In her wonderful book, 'Birthing Autonomy',[8] Nadine Pilley Edwards discusses trust at some length. She asserts – surely correctly - that trust is based on relationships. She argues that women desperately want to trust their midwives, but repeatedly find that the hospital or 'the system' disrupts a trusting relationship:

> *There is an inherent paradox in obstetric ideology focusing on safety and at the same time decreasing safety by placing obstacles in the way of trust developing between women and midwives.* (p186)

So where do we go from here? If many midwives are finding it increasingly difficult to respond to women's choices in labour and birth, and to trust women's understanding of their bodies and their babies, this will ultimately reduce women's trust in themselves. The likely consequence of this will be a gradual or steep decline in the incidence of straightforward, unassisted, uninterfered with labour and birth. There would be those who argue that a 100% caesarean rate would be no great problem. It would. Every time a medical intervention is administered – and surgical birth is *not* a minor procedure - there is a risk that something will go wrong. And with a 100% surgical birth rate, the frequency of things going wrong will inevitably increase. This is simply statistics. If every medical procedure carries a 1% risk of iatrogenic harm, and 100 caesareans are performed, all of which are necessary, 1 woman will be harmed as a result of the procedure itself. If caesareans are performed on all 650,000 women who give birth every year in the UK, 6500 women will be harmed – a large proportion of whom didn't need a caesarean in the first place. And, of course, this isn't taking into account harm that may be caused to the babies exposed to surgical birth.

Donna Ockenden, who has spearheaded the inquiries into failings in maternity care, has made numerous recommendations that she believes would improve trust in the maternity service, but remains pessimistic about the future. Her doubts as to whether the 'whole system' can be rescued are very evident in the 'if' of the final sentence of this extract from an open letter to the Secretary of State for

Health:

> *NHS maternity services and their trust boards are still failing to adequately address and learn lessons from serious maternity events occurring now. We recognise that maternity services have very significant workforce challenges and this must change. Clearly, workforce challenges that have existed for more than a decade cannot be put right overnight. However, it is our belief that* ***if*** *the 'whole system' underpinning maternity services commits to implementation of all the [recommendations] within this report, with the necessary funding provided, then this review could be said to have led to far-reaching improvements for all families and NHS staff working within maternity services.*[9]

So what is the answer? I believe that **if** trust is to be restored in the maternity service, firstly midwives' training has to be looked at. A midwifery lecturer told me recently that it is now common for students to graduate from her department without ever having witnessed a normal physiological birth. This is in direct contravention of the Nursing and Midwifery Council's (NMC) 2023 directive:

> *The aim of the birth standard is for all student midwives to facilitate 40 spontaneous vaginal births. Facilitated spontaneous vaginal births enhance the confidence in student midwives for registration and prepare them to practise autonomously, and in some instances, on their own in the birth environment.*[10]

It is not entirely clear what the NMC defines as a 'spontaneous vaginal birth' although it uses the term 'unassisted' alongside 'spontaneous'. If 'spontaneous vaginal births' include the whole panoply of medical interventions, including induction, acceleration, labour in bed, and epidural, and the 40 births students attend are all characterised by such interventions, then midwifery training is going rapidly in the direction of obstetric nurse training. In order to prevent this from happening, it is going to be vital, as Ockenden says, that government increases the number of midwives to enable continuity of carer. This is an unfulfilled aspiration of at least 30 years' standing, ever since it was the keystone of the famous 'Changing Childbirth' report, chaired by Julia Cumberlege.[11] Enabling continuity of carer in this way would facilitate better relationships between women and midwives, better births, and greater job satisfaction for all those midwives who want to be listening, responsive carers, and, by extension, create an optimal training experience for student midwives.

However, more midwives can't be the whole answer. The system remains strong, although I believe that the first inklings of a rebellion against 'the evidence' can be perceived, signalled by a growing appreciation that the evidence is often limited, insecure and based on analysis of populations which are racially, ethnically and culturally homogenous. 'The evidence', whatever it is and however derived, cannot be applied in all circumstances to all people. Human beings are far too varied in their epigenetics, their genetics and physiology, as well as their experiences, lifestyles and temperaments for it to be reasonable to believe that 'the evidence' could apply equally and without qualification to every single person. Instead, the 'evidence-based' approach needs refining to become far more nuanced; we need to

ask 'what works for whom, and in what circumstances?'

> *[Evidence Based Specialists] have highlighted the ….. importance of evidence-in-context [and advocate] more context-sensitive approaches to evidence evaluation, requiring multiple methods and information sources to be considered as the relevant evidence accumulates over both time and place……Nutley et al. (2019)*[12] *argue that the evidence required for effective decision-making includes evidence of the gravity and (a)typicality of any particular situation. They encourage academics and practitioners alike to deepen their examination of 'what works' by asking supplementary questions, such as precisely how and why interventions work, for whom, at what price and with what consequences.*[13]

In the meantime, it may be that women will need to look elsewhere for people to do the listening and provide the advocacy that the system quashes. They may need to look for people whose unique selling point is that they are *not* in the system. Would doulas fit this role? In putting together a recent issue (Vol 11, Issue 4, July 2024) of the International Journal of Birth and Parent Education of which I am Editor, with the theme of 'Doulas and Re-Imagining Birth', I was struck by how extensive the doula offer now is. Organisations such as the European Doula Network (EDN), and Doula UK provide support and resources for doulas; the EDN has recently organised doulas to work with displaced pregnant Ukrainian women. The NCT in the UK trains Birth Companions. Red Tent Doulas not only train doulas in the UK but support doulas working in some of the most dangerous parts of the world, such as Gaza. In the United States, the prestigious International Childbirth Education Association (ICEA) has a well-established and respected doula training programme and the American College of Obstetricians and Gynaecologists (ACOG)[14] has recognised doulas as an important strategy for improving maternal outcomes.

Midwives will rightly say that doulas are taking over their role, or, at least, the best bits of their role. This may be the case but until midwives can be liberated to truly be 'with women' in their vulnerable hour of need, what are women to do?

The tone of this article will seem to you pessimistic. And I do have very deep concerns about the relationship between mothers and midwives. This should be one of the most precious relationships a woman may experience in her lifetime, a relationship that can be transformative and leave a woman healed and triumphant, who was previously broken by lived experiences of not being able to trust or be trusted. I'll finish with the following quotation from a book written by a politician (a member of another much vilified and mistrusted profession); it captures the existential challenge that midwives and the maternity service are facing in the mid 21st century:

> *We come back to the question of trust…..Trust is a two-way process. You cannot secure trust simply by asserting that you are trustworthy. You can only win trust by showing that you are willing to work in a spirit of mutual respect with those whose trust you seek.*(Cook, 2003:87)[15]

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1 Wikipedia (2024) Trust (social science) Available at: https://en.wikipedia.org/wiki/Trust_(social_science)#:~:text=Trust%20is%20the%20belief%20that,ways%20that%20benefit%20the%20trustor <accessed 25 June, 2024>

2 Carter, M.A. (2007) Trust, power and vulnerability: A discourse on helping in nursing.

Nursing Clinics, 44(4):393-405.

3 Kirkup B. (2015) The Morecambe Bay Investigation. https://assets.publishing.service.gov.uk/media/5a7f3d7240f0b62305b85efb/47487_MBI_Accessible_v0.1.pdf

4 Ockenden D. (2022) Ockenden Report - Final. the final report of the Independent Review of Maternity Services at The Shrewsbury and Telford Hospital NHS Trust.www.ockendenmaternityreview.org.uk/wp-content/uploads/2022/03/FINAL_INDEPENDENT_MATERNITY_REVIEW_OF_MATERNITY_SERVICES_REPORT.pdf

5 Kirkup B. (2022) Reading the signals - Maternity and neonatal services in East Kent – the Report of the Independent Investigation. https://assets.publishing.service.gov.uk/media/634fb083e90e0731a5423408/reading-the-signals-maternity-and-neonatal-services-in-east-kent_the-report-of-the-independent-investigation_print-ready.pdf

6 Official website for the independent review of maternity services at the Nottingham University Hospitals NHS Trust. www.ockendenmaternityreview.org.uk

7 Clarke, T. (2024) Listen to Mums: Ending the postcode lottery on perinatal care. Available at: www.theo-clarke.org.uk/birth-trauma <accessed 3 July, 2024>

8 Pilley Edwards, N. (2005) Birthing Autonomy: Women's experiences of planning home births. London: Routledge.

9 Ockenden, D. (2022) Letter to the Secretary of State for Health and Social Care from Donna Ockenden. Available at: www.gov.uk/government/publications/final-report-of-the-ockenden-review/ockenden-review-summary-of-findings-conclusions-and-essential-actions#:~:text=Even%20now%2C%20early%20in%202022,challenges%20and%20this%20must%20change

<accessed 25 June, 2024>

10 Nursing & Midwifery Council (2023) Number of births to be achieved by student midwives. Available at: www.nmc.org.uk/standards/guidance/supporting-information-for-our-education-and-training-standards/number-of-births-to-be-achieved-by-student-midwives/#:~:text=The%20aim%20of%20the%20birth,facilitate%2040%20spontaneous%20vaginal%20births <accessed 23 June, 2024>

11 Department of Health (1993) Changing Childbirth Part 1. Report of the Expert Maternity Group. London: HMSO.

12 Nutley, S., Boaz, A., Davies, H., Fraser, A. (2019) What works now? Continuity and change in the use of evidence to improve public policy and service delivery. Public Money & Management, 39(4):310–316.

13 Tomkins, L., Bristow, A. (2021) Evidence-based practice and the ethics of care: 'What works' or 'What matters'? the Tavistock Institute, 76(1): doi.org/10.1177/00187267211044143

14 ACOG (2021) Approaches to Limit Intervention During Labor and Birth. ACOG Committee Opinion, Number 766 (Replaces Committee Opinion No. 687, February 2017). Available at: www.acog.org/clinical/clinical-guidance-/committee-opinion/articles/2019/02/approaches-to-limit-intervention-during-labor-and-birth <accessed 25 June, 2024>

15 Cook, R. (2003) The Point of Departure. London: Simon & Schuster.