

# Exploration of the concept of trust within the midwife-mother relationship.

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Award: Doctor of Philosophy

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## **Summary:**

**Background:** Evidence from midwifery research, policy and guidelines indicates that trust within the midwife-mother relationship is an important element of care provision, yet it is poorly defined as a concept.

**Aim:** The aim of the study was to explore the concept of trust within the midwife-mother relationship increasing understanding of the individual's experience of trust and its meaning to women.

**Methodology:** The Hybrid model for concept analysis was the framework for the study, combining theory and empirical data enabled the researcher to develop a deeper analytic understanding of the phenomenon and the meaning behind how it was experienced. Longitudinal semi-structured interviews were carried out at the beginning of pregnancy, thirty-seven weeks and eight weeks postnatal with a purposive sample of ten women with straightforward pregnancy. Participants were a mix of first time mothers and those having subsequent babies selected from a Health Board that provides midwife-led care.

**Analysis:** Data analysis was conducted using Nvivo 9 software to organise the data into initial themes. Themes were taken back to participants to guide subsequent interviews clarifying their meaning, authenticity and ensuring that the data gathered reflected their personal insight.

**Findings:** "Building blocks" were an analogy identified within the participant interviews which capture the evolving nature of trust. The participants described an initial trust associated with an expectation of assumed competence in the midwife. The core attribute was identified as the relationship between midwife and mother. The concept of trust was interwoven with women's agency, women expressed a desire to develop a two-way trust that included the midwife trusting the woman.

**Implications:** In order to develop evolved trust, maternity services need to develop systems that allow midwives to establish empathetic, reciprocal relationships and work in partnership with the women.

## **Declaration:**

This work has not been submitted in substance for any other degree or award at this or any other university or place of learning, nor is being submitted concurrently in candidature for any degree or other award.

Signed *M Lewis*

[candidate] Date 13/07/2015

## **Statement 1**

This thesis is being submitted in partial fulfilment of the requirements for the degree of PhD.

Signed *M Lewis*

[Candidate] Date 13/07/2015

## **Statement 2**

This thesis is the result of my own independent work, except where otherwise stated. Other sources are acknowledged by explicit references. The views expressed are my own.

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## **Statement 3**

I hereby give consent for my thesis, if accepted, to be available online in the University's Open Access repository and for inter-library loan, and for the title and summary to be made available to outside organisations.

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[Candidate] Date 13/07/2015

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## **Chapter 1: Introduction and background.**

**1.1 Introduction:** In this chapter I will set the scene by describing the rationale, aim and background to the research study, before providing an overview of the thesis including a brief summary of each chapter.

**1.2 Background:** In this section I will consider the background information that informed the rationale for the study. I will firstly consider myself as the researcher, then the characteristics of the research site before describing the professional context.

**1.2.1 The researcher:** I began my midwifery career in 1996 working in a busy obstetric unit consolidating my training in all aspects of maternity care. I also commenced a BSc Midwifery which helped to inspire my inquisitive mind and led me to question some of the practises carried out on the consultant labour ward where I worked, developing an interest in writing guidelines and auditing care outcomes. I found myself questioning some of the obstetric care guidelines such as not feeding women in labour as this seemed contrary to what I believed woman-centred care should be. In 1999 I was fortunate to work as a case-load midwife, providing complete follow through care to a dedicated number of women. This allowed me to develop relationships with the women for whom I was caring and provide care in partnership with the woman and her family. Throughout that time I developed an interest and enthusiasm for midwife-led care and promotion of normality in childbirth.

In 2000 I had personal experience of pregnancy and gave birth by caesarean section to my first of four children. My own experience of the relationship with the midwife was initially one of disappointment. I felt that the midwives were unable to support my decisions and did not share my passion for normal birth, which inspired me to pursue my interest in women's decision-making further as a professional. In 2001 I completed a master's degree in medical ethics and law, including a dissertation on the concept of informed consent. It was during this time that I began to consider the ethics of choice, autonomy and power, which led me to consider the concept of trust and trustworthiness within the midwife-mother relationship.

In 2003 I had my second child under the care of a consultant obstetrician with whom I had built a rapport as a close work colleague and felt more confident in achieving what was important to me – a natural birth. Following a successful natural birth, I regained my confidence in my own body's ability to birth. Furthermore, I had been working in a

birth centre environment which re-energised my passion for the role of midwives in supporting women. I went on to have two further births in 2006 and 2010 under the care of local midwives with whom I was able to develop a trusting relationship. I have experienced a range of care models from complete consultant-led care and caesarean birth to complete midwife-led care and labour care at home. My personal experiences and the varying levels of trust felt for my carers were influential in my decision to explore the concept of trust.

I currently work as the Practice Development Midwife in a midwifery system that offers women in a rural community complete midwife-led care from first point of contact to discharge. Working in this area and observing the interactions between women and midwives in decision-making inspired me to explore the concept of trust further within this site.

**1.2.2 The research site:** I chose to study the concept of trust within the midwifery system in which I work as the model of care offered potential for women and midwives to develop a trusting relationship. The maternity service at the research site is managed and staffed solely by midwives; there are no clinical maternity support workers and no doctors. There are thirty-eight clinical midwives who work across a wide geographical area in eight small teams. Care is provided within the community or from one of the six free-standing birth centres as there is no District General Hospital within the County. The midwives are the lead carers for all women [approximately one thousand-two hundred women per year] with around five hundred of the women classified as low-risk at booking enabling complete midwife-led care to be provided. Women classified as high risk at booking or who develop complications during pregnancy are still cared for by the midwife but are also referred to a consultant obstetrician in neighbouring facilities as required. Approximately four hundred women remain low risk at the onset of labour and are offered the provision of home birth or birth in a free-standing birth centre with the support of the community midwives. Around three hundred women will choose this option and of these approximately twenty-five percent will require transfer to a consultant unit in or shortly after labour. Reasons for transfer include induction of labour, delay in labour, fetal distress and haemorrhage. These outcomes are similar to those stated in other areas providing maternity care in free-standing birth centres, such as Rogers et al [2010] who published outcomes for women who chose to birth at Edgware birth centre, where approximately half of all women deemed low-risk at booking required transfer to consultant care at some stage in their childbirth experience. Of the women who commenced labour care at Edgware

approximately twenty percent were transferred to an obstetric unit. The research site provides a maternity service which enables midwives to facilitate complete midwife-led care from pregnancy booking to postnatal discharge predominantly by one named midwife working in a small community team. Yet a quarter of the women who are identified as low risk at the onset of labour choose to birth their babies in an external consultant unit rather than staying in county with the midwives whom they know. It is this group of women who further inspired me to explore the concept of trust. Was a lack of trust influencing the woman's decision not to give birth with the local midwives?

Availability of midwife-led care, and the opportunity for continuity of carer provided at the study site, enabled women to build a relationship with the midwife and had potential for me as a researcher to develop further understanding of the concept of trust within this context. To further assist understanding of the rationale for the study, I will consider here the professional context to midwife-led care in relation to trust.

**1.2.3 Professional Context:** Over the last three decades governments have published reports such as: 'Changing Childbirth the report of the expert maternity group' [DOH 1993] 'First Class Delivery' [Audit Commission 1998] 'Realising the Potential' [WAG 2008] 'Midwives 2020' [DOH 2010] 'A strategy vision for maternity services in Wales' [WAG 2011], recommending review and change in maternity services to improve clients experience of maternity care. The reports focused on the needs of women and emphasised that services should treat women and their families with more warmth and compassion and not focus solely on physical health. The reports embraced the principles of woman-centred care and within this informed choice and the role of professionals to support women, requiring women to become full partners in their care. The revised NMC code of practice emphasises the importance of promoting professionalism and trust as one of its key sections [NMC 2015]. The need for trust is frequently cited but it is not defined nor its importance in decision-making quantified. The government reports described, but did not fully address, issues such as the balance of power and its influence on the trusting relationship and how these could be changed within a traditional NHS hierarchical system. Women and their families entering the maternity services are required to place their trust and indeed their future in the hands of midwives, doctors and medical technology. In all social relationships or partnerships both partners need to know and understand the basis and balance of their relationship. It is essential that partners can communicate and trust each other; this may only be possible if power dynamics are understood and relationships are equal [Leap 2000].

Since the publication of the government reports [DOH 1993, DOH 2010, WAG 2011] there have been many initiatives to encourage midwives to provide woman-centred care through services that allow women to get to know and trust their midwife. Currently women birthing within the UK have access to a range of midwifery and obstetric services, they may be assisted by NHS midwives, general practitioners, obstetric consultants, independent midwives, un-registered birth companions or a combination of shared care. Services available vary depending on a woman's location, choice and financial status. Obstetric-led units account for the largest number of births within the UK; outcomes for births in Welsh obstetric units include an average caesarean section rate of 26% and instrumental delivery rates of 12% [National Office Statistics 2014]. Authors such as Wilkins [2000] suggest negative feelings and relationship issues are experienced by some women who receive care in obstetric units, where care is provided by professionals with whom women have not formed a close relationship. In the UK only 2.1% of women have their babies at home and in Wales this figure is slightly higher at 3% [Birthchoice UK 2013]. Just a further 4% of all births that take place in an NHS setting in Wales occur in a free standing midwife-led unit [RCM 2013]. NICE [2014] recommends that women who are classified as low-risk in their pregnancy should be offered midwife-led care and out of hospital births; the research site offers complete midwife-led care delivered through a caseload continuity scheme and birth at home [8% on average achieve this] or in a free-standing birth centre [12% on average achieve this]. Midwife-led care has been defined by the RCOG [2001] as:

*“The midwife is the lead professional in the planning, organisation and delivery of care given to a woman from initial booking to the postnatal period.” [RCOG 2001]*

Sandall et al [2013] described the philosophy underpinning midwife-led continuity care models as:

*“The philosophy behind midwife-led continuity models is normality, continuity of care and being cared for by a known and trusted midwife.” [Sandall et al 2013] P2.*

They go on to highlight:

*“midwife-led continuity is based on a premise that pregnancy and birth are normal life events.....the model of care includes continuity of care, monitoring the physical, psychological, spiritual and social wellbeing of the woman and family.” Sandall et al [2013] P3.*

These definitions seem appropriate and in agreement with the philosophy of the research site; the provision of midwife-led care and its known benefits to low risk women is the reason why the site was chosen.

The advantages of midwife-led care are supported by research. The Birthplace study [NPEU 2011] highlighted that for low-risk women who planned to birth their babies in a midwifery-led unit, significantly fewer interventions, such as instrumental birth, episiotomy or caesarean sections were experienced, and more 'normal births'<sup>1</sup> were achieved than for women who planned birth in an obstetric unit. However there were some outcome differences identified for the babies of first time mothers who were slightly more at risk when mothers birth at home than babies of those having subsequent pregnancies. Further evidence of the benefits of midwife-led care is presented by Sandall et al [2013] in their Cochrane review of midwife-led continuity models versus other models of care. They found that women who received midwife-led continuity models of care were more likely to experience a spontaneous birth without intervention and to be cared for by a known midwife; there was no noted difference in adverse outcomes. The reviewers suggested that the noted benefits were most likely associated to the process of midwife-led care itself rather than birth environment as many of the studies reviewed had taken place in obstetric units. However, Walsh [2007] describes the interplay between birth environments, relationships and support in his ethnographic study of a free-standing midwife-led birth centre similar to those present in the research site. Walsh suggests that birth centre settings can facilitate the creation of social networks that enhance trust and support within communities. Adding to the knowledge base around the interplay between midwife-led care and birth environments, Walsh and Devane [2012] in their metasynthesis of midwife led-care noted that the outcomes for women experiencing midwife-led care were influenced by the birth environment; relational mediated benefits as a result of increased agency and empathetic care, greater agency for midwives working in smaller midwife-led units and problematic interfaces between midwife-led units and the obstetric unit. Walsh and Devane [2012] associated the lower rates of intervention experienced by women in small midwife-led units to greater levels of agency experienced by both women and their midwives. Overgaard et al [2012] specifically studied the influence of birth place on the woman's birth experience in Denmark. They explored women's perceptions of care in free-standing birth centres compared to obstetric units and found significantly higher levels of satisfaction with care for those who birthed in the midwife-led birth

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<sup>1</sup> as defined by the 2007 Maternity Care working party

centres; this was associated with greater levels of participation in decision-making and a feeling of being listened to. These studies indicate potential benefits for women when cared for in a midwife-led models of care and highlight the link to relationships, associating some of the benefits seen in midwife-led care to the woman's ability to develop trusting relationships with the midwife.

Developing trusting relationships is a core theme in midwifery literature. Hunter et al [2008] suggest that good quality relationships are a key feature of maternity care and the importance of caring relationships should be considered when developing maternity care systems, as without consideration of the relationship issues, initiatives to keep childbirth normal may be ineffective. In Maclellan's [2011] discourse analysis exploring the art of midwifery, human relationships were identified as the core thread leading to a feeling of control, confidence and satisfaction for women. MacLellan [2011] describes presence, guardianship, intuition, confidence and courage as key themes, highlighting the importance of trusting relationships gained through delivering high quality care that features reciprocity, equality, openness, compassion and kindness. Dahlberg and Aune [2013] studied twenty-three women in the Netherlands and found that relational continuity gave midwives the opportunity to provide holistic care resulting in empowerment for the woman and her family; they also linked positive outcomes experienced by women to the development of trust within the relationship with a midwife. A positive birth experience was associated with the connection that women formed with the midwife; Dahlberg and Aune [2013] suggest that this connection is based on trust, mutuality and respect.

One approach to facilitating trusting relationships is caseload midwifery. The research site uses a caseload midwifery scheme to assist women and midwives in building trusting relationships through continuity of carer and the ability to get to know each other. McCourt and Stevens [2009], in their chapter on relationships in caseload midwifery, specify the importance of midwives and women getting to know each other in a reciprocal relationship in engendering a sense of mutual trust. Women in Williams et al's [2010] study of the value of continuity of care and case loading in Australia also described the relationship between women and the midwife in terms of a friendship built on trust with the women valuing the support offered by the caseload scheme. The partnership model of maternity care in New Zealand allows women to choose their lead maternity carer within the community, for approximately 80% of women this is a midwife but could also be a General Practitioner or Obstetrician. Where the midwife is the lead maternity carer, they provide complete continuity of care including an on call

service for birth [Pairman et al 2015]. The partnership model focusses on the fundamental principles of being 'woman-centred' and providing continuity through case loading regardless of a woman's risk factors [Davies and Walker 2011]. First-time mothers in New Zealand attribute their increased sense of birth satisfaction to the ability, through the partnership model, to develop effective relationships with the midwife during pregnancy that also fully involve their chosen birth partner [Howarth et al 2011]. While the research site does not offer the New Zealand complete partnership model to all women, I am intrigued that some low-risk women from the research site, where midwife-led care is provided through a caseload scheme and birth in a midwife-led birth centre is offered, chose to travel long distances to the nearest obstetric unit to receive consultant care. I am also intrigued by women who begin care with the community midwife and plan to use the midwife-led care system but still request to travel to an obstetric unit for the birth itself. As suggested above [NPEU 2011] this can not only reduce their chance of achieving a natural physiological birth but is also costly in monetary terms for commissioners of maternity services [Allotey et al 2012]. Women make such decisions based on complex values and personal experiences, could it be that a prominent feature in this decision-making process is trust in the health professional?

Women's decision-making around place of birth has been the subject of two large studies recently. Murray-Davies et al [2014] studied the factors that influence a woman's choice of birthing place using self-administered questionnaires. The top three decision-making priorities identified in the study were i) feeling safe, ii) feeling comfortable and iii) believing birth to be a natural process. Influential sources of information were books, the internet and the media. The decision of where to give birth was based on the women's individual values and beliefs and how they risk assessed the options available. Risk assessment is also the focus in a study by Chadwick and Foster [2014] who carried out a discourse analysis focussing on the lived experience of risk with twenty-four women in South Africa. They highlighted the individual nature of risk perspectives and the rational decisions that the women made based on their individual perceptions of risk. The planned caesarean section group used elective surgery to manage the risk of unpredictable childbirth and possible complications, placing their trust in medical knowledge, technology and intervention rather than midwifery care which the women in the caesarean group viewed as dangerous. In contrast the group of women who planned home births did so to manage the risks of un-necessary interventions and the potential loss of control expected if they entered

the hospital. Both groups of women in Chadwick and Foster's [2014] study identified control over decision-making as primary importance to the women. Could a midwife's ability to support women in decision-making influence the trust placed by women in midwife-led care settings?

In practice the principles of partnerships with women and informed decision-making can be difficult to establish alongside some of the other targets specified within Government strategies such as The Strategic Vision for maternity services [WAG 2011] which sets standards for Health Boards to achieve in controlling public health issues and reducing risk in maternity care. Employers respond with tighter guidelines and regulation that aim to reassure the public that the systems in place will protect them and by default encourages a level of trust in the system. Clark [1995] highlights the difficulties when organisational guidelines conflict with a philosophy of supporting individual decision-making especially where those decisions conflict with the organisational guidelines, placing midwives, as the care-giver, in a difficult position. Choice generally runs smoothly when a woman's choice is in line with recommended guidelines. However, when a woman's choice is perceived to be controversial, they are often met with resistance as midwives are caught between the organisation's need for risk control and the midwife's professional responsibility to support women. To ensure compliance with guidelines the term 'risk' is used frequently when discussing choices with women [Crawford 2011]. Furber and Thomson [2010] studied thirty midwives in England and found that the midwives used turns of phrase, tone of voice and body language which undermined women to ensure the decisions made were in accordance with recommended guidelines. This has been associated with a level of defensive practice by authors such as Scamell and Alaszewski [2012] who report from their ethnographic study carried out in four different maternity units in the UK. They observed the difficulties midwives appeared to have in defending normality in birth that is predominantly now managed and that professionals are held accountable in systems of risk and blame. Midwives described a fear of getting the blame when birth did not go well. Surtees [2010] identified a similar theme in her exploration of midwives' practises. Key themes identified by Surtees included defensive practice and management of risk with midwives expressing a need to keep themselves safe from blame. Clark [1995] described midwives as having the 'schizophrenic' task of supporting women's choice while upholding employer's policy. Could the organisational challenges faced by midwives in supporting women's choice influence their ability to uphold the trust placed in them by women?



In a UK survey AIMS [2012] reported top ten tips for what women want from the midwife; tip two highlighted the desire from women for midwives to be 'on their side' as their advocate and tip three was to encourage understanding of true informed decision-making where informed refusal is also accepted with respect. As described earlier this is not always apparent in maternity care and could account for a withdrawal of trust in the midwife. Wickham [2008], in her opinion piece, suggested that the incidence of doula support in UK births was rising as a result of negative experiences of NHS maternity care. Stockton [2010], in her description of the role of the doula, suggests that women can benefit from support gained from doulas who spend time 'being' with women, building a rapport and gaining the woman's trust that the doulas will respond to the woman's individual needs. Wickham [2008] suggests that where midwives are unable to provide a service that women want, that women will no longer want midwives; this is important to consider when exploring the concept of trust. If midwives are unable to understand what women are placing trust in them to do, they are unlikely to be able to uphold that trust resulting in a withdrawal of trust in midwives. It is therefore essential for research to be carried out to develop understanding of the concept of trust and what it means to women.

I have described above some of the micro level issues linked to trust in individual midwives but it is also important to consider the macro issues relating to wider public trust concerns. On one hand organisational guidelines and statutory midwifery supervision aim to promote trust through regulation, providing a reassurance mechanism for the public, but there is a dichotomy within this. Its presence raises concern that the public need to be protected from midwives. If the regulation is set up to protect the public from poor midwifery practice by default this implies that midwives themselves cannot be trusted as individuals. It could be that robust regulation promotes the development of trust through strong systems but it could also be true that the need for robust regulation implies an element of distrust in individuals within that system. This could account for some women's reluctance to engage with midwife-led care. But where trust for individuals is replaced with trust in regulatory systems there is a challenge to that trust when the regulatory systems are themselves called into question.

One of the biggest media reported failings in health care- described in the inquiry of mid-Staffordshire NHS Trust the report by Francis [2013]- contained two hundred and

ninety recommendations focussing on the accountability of all staff at all levels to put patients first. The report questions the systems and processes in place and calls for openness and transparency, ensuring a culture of truthfulness even when things go wrong. While the Francis report focussed on failures in management, medical and nursing care the recommendations are still relevant for maternity services. Midwives currently have a system of statutory midwifery supervision which allows supervisors of midwives to assist midwives in supporting women while ensuring that they are providing evidenced based transparent care. In theory the support from midwifery supervision should make the balancing act of risk management, regulation and women's choice easier for midwives. Midwifery supervision's main role is one of statutory regulation and protecting the public [NMC 2012] which aims to give women reassurance and promote the development of trust in this regulatory system. However, the Care Quality Commission [2012] highlighted specific failings in maternity care in Morecambe Bay including the need to review statutory midwifery supervision and how adverse incidents are dealt with and investigated. This raised questions about whether the public could trust the processes that were in place. One of the areas of concern was in relation to respecting and involving patients to ensure their safety and wellbeing. This has been followed by a further report highlighting failings in midwifery supervision in Guernsey, during an NMC review visit. Concerns were raised about the availability of supervisors of midwives and the compliance with NMC regulations, such as annual supervisory reviews and notifying intention to practice as well as concerns in the LSA's role in conducting midwifery investigations. The report concluded that there were serious concerns over statutory supervision and the protection of the public. It recommended that midwives be supported with training in best practice guidelines and appropriate referrals as well as improvements in support from the Local Supervisory Authority and implementation of more robust systems for escalating concerns relating to patient safety [NMC 2014]. The Guernsey report highlights the risk associated with services who do not properly implement regulatory systems and the need for such systems to themselves be tested, regulating the regulators raises questions over who or what can ultimately be trusted. Reports such as these are likely to lead women to question the trustworthiness of midwives, the midwife's role and the regulation intended to protect them. What influence does published examples of poor practice, poor regulations and failings in the system have on the concept of trust within the midwife-mother relationship?

Perceived trust in the maternity system in place in the research site was a key influence in my interest in trust as a concept. I began my research journey with a belief that women would only choose midwife-led care if they knew of its benefits and have trust in both the system and the midwives providing their care. In this chapter I have given both personal and professional background for the research study concentrating on the key elements identified in the research site that could influence the concept of trust; provision of midwife-led care, continuity through case load midwifery and the possibility of building relationships and trust in regulatory systems. I suggest that midwives need to know and understand how trust is built and maintained in order for professional drivers and promotion of midwife-led care to be successful, a key to my own motivation for conducting this study. This study therefore aims to explore the concept of trust and how it is experienced by women.

**1.3 Study Aim:** The aim of the study was to explore the concept of trust within the midwife-mother relationship increasing understanding of the individual's experience of trust and its meaning to women.

**1.4 Thesis structure:** The study uses a 'hybrid model' [Schwartz-Barcott and Kim 1993] as the theoretical framework, the existing literature in the form of a concept analysis is integrated with new empirical findings in a three stage approach. Stage one involved a theoretical concept analysis, stage two the empirical data collection and stage three analysis of the data to aid understanding of the concept being studied. The thesis is structured around this framework detailed in the following chapters:

**1.4.1 Chapter two:** I will present my methods in the format of a natural history chapter appropriate for qualitative research where the aim of the chapter is to inform the reader of the personal context in which the research was developed. I will describe the hybrid model framework and processes which were used for the exploration of the concept of trust.

**1.4.2 Chapter three:** Stage one of the study, an initial theoretical concept analysis, is presented including perspectives of both women and midwives focussing on the concept of interpersonal trust and its importance in building effective relationships.

**1.4.3 Chapter four:** Stage two of the hybrid model is detailed in this chapter and moves on from the theoretical concept analysis with the aim of understanding the lived experience of the concept of trust, through the collection of empirical data. The findings will be presented as a series of 'building blocks' which capture the evolving nature of

trust within the midwife-mother relationship, presented in three sections: antecedents- that which precedes the concept itself; attributes- quality or characteristic inherent in the concept; consequences- that which logically follows or results from the concept.

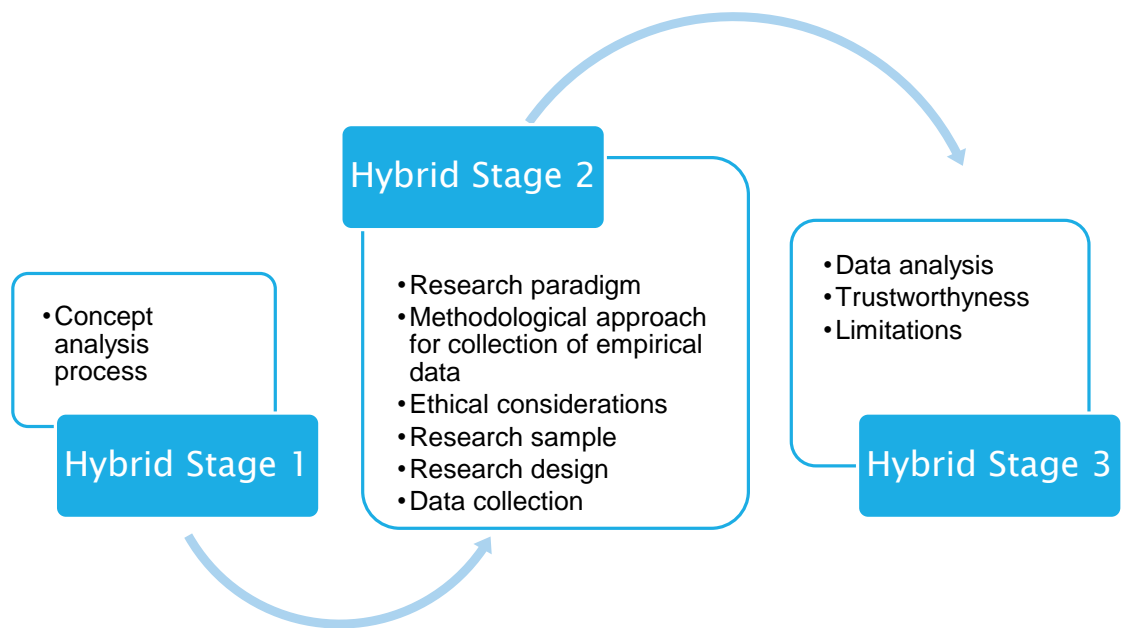
**1.4.4 Chapter five:** The final analysis will be presented in this chapter. Schwartz-Barcott and Kim [1993] suggest three key questions to structure this final stage of the analysis: Does the study support the presence and frequency of the concept? How much is the concept applicable and important? Was the selection of the concept justified? The most relevant ideas obtained from stage two [the empirical data] will be used to further understand the concept of trust and its relevance to midwifery practice.

**1.4.5 Chapter Six:** The conclusion of the thesis will include discussion of the study and reflexivity of the researcher.

## **Chapter 2: Methodology chapter**

**2.1 Introduction:** The overall aim for the study was to explore the concept of trust from the individual's perspective with a view to developing a better understanding of trust within the midwife-mother relationship. I will present my methodology in the format of a natural history chapter described by Silverman [2010] as a lively and vibrant account of the qualitative research story. Silverman suggested this format is appropriate for qualitative research where the aim of the chapter is to inform the reader of the personal context in which the research was developed and the reasons behind the design decisions, the challenges and the lessons learned [Silverman 2010 P335].

In this chapter I will describe the hybrid model framework, the foundations and processes which were used for the empirical exploration of the concept of trust and the final data analysis as detailed in figure 1 below.



**Figure 1: Structure of the chapter**

Figure 1 shows the format of the chapter which outlines how the ‘hybrid model’ was used as the theoretical framework, where the existing literature in the form of a concept analysis was integrated with new empirical findings. The foundation for stage two of the study will be discussed and set out within a naturalistic paradigm, which is appropriate for studying individual lived experience in the natural environment and Heideggerian Phenomenology will be discussed briefly as the influence for the method of empirical data collection.

This chapter will include a discussion of my decision to use semi-structured interviews, alongside a researcher’s reflective diary, to explore the phenomenon with a purposive sample of women experiencing straightforward pregnancy. The ethical issues relating to the study will be discussed under five human rights sub headings: the right to self-determination, the right to privacy, the right to anonymity and confidentiality, the right to fair treatment and the right to protection from discomfort and harm. I will also describe the analytical process through data reduction, analysis and writing. I will conclude the chapter with discussion of the trustworthiness of the study.

It is firstly important to explain that my journey did not begin here; it was commenced many years before I had even considered embarking on a research study.

**2.1.1 My Beginnings:** I bring to this research both my professional and my personal experiences of trust within the midwife-mother relationship. I progressed through

midwifery training with mentors and midwives who supported me to develop trust in the physiological processes of natural childbirth and a belief in 'normality' and midwife-led care. My experiences of trust within the midwife-mother relationship heightened during my own pregnancies where my role was reversed.

*In my first pregnancy I naturally believed that the midwives looking after me would support me and promote normality in my care. I hoped and trusted that they would share my beliefs, my values and would help me to achieve the natural childbirth that I wanted. But my pregnancy was not without complications. The attitudes of the midwives indicted to me that they believed I was never going to experience a natural birth. This was the first time since I had qualified as a midwife that I realised how important it was for me, as a mother, to feel trusted and to feel that others shared my philosophy and would look after me in the way I wanted.*

*Reflective diary 20/09/2010*

Following the birth of my first child I completed an MA in Medical Ethics and Law which enabled me to develop skills in ethics and philosophy. My thesis concentrated on the philosophical arguments around the notion of informed choice and its practical application within midwifery. This philosophical exploration led me to consider the importance of truth and its implications for trustworthiness. It was some time after completion and following a change of professional job role that I began to develop this interest further into a proposal for a research study.

I have been fortunate in the last decade to work in a Health Board where midwife-led care, continuity, low rates of intervention and facilitating client choices are paramount. Despite the research site's achievement of professional goals for providing midwife-led care and continuity as set out in the Welsh Government's Strategic Vision [WAG 2011] and the recommendation from NICE [2014] for low-risk women to birth in a midwife-led setting, some women actively chose to travel long distances to big hospitals to receive care and birth their babies. While there may be many reasons for their decision, I was interested in whether the women felt they could not trust the midwives to provide complete care. I began to pursue an idea for researching whether women trust their midwives.

I was shortlisted to interview for a RCM Ruth Davies Bursary to help fund my research. During this interview I was asked to define what the word trust meant to me. I soon came to realise that the word trust, while frequently used within midwifery, could have

several different meanings and it was incredibly difficult to articulate how I interpreted the concept. It was at this point that it was suggested to me that before I could contemplate studying trust I would first need to understand it as a concept. Trust appeared to be an important concept within the midwife-mother relationship yet evidence to define it as a concept and what it means to women was sparse. Without greater understanding of what trust was and what part it played in the midwife-mother relationship, it would be more difficult to shape services in a way that fulfilled the needs of women. Hence the rationale for my study aim:

**Aim:** The aim of the study was to explore the concept of trust within the midwife-mother relationship increasing understanding of the individual's experience of trust and its meaning to women.

The aim includes a broad exploration but no formal research questions were identified as the concept evolves throughout the process of concept analysis and is responsive to the theory and empirical data over the time of the study.

In this section I have provided some insight into my personal motivation for the study and will now outline the theoretical foundations on which it progressed commencing with a brief overview of the hybrid model before a more detailed description of each stage.

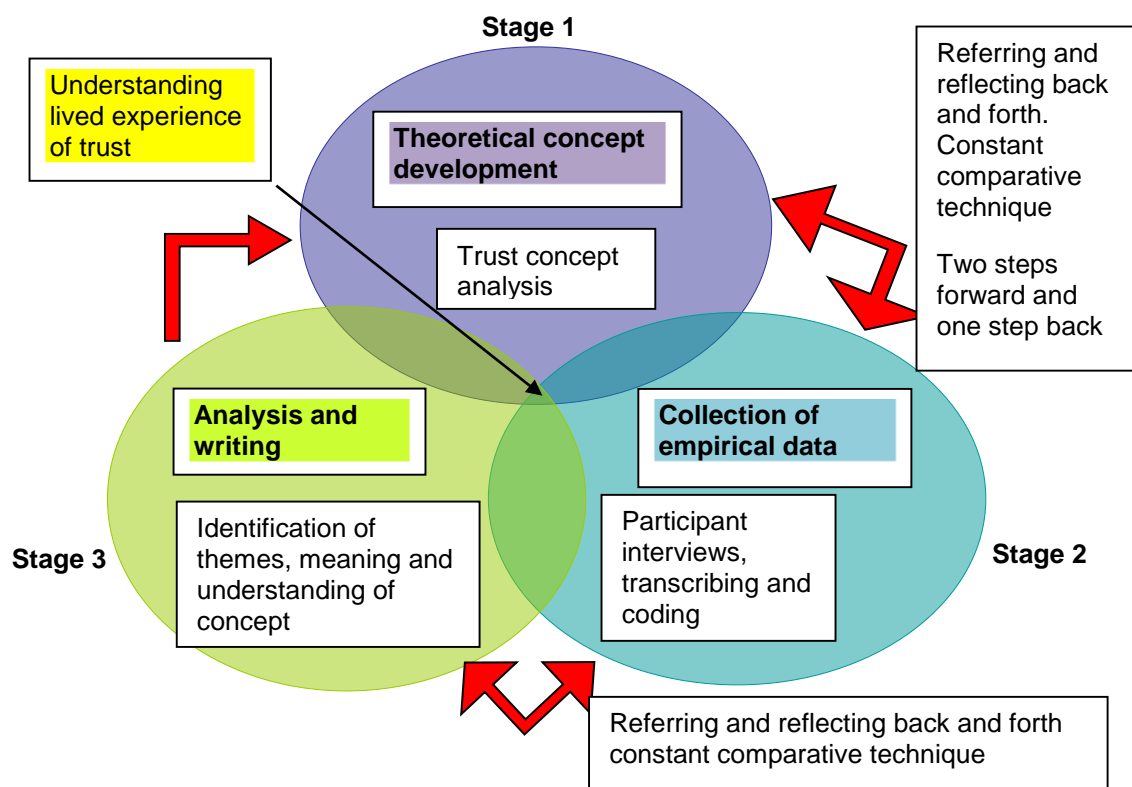
**2.2 The Hybrid Model:** My choice of the hybrid model was influenced by a study conducted by Davis [2010] to understand and develop the concept of normalcy in childbirth. She described the purpose of concept development to clarify the use of a concept in real life and to form the foundation for a further enquiry. Davis used the hybrid model together with hermeneutic phenomenology to incorporate the literature on normalcy with a fieldwork component. Her study involved thirteen midwives who took part in one to one interviews. It seemed appropriate to consider the hybrid model to assist me as a novice researcher in structuring the integration of the theoretical concept with the experiences of the women for my study. The hybrid model used with a phenomenological methodology for the empirical data collection as described by Davis [2010] offers a framework to ensure that the lived experience is used to develop understanding of the concept as experienced by the individual.

The hybrid model is described by Schwartz-Barcott and Kim [1993] as an approach which enables literature analysis to be integrated with empirical data to serve as an

ongoing comparison with the data being collected to identify, analyse and refine concepts and theory[ Schwartz-Barcott and Kim 1993]. It appeared to fit well with the descriptions of hermeneutic phenomenology in its intention to work back and forth between theory, researcher and participants in developing a new interpretative understanding. Schwartz-Barcott and Kim [1993] described three stages which I will briefly outline here, figure 2 demonstrates my understanding of the hybrid model and how it worked for my study while maintaining the principles of hermeneutic phenomenology.

The three stages run concurrently with the researcher working back and forth between each stage. The next stage begins before the preceding stage has been completed and for a time the two stages run concurrently. I understood this (see Figure 2) to be a rotating circle moving forward and backwards in a two steps forward and one step back type rhythm.

**Figure 2: Hybrid model with hermeneutic cycle**



- Stage one [the purple circle] involves a theoretical literature search looking for an initial working definition of the concept. As part of a hermeneutic cycle this stage may incorporate the researcher's prior knowledge and experience. This



stage included searching literature and completing the initial theoretical concept analysis.

- Stage two [pale blue circle] involves the collection of the empirical data and initial analysis, referring and reflecting back and forth between stage one and two in a constant comparative technique that I described as two steps forward and one step back [represented by the red arrows on the table]. Data obtained from the interviews was used to inform the further exploration of the literature with the resulting thinking being used to guide me at the follow up interviews.
- Stage three [light green circle] involves the final analysis and writing up which again runs for a time concurrently with stage two. I began transcribing and analysing the interviews as they were collected. Stages two and three again overlap in time as data collection, analysis and literature review are carried out concurrently. The final analysis [darker green triangle in the centre] results in the central understanding gained from all three stages which consequently informs the complete concept analysis [Yellow highlighted box].

Threading through the overlapping time from one stage to the next the researcher and participants work together in constructing the concept as described in the Heideggerian phenomenological approach as a hermeneutic cycle [Heidegger 1962, Davis 2010]. Participants reviewed the emerging themes from the previous interviews and gave further explanation to clarify their meaning and importance to the developing concept. Some participants suggested important areas for further theoretical exploration as a result of a theme identified in the initial data collection. While data collection and analysis are a concurrent process I will discuss them separately in the chapter as a means of assisting the reader to make sense of each related stage of the model.

**2.3 Hybrid Model Stage one:** In Stage One a literature review and theoretical exploration was undertaken to develop a theoretical concept analysis. The purpose of this stage was to develop a theoretical understanding of the concept being studied, language used and meaning behind terms and references to trust. I later used this to inform the interview process and discussions whilst being aware that I did not pre-empt participants' views in any way. It was useful for me to understand that trust encompassed other terms used more frequently such as 'satisfaction', 'need' and 'value' as these might be words that participants would use during the interviews. I will briefly describe the process to complete the concept analysis; the analysis itself is discussed in a separate chapter.

**2.3.1 Concept analysis:** Concept analysis models provide a framework for defining and clarifying what is meant by a given term, in my case 'trust'. The hybrid model [stage one] encompassed the principles of a literature review but differed from a systematic literature review in its wider focus, how it is analysed and presented. I chose to use this method instead of a systematic literature review because the emphasis of the concept analysis is to achieve greater understanding of the practice based meaning of the phenomenon being studied [Gould 2000] and the analysis allows exploration of common uses of the word to clarify, refine and sharpen the concept, dissecting it into smaller parts of the whole for improved understanding [Walker and Avant 2005]. I believed this would provide some clarity for me when gathering and analysing the data from the women's experiences, assisting me to dissect the transcripts into the relevant smaller parts of the concept. Using Rodgers' [1989] principles I was able to present a theoretical understanding of the language of trust and its meaning within the context of the midwife-mother relationship as will be seen in chapter three.

Concept analysis and its usefulness for nursing have been debated by many authors over the last two decades. Walker and Avant [2005] described the process as an important element of theory building and described eight steps to successfully completing a theoretical concept. However some authors have since disputed the usefulness of these steps suggesting that the theory generated lacks evidence of how it was derived and that Walker and Avant have not recognised the importance of concepts within a contextual framework [Duncan et al 2007; Rodgers 2000]. These concerns are discussed further in the concept analysis, chapter three. Rodgers (1989) suggested that concept analyses are aimed at defining the use of common language within a given context. Concept analysis needs to recognise the meaning of the phenomena within the context specifically being studied; the pattern of its use acknowledges the potential change of the concept meaning when the context of use is altered. This rationale was central to Rodgers' evolutionary method of concept analysis where she highlighted the potential changes within concepts and theories over time. Thus while words may be the same they may have different meaning to different people or in different situation. She suggested that it is essential in any concept analysis that the author acknowledges the conceptual similarities and differences within the language used and whether there are groups or circumstances which would suggest a different way of thinking about the phenomenon.

I began my exploration with the dictionary definitions of the word trust. In order to review the literature relevant to the concept I then completed electronic searches in

CINAHL, Medline, PubMed, MIDIRS and Cochrane database, using search terms of trust, trustworthiness and midwifery, midwifery models of care, midwife-mother relationship, trust and healthcare. Literature relating to nursing and maternity nurses was also included so as not to exclude countries that have different models of maternity care. All literature available in English was considered if it directly referred to the concept of trust from 1960 to the present day. Research, theory and opinion were included to give a rounded contextual view of the literature. The findings were divided into sections, trust within midwifery, trust in health care and the general concept of trust. A particular problem when reviewing the literature on trust is that the word trust is often interchanged with other terms such as: belief, confidence, reliance and satisfaction. Despite the debates around their meaning these surrogate terms were frequently interchanged with the word trust in the available literature and I acknowledged that this may also be apparent in the language used by the participants in the empirical data. Therefore it was necessary to explore these terms within the concept analysis to understand the common use of 'trust', as a colloquial concept [Rodgers 1989]. The detailed theoretical concept analysis will be discussed in chapter three.

Rodgers [1989], Walker and Avant [2005] and Johns [1996] suggested exploring the concept through model [cases that best demonstrate the concept], borderline [cases that display some but not all elements of the concept] and contrary cases [cases that do not demonstrate the concept at all]. Rather than using theoretical cases I anticipated using the data from stage two of the hybrid model [empirical data collection] to inform this aspect of the concept analysis. This was in keeping with hermeneutic phenomenology and the inner experiences of individuals, so it was necessary for me to leave the theoretical concept analysis here and move my discussions forward to elaborate on the development of the empirical data collection and stage two of the hybrid model. Hence stage two began before stage one was complete and for a short time I moved backward and forward between stages one and two using the theoretical analysis to inform the data collection and the data collected to inform the theoretical analysis.

**2.4 Hybrid Model Stage two:** The collection of empirical data was used to refine the concept whilst taking into account the lived experience of the participants. The purpose of this stage was not to test the concept but to understand the concept through the human experience of it, generating an understanding of the concept in the 'real world'. Before explaining Stage two – [the empirical data collection] in more detail I will

focus on the research paradigm and my choice of methodological approach for this empirical stage of the study.

**2.4.1 Research paradigm:** The foundation of any research project is determined by its research paradigm, a set of beliefs or practises which regulate the research enquiry [Weaver and Olsen 2006]. The paradigm guides the way in which knowledge is developed through the study. There are three key paradigms within healthcare research [Open University 2008]:

- The positivist paradigm investigates a world that can be measured objectively from an 'etic' position. The cause and effect relationship is observed by the researcher from outside the topic;
- The naturalistic paradigm seeks to understand phenomena from the lived perspective of those individuals who experience it. The researcher works with participants to explore an event in its natural setting;
- Critical theory research is guided by a belief that knowledge is associated with power and motive; all research has a purpose derived from a particular set of values introduced by the researcher to redress inequalities in the balance of power [Open University 2008 P15].

Traditionally many health related research projects were carried out within the positivist paradigm, a strong belief that investigation should be regulated by objective measurement and the testing of theory. However this approach is limited in its ability to address the study of social phenomena, personal experience and beliefs [Polit and Beck 2004].

There have been positivist studies of trust though I did not find any that specifically explored the phenomenon in midwifery. Many of the studies looking at trust within healthcare have been conducted within the USA and have attempted to quantify its meaning and presence through the use of a measurement tool or scale [Freburger et al 2003, Pearson 2000, Thom et al 1999, Kao et al 1998, Anderson and Dedrick 1990]. Pearson [2000] evaluates these tools and described the three main ones as: The trust in physician scale [Anderson and Dedrick 1990], primary care assessment survey [Safran et al 1998] and the patient trust scale [Kao et al 1998]. All the tools use a number of questions aimed at identifying the presence of trust within the relationship and comparing hierarchically the components of the concept. They do not agree on the definition of the concept and this may be interpreted differently by subjects making it difficult to compare the results. The scales are not designed for qualitative data but

may be used following the initial qualitative stages to measure the concept as it is understood to occur. The scales do not facilitate measurement of individual experience as they do not relate to specific situations or allow flexibility in the data obtained. The assumption appears to be that trust means one thing and that it is consistent across all people and all relationships.

The aim of the study was to explore the concept of trust within the midwife-mother relationship increasing understanding of the individual's experience of trust and its meaning to women. I decided that these scales and the positivist paradigm would be inappropriate for exploring the concept of trust as they would not facilitate exploration of the understanding of the women's individual experience. In order to achieve this, it was more appropriate to use a methodology underpinned by the naturalistic paradigm, which seeks to explore human experience in its natural setting.

Within the naturalistic paradigm, the key aim is to understand and uncover a truth or reality derived from the meaning that individuals place on the world which they themselves construct. It may not prove or predict anything but accepts that multiple realities can exist. Data are only relevant to the individuals being studied in the specific research setting [Polit and Beck 2004]. While naturalistic research is not broadly generalisable, in that the data obtained cannot be assumed to represent the wider population and the findings cannot be applied generically to the population as a whole, the findings can be transferable; ideas, themes and new knowledge can be transferred to other settings or contexts for further exploration. Data are read and interpreted by the reader who may identify with the described experiences or find new knowledge about the phenomenon and could transfer important aspects to similar contexts for their own benefit [Sheppard 2004].

Naturalistic research does not start out with a hypothesis to prove. Instead, naturalistic researchers search data for patterns and trends to understand the meaning behind an experience, a process which I undertook and that will be explained subsequently. Unlike positivist research the researcher is expected to conduct the study from an 'emic' position. That is, the researcher works within the topic area incorporating their experience and ideas with those of the participants [Currie and Richens 2009]. This is achieved through a reflective process and the study is driven forward by the emerging data in developing knowledge, theory and concepts [Hollaway 2005]. Conducting the study from an emic position appeared to be appropriate for my study, acknowledging that I was already familiar with the study setting, the concept and the relationship as

both a midwife and a mother. Therefore the naturalistic paradigm formed the foundations of the study and I will detail my consideration of the methodological approaches within this paradigm.

**2.4.2 Choice of methodological approach:** Three research approaches are described within the naturalistic paradigm [The Open University 2008]: Ethnography, Grounded theory and Phenomenology, each with a slightly different research aim. All three research approaches could have been useful in studying trust within the midwife-mother relationship. I will now briefly describe them and their appropriateness for my study.

**2.4.2.1 Ethnography:** focuses on describing a culture or group and the collective meaning of people's actions and belief within a specified culture. It usually involves collecting data using various approaches, for example undertaking interviews with key informants and participant observation. The aim of ethnography is to understand the social and cultural world. The researcher needs to adopt an exploratory approach with flexibility to respond to the emerging data [Holloway 2005]. Ethnography posed some difficulties in relation to the time intensiveness required to complete and the appropriateness for this particular study. The researcher takes on an insider role, observing the culture from within. It may have been challenging for me as a researcher to gain access to the intimate relationship between midwife and mother. The social interaction between midwife and mother could have been affected [Sharkey and Larsen 2005] potentially making it difficult for the midwife and the mother to establish a relaxed relationship which could, in turn, have a knock-on effect on the concept of trust. It may also have been difficult for me to separate my role as a researcher from my role as a senior midwife within the culture and social group being studied. My aim was to understand the concept from the individual's perspective and I did not feel that ethnography would facilitate the individual women's voices to be heard within the study.

**2.4.2.2 Grounded Theory:** is concerned with ways in which social interactions, motives, beliefs and social processes are constructed. Literature and empirical data are used together to formulate a theory. The researcher will continue to collect data until saturation point is reached, the point at which no further new information is being drawn from the collected data [Glaser and Strauss 1967]. Grounded theory research has many characteristics that may have been appropriate for this study; that is, interaction of researcher and participants, development of concepts by integrating literature and empirical data and focus on the meaning behind individual experience

[Willig 2001]. However, a grounded theory approach requires the researcher to know little about the phenomena being studied prior to the commencement of the study and to collect data until the point of saturation. I was already familiar with the topic and the relationships being studied and had begun work on a theoretical exploration of the concept including initial review of a moderate amount of literature. Bearing in mind Strauss and Corbin's [1998] caution about starting a grounded theory exploration without previous knowledge this would make a grounded theory approach more difficult and I decided to use a phenomenology based approach instead.

**2.4.2.3 Phenomenology:** The purpose of this study was to gain a deeper understanding of an existing theoretical concept through exploring women's lived experience of it, rather than generating new theory. Phenomenology shares many elements of methodology with grounded theory, but unlike grounded theory its emphasis is to explore and describe individual meaning rather than develop theory about social processes [Goodall et al 2009]. Brewer [2007] described phenomenology's aim as seeking to illuminate the nature of experience. Phenomenology is concerned with the meaning individuals place on their 'life world' and it was this that influenced my study design.

The main purpose of my study was to gain further understanding of the concept of trust by gaining an insight into the personal experiences of pregnant women. It was not my intention to establish whether one theory or another was best to represent women's experiences of trust but to use the experience of a specified group of women to provide greater understanding of the phenomena for midwives working in this field.

Phenomenology is the study of a conscious experience from the first person perspective. It seeks to develop complex awareness of one's own experience or inner self [Woodruff Smith 2008]. Therefore I designed my study based on phenomenological approaches and I set out to further understand this methodology from the available literature. I will now discuss the various approaches used within phenomenology and how this approach has been used in maternity care research.

**2.4.3 Phenomenological approach:** There are several types of phenomenological approach described within the literature; Husserlain, Heideggarian, Hermeneutic and Interpretive are used by authors to describe their phenomenological approach. Both Hermeneutic and Interpretive phenomenology appear to be based on the foundation of the Heideggarian philosophy in their attempt to work with participants, reflecting back and forth with the researcher to discover the meaning behind the phenomena.

Historically phenomenology was developed within philosophy during the 20<sup>th</sup> century by two key philosophers, Husserl and Heidegger, who in the 1960s were instrumental in developing this approach.

Husserl [1962] proposed that meaning could be described as distinctive/ personal constructs. He suggested that a person's life world included not only events but also what we make of them, our values, attitudes and beliefs. He felt that within a given phenomenon there was a deeper meaning or essence which could be influential to a wider society. The purpose of Husserlain phenomenology was for the researcher to "deconstruct" individual experiences in order to interpret and discover the essence of the phenomenon being studied which moved beyond the naive simple explanation to a deeper understanding which may be universal to society.

Husserl described the researcher's role as one of an interpreter whose aim was to avoid influencing the data by 'bracketing out' the researcher's individual experience. Berg et al [1996] used this approach in a Swedish study involving eighteen women and their experience of encountering midwives during childbirth. The study looked at the phenomenon of 'presence'. In their methods they described using four basic steps. The first involved 'bracketing out' the researchers' theoretical and experience based knowledge-{reflecting on their own position, thoughts and feelings and documenting them clearly in a reflective diary – separating it out and putting aside}- in order to secondly consider the data collected with an open mind. Not all authors agree that it is possible to put aside the researchers' existing knowledge and experience in this way.

Sociologist Alfred Schutz [1976] moved away from Husserl's strict methods to claim the importance of starting from the perspective of the life world of the researcher in relation to the phenomenon, suggesting that the researcher needs to understand their own meaning before they can understand the other person's meaning. He stressed the importance of communication, interaction and knowledge of self as a means to facilitating the understanding of what Schutz [1976] described as 'first order constructs' – the daily life experience of another. Schutz's ideas seemed appropriate to my own situation as a midwife researcher. I felt uneasy about the notion of bracketing out myself within the study as my own experiences as a midwife and a mother were central to the journey I had taken in developing my interest in this area. I believed these experiences had undoubtedly played a significant role in the person I had now become. I didn't feel I would be able to detach myself from these experiences as a researcher. It



was important for me to find a way of acknowledging myself within the research process.

In contrast to Husserl, Heidegger [1962] believed that people are intrinsically linked to the world in which they live; they are born into a set of circumstances. Identity is therefore partly pre-determined and to be authentic we must strive to understand ourselves. He argued that personal experiences were unique and that shared essences did not exist. In his descriptions, the aim of the phenomenological researcher was not to deconstruct and interpret data but to construct meaning through a hermeneutic cycle. That is, to use the evidence available from the researcher's own experience along with the experiences of participants and to work together in constructing meaning and ways of describing the world. Later authors who have been influenced by Heidegger tend to describe their research approach as hermeneutic reflecting the development of Heidegger's approach and the hermeneutic cycle. Lester [1999] suggested that a researcher is unable to remove oneself from the research emphasising the importance of making the process transparent with the researcher as a visible, interactive part of the research rather than an impartial observer. She suggested this can add an interpretative dimension which will improve the basis for the research findings to be used in developing clinical practice and policy rather than presenting a pure description. Maggs-Rapport [2001] described a type of phenomenology that embraced hermeneutics – an acceptance of the researcher as a positive element, examining the nature of reality, enquiry and the role of the researcher. The preconceptions and bias of the researcher are accepted as a positive element.

This reflexive involvement of the researcher is described a little more clearly in the phenomenological approach used by Hunter [2008] who adopted a Heideggarian phenomenology approach to analyse American midwives ways of 'knowing' during childbirth. This involved an active process of the researcher reflecting back on their own experiences and working with the empirical data in a hermeneutic cycle. First the researcher chooses to explore a phenomenon of serious personal interest and experience. This enables the researcher to utilise her past experience and 'tacit prior knowledge'. Secondly, the phenomenon is explored through the lived experience of the participants. Thirdly the researcher reflects on themselves and uses this knowledge to further develop the themes emerging through interpretive statements. Within the hermeneutic cycle, researcher preconceptions and prejudices are embraced and have value in enabling a deeper understanding of the phenomenon being studied [Koch

1999]. Koch suggested that many experiences of a given phenomenon can exist within the social world and in order to construct an authentic account the researcher must become an integral part of the study working in partnership with the participants. Becker [1992] described the importance of phenomenology as a valid and rich source of knowledge about human phenomena, as exploring human experiences can illuminate the phenomenon being studied. He, along with Schutz, [1976] suggested that phenomenological research has an important part to play in helping develop understanding of an individual's experiences of things that are otherwise taken for granted in everyday life.

Hermeneutic phenomenology was an appropriate approach for the empirical stage of my study as my aim was to understand the concept of trust within the context of the women's lived experience and I intended to use the empirical data to add meaning to the theoretical analysis, constructing an authentic concept analysis that reflected the context in which I was studying trust. I understood this type of phenomenology to be concerned with understanding the inner emotions and the intimate nature of an experience and using it for my study would allow the voices of the women to be the central focus. However, I also needed to recognise that as a researcher I had a keen interest in the concept of trust and my own experiences and knowledge meant that I was intrinsically linked to the phenomenon and I did not feel that I could bracket out my own experiences completely. While a hermeneutic cycle would enable me to acknowledge my presence, it would also ensure that the women's voices were not overpowered by my own professional voice. Working backwards and forwards in an attempt to fuse the ideas of the participants and the researcher as intended within hermeneutic cycles was an appropriate methodology for the hybrid model which also described a process of working backwards and forwards between the theory and the empirical data collection. Therefore, hermeneutic phenomenology used within the hybrid model would ensure that the concept analysis represented a contextual understanding of trust based on a fusion of theory, lived experience of the participants and the reflexive involvement of the researcher. It was important for me to explore other studies within midwifery that had used a phenomenological approach to improve my understanding of its appropriateness for my study. I had not encountered during my literature review other phenomenological studies involving collection of longitudinal data, as intended in my own study, however I was able to draw on two midwifery studies that explored women's experiences using a phenomenological approach at a given time. Both Goodall et al [2009] and Dibley [2009] used phenomenological

approaches in their studies involving women in the UK. They emphasise that the commonality and shared experiences of the researcher help in building a rapport with participants, enabling them to feel more confident in sharing experiences. The authors acknowledge that the necessary close involvement of the researcher inevitably led to findings being subjective and only reflective of the specific aspect and reality of the specified participants. Dibley [2009] emphasised the importance of what she described as 'insider' knowledge of the researcher and how this knowledge can enhance the dialogue between researcher and participants to allow a deeper exploration of the phenomenon. I anticipated using my 'insider knowledge' to build a rapport and aid discussions with my participants to enable a deeper exploration of trust. However researcher influence requires careful monitoring so Dibley [2009] adopted a reflexive stance and kept detailed field notes which were monitored and managed through research supervision. I intended to adopt the same process in my study.

I was aware of the potential for the women in my study to discuss at length their experiences. My role as a midwife was often to listen to women's birth stories and I understood the potential for this to generate a large quantity of research data. I would also be required to acknowledge and address my influence on the research as both a midwife and a mother. As a student researcher I was also nervous about my skills around conducting and analysing the research; there was a degree of uncertainty in my mind and the idea of detailing my journey through the study in a transparent way enabled me to feel confident in gaining reassurance from my supervisors at each stage of the process. Nothing would be hidden and therefore errors would be identified early and addressed effectively. I felt it was important for me to develop my skills and understanding of reflexivity to be able to commence this at an early stage of the research process and document the decisions made throughout the study.

**2.4.4 Reflexivity:** Reflexivity has been used in social science research where researchers recognised the importance of acknowledging themselves as human beings, experiencing a range of emotions and life experiences that would undoubtedly have an impact on the research they were conducting. Gilgun [2010] described reflexivity as awareness by the researcher of personal experiences, emotions, opinions and the effect these have on the research process, as well as an awareness of the effect the research process would have on the researcher as an individual. She suggested that writing and discussing emotions, experiences and emerging thinking will ensure that researchers share and consider their own influences on the research

and its emerging themes. This, in turn, will ensure the quality and credibility of the overall research I therefore used this approach for my study.

As the researcher for this study I must acknowledge my influence as an experienced midwife and the past relationships which I have formed with women in my care. I have also experienced the relationship from the participants' point of view in the relationships which I formed with midwives during the birth of my four children. I therefore already had my own personal understanding of trust from both sides of the relationship. As both midwife and mother, my preconceived ideas and prejudices about the concept of trust within this relationship would be very difficult to 'bracket out' or put aside. Instead I used these in encouraging participants to develop a relationship with me as a researcher. If my professional and personal background were to be denied it is possible that participants could have felt deceived and have become reluctant to share fully their own personal reflections. It seemed appropriate for me to formalise and monitor this exchange of self through the use of a hermeneutic phenomenological inspired approach. A reflexive diary was used and discussion with research supervisors explored how my personal experiences influenced the rigour of the data collection, analysis and interpretation.

My early thoughts and experience of the interview for the RCM Ruth Davies Bursary highlighted the importance of being clear about what was meant by the word trust and the elements that it included. It was important for the study to begin the concept analysis with the available literature on the concept of trust, in order for me to understand the experiences of the participants. The theoretical concept analysis, hybrid model stage one, assisted me in my evaluation of what aspects of the participants' conversations were important to my exploration of trust within the midwife-mother relationship. Phenomenological data collection appeared to have very little formal structure. In principle the idea of having open conversations with participants and letting them tell their stories about their own experiences and in essence allowing those stories to speak for themselves was both appealing and frightening in equal proportions. As a novice researcher I was concerned about my ability to participate in this very open method of data collection and how I would decide which data were relevant during analysis to gain a better understanding of the concept of trust as laid out in the research aims. I was concerned about my level of experience in data analysis and ensuring adequate rigour that would result in robust findings of interest and use to the midwifery services. During my initial early exploration of the literature I came across a phenomenological study [Davis 2010] which used a 'hybrid model' as its

theoretical framework. I felt confident that this approach would aid my ability to incorporate my concept analysis with the empirical participant experiences to develop a greater understanding of trust within the midwife-mother relationship.

The hybrid model carried out within the Heideggerian phenomenological approach seemed appropriate for my study. Phenomenology allowed the concept to be explored within the lived experience of the participants in the natural setting. Heidegger acknowledges and embraces the researcher's prior knowledge/ preconceptions and encourages the researcher to use these to assist in constructing meaning from the experience. The hybrid model provides a theoretical framework for incorporating the literature and theory in the developing concept analysis as a continuous concurrent process. It is a useful structure to guide a novice researcher such as myself.

In this section I have explained the influences on my study design particularly in relation to stage two of the hybrid model, the empirical data collection. It is important now to focus more clearly on the methodological detail for the collection of the empirical data hence I will describe in the next few sections the recruitment of the research sample, the longitudinal design and the interview process.

**2.4.5. Recruitment of the research sample:** In order to obtain rich, in-depth data that generates understanding of experiences, sample sizes in qualitative research tend to be smaller than those used for quantitative research and the type of sampling will vary according to the research design. It was anticipated that, during the six month period allocated, the research area would have a population of around three hundred pregnant women who would be suitable for recruitment to the study according to the inclusion criteria. The danger of too large a sample is the reduction of depth and detailed understanding [Gerrish and Lacey 2005]. Sample sizes vary in the literature but most agree that for a qualitative phenomenological study small numbers are ideal [Gerrish and Lacey 2005]. Ashworth [1997] suggested five to ten participants is usual while Schwartz-Barcott and Kim [2005] identified three to six individuals as appropriate. Similar studies carried out using the hermeneutic phenomenological approaches have used between eight and thirteen participants [Dibley 2009, Davis 2010, Peterson et al 2009 and Goodall et al 2009].

As I was exploring the concept longitudinally by conducting repeated interviews with the same participant, it was anticipated that a minimum of five participants should complete the study. Recruitment was initially slow, as I had feared the midwives and the women's priorities were not focussed on my research study and this was also

affected I felt by my lack of presence in the setting as I was on maternity leave at the time of recruiting. I returned from maternity leave three months into the recruitment process during which time several potential participants had not consented to take part – I wrote my frustration in my reflective diary.

*Sadly my first recruit cancelled our appointment for the interview at the last minute and, in fact, went on to cancel the next three appointments for various reasons. I took a while to acknowledge it but came to conclusion that really she didn't want to take part and so left it with her to contact me to arrange a fourth date. Up to now I have not heard from her. The second teenage girl did not answer any of my calls or texts so I wrote to her, enclosing the consent form. She never returned it and seven contacts later, I gave up. My third contact was keen to take part but when asked how many weeks she was it was too late in her pregnancy; the midwives had given the information to her at the birth plan visit rather than the booking visit. The fourth was a busy mum with four children who had thought it would involve a postal questionnaire and did not feel she had time for meetings and interviews.*

*Reflective diary 21/10/2010*

Following my return to work the midwives were able to ask me during our normal working day for more information about the study and how the recruitment was progressing. This appeared to encourage them to discuss the study with the women and participant interest increased during the last three months of recruitment when I received twelve contact forms.

Recruitment ceased after ten participants had consented and I commenced the research process. I felt ten was important to allow for participants leaving the study due to relocation, miscarriage, neonatal death, mental illness or other unforeseen circumstances. Only one participant left the study and twenty-five interviews were conducted in total.

A purposive sample was used for this study as this allowed me to deliberately select participants who had experienced the phenomenon [Polit and Beck 2004, Bowling and Ebrahim 2005]. In purposive sampling the researcher identifies the characteristics they desire within the participants in order to obtain deeper understanding of the phenomenon [Burns and Grove 2005]. For my study this included women who had the opportunity to experience a close relationship with a midwife throughout a straightforward pregnancy. A purposive sample is not necessarily representative and

findings may not be generalised but this is of less concern within a phenomenological approach which looks to understand individual meanings.

I selected a purposive sample from a target population of pregnant women, who were considered suitable for midwife-led care at initial booking [around 8-12 weeks of pregnancy] within a geographical area where midwife-led care was offered in the community setting to both nulliparous and multiparous women during the six month recruitment period. As the study was exploring the concept of trust within the midwife-mother relationship, it was important that the participants had the opportunity to develop that relationship with a midwife as their primary carer. This was more likely to occur when a mother was considered 'low-risk' i.e. she had a straightforward pregnancy [see table 1] and in an area where midwife-led care was routinely offered.

**Table 1: Women considered to be Low-risk**

<b>Not have any history of:</b>	<b>Not experienced a previous pregnancy complicated with:</b>
<ul style="list-style-type: none"> <li>• cardiac disease, including hypertension</li> <li>• renal disease</li> <li>• endocrine disorders or diabetes requiring insulin</li> <li>• psychiatric disorders (being treated with medication)</li> <li>• haematological disorders</li> <li>• autoimmune disorders</li> <li>• epilepsy requiring anticonvulsant drugs</li> <li>• malignant disease</li> <li>• severe asthma</li> <li>• use of recreational drugs such as heroin,</li> <li>• cocaine (including crack cocaine) and ecstasy</li> <li>• HIV or HBV infection</li> <li>• obesity</li> <li>• or underweight (body mass index below 18 kg/m<sup>2</sup>)</li> <li>• higher risk of developing complications, for</li> <li>• example, women aged 40 and older, women</li> <li>• who smoke</li> <li>• women who are particularly vulnerable (such</li> <li>• As teenagers) or who lack social support.</li> </ul>	<ul style="list-style-type: none"> <li>• recurrent miscarriage (three or more)</li> <li>• preterm birth</li> <li>• severe pre-eclampsia, HELLP syndrome, eclampsia</li> <li>• rhesus isoimmunisation or other significant</li> <li>• blood group antibodies</li> <li>• uterine surgery including caesarean section,</li> <li>• myomectomy or cone biopsy</li> <li>• antenatal or postpartum haemorrhage on two occasions</li> <li>• puerperal psychosis</li> <li>• grand multiparity (parity four or more)</li> <li>• a stillbirth or neonatal death</li> <li>• a small-for-gestational-age infant (below 5th centile)</li> <li>• a large-for-gestational-age infant (above 95th centile)</li> <li>• a baby weighing below 2.5 kg or above 4.5 kg</li> <li>• a baby with a congenital abnormality (Structural or chromosomal).</li> </ul>

[NICE 2010 Antenatal Care Quick Reference guide Pp7-9]

Participants had to be eligible for midwife-led care [care provided by a midwife as the lead professional] according to local clinical criteria [based on NICE criteria above] but did not have to actually receive it. It was decided that the sample would include women who had chosen to access care from a GP or Consultant, because as long as they remained low-risk, they would still receive a significant amount of care from the midwife. Participants birthed their babies in the home, the midwife-led care unit or the District General Hospital. Women who developed complications during the period of the study were not excluded but were offered the opportunity to continue to develop the concept. The change in circumstances enabled me to gain a deeper understanding of the concept for that individual participant.

Exclusion criteria included:

- Those women considered by the midwife unsuitable for midwife-led care at booking.
- Women identified by the local midwife as suffering from mental illness.
- Women who were unable to give informed consent to participate.

During the six months following approval by the Ethics committee, all pregnant women who were considered suitable for midwife-led care in the area being studied were invited to take part in the study. The time scale was applied to allow the study to collect longitudinal data while adhering to the time constraints of the PhD programme and ensuring timely completion. I will discuss my rationale for a longitudinal study before describing in depth the data collection method.

**2.4.6 Longitudinal design:** An initial review of the literature of trust and the midwife-mother relationship indicated that the phenomenon being studied may in fact develop or change as women progress through their pregnancies. Therefore I decided that it was appropriate to explore the phenomenon longitudinally over the period of the relationship that mothers usually have with their midwives. Longitudinal research allows data to be gathered on a number of occasions over a given period of time and is ideal in looking at the nature of change at an individual level [Ruspini 2002]. Similarly to Kabakian-Khasholian et al [2000] who studied Lebanese women's responses to the medical management of pregnancy, this study followed a time line covering the phases of pregnancy, birth and post birth. Longitudinal designs enable exploration of changes over an extended period of time and thus I considered this to be useful in exploring the changes in the concept over the duration of the midwife-mother relationship. Gerrish



and Lacey [2005] stressed that when studying a lived experience it can be difficult to obtain in depth data using just one interview. They suggested that capturing the rich detail of an evolving experience is more likely using a method of sequential interviews.

Conducting one snap shot interview would only allow the exploration of trust as experienced at that given time or what Johns [1996] described as the outcome of trust. It would not allow an understanding of the process of trust, how it changed and developed and the evolving experience of participants. This would limit my analysis of the concept. Rajulton [2001] suggested that longitudinal research allows the exploration of growth, patterns of change and a picture of cause and effect over a given time. Rajulton also acknowledged the debated negativity of longitudinal research in that it takes longer, is less economically sound and may not add any real value to cross-sectional research. He proposed that the alternative may be to collect cross-sectional data from groups at different stages of the process simultaneously and combine the data for a fuller understanding. This would be unlikely to provide adequate data for the study of trust within the midwife-mother relationship as the basis of the study lies in the interpersonal relationship being developed and it is essential to follow each pair in order to understand the concept of trust within that individual relationship.

Careful planning was required as longitudinal designs can be expensive and require a long time commitment and the amount of data generated can be large [Burns and Grove 2005]. Another aspect of concern for Rajulton [2001] was the limited resources available to assist the researcher with data analysis in what could be an excessive amount of data generation. Rajulton [2001] highlighted a need for more dynamic models for analysis responsive to the longitudinal method used. In order to manage this within the study I used the hybrid model to aid in maintaining focus and structuring the data collection. I managed the data using Nvivo computer software developed for qualitative data storage and ease of coding and identification of themes which I will discuss in more depth later.

Three interviews were carried out with each participant. The first took place as soon as possible following the booking visit with the midwife [approx. 8-10 weeks of pregnancy]. I was able to collect data important for exploring the concept of trust during the initial stages of the relationship. It enabled the participant to discuss the concept of trust at this early stage when a relationship between woman and midwife had yet to be formed. This was important to the concept development in relation to distinguishing between the two main types of trust described in the literature, interpersonal trust and

organisational trust which will be considered in chapter three, the theoretical concept analysis.

The second interview took place around thirty-seven weeks of pregnancy. My aim at this stage was to explore the concept in relation to the now established relationship and to discuss the possible changes to how trust was conceptualised or the experience of trust as the pregnancy progressed. Exploring the concept of trust at this point was intended to enhance the data gathered from the literature relating to the presence and influence of values and expectations and how the concept of trust influenced the decision-making process. After a period of getting to know each other and establishing a relationship the 36 week visit is a key point for both parties to formalise, write down and agree on the important wishes of the mother and how the midwife will aid her to achieve the outcome that she wants. It was important to generate the data at this stage as it allowed an understanding of the participant's experience of developing trust as a process up to this point. It also allowed an understanding of trust as an outcome at this specific point in time where need and expectations around birth were heightened. I prepared for this interview by mapping the initial analysis codes from the first interview and making notes about areas that I wanted to discuss further. I used these notes as pointers for the discussions with the women. This worked well as three of the women had also made some notes following the first interview and they appeared to be reflecting on the discussion, either reinforcing the ideas previously discussed or clarifying how those feelings and perceptions had now progressed. This was an example of myself and the participants working together to build an understanding of their experiences.

A third interview was carried out at six to eight weeks following the birth. The purpose of this interview was to explore the concept of trust after the end of the woman's relationship with the midwife. The participants had been discharged from midwifery care at this point and may have felt more able to disclose negative experiences related to trust within the relationship than when they were receiving care. The concept could have changed following the birth in relation to whether previous expectations had been met. It was also an ideal opportunity for the researcher and participant to share and clarify the data retrieved at earlier interviews and explore the meanings for the participant and how this compared to the literature and reflexions of the researcher.

None of the women shared any further information at this stage that they had felt unable to share earlier in the process and few references were made to issues during

the postnatal period. The majority of participants used this interview as an opportunity to tell their birth story and to share with me their service feedback. They discussed what they felt was good care and what could be improved within the local midwifery service. This related to the Health Board on an operational level rather than specifically related to the concept of trust. This presented some challenges to me as an employee of the maternity service as I felt obliged to acknowledge the women's comments while not compromising their anonymity or my research study. For the integrity of my study I needed to clearly separate my role as a researcher from my role as a midwife. I also needed to ensure that I did not disclose information locally that would be contrary to ethical research conduct or that could later have a bearing on my research findings. I managed this through regular discussion with my research supervisors, separating this data on Nvivo to be fed back to the organisation at a later date and recording in my reflective diary. For now I will focus on the interview process.

**2.4.7 Interviews:** The aim of this phenomenological study was to capture the lived experience of participants. Taylor [2005] suggested that interviews are the preferred method to achieve this.

It could have been possible to conduct group interviews such as focus groups. The advantages of focus groups are described as encouraging group dynamics to assist people in expressing and clarifying their dialogue. Participants may feel more confident in a group setting [Burns and Grove 2005]. However, this benefit can also be a disadvantage in a study wishing to collect individual data on a personal topic, as focus groups may not encourage all participants to share their experience of such an emotional and personal topic. Group participants with strong opinions may influence the thinking of less confident participants and the direction of the discussion may be guided by the most dominant participant in the group, thus missing essential information from quieter participants [Kitzinger 2005]. One to one interviews appear more appropriate for the study of trust than focus groups for their ability to collect detailed individual accounts as opposed to general group accounts. Advantages of the interview method are described by many and include: cooperation, greater quantities of information, flexibility allowing the researcher to explore with greater depth and the ability to collect data in participants' own words [Burns & Grove 2005].

Bowling and Ebrahim [2005] described three main types of interview. Structured interviews use a specific set of closed questions which are identical in every interview, whereas semi-structured interviews contain a mix of both open and closed questions.

Closed questions direct the respondent to choose one of a set choice of answers. The information required from the respondent is fixed whereas an open question allows the respondent more freedom to answer in their own way. The third type described are unstructured interviews which are entirely participant led allowing them to tell their own story without direction or intervention. Semi-structured or open interviews can be more flexible responding to the direction set by the participant and non-verbal body language can be noted [Bowling and Ebrahim 2005, Taylor 2005, Polit and Beck 2004].

Hermeneutic phenomenology is concerned with meanings behind an experience and as such the data gathered must reflect personal insight and in-depth descriptions [Gerrish and Lacey 2007]. I felt this would be difficult to predict and therefore a structured interview approach would not allow the flexibility required. Rapport [2005] emphasised that hermeneutic interviews need to encourage a conversational relationship for in-depth discovery, incorporating the views of both participant and researcher. An unstructured interview may not have allowed me to influence the direction of the conversation and there was a risk that participants could spend too much time discussing issues not relevant to the phenomenon being explored; this would not assist in the development of the concept. I decided to use a semi-structured interview as it offered a broad structure but was flexible enough to allow participants to develop their own narratives and expand on areas important to them, allowing the participant and myself to jointly develop and guide the interview process.

It is important when trying to generate understanding of a lived experience to allow participants to express their experiences in a language with meaning to them – their own words. One to one interviews enabled the focus to be driven by participants; this was essential for exploring the areas of the concept that were important to the women, not simply testing the concept as a theory. Interviews also provided an opportunity for me to probe and clarify meaning. It must be acknowledged that this face to face, one to one contact could also be a disadvantage. Obdenakker [2006] argued that interviewer's voice, social cues and body language can direct the participant in the desired direction and not be responsive to the emerging themes identified by the participant. Interviewees may be keen to please and say the 'right' thing. Obdenakker suggested minimising this risk by using a detailed interview guide and tape-recording the interview so it can be listened to and reflected upon accurately. This in itself is problematic – for open or semi-structured interviews it is not possible to have a detailed interview guide as the interviewer is required to respond to emerging themes through the interview. Obdenakker [2006] also warned of the inconvenience of one to one

interviews in terms of time taken and expense of travelling to meet participants, delays and inconvenience if participants cannot make the interview on the set day.

These issues were considered in the study; as the research site was rural in nature meaning that there was a lot of travel involved. However in line with the principles of the naturalistic paradigm it was important to interview participants in their own home environment to focus the content on them as an individual, allowing them to feel comfortable in the environment for the interview and this was anticipated to aid in recruitment and reduced inconvenience to participants.

Similar studies using a semi- structured interview method of data collection [Davis 2010, Dibley 2009,] specify the length of interview to be between forty- five and ninety minutes long and this time frame was experienced within the study. The semi-structured interviews used a flexible conversational interview technique as described by Taylor [2005] allowing the researcher and participant to jointly develop the concept. Taylor suggested using an interview guide which outlines themes, topics or events rather than formal questions. My interview guide was obtained from stage one, the initial theoretical concept analysis. Participants were guided to think about initial trust and interpersonal trust. Themes for the interview guide were the characteristics of trust in relation to midwifery as highlighted within the initial literature review and included: expectations, goodwill, risk, value and emotion [see interview guide in Appendix 7.3].

**2.4.8 Interview skill:** The quality of data collection is dependent on the quality of the interview and skills of the interviewer. Rapport [2005] explained the importance of researchers using prompts, interjection and active listening, sharing their own personal perspectives and interaction with the data. Taylor [2005] also highlighted the limitations of qualitative interviews and the risk of the impact of the interviewer on the process. Taylor [2005] suggested using probes and reflection during interviews but cautions researchers to remain non-directive. Similarly, Patton [2002] supports the use of probes to allow a deeper exploration of the experience. Four types of probe are described: detail [who, what, where, how], elaboration [non-verbal cues to encourage participants to keep talking], clarification [reflecting back a response] and contrast [something to push off against]. Patton also described six types of interview question suggesting that interviewers commence with background, easily answered questions moving through a process of sensory, knowledge, emotional, values and lastly behavioural type questions. Conversational interviewing can be difficult for novice researchers and Price [2002] suggested using a similar but easier to understand

technique as that described by Patton to assist the novice researcher. Price [2002] described a method of 'laddering' questions to help focus the discussion on the research topic. Laddering is aimed at clarifying the meaning of what a respondent has said using verbal probes to establish that what people say is what they mean [Rugg and Petre 2007]. 'Laddering' operates at three levels depending on invasiveness of the question. It begins with questions about actions [which are less intrusive] followed by questions about knowledge and lastly questions about feelings/ values [which are more invasive] [Price 2002].

"The advantage of laddering is that it encourages respondents to give their answers in clear short chunks rather than long ramblings." [Rugg and Petre 2007 P125]

Price [2002] emphasised that laddering does not necessarily have to be completed in one interview but may be more effective if used over a series of interviews where more intrusive questions can be left until the researcher-participant relationship has developed in later meetings. In order to do this it is essential for the researcher to keep a detailed diary/ notebook in order to highlight possible 'leads' which might be explored further in a subsequent interview [Price 2002]. I used all of these principles for my study.

**2.4.9 Interview process:** Accepting the advice of all these authors, the study interviews were organised in a format described by Legard et al [2003] that sets out the interview process as a set of stages.

**2.4.9.1 Interview Stage one:** *Arrival*- the first few moments of meeting are crucial in establishing a rapport with the participant, including a general personal introduction. In a study such as this the interaction of the researcher was accepted as part of the process for developing the concept. Ann Oakley's [1982] work looking at women interviewing women has influenced many feminist researchers. She described interviewing women as cosy, friendly, sisterly exchanges of information. Women interviewing women can lead to a sharing of stories and space as opposed to the more usual power and control issues noted in other research studies. Feminist researchers following on from Oakley suggested an idea of interviewing 'with women' rather than 'on women' [Puwar 1997].

Knox et al [2000] stressed the importance in qualitative studies of the research interviewer's credibility and trustworthiness in order to build a rapport and relationship

with participants. As a woman and a mother I had the ability to build a rapport with the study participants through a shared feminine identity similar to that described by Oakley [1982]. Dibley [2009] agreed with the idea that positive bias can allow a deeper exploration of the research topic and familiarity of the issues can enhance the dialogue. This can be helped by sharing one's own experiences of the phenomenon. However, Dibley also recognised the risks of being too close to the subject and 'blurring' the data. I adopted her description of managing this risk through adopting a reflexive stance and through accessing regular research supervision for my study.

**2.4.9.2 Interview Stage two:** *Introducing the research-* a brief explanation about the intention of the research was provided, similar to that already supplied through the participant information pack.

**2.4.9.3 Interview Stage three:** *Beginning the interview-* I began with a broad open question such as:

**Initial Interview:** "I'd like you to tell me about your first contact with the midwife."

**36 week interview:** "I'd like to hear more about your relationship with your midwife."

**Post Birth Interview:** "I'd like to know more about your relationship with the midwife since your baby was born."

**2.4.9.4 Interview Stage four:** *Guiding the participant through the key themes identified in the literature.* It was not possible in this study to detail exactly what these questions would be as they were developed concurrently with the literature, participant experience and researcher's reflexions as described within the hybrid model. Probes were utilised within the laddering technique described earlier. The four categories of probing were used as described by Legard et al [2003]. Exploratory: views and feeling behind described behaviour. Explanatory: exploring the reasons, asking why. Clarificatory: Clarify terms and explore the language used and sequences. Challenge: explore any inconsistencies. Where a theme was perhaps more difficult to explore in the initial interview, notes were made in my reflective diary and were followed up with both theory and empirical data at later interviews.

My experience of carrying out the interviews varied between participants and rapport was an important aspect. Some participants engaged in the conversation style process and the use of probes was easier where I felt comfortable with the participant. Despite my anticipation that probing may be more necessary with women who were less

comfortable discussing their experiences, I found it more difficult to naturally progress through the stages of probing where the interview was more challenging and where I had not taken enough time to prepare and rehearse. I reflected in my diary my experiences with one particular participant.

*Interview 6.2 was a challenge. After my euphoria from interview 5.2 I didn't worry about my preparation and had not had time to analyse her first interview. I went along confident but this participant had very little to say; very little had changed from the first time and her attitude to the midwives was perhaps one of indifference? Maybe that applied to me too as I too am a midwife. I tried, but perhaps not hard enough, to explore her feelings but I found it really difficult and my brain was frozen as to what to ask her. She paused a lot and so did I. It felt awkward and the silence was stifling. I tried to fill the gaps with chat about her other child but really this only added to the distraction from the topic and my ability to focus. Reflective Diary 17/07/2011*

For the interviews to be successful it was important for the participants to trust me and to build a rapport with me; to do that I needed to demonstrate that I had considered their individual rights and needs within the process. Prior to commencing the empirical study ethical approval and NHS R&D approval was required I will briefly describe this here.

**2.5 Research Ethics:** Important throughout research design, conduct and evaluation were ethical considerations. The proposal was reviewed by Local Research Ethics and the appropriate Research and Development Committee's full approval was sought and obtained [see appendix 7.1]. Ethical research is important not only for the trustworthiness of healthcare research but also for the trustworthiness of the healthcare profession and the researcher needs to be constantly aware of ethical issues [Royal College of Nursing 2009[RCN]. Burns and Grove [2005] discuss the ethical issues involved in conducting a research study under the subheadings of five human rights which require protection: right to self-determination, right to privacy, right to anonymity and confidentiality, right to fair treatment and right to protection from discomfort and harm.

**2.5.1 Self-determination:** All women who were approached were autonomous individuals capable of informed consent. Informed consent is essential to ethical research practice [RCN 2009]. In order for informed consent to be sought, study information was provided in accordance with guidance from the National Research Ethics Service [National Research Ethics Service [NRES] 2009]. An information sheet



was written in two parts. Part one included clear and brief information about the study topic and specific elements of interest to allow women to decide whether the study was of interest to them. Part two contained more detailed information about the study process, confidentiality and data protection [NRES 2009], [Appendix 7.2]. Local Midwives were asked to give information to women who were eligible to take part in the study and gain consent to pass the woman's contact details to the researcher. Once the contact form was received I made direct contact by phone with the potential participant in order to clarify and discuss study information and allow time for women to ask questions. Discussion is suggested by NRES [2009] as the most effective way of obtaining consent; women were free to choose at this point whether to participate or not. Reassurance was given that this decision would have no effect on the midwifery care they received. Written consent to participate in the study was obtained without coercion. Participants were informed of the right to withdraw from the study at any time without penalty. Participants were free to disclose or withhold information at any point during interviews.

**2.5.2 Privacy:** It is inevitable that in order to recruit participants and to complete the PhD, data needed to be shared with a limited number of key individuals and this has implications for the researcher in managing data sharing while respecting a woman's right to privacy. Women were in the first instance asked by their midwife for permission to pass contact details to the researcher and only the women who consented to this were approached for the study. Protection of privacy was important in this study as the very nature of phenomenology involves exploration of personal beliefs and experiences. Interviews were being audio recorded with consent. Data were anonymised and stored on a secure NHS laptop in the form of anonymous electronic transcripts that I typed. Hard copies of notes, transcripts and tapes were stored in a locked filing cabinet in a locked office within a secure NHS building. Participants were informed that anonymous data would need to be shared with the research supervisors and the final research report would be shared with the Local Health Board and professional groups. They were also informed that findings would be published in relevant professional journals and that data would be kept for up to five years following completion of the study to allow for audit and reflection [RCN 2009].

**2.5.3 Anonymity and confidentiality:** Complete anonymity was not possible as I needed to know the identity of participants in order to conduct face to face interviews. It was necessary to connect transcripts to individuals in order to ensure a link with the discussion in follow up interviews. However anonymity was provided in the research

study by the application of an interviewee number rather than name and transcripts were coded within NVIVO 9 in order for individual lines of text to be linked back to the original interviewee number. Participants were later given pseudonyms for writing up. As a practising midwife I was guided by the Nursing and Midwifery Council Rules and Code of Conduct in relation to confidentiality. All efforts were made to protect the participants' privacy, anonymity and confidentiality but any circumstances of disclosure of an illegal act, child protection issue or professional misconduct would have led to a professional responsibility on my behalf to breach confidentiality. Participants were informed of this requirement prior to taking part. Where sensitive issues were discussed which highlighted any of the above circumstances it had been agreed with the Local Research Ethics Committee that a process of dealing with this would have been employed through reporting to local midwifery supervision. This was not necessary during the study.

**2.5.4 Fair treatment:** Women who were approached to take part did so specifically because of their experience and ability to explore the phenomenon being studied. All participants were treated fairly and with respect for their wellbeing. They were made aware of the purpose and processes, including what participation involved for them. The three interviews were carried out at a time and place convenient to the participant by prior arrangement. I ensured that I arrived on time and terminated the interview at the agreed maximum duration of ninety minutes though some were terminated early by the participant. Participation in the study did not change or alter the midwifery care they received.

**2.5.5 Protection from discomfort and harm:** This study carried relatively low-risks of harm or discomfort for participants; however it was acknowledged that any study which asked participants to explore their beliefs, values and emotions had the potential for causing emotional upset [RCN 2009]. Before the commencement of the study participants were informed of the process for dealing with this where necessary. If the participant found discussing the concept of trust intrusive or upsetting, the interview would have been suspended in order for the needs of the participant to be addressed. If further assistance was required the participant would have been offered the opportunity to discuss her experience with a local supervisor of midwives who could follow up appropriately. This did not occur during the study.

One key element considered by the Research Ethics Committee was the recruitment of participants and the necessity to protect them from coercion. The committee requested

that the recruitment process be altered from the initial proposal, whereby I intended to make direct contact with women, to midwives making the initial contact and asking the women to complete and send back a contact sheet. I could then contact the potential participants and obtain their consent to take part in the study. The challenge with this amendment was that it required a reliance on a group of midwives who had no investment in the study and could lack an incentive to inform the women about it, or who may not understand the study enough to give adequate information to women, especially if they perceived the outcome of my study to have possible negative consequences for them. The research information form was given to women along with their initial pregnancy information pack and the possibility of the study information getting lost within the other pregnancy information was high. Whilst I was obliged to follow the ethics committee's advice I was fearful, relying on the women to return the contact form at this time and the possibility of not recruiting sufficient numbers to the study. My recruitment was indeed slower than I had hoped as a consequence of this recommendation.

The aim of stage two of my study was to generate narrative data which would give access to the 'insider view' of the phenomenon. In order to achieve this, participants needed to be able to guide the process and express the experience in their own way. The important process of note taking and reflecting on the emerging data began stage three of the hybrid model which would now occur concurrently while continuing with stage two.

**2.6 Hybrid model Stage three:** Stage three involves final analysis and writing up, with final analysis resulting in the central understanding gained from all three stages informing the completed concept analysis. Stage two and three overlap in time as data collection, analysis and literature review are carried out concurrently. I began stage three - transcribing and analysing the interviews as they were collected.

The interviews were audio-recorded and transcribed verbatim. Whilst I understood the importance of also keeping detailed notes, I found this more challenging than anticipated. Obdenakker [2006] warns against relying on the interview audio recording instead of taking notes during the interviews as important additional information about body language, facial expressions and emotional cues may be lost. As both a midwife and researcher I wanted to establish a rapport with the women and demonstrate my caring nature and willingness to listen to them. I felt this was important to assist them in feeling comfortable with me and willingness to discuss their inner feelings and

emotions.

*She seemed to want to talk and for me to just listen. I had planned to make notes but at the time it didn't really seem a good thing to do as it might have distracted me from her conversation and her eye contact. I am glad in the end that I didn't write anything down as this was something she discussed in her interview about doctors and how impersonal it was when they are more concerned about writing than listening. I know it could be beneficial to the study to have notes and additional information but I felt at this first interview I needed to build trust in our relationship and I didn't want to appear distant or distracted. Reflective Diary 21/12/2010*

During the first interview that I conducted the participant described her experience of health professionals who 'pretend' to listen but who are really 'just busy filling in paperwork and writing things down', not really making eye contact or paying attention to her. Her words stayed with me during every interview and I felt unable to write detailed notes for fear of losing the connection with the participant. I attempted to write retrospective notes following the interview but recognise that this was not as effective and was perhaps a reflection on my inexperience as a researcher and the ability to make notes while focussing on listening to the participant. This may have been improved if I had conducted some pilot interviews to help develop my skills. Instead my notes were often retrospective and used reflectively with the theory and the transcripts to inform the data analysis which I will now describe in more depth.

**2.5.1 Data analysis:** Schwartz-Barcott and Kim [1993] do not give detailed description on how to analyse the data obtained in stage two; therefore I utilised data analysis literature from phenomenological approaches as phenomenology had underpinned the data collection stage of the model.

The aim of data analysis in a Heideggarian phenomenological study is to construct a mutually defined meaning of an experience. As such the data analysis must include all aspects of the data collection from both the reflexive thought of the researcher and that of the participant, making data analysis introspective in nature [Open University 2008]. Silverman [2010] suggested that using theory in data analysis can make the analysis more fertile and aid theory building. Combining the theory and empirical data enables the researcher to move from description of the lived experience to a deeper analytic understanding of the phenomenon and the meaning behind how it was experienced.

The data analysis occurs concurrently with the data collection and an instrumental part of the process is the recording and transcribing of the data.

**2.5.1.1 Digital recording and transcription process:** Interviews were audio recorded using a digital recorder and transcribed. The transcription process helped to maintain my connection with the data, my understanding of what had been reported by the participants and began the first stage of analysis and reflexion. Repeated listening to the recordings was an important first step for me in the analysis as it enabled me to stay close to the data. One of the major aims of phenomenology is to uncover meaning from the text and this was achieved through immersion in the data. Transcripts were read as a whole in order to identify an overall meaning.

**2.5.1.2 Coding and analysis:** Data analysis in Hermeneutic phenomenology aims to gain an understanding of the human experience, the nature of reality. The hybrid model was the framework for thematic data analysis within the hermeneutic cycle requiring the researcher to work back and forth between the participants' views as expressed in the interview and the conceptual literature for interpretive understanding. The Hybrid model is more commonly used with grounded theory research and for consistency with the model the method of data analysis utilises a grounded theory technique. Transcripts from each stage of data collection were coded and key themes identified at each stage. The text was analysed as a whole, by sections of text and by line by line coding examining the participant's words for meaning. As in the study by Davis [2010] these extracts were coded, clustered and synthesised into overarching themes. Comparison of the themes at each stage assisted in the understanding of the development and changes within the concept being studied over a set period of time. To ensure rigour within the study, I kept a journal of the coding process and how interpretations were formed in order for my research supervisors to be able to follow the process and ascertain whether they could follow the direction and understand the decisions made. Many themes were identified initially and the biggest challenge at this

stage was data reduction as described below.

*I initially started by coding the first four transcripts. I read them as a whole and made notes in word of the overall themes and first impressions, questions and things that I want to follow up in the next interview. Using Nvivo I then coded the transcripts using free codes. I tried wherever possible to use in vivo codes as I wanted to keep the analysis as close as possible to the original words of the participants and ensure that my priority was the lived experience and the language used by participants as required for a phenomenological method. Using in vivo codes was good for keeping to participants words but it has meant that I have loads of codes which are similar but perhaps said in a different way and it is hard to code future transcripts to the same code as no two people really say the same thing. I began to feel a bit panicky about the number of codes I was generating and how I would really use these to analyse the project as a whole?*

*Reflective Diary 29/05/2011*

I will now discuss the process of coding and data reduction.

**2.5.1.3 Coding:** A code is a symbol or abbreviation used to classify words or phrases in the data and must be consistent with the philosophical background of the study [Burns and Grove 2005]. Burns and Grove [2005] described three types of codes that were used for the coding process. Initially 'in vivo' descriptive codes were applied using the words and language used by participants, however as described in the literature, this generated a lot of codes.

As the study progressed I developed a deeper understanding of the meaning behind the descriptions and interpretive codes were applied. Participants' words were used to attach meaning to the descriptions. The final part of coding, explanatory coding connects the data to the emerging theory and attempts to construct meaning from the experience. The data were searched for those themes or meanings which occurred again and again throughout the study indicating that they were essential in the construction of the concept for individual participants.

**2.5.1.4 Computer aided data management:** There is some debate amongst researchers of the value of using computer aided analysis programmes. Saldana [2009] highlighted that for student researchers it can be overwhelming to try and learn to use new computer software at the same time as learning to undertake qualitative data analysis. He recommended that students become familiar with manual coding prior to attempting any computer programme. Gilbert [2002] suggested one of the problems associated with computer aided analysis is that researchers can lose the closeness to their data with segments of text taken from the whole, losing perspective.

There is a danger that the researcher can miss the bigger picture while concentrating on single words or codes. Manual coding and physically handling data assists the researcher in developing ideas and understanding.

However Bazely [2010] proposed some important advantages of using a computer programme in that large amounts of data can be stored, recorded and matched, helping the researcher to organise and keep track of their work in the form of literature, diaries, memos, reflections and transcripts all in one place. The programmes provide the researcher with a set of tools that do not replace the researcher's thinking and coding but merely help them to record it using reports, graphical models and data queries. These can be dated and kept within the programme to maintain an audit trail of the research process and decisions made. This was an important point for me to consider as the amount of data generated within the study was large and to code manually would have required a space to spread documents out to code them, add post it notes and leave them there for a period of time. This was not possible in my home or work place and would have been unsustainable. With this in mind I sought to improve my understanding of the use of computer assisted data management.

*I took some time out and did what I guess I should have done from the start: I bought two books, one on using Nvivo and one on Coding. Both helped me to sort out in my head the best way forward. Bazely. P [2007] Qualitative data analysis with NVivo. Sage London. Suggestions for managing project:*

*1] Use models to document thinking at each stage: My perspectives and preconceptions [Journal], Theoretical concept: [Concept analysis], each case and initial transcript ideas, where next, expectations*

*2] Nodes: Use concept analysis to identify node titles, look at relationships between nodes.*

*3] Journal: Do a ships' log type with dated entries, do reflective pieces for initial thinking/ideas.*

*Reflective Diary 29/05/2011*

Based on this reading I used Nvivo 9 computer assisted software to organise the data into sources, Nodes [descriptive codes], Tree nodes [interpretative codes] and Explanatory themes [Bazeley 2010]. Models [see appendix 7.4] were generated to graphically illustrate the decisions made and were used during supervision sessions for discussion and reflexion. To maintain my closeness to the data and ensure my thinking

took into account the whole process, I continually listened and re-listened to the recordings of the transcripts as a reminder of where the codes had been taken from. Recurring themes were explored iteratively with the literature and my reflexivity in an attempt to interpret their meaning. Initial themes and meanings were taken back to participants and used to guide subsequent interviews in order to clarify their meaning and authenticity.

**2.5.2 Final analysis:** In order to maintain the principles of phenomenology, it was important for me to analyse the data in a longitudinal way and to appreciate the journey experienced by the participants in developing trust as a process not simply as an outcome. It appeared from this initial analysis that the women experienced trust as a set of building blocks that mirrored the distinctive journey through a pregnancy. I felt it was important at this stage to describe this aspect using the metaphor of a journey helping to maintain closeness to the emotional experiences of the participants before examining the individual data nodes in more detail.

Schwartz- Barcott and Kim [1993] suggested that participants be selected to represent: the model case [those that most resembles the theory], the baseline case [those that could not be categorised either way] and the contrary case [those that least matched the theoretical concept]. It was not possible during my study to select cases in this way; as a researcher I had no indication of how the pregnancy journey, the relationship with the midwife or the experience of trust would develop and as such could only classify cases retrospectively following collection of the data.

This study used a more inductive process than Schwartz- Barcott and Kim [1993] proposed where participants were categorised retrospectively following collection of the data when it was possible to map their experiences against the theoretical concept of trust – specifically John's [1996] process-outcome model of the concept. The transcripts for each individual interviewee were coded and compared in order to understand and described the individual's experience of the journey through the development of trust. Passages or specific lines of text from the transcripts were then highlighted to identify themes which could account for the phenomenon being studied. These were mapped against the theoretical concept to identify cases [See table 2 and appendix 7.5].

Whilst the identification of model and borderline cases was relatively easy, the identification of a contrary case was more challenging. All of the participants



demonstrated some elements of the concept, in particular the initial trust. This is not unexpected when one considers that the participants were recruited via maternity services and therefore had voluntarily engaged with midwives, thus suggesting that identification of a truly contrary case may only have been possible if women who had chosen not to engage with a midwife had been recruited. This was outside the scope of this study.

Kate was identified as the least closely matched as, although she demonstrated the concept in the initial phase and her willingness to engage [therefore should not really be categorised as a contrary case], she did not appear to demonstrate the involvement to interpersonal trust – [step three of John’s model], the willingness to develop a relationship and for this reason I have categorised her as a contrary case. The borderline cases were identified as those that mapped some but not the entire concept. Two of the participants were categorised as borderline as they had missed the second interview and it was not possible to compare their journey with the concept as a whole.

**Table 2: Identification of cases**

<b>Model cases [most closely matched with concept analysis]</b>	<b>Border line cases [unable to classify as some elements but not all matched]</b>	<b>Contrary Cases [Least closely matched to the concept analysis]</b>
Participant 1 matched most elements to some degree	Participant 3 matched some of the common elements	Participant 6 made reference to a limited number of the elements
Participant 2 matched all elements on several	Participant 4 missed second interview so unable to map complete journey	
Participant 5 matched most elements to some degree	Participant 7 Matched many of the elements to some degree but had many midwives and referenced items in a more general sense	
	Participant 8 missed second interview so unable to map complete journey	
	Participant 9 made reference to some of the elements	

**[The full process table for mapping against the concept can be viewed in appendix 7.5]**

Following this exercise the participants were given pseudonyms to allow a more personal feel when writing up their experiences and to aid the reader in connecting to

the data of real people as is essential within the phenomenological method used. Sally and Paula matched many of the elements noted in the theory but they referred to a minimal amount of the concept in relation to interpersonal trust. Jo, Molly and Lucy most closely matched the theoretical concept and were categorised as model cases.

The final narrative of the concept contains the central essences from all three stages of the hybrid model and demonstrates the concept through the experience of participants by including direct quotations and original detail from the empirical data [Giorgi 1997]. This is completed during stage three of the hybrid model where Schwartz – Barcott and Kim [1993] suggest the researcher asks themselves the following questions:

1. How important is the concept?
2. Was the initial selection justified?
3. To what extent do the findings support the presence of the concept within the population studied?

The findings from the study are provided in chapter five of the thesis and include discussion around the suggested questions.

In the final analytical phase I re-examined the findings in light of the initial focus of interest, to explore the concept of trust within the midwife-mother relationship increasing understanding of the individual's experience of trust and its meaning to women and the emerging concept analysis of trust. The findings did not necessarily confirm or dispute any existing theories but added depth to the concept described through the literature and assisted in refining the concept in line with the lived experience of participants [Schwartz-Barcott and Kim 1993]. The Hybrid model was a cyclical process where stages one, two and three were conducted concurrently informing the progress and development of the study until a greater understanding emerged.

It was important throughout this three stage process to ensure the study was robust and trustworthy; this was achieved with the support of two experienced research supervisors. I will complete this chapter with a discussion of the issues considered to ensure the trustworthiness of the study.

**2.7. Trustworthiness of the study:** It is important for research studies to be able to demonstrate the trustworthiness of the study in order for the findings to be dependable and to be credible as a source of information for the reader. Lincoln and Guba [1985]

have written extensively on the topic of trustworthiness within qualitative research. Their discussions focus on four main areas:

**2.7.1. Credibility:** Credibility is described by Parahoo [2014] as the extent to which the findings reflect the experience of the study participants. Lincoln and Guba [1985] suggested that credibility can be demonstrated by prolonged engagement in the field to ensure the researcher understands the culture and the setting in which the study is being conducted. This was an integral part of the study methodology and I was a member of the setting so knew the culture and context well. Burns and Grove [2005] highlight some potential challenges with the interaction of the researcher where they are overly involved in the study or have a conflict of role. This can lead to over familiarity, loss of focus and a difficulty in maintaining perspective as well as the potential challenge to professionals in the research field who uncover unethical behaviour of co-health workers. Research supervision takes on an important role here in advising and reviewing the thought process of the researcher and aiding the researcher to maintain objectivity while not losing the benefits of being part of the 'life world'. I found the discussions with my two supervisors to be very grounding experiences essential for maintaining objectivity and reflexion.

**2.7.2. Reflexivity:** Reflexion is a key element of trustworthiness. Husserlain's approach to phenomenology recommends that researchers 'bracket out' their own self and Wall et al [2004] described their use of a reflective diary to aid them in doing this. The use of the diary allowed researchers to show transparency in detailing where 'bracketing' had taken place. Heideggarian phenomenology does not require researchers to 'bracket out' their own self but the use of a researcher diary can be useful to show transparency in the decisions made. In order to acknowledge and utilise my impact on the research process, a reflective diary was kept to ensure there was rigour within the study. Holloway [2005] proposes that research must take a pragmatic approach and that data collected has to be viewed in relation to the theoretical standpoint of the researcher as it is impossible to separate the researcher from the research. She suggested that researchers must demonstrate reflexivity and transparency in the decisions made about the theory and empirical data.

For health care professionals undertaking research there are particular challenges, Allen [2004] discusses the issue of being 'inside' the research project, stating that it is impossible for healthcare workers conducting healthcare research to do so from 'outside' the project as by definition we are unavoidably part of the world being studied.

The benefits of this include a privileged understanding of the environment and prior knowledge of normal practice. However, Allen does highlight the possible disadvantages of this as familiarity may lead to issues being overlooked, unsubstantiated assumptions being made and lack of willingness by participants to share sensitive information. The women in my study knew that I was a midwife and one of the midwifery managers for the area being studied. They may have felt uncomfortable talking to me about concerns with the midwife who was looking after them. They may have feared that the midwife would find out, that I would act on the information as a manager and that the midwife could get into trouble. It was important for me to separate my role as senior midwife from my role as researcher and to ensure that women understood how I would use the information given to me, maintaining their privacy and anonymity and my responsibility to reflect on the data and the process of collecting it. Researcher reflexivity ensured objectivity and demonstrated my thought processes.

As discussed earlier in the chapter reflexivity can be used as part of the validation process. Goldberg [2008] conducted a feminist phenomenological study using interviews. She kept a reflective diary and research notes to maintain the awareness of her influence on the findings and how they made her feel. My diary incorporated the notion of both reflective notes [reflecting back on what happened] and researcher reflexion [confessional account exploring the interaction of the researcher with the research] [Holloway 2005]. Whilst the diary had important influence on the data analysis it was not used directly as a source of data. Researcher reflexion was an important element of the constant comparison techniques used within the hybrid model and formed the basis of supervision discussions to maintain rigour. Incorporating the thoughts and feelings of the researcher, exploration and reflection on the meaning of emergent themes should enrich the final text and add to the trustworthiness of the study [Koch 1999, Taylor 2005].

The research diary included insight into my experience of undertaking the interviews, the challenges of discussing trust and participant's difficulty in articulating what trust was; these insights will be included in the final findings chapter as part of the study evaluation process.

**2.7.3 Confirmability:** Lincoln and Guba [1985] discuss how the audit trail, external audit of the process, reflexivity and triangulation of the data can be used as methods for maintaining confirmability, the process by which findings and analysis are

confirmed. Reflexivity helped the researcher to show how the concept had been constructed from the data. A clear audit trail must be visible for readers to have confidence in how decisions were made by the researcher [Rapport 2005]. Through using the Nvivo 9 package I was able to document clearly the decisions made regarding research design, method, data collection and analysis.

**2.7.4 Dependability:** Lincoln and Guba [1985] suggested member checks [that is referring back to participants] and peer debriefing to provide robustness to the analytical phase. Initial themes and thoughts were shared with the participants at their subsequent interviews allowing them the opportunity to discuss and probe further. It was important for me to return to the participants to clarify and authenticate the themes and meaning of the concept which had been developed through the study. The transcripts provided a joint record of the narratives from both myself and participants while exploring the phenomenon of trust within the interviews. The same models were also used at supervision sessions for review and analytical probing. Lincoln and Guba [1985] express the importance of external audit in ensuring for the reader that the information within the study can be depended upon. This can be achieved by having peers outside of the study to be able to 'look into' the process of the study and follow the process and decisions made by the researcher. This requires self-awareness and critical evaluation from the researcher all of which were achieved with support from the research supervisors who advised and guided me in developing these skills, ensuring that I acknowledged my response as a researcher, a professional and a mother while allowing the voices of the participants to be heard in the writing up [Hollaway 2005]. Research supervisors were on hand to 'look into', mentor and discuss my beliefs, assumptions and pre-conceptions assessing the implications these had for the study [Burns and Grove 2005]. These were supported by the University review processes.

**2.7.5. Transferability:** This is described by Lincoln and Guba [1985] as a thick description with sufficient detail for the reader to understand how the findings may be used in other settings or with other groups. This phenomenological study was specific to the lived experience of the women being studied and as such it may be difficult to generalise the findings. One must remember the aim of the study was to understand the concept through the lived experience of the participants and not to generate new theory. The write up of the study should allow the reader to understand the context in which the data were collected as well as reflecting the richness of the lived experience of the participants. Through this the reader may identify some general themes or ideas that can be transferred to a wider community or inform other areas of research.

**2.9 Conclusion:** In this chapter I have described and justified the foundations, framework and process utilised for the research study, linking the approach used to the underpinning research aim. The research approach is set within a naturalistic paradigm which is appropriate for studying individual lived experience in the natural environment. The overall research design was influenced by Heideggarian Phenomenology as it offered the benefit of embracing the researcher and participant as partners in exploring the lived experience of trust thus providing a more rounded conceptualisation.

A brief description of the philosophy behind Heideggarian Phenomenology was given and method of data collection was discussed and justified. Longitudinal, semi-structured interviews alongside a researcher's reflective diary were selected as the most appropriate method to explore the phenomenon, accessing a purposive sample of women. Advantages and disadvantages of this method were considered, and the use of a 'laddering' interview technique for deeper exploration of the concept was described.

In order to develop the concept it was necessary to consider the integration of the literature with the empirical data and a 'hybrid model' was selected for this purpose. A brief description of the model and examples of how it has been used in other studies was provided. A three stage research design approach is described incorporating the literature, empirical data and researcher reflexivity to help construct meaning behind the concept of trust through a constant comparative technique. The ethical issues relating to the study are discussed under five human rights sub headings: right to self-determination, right to privacy, right to anonymity and confidentiality, right to fair treatment and right to protection from discomfort and harm. The methods to ensure protection of these rights within the process of the study have been described.

In the next chapter I will present stage one of the hybrid model- the theoretical concept analysis.

## **Chapter 3: Theoretical Trust concept analysis**

**3.1 Introduction:** In this chapter I will use Rodgers' [1989] concept analysis framework to gain greater understanding of the phenomenon of trust. Concept analysis models provide a framework for defining and clarifying what is meant by a given term, in this case 'trust'. The analysis allows exploration of common uses of the word to clarify, refine and sharpen the concept dissecting it into smaller parts of the whole for improved understanding [Walker and Avant 1983]. The emphasis of the concept analysis is to achieve greater understanding of the practice based meaning of the phenomenon being studied [Gould 2000]. I will briefly describe the advantages of this method before embarking on the concept analysis of trust in which I will present the concept's antecedents, attributes and finally the consequences within the context of healthcare and more specifically midwifery. In the following two chapters I will further the understanding of the concept of trust by analysing and synthesising the empirical research data adding to the theoretical concept the perspective of the lived experience.

The theoretical concept analysis included perspectives of both women and midwives focussing on the concept of interpersonal trust and its importance in building effective relationships. There is little evidence in the literature of any substantial studies looking at trust within the midwife-mother relationship, how this grows, deteriorates or how it influences the choices made by women. My discussion will focus on the importance of exploring trust within midwifery and the potential benefits of this investigation. The concept analysis will demonstrate that trust changes over time in response to social interactions, experience and that the concept of trust is not purely a value, emotion or belief, nor is it confidence, satisfaction or reliance but rather a broad concept which encompasses all. I highlight the need for this concept to be explored more thoroughly. I will begin by describing the process of concept analysis.

**3.1.1 Concept analysis process:** Concept analysis models provide a framework for defining and clarifying what is meant by a given term, in my case 'trust'. Concept analysis encompasses the principles of a literature review but differs from a systematic literature review in its broad nature, the way it is presented and analysed. I chose to use this method instead of a traditional systematic literature review because the emphasis of the concept analysis is to clarify, refine and sharpen the concept dissecting it into smaller parts of the whole for improved understanding of its practical use [Walker and Avant 2005]. While the concept analysis provided some clarity for me

about the language used and the theoretical application of the concept which would be useful when gathering the data from the women’s experiences, this did not impede my inductive process for the empirical stage of the study as the concept of trust in midwifery was still poorly defined. It was important at this stage not to focus in too much detail on the literature in order to keep the women’s voices as central to the analysis in the next stage.

The benefit to the research process of concept analysis is in its ability to define meaning rather than simply describing a concept [Baldwin 2008]. Its strength lies in an ability to isolate the concept enabling exploration of its inner content distinguishing the meaningful attributes from the less useful attributes [Toftthagen and Fagerstrom 2010]. Baldwin [2008] highlighted the importance to the research process of clearly defining and understanding the practical nature of the language being used within the given concept. Concept analysis has been developed over the last two decades with influence from key authors such as Wilson [1963] and Walker and Avant [1983] who described the process as an important element of theory building and described steps to successfully completing a theoretical concept analysis [See Table 3].

**Table 3: Walker and Avant steps for concept development [1983]**

1	Select a concept
2	Determine the purpose of analysis
3	Identify all uses of the concept
4	Determine the defining attributes
5	Construct a model case
6	Construct borderline, contrary, invented and illegitimate cases
7	Identify antecedents and consequences
8	Define empirical referents

Authors have since disputed the usefulness of these steps suggesting that the method of concept development needs to acknowledge the importance of concepts within a contextual framework [Duncan et al 2007; Hupcey & Penrod 2005; Paley 1996; Rodgers 2000]. Therefore the steps may be too rigid and not easily applied to some contexts or following the steps could exclude inclusion of important contextual factors. MacLellan [2011] suggested that concepts have a contextual nature in that they are not fixed but rather change and evolve within society reflecting the evolutionary changes that are experienced over time. This requires inductive exploration resulting in a



reflective theoretical process. Rodgers (1989) suggested that concept analyses are aimed at defining the use of common language within a given context. That is, words gain meaning from how they are used in practice rather than having some inner meaning that is followed by all, in all situations. For example 'mouse' in the context of animal species would have an entirely different meaning to 'mouse' in the context of information technology equipment.

This rationale was central to Rodgers' evolutionary method of concept analysis where she described three aspects which acknowledge the potential changes within concepts and theories over time: 'significance', 'use' and 'application'. She suggested that it is essential in any concept analysis, that the author acknowledges the conceptual similarities and differences within the language used. Rodgers' evolutionary method assists the researcher to identify the attributes central to the given concept, aiding a meaningful definition.

Rodgers [1989] recommended [see table 4] a broad literature review allowing for aspects of the concept to be sought from various disciplines and contexts to inform the core analysis phase which involves the identification of surrogate terms, antecedents, attributes, examples and consequences of the concept. Walker and Avant [2005] also recommend using a model case during this stage to explore the concept within a given context. Rodgers' final phase includes using the concept analysis for further exploration through research, identifying the questions and areas of importance for future research in practice.

**Table 4: Rodgers [1989] recommended process for concept development.**

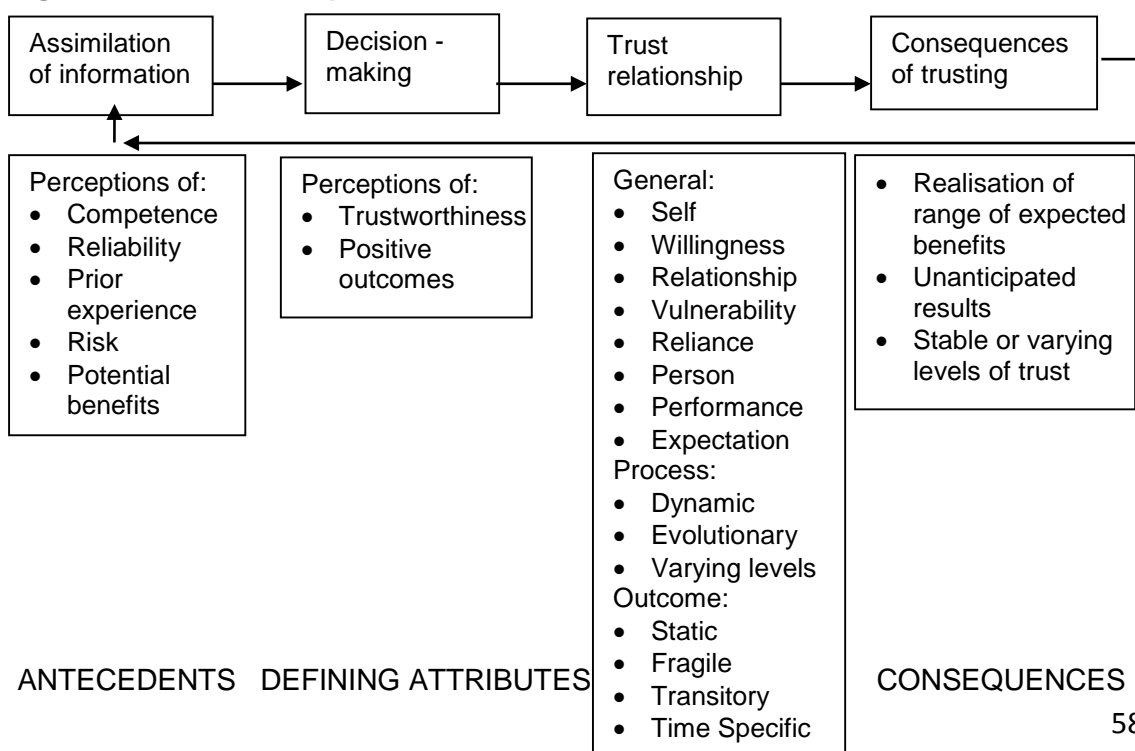
1	Broad Literature review
2	Core analysis phase: surrogate terms, antecedents, attributes and consequences
3	Further explanation through research

I chose to use Rogers' approach to concept development as it acknowledged the possibility of concepts changing over time, requiring a broad understanding of the theory before focussing on the experience of the concept gained from the empirical research, negating the steps of pre-determining border line and contrary cases. This approach seemed most appropriate for use within the hybrid model and my data collection method where empirical cases could not be pre-determined. During the process of developing the theoretical concept I read other concept analyses in related

topics, for example; normalcy, trust in nursing and connectedness but I settled upon Johns's [1996] concept analysis of trust within nursing as an example of a model case of the concept of trust as I did not discover any concept analyses related to trust in midwifery relationships. Johns [1996] concept analysis related most closely to my theoretical understanding of trust within the midwife-mother relationship and hence I selected it as a model case. Johns [1996] focussed on trust as a contextual concept which seemed appropriate from a sociological perspective and she added another dimension to the traditional concept analysis described by Rodgers [1989] and Walker and Avant [2005] in her acceptance and exploration of trust as both a process and an outcome; she developed a model which detailed four sequential steps in establishing trust. I was curious to see how my empirical data would compare or contrast to the concept of trust that she had described in the context of the nursing relationship. I will describe Johns' model here as it is important to acknowledge it as an influence on the overall framework of the concept analysis.

**3.1.2 Johns' Model case:** The first stage in Johns' [1996] concept analysis is the assimilation of information consisting of perceptions of competence, reliability, experience and risk. The second stage is active decision-making based on the perceptions of trustworthiness and positive outcome. The third elements involves developing trusting relationships. The last stage details the consequences which will continually feedback to the first stage to re- start the process again [see figure 3].

**Figure 3: Johns [1996] process-outcome model**



Johns' [1996] suggested that trust should be looked at as both a process and an outcome; it is important to capture the concept at given points in time to understand the outcome at that time as well as understanding the development of the process between the points. This suggestion influenced my research design exploring the concept of trust longitudinally at three given time points during the midwife-mother relationship over the duration of the pregnancy.

The boxes at the top of the diagram indicate each of the four stages of trust identified by Johns. The box underneath each of these demonstrates what may be included within this stage and the arrows denote the cyclical nature of the model continuously repeating itself. The process is dynamic and changes in response to given experiences of the concept and the consequences having an impact on the assimilation of future information. Johns associates stage one and two with the antecedents of the concept, stage three with the defining attributes and stage four with the consequences as would be described using more traditional models of concept analysis [Rodgers 1989, Walker and Avant 1995]. I will return to Johns' influence as a theoretical model case throughout my discussion and this model will feature in the chapters when analysing the empirical data.

Within Rodgers' [1983] evolutionary concept development framework, defining the concept and considering the surrogate terms used is suggested as an important first step to concept analysis and I will detail my consideration of this now.

**3.2 Definitions of trust:** Trust is an important concept but it is complex in meaning and there is little agreement in the literature of a definition. The standard definition from the dictionary is.

*“Trust: firm belief in the truth of anything, faith in a person; confidence in..... to have confidence in; to believe....” [Webster's Compact English Dictionary. 2007 p495.]*

A particular problem when reviewing the literature on trust is that the word trust is often interchanged with other terms such as: belief, confidence, reliance and satisfaction. It could be argued that trust is made up of all of these but the literature also provides arguments for why these terms may be distinguished from trust [Sellman 2006, Sellman 2007, Hupcey et al 2001 and Daly 2003]. Some of the arguments distinguishing between trust and surrogate terms will now be reviewed.

**3.2.1 Belief:** Many authors described trust as a belief in the honesty, integrity and reliability of another person, the belief that they will act in a way that serves an individual's best interests. This sense of belief represents an expression of commitment to that person or organisation more likened to faith and implies a permanency [Clark and Payne 1997, Fugelli 2001, Thorstensen 2000, Gilson 2006, Mckinstry et al 2006]. The idea of moral integrity could be the basis for social trust, as personal knowledge and experience is not necessarily known, but inter-personal trust involves a more intimate knowledge of a person and trust may grow or deteriorate. The belief in moral integrity could be altered by people's actions and therefore cannot always be maintained.

**3.2.2 Confidence and satisfaction:** Confidence and satisfaction are also found in the literature but it is suggested that these are conceptually different to trust in that they are built upon knowledge and security derived from previous experience. For example understanding of what has happened in the past, a professional's reputation and past experience. It is based on what we know and therefore have confidence in. Trust is necessary where knowledge is lacking and a level of uncertainty is present [Sargeant and Lee 2002, Gilson 2006, Hall 2006, Thom et al 2004]. This initiates a need which requires reliance on another.

**3.2.3 Reliance:** A person may show signs of relying on another because they need to, as is the case often with health professionals, but they may not necessarily trust them personally. It could be that they rely on the systems and professional accountability rather than show signs of inter-personal trust. Equally they may trust in the good will of the professional but have little confidence in the professional's clinical skills for a particular aspect of care. Sellman [2007] suggested that trust and trustworthiness mean more than reliance in the impact they have on the emotional wellbeing of an individual.

Despite the debates around their meaning, the above surrogate terms are frequently interchanged with the word trust in the available literature and I acknowledge that this may also be the apparent in the language used by the participants in the empirical data. It was necessary to explore these terms within the concept analysis to establish the common use of trust as a colloquial concept [Rodgers 1989]. Using Rodgers' [1989] principles I am able to present a theoretical understanding of trust and its meaning within the context of the midwife-mother relationship. The initial phase of

Rodgers' evolutionary cycle is centred on significance of the concept. She suggested that the concept chosen must serve a purpose to the context in which it is being studied. My rationale for exploring the concept of trust within the midwife-mother relationship is that understanding the concept of trust from the woman's perspective is important for developing maternity services that meet the needs of women.

I will now present an overview of the general literature around the concept of trust from the various disciplines by identifying the antecedents, attributes and consequences of the concept. I will use the relevant midwifery literature to stress the importance of the concept of trust within the midwife-mother relationship.

**3.3. Literature review:** In order to review the literature relevant to the concept electronic searches were conducted in CINAHL, Medline, PubMed, MIDIRS and Cochrane databases, using search terms of trust, trustworthiness and midwifery, midwifery models of care, midwife-mother relationship, trust and healthcare from 1960 to present day. The time frame allowed the breadth of exploration encompassing changes in maternity services while remaining relevant to current day. All literature available in English was considered if it directly referred to the concept of trust and included research, theory and opinion based papers to give a rounded review of the literature. Literature relating to nursing and maternity nurses was also included so as not to exclude countries that do not have practising midwives such as some areas of the USA. At this initial stage the literature contributes to the rationale for undertaking the study and builds understanding of what aspects of the concept need to be studied. Further discussion of the literature will take place in the later chapters using the hybrid model to analyse the theory in relation to the empirical data and synthesise the findings.

I will focus my discussion on the three disciplines I consider to be most relevant to the concept of trust within midwifery to assist in understanding the background to the concept: Philosophy, Sociology and Psychology. Within the literature the way trust is described often depends on the individual disciplines describing it. Taking time to consider these will set the back-drop for exploring the concept and the viewpoint of me as a researcher and how I interpreted the findings.

**3.3.1 A philosophical view point:** The literature from Philosophy suggested that trust can vary from a state of complete trust to a state of complete distrust. Philosophers

contend trust is based on the concept of 'doing right' and propose two theories to explain the motivation for placing trust that a person will 'do what is right'. Firstly, that people do what is right through fear of detection and punishment meaning that trust is well placed in people or institutions who demonstrate strict punishments for doing wrong [Harrison et al 2003 p18]. In relation to midwifery, this is enhanced through its regulation by the Nursing and Midwifery Council [NMC] whose primary aim is to protect the public by monitoring and supporting midwives through a robust system of midwifery supervision. This mandatory professional regulation and the first philosophical theory of 'doing right' for fear of detection may explain why some women place initial trust in midwives and the midwifery system and could be important in the antecedents of the concept.

Secondly, some philosophers base their discussions on a belief that trust is founded on a Kantian idea that we all share an innate sense of morality to do what is right because of our inbuilt love and caring for each other. Therefore trust is based on the belief that people are good and they care about others [Harrison et al 2003 p18]. If this were true, it could be argued that the necessity to 'get to know' the midwife and form interpersonal relationships is not integral to placing trust. The placing of trust would be more moralistic and given to all individuals as all would be assumed to have morally good intentions.

At one end, trust may be a value which is largely instrumental, a conscious decision to achieving something and at the other end trust may be moralistic, an unconscious virtue embedded in an expectation of goodwill and moral integrity [Gilson 2003]. From this perspective, those women will have a fundamental belief in the moral integrity and goodwill of midwives. The philosophical idea of moral integrity comprises of four elements: honesty, transparency, confidentiality and autonomy [Gilson 2003, Fugelli 2001].

However, within midwifery there are publically reported cases of people who have not acted in another's best interests and where the regulation of the profession has not been effective. For example I highlighted in the introduction the issues raised by The Care Quality Commission [2012] who highlighted specific failings in maternity care in Morecambe Bay in relation to respecting and involving patients to ensure their safety and wellbeing, including the need to review statutory midwifery supervision. Such

examples suggest that the application of a moralistic trust based on a notion of goodwill in maternity care is difficult to justify as is the theory of placing trust in response to regulation and detection of 'wrong doing', especially where cases of poor practice not detected in a timely manner are publically reported. It could be more appropriate to consider the placing of trust in midwives as a conscious decision made by women in response to their own experience, as is the background to the sociological viewpoint. This is identified as part of the risk assessment described in Johns' [1996] model of trust.

**3.3.2 A Sociological view point:** Current discussions within the sociological literature tend to consider contemporary society to have changed from one based on a belief in fate to a society now based on risk [Calnan and Sanford 2004, Raybekill 2008, Etchels 2003]. This has implications for trust. With more individual choice, decision-making and independence, trust has become more an active choice not simply passive acceptance [Lee and Lin 2008]. Individuals can exercise 'agency', although there are a number of factors such as environment, economics and vulnerability that influence whether or how much this is possible [O'Neill 2002]. This emphasis on agency would certainly be reflected in the current day approach to the midwife-mother relationship which is ideally based on promoting independence and individual decision-making [WAG 2011]. Women's agency will be discussed in more depth in the next two chapters as part of the data analysis.

Harrison et al's [2003] sociological model of trust has four foundations, as set out in Table five: The primary foundation which is the initial trust placed is based on first impressions, reputation and past experience. This is considered to be willingness to commit to a basic contract. Secondary trust, which is based more on the regulation and enforcement of rules similar to the theory discussed by philosophers. This stage is thought to enable people to move beyond the basic contract and relies more on the accountability of professionals. The third level in the model is the 'trusting impulse' which is described as an individual's propensity to trust. That is, some people may be more naturally willing to place trust than others. Lastly the model described a trusting culture, which encompasses the wider values and experiences of the society in which people live [Harrison et al 2003 p21].

**Table 5: Harrison et al [2003] Pp21-23**

Primary trust	Reputation Performance Appearance	Track record/ status Experience of the person Impact of people and the environment
Secondary trust	Accountability Pre-commitment Situation	Credible enforcement regime Willingness beyond basic contract Social setting
Trusting impulse		Client's psychological propensity to trust
Trust culture		Norms and values within the wider society

Any one of these foundations of trust may impact individually or in a combination on the trust found within a relationship. This model with its four foundations has some potential applications to the midwife-mother relationship. A woman experiencing her first pregnancy perhaps requires a level of primary trust in order to engage with midwifery services. This may be based in part on the reputation of local midwives. This initial trust will be further enhanced by the woman's willingness to trust the accountability of the midwives and the credibility which is gained through regulatory procedures. Some women will be potentially more trusting than others, which could be due to their trusting impulse as well as the wider norms and values of their families and social networks.

Harrison et al's [2003] stages highlight the progressive nature of trust which develops alongside the interpersonal relationship and 'getting to know' an individual. This would seem relevant to explore within healthcare. Trojan and Yonge [1993] studied home care nurses in Canada and concluded that there were four phases of trust: Initial trust [general trust for the profession, accepting the level of skill possessed], connecting [getting to know each other and assessing each other's needs], negotiating [sharing control and decision-making] and lastly helping. They again stressed that while initial trust is evident in most relationships, this will grow or deteriorate dependent on the other stages being completed adequately. Harrison et al [2003] and Johns [1996]



described models of trust that are made up of stages or levels and the sociological perspective would lead us to believe that this development of trust is linked to experiences and events. It is this growth or deterioration which would be interesting to explore within the midwife-mother relationship. Greater understanding of how it occurs and what influence it has on the level of trust placed by women could help midwives to shape the way care is delivered and this is the focus of my study.

The trusting impulse is interesting and may be a key to exploring trust within midwifery as some women are more likely to place trust in midwives for birth, while others may prefer to birth alone as they are unable to place such trust. This could be associated with the trusting impulse which forms the basis for the psychological viewpoint.

**3.3.3 A Psychological view point:** In any interaction between two people there is often a 'gut feeling' that is difficult to articulate, perhaps resulting from the 'trusting impulse'. Some psychologists propose that this gut feeling is the basis for trust, an unexplained value, emotion or belief that for some reason is just there. It is a psychological phenomenon rooted in experience; it develops as a result of social interaction or is biologically or culturally influenced; it unconsciously builds over time as a result of repeated interactions, family occurrences and storytelling amongst members of close communities. Trust becomes part of the subconscious evolution of a given group and assumes the reliability of another within that group [Mechanic and Meyer 2000, Theide 2005].

Even infants' trust is genetically rooted in the experiences of the species. Infants show at least some trust in other humans in order to accept basic food and water necessary to survive. It is argued by Fishman [2005], Theide [2005], and Sellman [2006] that there is a natural human position of trust, rather than distrust, and an overall willingness to anticipate good will. Smuts [2002] looked at how animals gain security and trust. She proposed that the desire for trusting relations in helping us to feel secure within our social environment is apparent in all social mammal groups. Equally the fear and anxiety felt when trust is absent can be observed in many species. This has relevance for the midwife-mother relationship. Let us assume that women do generally want to trust midwives and midwifery services. If the psychological perspective was accepted it may seem logical that all women from a given society, having genetically experienced

similar things at a species level, would all have the same propensity to trust. However we know that this is not always the case.

Other authors [Sytych 2008, Rose-Ackerman 2001, Calnan and Rowe 2006, Thom et al 2004] described trust as a multi-level phenomenon based on the premise that trust is a state of mind rather than a particular character trait. It will vary in different conditions and contexts and is subject to change and sensitive to life events. It is neither merely instinctive nor altruistic but is brought about by a 'gut' feeling and social experiences. The descriptions indicate an agreement amongst psychologists that trust is subject to change depending on the circumstances in which it is being placed and that the willingness to place trust may be linked to sensitive life events. All of the disciplines acknowledge the effect of the wider society. I will provide a brief summary of all perspectives before moving onto explore the concept of trust in more detail.

The Philosophy literature was divided into two main themes focussed on trust as a notion of 'doing right'. Some philosophers believed the notion was a direct result of fear of detection and punishment while others believed the notion was founded in a moralistic view that individuals have a moralistic desire to do what is right and good as they care about each other. Both these theories were limited when applied to the concept of trust within the midwife-mother relationship.

Both the sociological and the psychological disciplines discussed the trusting impulse – an unconscious inner feeling - as a key element of the trust concept. This at times is interpreted as recognition of a 'gut' feeling that lends itself to a propensity for placing trust. Some psychological perspectives described this element as more a reflection on the experience of the species over time, a state of mind rather than a rational decision or a genetic evolutionary development outside of individual control. Less importance is given to specific past experience within a given society than in some sociological descriptions which focus more on the placing of trust as a rational active decision.

The sociological perspectives described trust as constructed over time, changing and responding to social interaction and experiences. Many authors described trust as a multi-level concept incorporating different stages influenced by the direct actions of individuals. I was drawn toward the sociological perspective when considering the concept of trust within the midwife-mother relationship. It seemed appropriate when

considering the changes in trust over time, the responsiveness to varying midwifery models of care and would take into account a woman's experiences and social context.

Exploring the literature on the concept of trust from the physiological, psychological and sociological perspectives is important to understanding the contextual nature of the concept and the varying viewpoints that may underpin an individual's experience of trust. Exploring the three approaches enables a broad understanding of the concept in a wider context. However, the sociological literature offers more insight into the concept of trust within the context of the midwife-mother relationship in the suggestion that trust will change and develop over time in response to the social interaction between individuals. This social interaction and the influence on the woman's experience of trust will be explored in more detail using specific midwifery literature in the following sections considering the antecedents, attributes and consequences of the concept.

**3.4. Antecedents:** Antecedents of the concept are those events or circumstances which generally precede an incidence of the concept. Walker and Avent [1983] situated the antecedents of the concept rather late in their steps for concept analysis, appearing to advocate exploring the core attribute of the concept and constructing model cases of the actual concept before attempting to understand what came before or after it. Rodgers' [1989] suggested framework however concentrates on the contextual nature of concept analysis and considers the antecedents of the concept much earlier in the process of analysis as a way of understanding the context within which the concept is being studied. Within Johns' [1996] concept analysis of trust stage one and two involve gathering information and making a decision based on the antecedents of trust. This would seem appropriate when considering trust from the sociological perspective and with the idea that the concept is constructed over time in response to a woman's experiences. Therefore it is important in developing understanding of the concept to consider the antecedents of trust relevant to the midwife-mother relationship as this would be a logical starting place for the contextual understanding of the construction of trust.

In Johns' concept analysis [see section 1.3] she suggested that antecedents which include need, past experiences, risk and competence should be explored to gain a better understanding of trust. I will consider these elements here.

**3.4.1 Need:** Trust is important when a person has a specific need for something such as health care that cannot be met without embarking on a relationship with another person. By placing trust in that person, individuals place themselves in a vulnerable or dependent position. Trust requires a need in order to exist [Johns 1996].

Childbirth is a complex natural phenomenon that for some women can be the cause of intense fear and vulnerability. This in turn may lead them to seek assistance from midwives and maternity services placing trust in them to meet their needs. Carty [2011] suggested that fear is a common emotion experienced by women leading up to birth. Lack of confidence and trust in the body's ability to give birth can lead to increased levels of fear and loneliness. Otley's [2011] review of the literature related to fear of childbirth, found a significant link between fear and negative birth experience resulting in a detrimental effect on a woman's perceived ability to give birth. She found that within the studies reviewed, on average twenty percent of the women included in the literature described an intense fear of childbirth and the most common reason for fear was lack of trust, though it does not specify in whom or what the concept of trust relates to. In an opinion piece Kirkham [2011] suggested that one of the most important elements of trust for women is their self-trust and trust in their ability to birth and nurture a child. She suggested that good midwife-mother relationships can help alleviate fear, promote confidence and foster a woman's self-trust.

It is suggested by Nilson and Lundgren [2007] and Oudshoorn [2005] that women's fear of childbirth can be a driver for increased professional regulation, policies and rules in order to enhance clinical safety but that this in itself can assist in further destroying women's self-confidence and increasing the power and control held by professionals. Women are placing trust on behalf of their baby and may therefore feel an increased level of responsibility for maintaining safety for both themselves and their unborn child.

Feeling safe has been explored from various contexts within the midwifery literature; Anderson's [2000] [chapter 'Feeling safe enough to let go'], discussed her grounded theory research involving sixteen women and their experiences of the second stage of labour. She described women's accounts of their fears during this intense stage of labour and highlighted that a woman's predominant fear was of losing control. Anderson also described the need for a woman to feel safe in naturally 'letting go' and

allowing her body to be in control. The women in Anderson's study suggested that the midwife was crucial in allowing them to feel safe in entering this altered consciousness - letting go psychologically in order to give birth. This would leave women vulnerable to the power of those surrounding them and would indicate the importance of trust between midwife and woman.

Other studies have also explored the idea of safety in relation to women's confidence in their body's ability to birth safely. Goldberg [2008] used a feminist phenomenologist approach to explore women's relationships with their maternity nurses in Canada. She discusses the importance of the trusting relationship and that this should form the backdrop for fostering the woman's self-trust for her body's ability to birth her baby.

Goldberg draws on the findings of her earlier unpublished study in which embodied trust in the natural ability to give birth was identified as one of four major themes in the nurse-woman relationship. The ideas generated from Goldberg's [2008] nurse-woman relationship study could be transferable to midwifery models of care as Parratt and Fahy [2003] conducted a small pilot study with women which, similar to Anderson's [2000] study discussed earlier, found that when women have a trusting relationship with their midwives they were more able to enter a state of mind during labour which allowed them to trust in their body's ability to give birth. Having a trusting relationship was shown to increase their confidence and aid the birthing process. It would appear from the literature that fear and vulnerability around the process of birth may indicate a need for women to place trust and that midwives and maternity services have the potential to meet their needs where a trusting relationship can be developed. The literature suggested a complex interweaving of self-trust [ability to give birth and cope with pain] with trust in the midwife. While a need exists it could also be suggested that the woman's propensity to place trust in midwives may be affected by her past experiences of health care.

**3.4.2 Past experiences:** Sellman [2006] suggested that in order to place trust in health care professionals, clients have to quickly decide whether the stranger they meet is likely to do them harm or whether that stranger will care for their individual values. The general willingness to trust will depend upon their past experiences and that of the social group in which they live. Within maternity care, this may be specific to a woman's previous birth experience. It could also be related to the birth experience of friends and

family members who relay stories of both positive and negative experiences [Christiaens et al 2008].

Several midwifery authors [Andrews 2004, Bryanton et al 2008, and Laurel & Carmoney 2012] described the importance to women of a positive birth experience and how this can influence their self-confidence, satisfaction and personal empowerment. The opposite is also noted where women experience negative birth process, leaving them feeling anxious, critical of staff and less likely to engage with services in the future [Beech 2008, Baston et al 2008]. Past experience may also be based on interpersonal relationships with other health or social care professionals which have not met expectations.

Many studies have explored the influence of the midwife-mother relationship and reported positive long term benefits where women have experienced a reciprocal equal relationship with their midwife, resulting in them feeling empowered, safe and satisfied with their care [Edwards and Leap 2006, McCourt and Stevens 2009, Crawford 2011]. What is not clear from the literature is how these past experiences influence the placing of future trust, whether trust is altered or eradicated altogether. Even where interpersonal relationships were good, adverse outcomes may have been experienced, such as the death of a baby. This could also have an effect on the future trust placed in midwives and maternity services. What is unclear is whether specific experiences of trust are more generally transferred to all midwives or simply remain with those particular individuals. Simkin [1992] explored women's long term recall of birth experiences in her research study where women reported vivid memories of their birth experience up to twenty years after the event. Simkin [1992] described how women could recall in detail the action of the doctors, nurses and specific interventions around the birth. The literature does not assess in detail the long term effect on trust of a negative past experience and whether trust is repaired if future positive experiences are achieved. This will be explored further within the empirical data chapters. What seems important is the link with a person's expectations and the resulting realisation of these or not and how this influences a person's assessment of risk in their willingness to place trust.

**3.4.3 Willingness to place trust- a woman's risk assessment:** The assumption in the literature on trust is that trust is something which applies between two equally

competent, autonomous adults. But this does not necessarily explain the relationship when applied to nursing or midwifery as these relationships are mostly based on unequal power dynamics. It could be argued that trust is most needed when we are vulnerable and not able to exercise true autonomy [Sellman 2007]. Therefore the benefits of trusting must outweigh the risks of not trusting [Hupcey et al 2001, Thom 2000]. Authors such as [Sellman 2007, Thom 2000, Hupcey et al 2001] from across the disciplines described trust as an acceptance of a vulnerable situation involving some element of risk.

In relation to midwifery care the benefit of trusting the midwife would be a perceived increased chance of a safe birth of a healthy baby. This would be weighed against the risk of placing trust in a person who may betray that trust or the risks associated with no care at all. Wilson [2010] suggested that women's beliefs are more than a simple idea of natural versus medical when considering the risks associated with childbirth. Women make choices based on individual risk assessments, interactions and social backgrounds. MacLellan [2011], in her discourse analysis exploring the 'art' of midwifery from a woman's perspective, suggested that the birth process was viewed more as a continuum of risk rather than the historical viewpoint of normal versus abnormal. She suggested that trust is gained not simply through achieving natural birth but by human relationships that address women's desires through reciprocity and equality. Lindgren and Erlandsson [2010] focused on the sense of self-empowerment experienced by women in Sweden when accomplishing a desired home birth. They found that this came predominantly from maintaining a feeling of control. A similar finding was discussed by Cheyney [2008] who studied women choosing homebirth in the USA. She explored the issues of power, knowledge and trust describing women's process of unlearning and relearning information in an attempt to create their own new embodied knowledge. Her findings recognised the importance to women of this knowledge in achieving personal empowerment and their ability to make choices through direct action. Trust could be perceived as betrayed if women feel that they are not being treated as equal partners in the relationship with midwives.

The idea of equal relationships is not always easy to achieve within midwifery. Thorstensen [2000] described a conflict for midwives who strive to promote women's self-determination. Midwives face difficulties when women make choices which are known to alter the physiological process of birth such as epidural anaesthesia. She

stressed the need for midwives to have trust not so much in natural childbirth but more trust that women know what is best for them and their baby and will make the right choices.

Despite a general belief that the relationships within maternity care have changed there is some evidence to suggest that paternalistic practises are still prevalent. Studies have shown that both midwives and doctors still act in a way to ensure compliance rather than true choice [Stapleton et al 2002, Mander 1993, Levy 1999]. Crawford [2011] highlighted that while choice is regularly described and accepted within midwifery texts it is not always executed positively when the choice women wish to make is not in line with medical or midwifery guidance. This not only reflects choices in relation to women declining medical care but more recently there has been much debate in the midwifery press and discussion groups about women who request medical intervention such as caesarean section for childbirth when it is not recommended or needed [Duperron 2011, Cheng 2011]. Health care organisations have to balance the promotion of choice and supporting women against a backdrop of limited resources, the benefits to the population, equity and long term provisions. Getting this balance right would seem key in the construction of trust between organisations and the women they serve.

In Edwards' [2003] study of women's decision-making around home birth, the women acknowledged the difficulties that midwives could experience in giving women an authentic informed choice and involving them in shared decision-making. They recognised that midwives work for organisations with restrictive policies and guidelines for how and what information should be passed to women. Midwives therefore could not be completely trusted to provide unbiased information. In a bid to become equal and share decision-making the women felt that they needed to gain information for themselves and become 'experts' in their own right. Women described how they were offered choice in such a way as to control the decisions made. The language used by midwives, the level of information supplied and the emphasis placed on some choices could influence the control over decision-making that women actually had.

In the ethnographic study by Stapleton et al [2002], midwives' language use was also thought to signify power and control. Observational fieldwork showed that midwives were found to use words such as 'mini', 'little' and 'quick' to minimise the significance of certain interventions as an attempt to keep control over the choices made. This suggested that midwives have the opportunity to control the type of information



available and deliver it in such a way as to ensure conformity, offering potential for women's trust to be misplaced. Women may acknowledge this while still placing trust out of necessity.

There is also a tension for midwives between risk aversion and a desire to trust in normal physiology. This is not easy for midwives as reports which describe poor care and adverse outcomes associated with childbirth, such as Knight et al [2014] MBRRACE 'Saving lives, improving mothers care', greatly influence the guidelines and policies which midwives are required to work within. Often these directly conflict with a notion of belief in the body's natural ability to give birth or trust in women's ability to make appropriate choices. Scamell and Alaszewski [2012] explored how midwives make sense of normality and risk in practice through their ethnographic study carried out in four different maternity care environments across the UK: an obstetric unit, an alongside birth centre, a free-standing birth centre and a home birth service. Scamell and Alaszewski described the changes in the NHS system which have resulted in birth being a managed process focussed on risk reduction, blame and note the difficulty midwives had in articulating or defending normality. Midwives across all four sites in Scamell and Alaszewski's [2012] study described lacking confidence and belief in physiological birth as they feared that they would get the blame if the birth did not go well. McCarthy [2011] discussed the potential to damage women's trust in the midwife caring for them, if the service and related guidelines require that midwife to constantly seek opinions and guidance from other senior colleagues, which could result in women doubting their carer's abilities. Scamell and Alaszewski [2012] suggested that the anxiety around blame and risk results in disempowered midwives and subsequently disempowered women. If women are placing trust in the midwife to support them in making their own decisions, the midwife needs to have the confidence and support within the system to ensure that the woman's trust can be upheld.

How women assess midwives' competence and motivation to engage in a relationship that recognises their individual needs is an interesting area to explore in relation to the concept of trust. Edwards [1998] conducted a longitudinal based study following the experiences of thirty women who were planning to give birth at home in Scotland. The women in Edwards' study openly recognised that childbirth was a very vulnerable time for them, which made it necessary for them to place trust in the service, the philosophy of care and the individual midwives who would be looking after them. The women

expressed a desire to get to know the midwife in order to be sure they could trust the midwife to support their wishes. Edwards' [1998] data analysis suggested that women either had complete trust in their community midwife or very little trust at all; this was dependent on the support and attitude with which their decision for home birth had been met. Many of the women described the criticism and discord that they experienced from health professionals and family members when planning to birth at home. In particular, women described a difference in the beliefs and values that they held compared to the community midwife who looked after them. A key theme was the midwives' attitudes to transfer in labour. Women expressed concern that they would be transferred earlier than necessary and that midwives' conversations dwelled on the possibility of complications rather than on positive natural birth. Similar to Anderson's [2000] findings, the women in Edwards' [1998] study wanted a supportive midwife who would enable them to concentrate and have confidence in their body's ability to give birth, caring for their spiritual and emotional wellbeing as well as their physical health. Where this was not apparent the women were more likely to suggest that they did not trust their midwife.

It is interesting to consider the reasons given by women for **lack** of trust in midwifery services or in individual midwives, as these provide additional insights into the concept and risk assessment. Examples of mistrust can be found in the opinions of those authors who write about 'free birthing' [women who choose to birth without a health professional in attendance]. Negative past experiences may lead to reduced confidence and trust in the midwife and midwives in general. Women may be frightened by the inflexibility of the systems in place and feel unable to conform to them and therefore make the decision to birth without midwifery assistance [Edwards and Kirkham 2012, Beech 2008, Nolan 2008]. This is important for maternity services and the need to understand women's perspectives on the concept of trust as intended by my study.

For the women in Edwards' [1998] study who were not able to build trust, some replaced the trust in the midwife with trust for another known person, such as a family member or doula. They would then disengage with the midwifery service and often did not seek assistance until late on in their labour, if at all. Distrust in the maternity care system is also evident in studies from other cultures. For example a study by Viisainen [2001], which investigated women's choice for home birth in Finland, found that they did not trust the advice being given by professionals either based on past experience,

reputation or social norms within their community. Their mistrust of the system was at the core of their decision to stay out of the institution. They perceived themselves as having more control over decisions and processes if they remained at home in their domain, outside of institutional pressures.

In this respect the findings from Viisainen's [2001] study are similar to comments made by women in Edwards' [1998] study in relation to lack of support by the midwives for the decisions women had made. Both studies described the contradiction between client choice, medical policies, control and power. Coming from a different perspective, but with similarly interesting findings, Eliasson et al [2008] studied the experience of sixty-seven first time mothers in Sweden in relation to the attitudes of midwives caring for them during birth. Although the researcher was not specifically investigating trust, nearly half of the mothers interviewed expressed that midwives did not care for them, did not believe them and treated them in a careless manner. This study takes a different focus to the other two in that it looked specifically at midwives' actual behaviour during birth rather than their perceived attitude towards women's decisions. Similar findings were discussed: women experienced that many midwives exercised power and control with a lack of support and belief in the woman's ability to know what was best for herself.

Trust will always involve an element of risk; there is always a possibility that the person being trusted will betray that trust. This aspect of the concept could be a key factor when exploring the application of trust within maternity services and more specifically for exploring which professional (midwife, doctor) women choose to place trust in for birth. It would be interesting to explore how women use this risk assessment in their decision-making and placement of trust.

Whether trust is based on rationality is debated in the literature. Hall [2006] and Sobo [2001] argue that trust itself is not rational as it is driven by vulnerability and dependence and is therefore more emotive than rational. However this really only applies to initial trust which may be more subconscious. As initial trust develops I suggested that it may become much more a calculated judgement based on risk assessment, so that trust is a rational decision by a person who believes that another person will act for the benefit of the one placing trust. It is a cognitive decision based on experiences, an active choice rather than an acceptance of fate [Gilson 2006, Theide 2005, and Harrison et al 2003].

The presence of decision-making in Johns' [1996] model of the trust process was an important consideration for me when comparing it to other models and its applicability to the study. As the elements of decision-making seem appropriate to the midwife-mother relationship where choice and decision-making are frequently discussed and appears from the literature to be important to the concept of trust. This will be further explored through the empirical study and women's experience of trust and decision-making.

I have established that in order for trust to be necessary, a need must exist and that the assessment between need and risk will influence the person's willingness to place trust. It is important to consider the main attributes of trust once that decision has been made and trust is placed.

**3.5 Attributes of the concept:** The attributes of the concept relate to its common use and are based on the values and beliefs of those using it. In Johns' [1996] model [see section 3.1.2] she described one main defining attribute and that is the 'trusting relationship' on which I will concentrate my discussions in the next section and this will continue to be the main focus of the discussions in the later chapters. Firstly I will address the characteristics of trust in relation to midwifery as highlighted within the theoretical literature and include expectations, value, emotion, goodwill and relationships. These characteristics were included in Johns' model within the relationship stage.

**3.5.1 Expectation:** Most definitions of trust include the central concept of expectations. Trust is often initiated with expectations of how somebody will behave, what they will do in a given situation and what the future outcomes will be [Gilson 2003, Thom et al 2004, Gilson 2006, Lee and Lin 2008, Sytch 2008 and Calnan and Sandford 2004]. These will undoubtedly have links to their past experience as discussed previously.

Trust is described as a multi-dimensional concept, referring to expectations that a person will perform various duties i.e. placing the clients' welfare as a priority. As many as eight dimensions of expectation are mentioned and include: expertise and skill or competence, quality of care, provision of information and communication, appropriate behaviour and availability [Straten et al 2002, Haas et al 2003]. However when the dimensions are reviewed it is apparent that these relate to expectations of aspects of care in which trust is placed rather than the dimension of trust itself.

Expectations of childbirth have changed over time. Women in the UK generally do not expect to die or to have a less than perfect outcome. However the search for perfection may be unrealistic. This could impact on the level of trust in the midwife-woman relationship if a woman has expectations that are unrealistic and is placing trust in the midwife to achieve these. For example a woman may have an expectation that the midwife will help her to birth her baby on the exact date that she is due. The midwives are likely to fail and the woman may perceive that her trust was misplaced. The development of the professional midwife and the move into the NHS could be responsible for changing women's expectations of childbirth. Women have been encouraged to trust in this trained professional and the development of medical science. Common sense would suggest that an improvement in care and better outcomes should follow the implied increase in knowledge, skills and expertise. The decline in mortality and morbidity rates [Knight et al 2014] would indicate that this is the case to a degree which reinforces trust in the services available alongside societal improvements in the environment, education and general health and wellbeing.

Childbirth in the western world is increasingly being 'managed' and the use of technology such as electronic fetal monitoring, intravenous infusions and epidurals are now part of the 'usual' birth environment. Attitudes towards this technology and the changes in society's attitudes to 'what is normal' in childbirth are likely to contribute to women's experiences of trust and whether this leads to an increase or decrease of trust in maternity care [Sinclair 2011]. Montague et al [2010] described how patients develop trust for technology in general health care. Patients applied different criteria for developing trust in technological advances which reflected their different personal expectations, self confidence and trust in the existing healthcare systems.

Technological childbirth has rapidly replaced the natural childbirth experience and many authors argue that both midwives and women need to regain trust in the physiological processes of childbearing and the body's natural ability to give birth [Goldberg 2008]. The midwives in Scamell and Alaszewski's [2012] study described birth as potentially hazardous and that they were always alert to possible adverse outcomes, constantly searching for abnormality; normality, [physiological birth] could only be defined in retrospect as it was not predominantly expected to be the outcome of a woman's pregnancy. There is also evidence in the literature of women's lack of trust in the natural birth process, Lavender and Chapple [2005] surveyed women

across twelve maternity units in England; sixty-two percent of participants wanted to give birth in a place where doctors were available and they felt 'safer'. Seventy-three percent said they wanted to give birth in a place with special care baby facilities. Rogers et al [2011] carried out a survey involving one hundred and twenty-one women who were asked to identify reasons why they would chose to give birth in a stand-alone birth unit. The main reason given for not choosing this option were concerns around safety and the women's expectation that the midwife would need to transfer them in labour to another hospital. These findings support the idea that women and midwives have perhaps lost confidence and trust in woman's ability to birth safely without technological support; there is an underlying expectation that they will need help with either the birth itself or for their babies. For some women, trust seems to be linked to a perceived clinical safety and safety is often linked to medical and by extension, access to technology rather than purely midwifery presence. Some women need to have the technology present in order to place trust – whilst for others the presence of that technology may disrupt trust. The presence of the technology almost implies that women are likely to need assistance.

Women's expectations and interpretation of good care may also have changed. As the risk of death and serious illness has decreased in well-resourced countries, perhaps women's expectations of good care now focus more on emotional satisfaction and exercising choice. It is no longer enough for professionals to simply reduce the risk of death. Government reports over the last twenty years have indicated a desire to continue the reduction of mortality and morbidity but alongside this to optimise psycho-social care by recapturing the essence of the midwife- mother relationships [for example, Changing Childbirth, DOH 1993: Maternity Matters, DOH 2007: Designed to realise our Potential, WAG 2008, Midwives 2020 DOH 2010, A strategic vision for maternity services WAG 2011]. Despite the similar focus of all these documents, achievement of their aims – [woman-centred care] has been limited. Models of care to enhance the relationship with midwives through continuity and midwife-led care have been difficult to sustain and the literature highlights the continued dichotomy between health-care providers' risk management processes and supporting individual choice. The theory presented in this chapter indicates that, in order to help achieve the aims of the government reports, it is necessary to understand the woman's conceptualisation of trust and the effect this has on the midwife-mother relationship, as is the focus of this thesis.

I suggest that women's expectations will vary between individuals. As indicated by the sociological perspective, it may be that certain factors such as ethnicity, sexuality, disability, education, level of information available, living conditions and social class could all have an effect on the expectations of pregnant women. Sociologists suggest that trust is influenced by the personal experiences of an individual. Trust may be built or lost as a result of an individual's experience within the relationship; for example, a woman in the UK from an ethnic minority who has a low income and challenges with communication may experience the relationship with the midwife differently to a white British woman who communicates well in English, who understands the systems in place and how to get the most from the midwife- mother relationship. As a result, their personal experience of developing trust will be different and the levels of trust expressed are likely to vary. It is also likely that expectations will adapt to changes over time and respond to developments within the maternity services. As outcomes for babies have improved over time, some women's expectations may be less focussed on safety for the unborn baby, which is automatically assumed. Women have perhaps developed expectations that midwives will also trust them in a reciprocal relationship; that a woman will remain in control of decisions relating to her care and that her baby will be born safely in an environment of her choice. Women may have an expectation for reciprocal relationships, equal power and control [Cheyney 2008, McCourt & Stevens 2009, MacLellan 2011].

These initial expectations may be born out of the social construct based on shared values and reputation. A feeling of betrayal may be more likely where the expectations of the client have been unrealistic [Sellman 2007]. If the expectations are not met, levels of trust in the future may be diminished [Lee and Lin 2008]. It may not always be that a woman's expectations are unrealistic but if midwives do not know or understand what the woman's expectations are, there is a chance that these expectations will not be met because midwives may assume that a woman's expectations are predominantly for the safe birth of the baby, however that is best achieved.

This could be likened to values or outcomes, the successful achievement of which will strengthen or confirm the trust placed. However not achieving the valued outcome could have the opposite effect in weakening the trust placed. The importance of each value or outcome will vary dependent upon the situation in which trust itself is placed. The value may have a higher or lower order within the individual's overall trust,

subsequently having greater or lesser effect. However the notion of trust remains constant in that it is still present [Thom et al 2004, Hall 2006].

**3.5.2 Value:** Value is an interesting and relevant attribute to consider. Fulford's [2004] theoretical discussion on values has similarities to my theoretical discussions on trust. Values are described on a scale from implicit values, which are universal, shared and often invisible, to explicit values, which are different depending on individuals and the situations they are facing. This would seem to hold some relevance when looking at the concept of trust. Social or organisational trust would be based upon the implicit values held in a particular society, while interpersonal trust would vary from person to person and would be influenced by that individual person's values.

Within maternity care, values will vary between women. One woman may value the opportunity to experience natural childbirth with no intervention while another may value a pain-free birth with the use of an epidural. For some it may be valuable to birth in hospital where they feel safer, while for others they may value the freedom and control of being in their own home. Everly [2012] explored American midwives' perceptions of what influenced their decisions during labour. The midwives interviewed recognised the importance of considering the woman's desires and preferences but expressed some challenges in focussing care on the individual's values where that care took place within a hospital and medicalised model of maternity care.

As recommended in Government policy [DOH 1993, DOH 2010 and WAG 2011], many areas in the UK now strive to provide midwife-led care and the role of the doctor in normal midwifery has been greatly reduced. The recent English Birthplace study [NPEU 2011] highlighted that birth centres [which are usually midwife-led] are a safe option for 'low-risk women' to birth their babies. Hatem et al's [2008] review of trials involving the evaluation of midwife-led care provides strong evidence that women value this form of care. Those who receive care from a midwife are less likely to experience interventions and demonstrate higher levels of satisfaction than women who did not have midwife-led care; this is usually associated with the relationship between midwife and mother. It is important to note that not all areas offering midwife-led care have models of care that encourage continuity of carer. However, the research site did have a model of midwife-led care that encouraged continuity of carer through case loading and evidence exists to support the benefits to women of building a relationship with the midwife throughout pregnancy and birth.



The literature on continuity of carer is vast and it is not my intention to debate continuity of carer within this thesis; I will however highlight some examples of the benefits of continuity and its importance to the concept of trust. Huber and Sandall [2006] discussed the value of continuity of carer for the development of trust and supporting women with breastfeeding. They described several characteristics of continuity of carer as a model for building trust within the relationship: the bridging of life worlds, space to develop self-confidence, development of supportive relationships and joint expectations leading to greater technical expertise and confidence. McCourt and Stevens [2009] described their two research studies exploring how organisation of care, specifically case holding midwifery and its effect on the emotional work of midwives and women. The benefits of women getting to know midwives as 'real people' was highlighted by midwives who described feeling valued as an individual person, not just a 'cog in the wheel'; midwives described the benefits of getting to know women through continuity of care schemes which meant they did not have to consistently start over and could develop an understanding of the woman. In the report Front Line Care [Prime Minister's Commission 2010] the commission again calls for every woman to have a named midwife to provide her support and care for pregnancy and birth in an attempt to improve quality of care and increase levels of patient satisfaction.

For many women today their main relationships within maternity services are with midwives. Timmis [2010], in her opinion piece about caseload midwifery, described the improved safety, effectiveness and satisfaction experienced by women who were cared for by midwives providing continuity of care. Continuity is associated by Timmis with higher levels of trust, enabling women to feel confident and able to discuss sensitive issues and their values. Maclellan's [2011] discourse analysis of the 'art' of midwifery described four fundamental midwifery skills identified in the literature: presence, guardianship, intuition and confidence. She suggested that women value more than the mere presence of a midwife but that what was important was the trust resulting from knowing and understanding a woman intuitively.

These values may change depending on women's circumstances. A woman having an uncomplicated pregnancy may in the first instance most value a birth in a home environment with no intervention and place trust in her carer to provide this. If that same woman is informed of a complication during pregnancy, which places her baby at risk, perhaps her values will change. She may value more a hospital birth that can limit the risks, and make rapid intervention possible, thus placing trust in the hospital

midwives and doctors and hospital systems. It may not necessarily be that her values have changed but that the trust placed on behalf of the baby has become more important than the trust placed by the mother for herself. These issues require further research to gain better understanding.

The importance of value is more visible in a relationship between two competent individuals as is mostly the case within midwifery. However trust as a concept is most relevant in situations where people are vulnerable and have perhaps lost the ability to make decisions themselves. This is an interesting point when thinking about placing trust on behalf of the fetus. The trust placed is perhaps done so based more on the values of the mother or the values which the mother assumes the fetus would have if they could voice them. A person may not be able to voice their preferences and it may be difficult to judge what they value most at any given time. In this circumstance personal values are more difficult to incorporate and again we return to a notion of belief that the professional will act in the person's best interests [Sellman 2007]. Therefore trust itself must involve more elements than value alone. From what has been discussed so far trust appears to impact on a person's feelings of satisfaction, confidence and self-empowerment suggesting that trust has a strong emotional basis.

**3.5.3 Emotion:** Gilson [2003] argues that rather than being a calculated decision, trust is actually based on emotional bonds developed through repeated interaction and a greater understanding of each other's desires. Maybe trust is better thought of as an emotional state that builds over time. Juckel and Heinz [2004] described emotions as having several dimensions including emotion, cognition and motivation. This is not dissimilar to our earlier discussions of the dimensions of trust.

While trust would appear to have an emotional basis, there is evidence that it also includes risk assessment, calculation and judgement. It would seem unrealistic to suggest that a person can be completely rational without any influence of emotion, with trust containing elements of rationality and affect. The literature discussed earlier implies that trust is a process which incorporates emotion and evaluation. Gilson [2003] described trust as a multi-layered concept primarily consisting of a cognitive element [grounded in rational, instrumental judgements] and an affective dimension [grounded on relationships, interaction and empathy]. If we applied this to the midwife-mother relationship it would be reasonable to suggest that women place initial trust in the midwife following a rational judgement which could account for their 'gut feeling' and

build on this by establishing an emotional connection through continued interaction and achievement of empathy. The empirical data from the study may help to define and understand this further. Ultimately however the relationship may still be reliant on the midwives' goodwill to act in a way that would achieve the woman's desired outcomes.

**3.5.4 Goodwill:** Throughout all the discussion so far goodwill [the intention to act in a way that is beneficial to another] and its importance to clients can be seen as the foundation of trust in all the health care literature. Whether we consider expectation, values or emotions, the underlying element remains the goodwill of those being trusted. Trust is most needed where there is uncertainty and vulnerability. Childbirth is such a time as outcomes are not guaranteed and families rely on the goodwill of the midwives, doctors and maternity services to assist them in the safe arrival of a healthy baby. I suggested women trust in the goodwill of midwives in providing them with the correct information on which to base decisions, good will to act in accordance with their wishes and, at times of reduced competence, such as extreme pain or altered conscious levels, to act in accordance with their best interests and that of their baby. It is important to consider here how a person placing trust can assess the trustworthiness of the trusted, through first impressions and perceptions of competence, influenced by a person's characteristics.

Initial trust could be affected by first impressions. A small research study by Bundy et al [2006] found that patient trust was influenced by professional's attire. Increased trust was noted when professionals wore white coats, visible name tags and smart clothing, in contrast to a reduction in trust when professionals wore dangly earrings, facial jewellery, tattoos and scruffy clothing. Research studies have shown that clients use tactics, such as questioning, interpretation of body language and comparing, in order to get to know and test professional's competence and overall personal characteristics [Edwards 1998, Mechanic and Meyer 2000, Hall 2006]. In Edwards' [1998] study women highlighted the importance of getting to know midwives, in order to judge their competence and build confidence in their beliefs and views. The women in the study who did not have an opportunity to do this were seen to reduce or withdraw their initial trust.

Thus an opportunity to get to know the personal characteristics of both the person placing trust and those being trusted may be important when developing interpersonal trust within the midwife-mother relationship and I will briefly discuss the perceived

connection between personal characteristic and assessment of trustworthiness. Fahr and Irlenbusch [2008] conducted a psychological experiment using a game to look at potential correlations between personality traits and trust behaviour. They looked at what they termed the 'big five' considerations: extraversion, anxiety, self-control, independence and tough mindedness. The study found that both low anxiety and high levels of self-control in the person placing trust led to enlarged trust. Honesty, good communication and ability to establish effective relationships are central to many other authors' descriptions [Thorstensen 2000, Thom et al 2004, Murrey et al 2006, Lin and Lee 2008]. In a research study by Nicholls [2006] women's views were sought on what makes a good midwife. Good communication skills were found to make the greatest contribution to being a good midwife alongside compassion, kindness, support, knowledge and skill. Similar findings were found in a study of General Practitioners by Tarrant et al [2003]. Personal characteristics may be important features for developing initial trust into a stronger interpersonal trust through an assessment of the goodwill present within the relationship.

As trust assumes the reliability of another, professionals have a duty to uphold this by being trustworthy [Theide 2005, Trojan and Yonge 1993, Rhodes 2001]. Though they do not give a specific definition of trust, the Nursing and Midwifery Council highlights it in 'The Code', promoting professionalism and trust as one of its four key themes and within this they include:

- *Act with honesty and integrity at all times, treating people fairly and without discrimination.*
- *Treat people in a way that does not take advantage of their vulnerability or cause them upset or distress. [NMC 2015]*

Ultimately professionals must earn trust over time and with support from the system professionals need to demonstrate trustworthiness; they can do this by being honest and involving clients in decision-making [Harrison et al 2003, Coulter 2002]. This aspect will be given greater clarity through understanding the experiences of the participants in the empirical data discussion chapters.

It is not possible to know for certain if we can trust the goodwill of another. If it were possible then trust would not be necessary [Sellman 2007]. It is therefore appropriate to look at the circumstances surrounding the placement of trust and the value, emotion and goodwill within the relationship itself.

**3.5.5 Relationships:** Historically it was patients who sought help from a doctor, who had then naturally acquired a position of trust as they had committed themselves to the principles of beneficence and non-maleficence. This was seen as sufficient basis for the relationship without need for the notion of consent [Habiba 2000]. The same could obviously be applied to the midwife-mother relationship and the theoretic shift from paternalism to informed choice discussed earlier in the chapter. Recent publications within maternity services have emphasised a need for a more mutual or deliberative form of relationships where clients are treated on an equal footing with an equal balance of power [DOH 2010, WAG 2011].

It would appear that there is a belief that trust within the midwife-mother relationship is a two-way process and that women desire that they themselves will be trusted by midwives in a reciprocal manner [McCourt and Stevens 2008]. The importance of receiving trust, as well as placing trust, has been shown in research studies [Oudshoorn 2005, Tanassi 2004, Huber and Sandall 2006] to give benefits to women such as increased satisfaction with care, dispelling fear, feeling in control and self-efficacy. Thorstensen [2000] explored the theoretical literature around the concept of trust within midwifery care and related this to the issue of trust in women's ability to make decisions. She used the example of epidural anaesthesia to focus her discussion. It is suggested that when a woman has trust in her midwife she will be happy to disclose necessary sensitive information, follow recommended care principles and become more empowered. She described the benefits to women of trusting the midwife but also discussed the benefits of women trusting themselves, their own bodies and the importance of midwives trusting women to make the best decisions for them. Thorstensen [2000] argued that trusting women should be at the heart of midwifery care. Women who felt trusted were more likely to make choices that benefited their own health and that of their family but also were more likely to return that trust to their carer. Thortenson's theoretical exploration of the literature truly described the benefits of trust within a reciprocal midwife-mother relationship.

Trust depends on the quality of the relationship and protecting it from conflict and suspicion may preserve the trust within it and protect future health care relationships [Mechanic and Schlesinger 1996]. Gillon [2000] highlighted the obligations to foster trust that are paramount within any type of relationship. These obligations are respect for autonomy, to not harm each other, to be just and to benefit at least some others.

Gillon goes on to describe some prima facie duties: to provide adequate information, not to lie or deceive and to allow the client at least some control over what course of action to take. Beauchamp and Childress [2001] described characteristics of a good client-professional relationship, as respect for others, fidelity, promise keeping and trust.

The midwife-mother relationship has been the focus for midwifery literature for several years and several authors have contributed to midwives' understanding of the complex nature of this relationship in two excellent editions of Mavis Kirkham's books 'The midwife-mother relationship' [2000] & [2010]. Chapter authors explore research studies, with examples from independent and NHS practice, to identify the important elements of the 'good' relationship and central to many of the chapters is the importance of reciprocity.

Reciprocity is described by Hunter [2006] as an exchange between two people for mutual benefit. Drawing on an ethnographic study of the emotion work of midwives, she develops a model of reciprocity within the midwife-mother relationship which may take four forms: Balanced exchange, which involves give and take on both sides. This is seen as emotionally rewarding for both parties. Rejected exchange, which is when the midwife gives but the mother rejects. This can be unrewarding for midwives and hard work emotionally. Reversed exchange where the woman and the midwife are both seen to give, the woman supporting the midwife which is often felt to be inappropriate by professionals. Unsustainable exchange, this involves the midwife giving and the woman taking. The woman may want to take more and more and for this reason this is seen as unsustainable as it may be built upon unrealistic expectations. In relation to trust the first example of a balanced exchange could be the most beneficial in establishing and maintaining trust.

Historically the NHS and indeed the midwife-mother relationship may have been based on more of a paternalistic model of care. Hunter and Leap [1993] gave us the opportunity to take a look back at the relationships that women had with midwives in the early days of regulation of the profession. In their oral history they interviewed women about their experience of childbirth either as midwives or as mothers through times when the midwifery profession moved from 'Handy woman' to 'professional'. Their intention was not to focus solely on the relationships in this time but to tell the

story of the lives of midwives and mothers. However, the text gives a valuable insight into relationships and indicates the level of trust that may have been present within these.

The 'handy woman', whom women sent for to assist them when giving birth, was known within the community, seen as reliable and acted in a way that was expected, all of which are key ingredients described within the literature on trust. The text implies that both women were equal in their relationship and asserting power was not described within the recollections of this time. Women could be seen as the 'handy woman's' employer which may account for this lack of power struggle. They were also of equal social status.

It would be easy to romanticise about this reflection and surmise that it was a relationship based on trust. But we must remain cautious, as women paid directly for midwifery care. The 'handy woman' was cheap in comparison to the expensive doctors whom lower class women could not afford. The relationship may also be one of necessity and women could be said to have had no choice but to use the 'handy woman'. The fond recollections within the text could be due partly to nostalgia and partly to the level of expectation in society at this time. Imperfection and death were regular occurrences and the women may not have assumed that perfection would be the outcome. Women trusted the 'handy woman' to come, to support them in their own homes and to not judge them.

Trained midwives rapidly replaced the traditional handy woman as maternity care progressed through the developing NHS systems. Leap [2000] discusses the shift in power within the midwife-women relationship; she feels that the shift in power started with the First Midwives Act 1902, which began the registration of professional midwives. The subsequent acts increased training and introduced a uniform, ensuring that only middle class ladies were able to become midwives and that it was out of reach for the traditional, lower class handy woman because of the costs involved. The professional midwife was increasingly aware of her status and the introduction of the NHS in 1948 meant that women no longer directly employed midwives. Home birth and community midwifery were almost completely phased out in favour of hospital birth, medical intervention and an increased involvement of the doctor. It would be interesting to study what effect training and regulation had during this period on the trust women were able to place in this 'New qualified' midwife. In Hunter and Leap's oral history [1993] many women described the professional trained midwife as judgmental, strict

and assuming an apparent professional status that created a barrier. This may have made it more difficult for women and midwives to relate to each other in a way that fosters trusting relationships. A shift in the interpersonal relationships had occurred. The woman was no longer the employer, her relationship was no longer equal and the assertion of power through professional status and social standing is apparent. A modern day occurrence worthy of further study in relation to the basis of trust could be the current day independent midwives who do have professional status and in theory could use this to assert power. However, they are also directly employed by the woman which could shift the power base back and result once again in a more reciprocal relationship.

In all social relationships or partnerships both partners need to know and understand the basis and balance of the relationship. It is essential that partners can communicate and trust each other and this may only be possible if power dynamics are understood and relationships are equal [Leap 2000]. Goodyear-Smith and Buetow [2001] state that power principles are present in all social relationships and should therefore be viewed as neither good nor bad but merely fact. They discussed the necessity of power to enable both doctors and clients respectively to fulfil their responsibilities. They stressed that even in adult-to-adult relationships conflicts of power will arise and that empowerment of all parties is not always possible but can more likely be resolved where each party acknowledges the power issues.

Within midwifery, it would appear from the literature available that the relationship has changed from one where clients placed their trust based on an expectation that professionals would act in their best interests, to an additional expectation that women trust that they will be equal partners in their care [McCourt & Stevens 2008]. This expectation includes being given enough unbiased information to make decisions and that those decisions will be respected. However, I have also outlined some challenges within healthcare and the notion of equal relationships. The relationship may never be entirely equal as there will always be an unequal distribution of knowledge and power [Cooper 2001]. What remains for pregnant women is a need to engage; trust requires this need in order to exist. What is still unclear is how this potential imbalance between women and their midwives will affect their relationship and feelings of trust if their expectations of the relationship are not realised. Which leads me onto discuss the consequences of trust within healthcare.



**3.6 Consequences:** Consequences are those events which may follow an incidence of the concept. In Johns' [1996] concept analysis of trust, the consequences of trust are described as: the realisation of expectations, unanticipated outcomes and the impact these then have on the continuing levels of trust. I will describe some general consequences of trust within healthcare from the theoretical exploration but it will be valuable to return to this section in the later chapters using the empirical data.

There are important reasons for looking at trust in the health care system - trust can be a valuable indicator of client's support or, lack of, for the system or changes within that system. The benefit to the organisation, particularly from an economic perspective, of securing trust includes:

- Organisations and indeed individual professionals could be more effective when they have been able to build on a culture of trust.
- Staff may be seen to use time, energy and communication more effectively.
- Increased patient satisfaction
- Lower transaction costs due to less need for repeated patient reassurance
- Fewer costs associated with repeated tests and additional referrals [Straten et al 2002, Thom 2000, Fitzpatrick 2001].

This assumes the trustworthiness of the professionals. An abuse of this power could equally result in distrust which would have the opposite effect for the organisation. Within midwifery this may be associated with the increased number of women who choose to birth without a professional for fear that the midwife will use her power to control and manipulate the birth process [Beech 2008]. Raeve [2002] points out that a trusting relationship not only fosters benefits but can also enable exploitation and for conspiracy to thrive. Ultimately, professionals must earn trust over time; with support from the system, professionals need to demonstrate trustworthiness, achieving this by being honest and involving clients in decision-making [Harrison et al 2003, Coulter 2002]. Clients need to place trust with caution as it is open to abuse as even competent adults can be coerced with threats or offers. Autonomous choice can only truly be achieved in the absence of such coercion [Schramme and Thome 2004]. There is never a guarantee that trust is not misplaced.

On a more personal level, small scale research studies have related trust to a patient's behaviour and its influence in the relationships between health professionals and

clients. Rhodes [2001] emphasises that the practice of medicine would be impossible without the trust of patients. Patients who lack trust rarely attend appointments or follow advice given, making it difficult for care to be effective or worthwhile. Thom [2000] found that high levels of trust could be associated with increased patient satisfaction, lower transaction costs owing to less need for repeated patient reassurance and fewer costs associated with repeated tests and additional referrals. Positive health outcomes include increased quality of life and better compliance with treatment regimes. Patients who express trust in a physician may also have a positive effect on that physician's behaviour, encouraging them to behave in a more trustworthy way and show a more caring attitude [Lee and Lin 2008, Piette et al 2005]. Previous experience of unmet expectations can lead to reduced trust and the competence of future physicians being called into question. Straten et al [2002] looked at future behaviour of clients when trust was low. This included more clients requesting a second opinion, seeking care from alternative practitioners and a search for the 'best' institution or professional; even when patients have sought this, low trust was still associated with lower levels of compliance.

The philosopher, O'Neill [2002] observes that general mistrust in health care has become wide-spread throughout the UK. Maternity accounts for the third highest number of claims for negligence within the NHS and they represented the highest cost to services in 2013 amounting to a total value over 3 billion pounds [NHS Litigation Authority 2014]. The results and recommendations from the NHS litigation authority often include improving risk management processes, appropriate learning and training, supervision and support. These claims are likely to be reported in high profile media coverage with the recommendations reflecting a failing within NHS maternity care. Calnan and Sanford [2004] investigated general trust and confidence in healthcare via a postal structured questionnaire sent out to a random sample of people on the electoral register in England and Wales. One thousand one hundred and eighty seven [48%] were returned. The results indicated that respondents' mistrust was predominantly associated with how the National Health Service is run and managed. The rise in complaints and litigation claims could be indicative of a reduction in public trust [O'Neill 2002]. Etchels [2003] reviewed the increasing number of complaints within the 1990s and found that most were focused on poor communication and similar themes are highlighted in more recent investigations [Francis 2013]. The desire by patients today to search for independent information on the internet could be an

indication of their mistrust in the information provided by health care professionals. This may have some relevance to the midwifery evidence regarding free birthing. One could speculate that the desire to birth without assistance could be linked to a reduction in public trust for midwifery services in the NHS.

A decline in public trust may be the consequence of intense media scrutiny. Allsop [2006] discussed the decline in health care trust and its correlation with high profile media coverage of scandals such as the Bristol enquiry, the conviction of Harold Shipman and the organ removal scandal at Alder Hey Hospital. The increased in number of complaints and claims of negligence could be an indication of the betrayal of trust [Allsop 2006]. More recently professionals have come into the media spotlight in the Morecambe Bay investigation [Care Quality Commission 2012] and the review in Guernsey [NMC 2014] which highlighted concerns, not only around midwifery care provision but also in relation to midwifery regulation. These reports recommend improvements to care and implementation of more robust systems for ensuring patient safety. Health professionals need to rebuild and secure trust in the new arrangements following these investigations to reduce the risk of lasting damage [Allsop 2006, Raybekill 2008, and Dimond 2002]. Media interest in 'bad news' stories of health care such as those highlighted above may help to fuel a culture of mistrust.

In an attempt to secure public trust in professionals, legislation and professional regulation have been increased in an attempt to reinforce professional accountability. Policy, audit and standards were intended to improve public trust in professionals by demonstrating a robust system for monitoring and reinforcing the application of rules and regulations. The aim was to demonstrate the achievement of high standards but they also had the potential to reduce it by highlighting the faults in the system. Hence, O'Neill (2002) argues that initiatives to improve risk management processes within the organisation could in fact have damaged the trust between client and professional rather than enhancing it. It is interesting to consider the views of staff working in the NHS as an indication of inter-colleague trust and trust in the systems in place. NHS staff surveys often reveal discontent within staff groups with the relationships that staff have with managers and the organisations who employ them. In the NHS staff survey [2013] responses from staff suggest that managers could not be trusted to act on staff concerns. Only thirty-six percent of staff said that communication between staff and managers was effective, less than a third of respondents felt that managers acted on

the feedback that they were given and only thirty percent of staff felt they were involved in important decisions that were made. Discontent is also implied in staff responses to safe staffing levels; only thirty percent of staff felt that there was enough staff to enable them to do their job well. The survey responses are an indication of the lack of trust that employees have for the management systems in place in the organisations that employ them which leads one to question what effect staff trust has on the process of developing trust with patients. It is also interesting to consider whether the emphasis on audits and completion of documentation could have the unanticipated consequence of reducing trust, as professionals are seen to spend time filling in forms and have less time to build trusting relationships with their clients. This will be an interesting point to consider within the empirical data collection.

Not surprisingly, loss of trust is often associated with the perceived untrustworthiness of the professionals. O'Neill [2002] suggested that people withdraw trust when professionals prove to be unreliable. However, she acknowledges that complete withdrawal of trust is not possible. If a person is sick or injured they will need to place trust in something or someone in order to improve their wellbeing. O'Neill used examples from our environment - the air we breathe, the water we drink - discussing that most people have no control over whether these will contain pollutants. Therefore we have to place trust that they are safe as we cannot control it. For most people complete self-sufficiency is not achievable.

This brings my discussion back to the beginning in highlighting the antecedents of trust: need, past experience and risk. I will now conclude the chapter with a summary of the sections presented.

### **3.7 Discussion and conclusion:**

**3.7.1 What can we learn from the theoretical concept analysis?** In this chapter I have highlighted the importance of looking at trust within midwifery and have described the potential benefits to both individuals (mother and midwife) and the system as a whole. It is widely acknowledged that the definition will vary upon the theoretical perspective, the situation and the people involved. Within midwifery the concept is more complex to define because trust is not only placed between two people but there is also the third party fetus.

My discussion has focussed on the concept of interpersonal trust and its relevance to building effective relationships, but I have also highlighted the importance of understanding the social trust for an organisation or service. I have suggested that trust is multi-dimensional. It is not purely a value, emotion or belief, nor is it confidence, satisfaction or reliance but rather a broad concept which encompasses all. It seems that initial trust may, on face value, be more focussed on non-rational 'gut feelings' or belief but interpersonal trust is based more on a rational calculation. I have presented evidence which suggested that trust changes over time in response to social interactions and experience. What is not clear from the literature is what value women place on each type of trust individually.

**3.7.2 What is still unclear?** The literature does not allow a full understanding of what particular aspects of trust are important or at what point in particular the trust within a relationship is crucial to aiding the care process or what influence a woman's consideration of her fetus has for women when placing trust. Nor does the literature explain how women use the interactions with the midwife to assess their level of trustworthiness. For example, it is not clear that the trust placed on midwives providing routine antenatal care is the same as the trust placed in a midwife to safely help birth the baby. This trust isn't necessarily different but may take trust to a different level. This could be demonstrated through looking at the development of trust as the relationship moves through different stages of the childbearing process as is the intention of this study.

**3.7.3 Implication for midwife-mother relationship:** I have discussed the role of trust within the changing focus of health care and how it exists alongside a drive for shared decision-making and autonomy. This has been challenging in relation to midwifery as the larger body of literature exists in relation to doctor-patient or nurse-patient relationships which may focus on illness and vulnerability and reduced capacity to make choices. It is not always easy to transfer this to midwifery where clients are generally well and usually in a position to make their own decisions and remain to a great extent in control.

The notion of expectations in itself makes it difficult to understand trust. Expectations of women will vary greatly and maintaining trust under these circumstances will always be challenging to the midwifery profession. Midwives will need to understand women's experience of the concept in order to maintain the woman's belief that trust was well

placed. This requires an understanding of what women need to feel safe and which elements of trust influence women's choices the most. The research site provides examples of women with straightforward pregnancies who, despite positive relationships with individual midwives, still choose to birth their babies in large obstetric led units, indicating greater confidence in the consultant as the lead professional. This could indicate that the level of interpersonal trust is crucial to enable women to have confidence in the midwife for specific situations such as birth in midwife-led settings. In these situations it is unclear whether social trust or interpersonal trust impact most on the woman's confidence in the regulated systems. Perhaps this links back to the attribute of expectations. Women's expectations of what a midwife can provide in particular situations will vary and they may place trust in alternative professionals to meet the expectations of birth.

The idea that trust takes on a multitude of co-existing forms is plausible within the midwife-mother relationship. For the purpose of studying trust within the midwife-mother relationship, I favour a sociological approach looking at two main types of trust: initial trust, which is based on social norms, reputation and is aimed at professional groups as a whole and interpersonal trust, which is based on knowledge and experience within the person to person relationship. I favour this approach because it seemed feasible when reviewing the literature to say that midwifery and the midwife-mother relationship has been strongly influenced by social norms, changed over time from one based on a belief in fate to one based much more on active choice and risk assessment. For first time parents in particular the notion of trust may be embedded in the culture and experiences of the society in which they live. This can then develop through a continued relationship into interpersonal trust.

It would appear appropriate to use the sociological models described which encompass primary, secondary, trusting impulse and trusting culture to aid in looking at the trust within midwifery. There is little evidence in the literature of any substantial studies looking specifically at trust within the midwife-mother relationship, how this grows, deteriorates or how it influences the choices made by women. This concept needs to be explored more thoroughly within midwifery as the relationship is unique in that it involves a tri-party relationship where trust is also placed on behalf of the fetus or baby. As birth in the western world is increasingly being managed using advancing technology, women's attitudes to this are likely to affect their experience of trust. There

is also a tension between risk aversion and desire to trust in normal physiology. The issues described in the studies around power, control and belief in a woman's decision-making ability indicate a desire by women to themselves be trusted by midwives in a reciprocal manner. Women may be frightened by the inflexibility of the systems in place.

The concept analysis confirms that trust is an important element of professional-client relationships and that investigating trust within this relationship can give insights into individual communication issues and even system wide failings. In order to study the concept in more depth it would seem important to gain an insight into individual women's experiences of trust as a process, including how this is influenced by their values and emotions. This will be the focus of the empirical stage of my study.

This raises the question of how best to investigate trust within empirical studies. Some studies have attempted to measure trust, however this creates a number of challenges as the scales are not designed for measurement of individual experience as they do not relate to specific situations or allow flexibility in the data obtained. The assumption appears to be that trust means only one thing to all people, which is in conflict with the ideas presented within this concept analysis. That is not to say trust should not be measured at all. Thom et al [2004] argue that low levels of trust can be changed and improved, reducing disparity and increasing uptake of services and client satisfaction with care. They suggested that if we do not measure trust we are ignoring a serious element of our care, we may fail to cultivate it and could ultimately risk losing it altogether. It may be more appropriate to use a methodology which seeks to explore human experience in its natural setting, in order to provide a contextual understanding of the concept.

Johns [1996] suggested that in order to measure trust effectively within the process-outcome model, studies must associate it with a specific period of time but that numerically attempting to measure trust may be of limited value if that score is only relevant at that particular point in time. While scoring trust might be useful in looking at trust from the outcome perspective it cannot inform our understanding of trust as a process. It would also be difficult to generalise from the scores if trust is linked to individual experiences and beliefs.

Therefore it would be useful in developing this concept analysis to use a qualitative method of enquiry. Hermeneutic phenomenology involves examining the nature of reality, enquiry and lived experiences of the participant. Understanding is gained from being in the world of the participants and combining information gained from theory, researcher and participant as a continuous cycle [Koch 1999]. The aim is to develop practice based understanding of the concept being studied. This approach formed the basis for my study and has been covered in more detail in the methodology chapter.

In this chapter I have detailed my theoretical concept analysis of trust within the midwife-mother relationship by firstly describing the process of concept analysis and setting the context of its use as an exploratory process to aid understanding for an empirical qualitative research approach. I have introduced the various discipline viewpoints and my rationale for leaning toward the sociological frameworks, before detailing my discussion of the antecedents, attributes and consequences of the concept of trust. I have introduced Johns' [1996] analysis as a theoretical model case which will be explored further using the empirical findings in the later chapters. The theoretical concept analysis provides a broad overview of the language used and potential contributing factors which influence the concept of trust. The available literature focusses on general aspects of trust mainly within a more generic nursing field. There are no detailed midwifery studies exploring the concept of trust and very few studies on trust explore the concepts meaning from the perspective of the person placing trust. The literature available implies that trust is important yet fails to demonstrate understanding of the contextual meaning of trust within the midwife-mother relationship. The development of trust linked to individual social experience is not clearly described yet greater understanding of how personal experience aids decision-making and placing of trust could help to shape the way maternity care is delivered. Hence the aim of my study is to explore the concept of trust within the midwife-mother relationship increasing understanding of the individual's experience of trust and its meaning to women. By researching trust we should be able to increase our understanding of the elements involved and also consider their implications for midwifery practice. This will be explored using the empirical data in the chapter that now follows.



## **Chapter 4: The Building Blocks of Trust: Empirical data.**

**4.1 Introduction:** The study's aim was to explore the concept of trust within the midwife-mother relationship increasing understanding of the individual's experience of trust and its meaning to women. The hybrid model of concept development as described by Schwartz –Barcott and Kim [1993] was used to structure the study. The three phase approach included a concept analysis undertaken in the first stage to establish an understanding of the theoretical meaning of trust within this context, as described in the previous chapter.

Stage two of the hybrid model moves on from the theoretical concept analysis to add understanding of the lived experience of the concept of trust, through the collection of empirical data. In this chapter I will begin with some background detail of the participants, followed by an overview, before describing in more detail the participants' data relating to the antecedents, attributes and consequences of the concept. In keeping with the Heideggarian phenomenological approach which accepts the individual nature of the data and the researcher's influence within the research. I felt it was important to present the data in isolation from the analysis, allowing the reader to fully engage with the participant data, ensuring that the woman's voice is heard and the reader develops their own understanding of the participant's journey and experience of the concept of trust. Hence I aim to simply present the empirical data, allowing the reader to engage with the lived experiences of the participants and gain some insight into the concept of trust as they described it. Data is presented as direct quotes but where participants repeated the same point, or used words such as 'umm' or 'ahh' the quote has been edited and these words replaced with [...] to assist the reader. In the following findings chapter I will return to the hybrid model [stage three] - with critical discussion and analysis of the relevance of the concept itself and how the data assists in developing understanding of the concept of trust within a clinical midwifery context.

The findings will be presented in this chapter as a series of 'building blocks'. Building blocks were an analogy identified within the participant interviews which capture the evolving nature of trust within the midwife-mother relationship. For example, Fiona described her experience as a set of building blocks, a progressive process of developing trust with attendance and support at the birth as the final aim.

*"Like building blocks I guess you start off with a certain level of trust because you know they are a professional in that, a professional in that field. But as you move*

on [...] I imagine you would need to stay with that midwife to build a relationship because at the end of the day she is going to be there at the birth. More than likely she may not be of course, but it is what you're aiming towards isn't it really? "[Fiona Interview .1]

**Figure 4: Building blocks of trust**

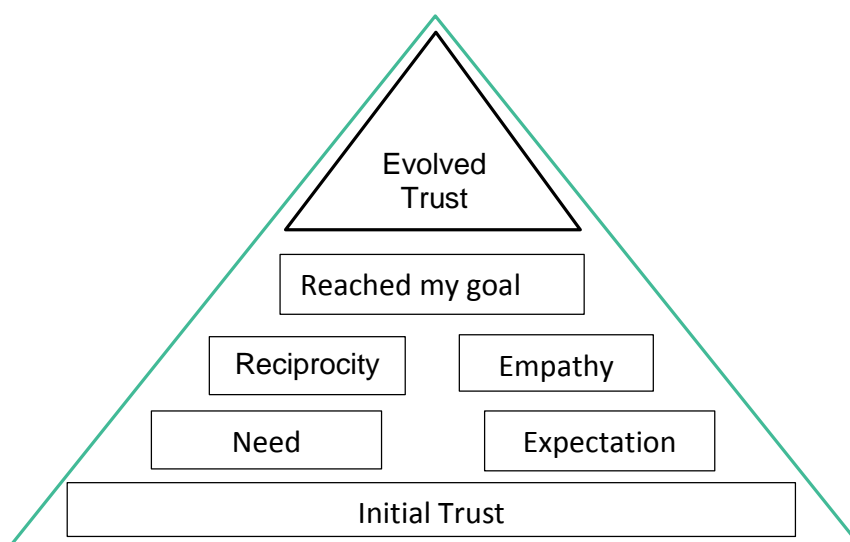


Figure four demonstrates the idea of building blocks identified through the empirical data [see appendix 7.6]. The diagram was produced at the end of the data analysis to represent the themes identified in the empirical data but appears here at the beginning to assist the reader in navigating through the chapter. The participants described an initial trust that was 'just there', something which I suggest is the foundation to the building blocks. The participants' journey can be represented through a series of blocks which would influence the evolvement of their concept of trust to a trust based more on the interpersonal relationship with the midwife. Participants described trust as progressing through the pregnancy in distinct blocks, changing and evolving from an initial trust to a more interpersonal trust. Some participants described less positive experiences where some blocks were not successfully built on. Conducting a longitudinal study was beneficial in allowing the researcher to follow the participants' journey, this aided understanding of the building blocks model in terms of the barriers identified by the participants to developing the evolved trust. The antecedents, attributes and consequences of trust as experienced by all of the participants could be encapsulated within in the same building blocks, however their individual experience of

each block was different; for some it was a positive experience while for others it was a negative experience. The findings will be presented in three sections:

- Antecedents- that which precedes the concept itself. This focussed on the need to feel safe and included the building blocks of need and expectation.
- Attributes- quality or characteristic inherent in the concept. The relationship, included the building blocks of reciprocity and empathy.
- Consequences- that which logically follows or results from the concept. That is evolved trust. Included the building block of reached my goal.

I will begin with background information relating to the participants before discussing in more detail each identified building block.

**4.1.1. Background:** A purposive sample of ten women was selected from a target population of pregnant women, who were considered suitable for midwife-led care at initial booking<sup>2</sup> in a setting where midwife-led care was offered within the community and the case-loading model was used as described in the methodology chapter. This is the type of setting where trust will be foregrounded. Participants birthed their babies in the home, the midwife-led birth centre or the District General Hospital [DGH].

Three interviews were carried out at set intervals during the pregnancy and following birth with seven of the participants. One participant was excluded from the study following the initial interview as she did not meet the study inclusion criteria; she is not included in the table and her data were not used in the study. Two of the participants were unavailable for the second interviews as they were in hospital but were followed up after the baby had been born. Participants are referred to by pseudonym throughout the thesis and a brief introduction to each is given in Table 6 to aid understanding and provide some context to the participant's experiences.

**Table 6: Background information for participants**

<b>1: Jo</b>	Was experiencing her fourth pregnancy. She self-reported a previous negative experience of birth. Her subsequent two babies were born at home with a local midwife. In this pregnancy she had planned to have a home birth but due to social reasons Jo decided to undergo	<b>6: Kate</b>	Was experiencing her second pregnancy. Her previous pregnancy was low-risk but she chose to birth in hospital. She had the same community midwife in her last pregnancy as in this pregnancy. During this pregnancy Kate planned to birth in the local birth centre however
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<sup>2</sup> around 8-12 weeks of pregnancy

	induction of labour and a water birth in hospital.		complications arose during her pregnancy which led to a hospital birth.
<b>2: Molly</b>	Was experiencing her fourth pregnancy. She reported a previous negative birth experience which had resulted in a severe fear of childbirth. Molly's subsequent two babies were born at home with a local midwife. Despite her positive feelings about these two births, in this pregnancy she still reported an intense fear of not being looked after during the labour by a 'nice' midwife. She was cared for by the same midwife in her previous pregnancies as this time. Molly planned and achieved a home birth.	<b>7: Sally</b>	Was experiencing her first pregnancy, she had no previous experience of maternity care. Initially Sally was cared for by one midwife but she had to change midwives half way through her pregnancy due to organisational changes. Sally planned to birth her baby in the local birth centre however complications developed during her pregnancy which required her to change her plans to hospital where her baby was born by caesarean section.
<b>3: Alice</b>	Was experiencing her second pregnancy. Her previous pregnancy was complicated and her plans for a low-risk birth were changed by admission to hospital. She reported elements of dissatisfaction with her hospital experience. This pregnancy she planned and achieved a home birth.	<b>8: Jane</b>	Was experiencing her first pregnancy and had no previous experience of maternity care. Jane initially planned to birth her baby in the local birth centre but was later diagnosed with a twin pregnancy and changed her plans to shared care with the hospital. Jane went into labour and birthed prematurely.
<b>4: Fiona</b>	Was experiencing her first pregnancy and had no previous experience of maternity care. Fiona had planned to birth her baby at home but complications developed during her pregnancy which resulted in a planned caesarean section.	<b>9: Paula</b>	Was experiencing her first pregnancy. Her only experience of maternity care was from her supportive involvement with a work colleague who had experienced a still birth recently. Paula planned to birth her baby in the local birth centre however complications developed during her pregnancy which required her to change her plans and she achieved a normal birth in hospital.
<b>5: Lucy</b>	Was experiencing her first pregnancy and she had no previous experience of maternity care. Lucy reported that she had friends who had chosen to birth their babies without assistance from a midwife. Lucy planned to birth her baby at home but was unsure at the outset whether to hire a doula for intrapartum support. She decided against the doula due to the expense and was cared for by community		

	midwives. Lucy was transferred to hospital following complications during labour and had a normal birth in hospital		
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Within the sample there were five participants: Sally, Jane, Fiona, Paula and Lucy who were experiencing their first pregnancy and had only indirect experience of maternity care. As a result, their knowledge of pregnancy was initially derived from friends, relatives and the media. Four of the participants: Jo, Kate, Molly and Alice had previous direct experience of maternity care, with three of these women, Jo, Molly and Alice, having encountered a negative birth experience in a hospital setting which appeared to have a strong influence on their expectations of maternity care.

All of the nine participants were cared for initially by the community midwives and they all planned to give birth in either the local birth centre or at home. Five of the participants developed complications during pregnancy necessitating a change in planned care and place of birth to the hospital consultant unit. One participant had a change in her social circumstances and decided to change from her planned home birth to a hospital birth. One participant developed complications during labour and was transferred to hospital for birth. Two of the participants achieved their planned home births- both women had direct previous experience of childbirth. No women birthed in the midwife-led unit. The nine cases will be the focus of the following sections but before describing the data in relation to each block I will recap on the coding and analysis detailed in the methods chapter followed by a brief overview of the findings.

**4.1.2 Process of data analysis:** The data were analysed thematically, as part of the overall hybrid model for the study. The Hybrid Model is more commonly used within grounded theory research and to ensure consistency with the model a grounded theory technique for data analysis was adopted. Transcripts from each stage of data collection were coded and key themes identified at each stage. Initially 'in vivo' descriptive codes were applied using the words and language used by the participants, descriptive codes were numerous and emergent. I then moved on to a process of clustering some of these codes where participants' own words were used to assign labels to each cluster. Thus a process of data reduction, codes to clusters and interpretation in attaching meaning to clusters based on the women's words was undertaken. The final part of coding, explanatory coding, connected the data to the emerging theory and attempted to highlight meaning from the construction of the concept for individual participants. The identified building blocks were formed from the explanatory codes identified and I

discussed the process of analysis, emergent findings and interpretation of data with supervisors throughout this time, thus ensuring credibility. The findings related to each building block will be presented in the following three sections but first I will provide a brief overview.

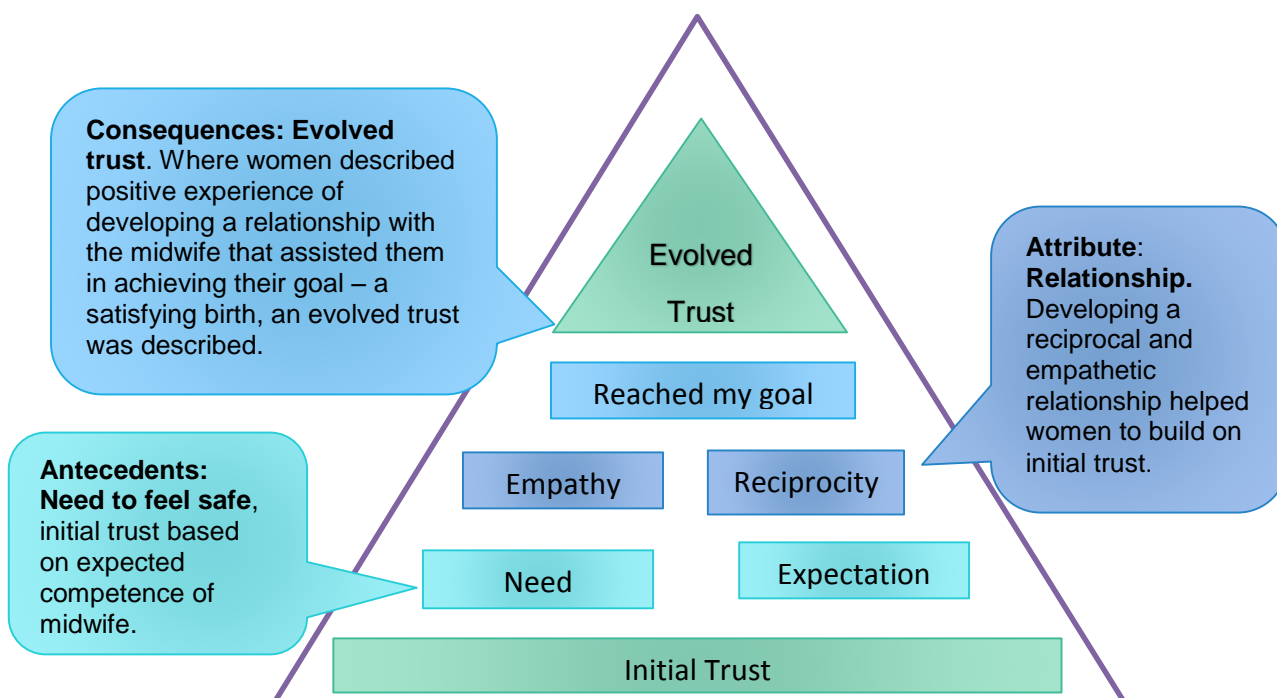
**4.1.3 Overview:** Many of the participants found it difficult to articulate the meaning of trust. They often interchanged the word trust with words such as faith and confidence. Similarly to the theoretical concept analysis, participants described trust as a multifaceted concept. For example Sally described trust as psychological, physical and emotional.

*“ ..... I think it is psychological as well as physical and emotional and practical as well really? So it is all kind of multi.” [Sally Interview .1]*

The women described this initial trust as 'just there' and that it was sufficient as a starting point in the relationship. They did not consider initial trust to be complete but anticipated building on the trust as described here by Jane.

*“The trust is there and it is something that you will build on.” [Jane Interview 1]*

It was possible to identify antecedents, attributes and consequences of the concept of trust in the empirical data, which I will discuss in detail in this chapter.



**Figure 5: Antecedents, attributes and consequences of trust**

Figure five demonstrates: The **antecedents**- the reasoning that the women had prior to the midwife-mother relationship was primarily a need to engage with the midwife which was based on a need to feel safe and an expectation that engaging with the midwife would meet their need. Women had some idea of their anticipated needs for a safe birth and they appeared to use the journey of pregnancy to establish relationships with the midwife, the core **attribute** of the concept. The women appeared to invest in this as they anticipated that it would help to achieve their goal- a safe birth. The **consequence** of the trusting relationship was an evolved trust described by the participants as ‘*more than*’ or a ‘*different sort*’ of trust that I have termed interpersonal trust.

*“It would be a different sort of trust.” [Sally Interview 2]*

Throughout the women’s accounts there was a strong sense of women’s agency and while I do not consider women’s agency to be an element of the concept of trust itself, I acknowledge the importance of agency as it appeared to influence the evolution of trust and will discuss agency as and when it arises within the findings chapters. Therefore it is important to identify what is meant by women’s agency when looking at the data.

***“the term agency is often no more than a synonym for action, emphasizing implicitly the undetermined nature of human action [...] if it has a wider meaning, it is to draw attention to the psychological and social psychological makeup of the actor, and to imply the capacity for willed[voluntary] action.” [Scott & Marshall 2009]***

Within the sociological literature the notion of agency has been debated by several theorists who focus on agency as a conception of action associated with freedom and a rational decision for progress. Some sociologists describe agency as dimensions of perception incorporating past, present and future social experience [Emirbrayer and Mische 1998]. This perspective of agency is important when analysing the concept of trust as the context of the study is set within the social experience of childbirth. The study explored trust within the relationship with the midwife, encompassing the experience of free will and the women’s past experience, present decision making and the motive for action to secure a future outcome. So using the sociological definition for the study, women’s agency means the capacity for women to feel in control and to have the power to act in the way that they chose to enable them to achieve their goal.

I will begin by presenting the empirical data on the antecedents of trust and the building blocks identified in the study: need and expectation.

**4.2 Antecedents:** By antecedents I mean the blocks which existed before the concept and were deemed necessary for the concept to exist. I will divide the participants into two groups for this discussion: Those with direct past experience [they had experienced pregnancy and childbirth previously] and those with indirect experience [experiencing their first pregnancy] Please see Table 7 below for a summary of the participants.

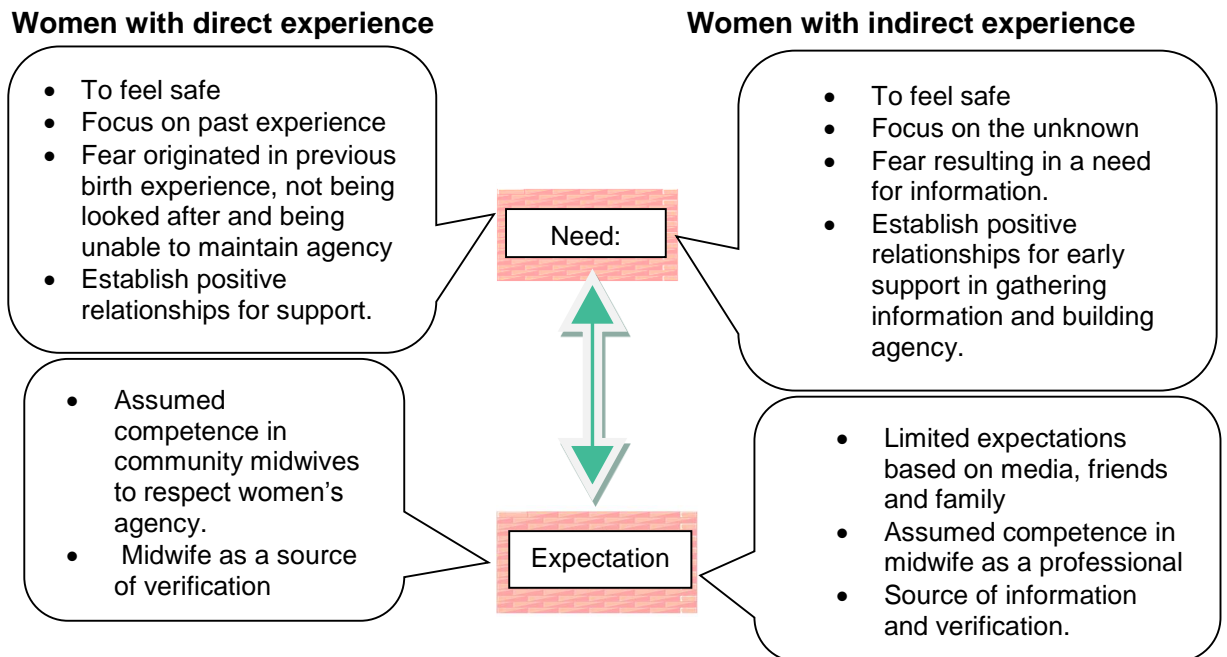


**Table 7: Participant summary**

Participants with direct experience	Participants with indirect experience
<b>Jo:</b> Fourth baby and history of multiple miscarriages. Cared for by community midwives. Achieved a planned hospital normal birth.	<b>Paula:</b> First baby. Developed complications and achieved an unplanned hospital normal birth
<b>Molly:</b> Fourth baby. Was cared for by a known community midwife. Achieved a planned home birth.	<b>Fiona:</b> First baby. Developed complication and missed second interview due to hospital admission so unable to map complete journey. Achieved an unplanned caesarean section birth
<b>Alice:</b> Second baby. Cared for by community midwives and achieved a planned home birth.	<b>Sally:</b> First baby. Developed complications and achieved an unplanned caesarean section birth.
<b>Kate:</b> Second pregnancy. Developed complication late in pregnancy and she achieved an unplanned hospital normal birth.	<b>Jane:</b> First pregnancy. Diagnosed twin pregnancy. Due to premature birth in hospital missed second interview so unable to map complete journey
	<b>Lucy:</b> First pregnancy. Cared for by community midwife. Began labour at home but developed complication and was transferred in labour to the hospital where she achieved a normal birth.

There were some similarities between these two groups but also subtle differences [see figure 6]. The core building blocks were the same, need and expectation but the women’s experience of these were different.

**Figure 6: Experience of the antecedents of trust**



For the women with indirect experience trust was influenced by their fear of the unknown. The women in this group identified a need for information and early support to help build their knowledge and increase their feeling of safety and agency.

Participants with direct experience expressed a need that was embedded in their past experience; a fear of not being looked after emotionally and not maintaining agency. Identifying fear as a core element indicated that the women did not feel completely safe. The women identified a need to feel emotionally safe and within this they discussed the importance of establishing a positive relationship with the midwife for reassurance and support. From their past experience these women had a degree of agency in that they knew the system, they knew the process of childbirth and they had their own knowledge of what they required to feel safe.

For the women with indirect experience, feeling safe focused more on medical safety, tests, equipment and clinical tasks. This was one of the main differences between the two groups; the women with direct past experience were less focused on medical safety, focusing on the importance of emotional connection during their relationship with midwives, gaining strength from support and comfort from knowing that their agency would be respected .

I will present the data related to the antecedents in two sections, firstly the building block of need followed by the building block of expectation. While I am separating the two blocks for ease of writing, it is important to acknowledge that these two blocks did not exist in isolation or have any ranking. Need and expectation were entwined, reactive and responsive to each other. I will firstly focus on the data from those women with indirect experience of maternity care, followed by the data for the women who had direct past experience to inform their trust. The differences between direct and indirect experience of care are not well documented in the theoretical concept or in the literature on trust. Hence the findings from this study will add to the body of knowledge in this area.

**4.2.1 Need to feel safe:** There are two important aspects within this section of the findings: need and safety. To understand how these two aspects emerged from the data, it may be useful at this point to establish the theoretical meaning of the terms- 'need' and 'safe':

*Need: "verb [with object] require (something) because it is **essential** or very **important** rather than just desirable: I need help now..... Noun [mass noun]*

circumstances in which something is **necessary**; necessity: the basic human need for food" Oxford Dictionary Online accessed [2013] <http://www.oxforddictionaries.com/>

*Safe*: "adjective 1 [predic.] **Protected** from or not exposed to danger or **risk**; not likely to be **harm**ed or **lost**.....2 not likely to cause or lead to harm or injury; not involving danger or risk..... (of a place) affording **security** or protection." Oxford Dictionary Online accessed [2013] <http://www.oxforddictionaries.com/>

Need therefore emerged from the data as something important and necessary while safety implied feeling protected, with a reduced risk of harm, feeling secure as a result of building trust. Both groups of women recognised pregnancy as an important phase in their lives. In relation to the group of first time mothers, Lucy described it as 'a *big thing*', suggesting a sense of importance and hence there was a necessity to engage with the midwife for this important event.

*"It's a big thing isn't it? [...] it was just quite a big thing and I see it's not so much as a medical thing but just something where you would need some involvement with somebody like a midwife" [Lucy Interview 1]*

Sally anticipated 'needing' the midwife as she described a feeling that she 'cannot go through this without her'. Sally anticipated that she would be unable to complete pregnancy and childbirth without the midwife's support.

*"You can't do it without her [...] you are going to need her." [Sally Interview 1]*

While Molly, having her fourth baby, made a direct reference to need and safety in relation to engaging with the midwife:

*"I am really scared of child birth anyway. I have had two at home but I think I need someone you know rubbing my back and looking after me [...] I think the thing about having home births is for me I feel safe having a midwife [...] feel safe because I think she knows her stuff and I think that she would think about the safety of the baby and me. [...] I need to feel safe." [Molly Interview 1]*

I will use the two definitions for need and safety while exploring the data in the following sections starting with the expression of need by participants with indirect experience.

**4.2.1.2 Need: Participants with Indirect experience:** Paula and Jane's extracts (below) indicate that a feeling of need originated in their lack of knowledge and the need for information, suggesting aspects of the midwife's expertise that they felt they would require.

Jane in her first interview described difficulties when there is limited past experience on which to base expectations:

*“Being my first baby I don't know what to expect. [...] I was going there completely blind really [...] I wouldn't have known what else to do really [...] I asked a lot of questions that day [...] questions just come up in random places [...] I had been in limbo with all these questions that had kind of been building up.” [Jane interview 1]*

Jane [above] described her lack of experience as leaving her completely ‘blind’ to maternity care and in a state of ‘limbo’, which implied that she was unaware of what to expect, how it would work, having no knowledge to inform her expectations. The women implied some anxiety in this early time that had built up until they were able to meet with the midwife, where an opportunity to ask questions and gain information such as the anticipated birth ‘date’ could be fulfilled:

*“I did have some questions in my mind [...] you don't really know anything [...] you don't know do you because you don't have a book or the date or anything.” [Paula interview 1]*

Paula’s quote indicates that anxiety could be relieved by gaining knowledge that she perceived the midwife to hold. At this point it would appear that the need for information was a priority. Describing her rationale for engaging and initially trusting the midwife, Sally’s account [below] focused on her perceived need for essential expert medical assistance and specialist equipment which she believed the midwife was capable of delivering.

*“She has got all of the equipment [...] because she does all the medical things as well [...] she has got all the expertise hasn't she?” [Sally Interview 1]*

An expectation of assumed competence and expertise focussed on the midwife’s technical skills. Lucy’s extract (below) also implies that the midwife would provide support as well as information and expertise:

*“I think for the first few weeks I was a little bit unsettled to be honest. Because I just didn't know what was going on, it's a big thing isn't it? I just think that there was a lack of information [...] I just felt a little bit on my own; I had not told my family or anyone. [...] it was just quite a big thing and I see it's not so much as a medical thing but just something where you would need some involvement with somebody like a midwife or doctor.” [Lucy interview 1]*

Lucy's description [above] indicated an element of insecurity as '*she didn't know what was going on*' and felt '*a little bit on my own*'. For the women who had indirect experience of childbirth an element of anxiety originated in their fear of the unknown and was apparent in their description of waiting for the professionals as they had not experienced a pregnancy before.

The women's accounts indicated the need to feel safe and for women with indirect experience safety appeared to be entwined in the need for more information and improved knowledge of pregnancy. The participants' accounts indicated an expectation that the midwife was a trusted source of information and expert knowledge.

In contrast, the women who had experienced childbirth before, the need to feel safe appeared to focus on their past experience and any fear of childbirth associated with this. I will present their experiences here before considering the similarities and differences between the groups in relation to need.

**4.2.1.3 Need to feel safe: Participants with direct experience:** Rather than a need for information and medical knowledge, the women with direct experience emphasised the importance to them of building a trusting relationship with a midwife which would lead to mothers feeling safer emotionally. Molly indicated that she expected the midwife to assist her in overcoming her feelings of fear:

*"...it is a very scary experience. I think you put a lot of trust in them to help you through that." [Molly. Interview 1]*

Molly's fear was directly associated to her knowledge of a previous negative birth experience which left her feeling vulnerable and emotionally harmed. In her first interview, Molly described her distress at the care she had received from the midwife who she felt could not provide her with the necessary time and compassion. Molly attributed the uncaring nature of the midwife to the hospital environment as she mentioned several times being frightened by the midwife leaving her alone in the room but that the midwife was busy. In essence Molly had a fear of not being cared for rather than a fear of the birth itself. The fear initiated from her first birth still remained, in this her fourth pregnancy, despite what she described as two further positive home birth experiences. Molly's first experience appears to remind her of the feeling of being exposed to the risk of not being cared for or unsafe. The subsequent positive experiences do not take away this knowledge of trauma and Molly remained aware that

complete safety in relation to emotional care could not be guaranteed. She made reference to hospital care and the need to avoid going there:

*“You know the first time I did not have a nice experience at all. [...] it was awful and I said I wouldn’t have any more. I know lots of people say no more. But it wasn’t just that it hurt. The experience that I had was just awful. And you know I couldn’t even go past the hospital for quite a long time because I had felt that panicky and I had nightmares [...] when I got pregnant with the second that was it nightmares [...] I don’t think it was a normal ‘Oh I am scared’ it was I was really frightened. [...] I was awful all the way through and then having the third because the second hadn’t been so bad, I wasn’t that bad [...] But this time if they would let me have a caesarean I would have one[...] I think I do I just remember that [the first birth]. I think all the time and I think ‘Oh my god’. You know what if it was ever like that again. If I had to go to hospital, you know.” [Molly Interview. 1]*

There is some contradiction in Molly’s above quote in her suggestion that she would be happy to have a caesarean section yet she also seemed to suggest that she didn’t want to go to hospital again. This would imply that Molly’s fear was around emotional care from the midwife for labour and not necessarily a fear of the hospital environment itself. The extract indicated that in Molly’s view it would be better to have a planned caesarean in hospital rather than risk receiving poor emotional care from the midwife during labour. Even though Molly had experienced two subsequent caring births she remained frightened that her first experience could be replicated.

The women who had direct past experience appeared to value emotional support to help build confidence and reassurance. Molly referred to the importance of a one to one relationship and support to help her feel secure. For Molly more than equipment and medical knowledge was needed for her to feel safe and cared for:

*“[...]but for me I need to feel safe but I also need to feel safe that someone is right by me and is saying ‘oh you know you are Ok,’ giving me attention and I would feel oh I am ok now actually.” [Molly Interview 1]*

Jo described her awareness of being exposed to risk and a sense of insecurity but not in relation to childbirth itself. Jo had experienced recurrent miscarriages in the past and she feared for the continuation of her pregnancy:

*"I've had these miscarriages, [...]Conversation about it, giving me confidence in them that they understood [...]But, I think I hope that on my next visit she opens up more[...] I hope that she will be more, you know [pause]. [...] one of the ways to build that relationship is to talk about your previous pregnancies. [...]You just want opinions as to why things happen the way they do. Just to hear a midwife say well that could have been this or why don't you try this, this time. Or you know we could look at this next time." [Jo Interview 1]*

Jo highlighted sensitive communication as essential, an opportunity to discuss her fears and to gain confidence from knowing the midwife understood her feelings. Jo used this opportunity to not only gain information regarding miscarriage but to also use the interaction to help build the relationship with the midwife; *'One of the ways to build that relationship is to talk'*. Jo appeared to want the midwife to be knowledgeable but to also demonstrate an emotional understanding or empathy, *'giving me confidence in them that they understood'*. Jo mentioned *'confidence'* several times which could indicate a need for reassurance and an understanding of pregnancy as risky. Building a trusting relationship to gain confidence suggested some form of investment on Jo's part to build trust in the midwife to assist her in feeling safe.

The participants also compared their initial contact with the midwife in this pregnancy with previous encounters. For Molly and Jo, the need to feel safe and the placing of trust was influenced by their various past encounters with midwives and healthcare in general. Both women highlight the importance of good communication with the midwife, although for different purposes:

*".....different to previous pregnancies because it wasn't quite like that with the others [...] there was more discussion [...] about previous births, maybe what I want this time[...] First impressions, [...] that I hope this gets better [nervous laugh]. But [sigh] she does have an extremely hard act to follow. [Pause, looked like she was remembering with fondness a previous midwife.]" [Jo Interview 1]*

Jo described her positive experience of interacting with her previous midwife and indicated a disappointment in her early interactions with the midwife in this pregnancy. Molly highlighted that she was *'a bit unsure'* indicating a sense of insecurity on making contact with the midwives and relieved when she was allocated a midwife whom she knew:

*"I rang and obviously having three other you get to know them all. So I spoke to \*\*\*\*\* , who is really nice [...] very positive. Because I was a bit you know not sure [...] then \*\*\*\*\* rang me, who's been my midwife all the way [...] she was my midwife with all the other three." [Molly Interview. 1]*

Both Molly and Jo reported previous negative experiences which accounted in part for their anxiety, yet they also described previous positive encounters with community midwives. Nevertheless they expressed some ambivalence about the midwives they had been allocated for this pregnancy. This suggested the persistence of the negative experiences and the need for the women to establish positive relationships with individuals in order for trust to develop particularly where a previous negative experience was evident.

During the interviews, the women with direct experience spent time reflecting on their previous births and the impact these had on expectations for this pregnancy journey. Alice described knowing what to think and how to react making this pregnancy easier:

*"From just going through all the stuff the first time I know what I want to do already and I have expressed that." [Alice Interview 1]*

*"Everything was scarier the first time [...] you don't really have a chance to think about it [...] you don't know how to react [...] this time that has been easier." [Alice Interview 2]*

The women with direct experience did not describe themselves as 'blind' or in 'limbo' as the women with indirect experience did. Instead the women with direct experience appeared to use their own knowledge to make decisions and plan for birth; they sought verification from the midwife that she would support them to maintain their agency within the trusting relationship. Jo's expectation for the relationship in this pregnancy was based on her previous experience:

*"Conversation about it, giving me confidence in them that they understood. I may have come across very confident strong person, [...] keen to get across that I wanted my home birth and that I was low-risk. [Sat up straighter into a stronger looking body stance,]You know this was my first priority!" [Jo Interview 1]*

Jo was clear about her intentions and used the conversation with the midwife in the early stages to 'gain confidence in them' to understand her wishes resulting in a feeling of security. The need to establish a trusting relationship appeared to include a need for



reassurance that the midwife would support the woman's agency and demonstrate understanding of her need to feel safe.

**4.2.2 Interpretation of need to feel safe:** Both groups of participants recognised that pregnancy was an important event and particularly those with direct experience had an awareness of pregnancy as a 'risky' process. Engagement in a trusting relationship appeared to focus on the need for women to feel safe in preparation for the birth as their ultimate goal. What is interesting in the extracts is the interpretation of safety by the women. Midwives' training, regulation and organisational risk management practices were barely mentioned by the participants. This could be accounted for in two ways: the lack of consideration could be an indication that society is satisfied with the systems in place to regulate clinical safety and hence the trusting culture indicated an acceptance of this as a given. Or safety for the women was not associated with risk management and risk of physical harm but was associated with emotional wellbeing and the ability to maintain agency.

The women's extracts in fact appeared to indicate a combination of these two things. Their initial engagement particularly for those with indirect experience suggested that the initial trust was based on a belief that the midwife was a professional and had the necessary skills to ensure their physical safety through the use of equipment, knowledge and tests. Equally important to the women was the need to feel safe emotionally. This appeared to encompass a need to be cared for in such a way that would also maintain the women's agency.

In a similar way to the need to feel safe, both women with direct experience and indirect experience had similar **expectations** of assumed midwifery competence and of building a trusting relationship with the midwife to assist them in meeting their needs. The difference again was in the way the two groups experienced this building block within their concept of trust. In the next section, I will consider the data related to the expectations of those with indirect experience before returning to the data from the women with direct experience.

### **4.3 Expectation:**

**4.3.1 Participants with indirect experience:** Women with indirect experience had limited expectations. Many of the participants with indirect experience described basing their expectations on the assimilation of information gained socially from friends, family

and the media. Lucy described her expectations which were based on what she had seen on the TV:

*“The birth centre down there is quite a small unit and I kind of had in my head that I would be in a room with twelve people giving birth at the same time screaming and moving around everywhere. I really had no idea [...] I guess from the TV or something, [laughing] Casualty I guess, [...] it is basically because I have never known, I don't know. “[Lucy Interview. 1]*

Lucy appeared in the above extract to recognise that while the media had influenced her expectations, these expectations were also unlikely to be realistic and hence she didn't really know what to expect. Fiona also acknowledged the media as a source of information but recognised the ‘*dramatization*’ of the real life experience and the need to verify these with more reliable sources:

*“I suppose it's from people I know that had children, family and friends. The things I suppose you think what you see in the media, dramatizations of birth in hospitals and that sort of thing because I have not spent any time in hospital. [...] so for me all my preconceptions are about what it is like are from what people have told me. [...] is all from what I had seen on the TV or films and obviously what you see on the TV is very different from what happens in real life sometimes.” [Fiona Interview 1]*

When asked about her expectations of the next appointment with the midwife, Fiona used the words ‘*guess*’ and ‘*assume*’ indicating a level of uncertainty in the role of the midwife and the processes of maternity care. Fiona did however indicate an initial level of trust in the midwife ‘*if there was an issue she would be telling me straight away*’:

*“I don't really know [giggle]. I made the appointment and I guess, I will have to take a sample in. I guess we will talk about the result because I haven't heard from her about any of my results from my booking appointments. [...] I guess that is the one thing that if there was an issue she would be telling me straight away [...] I assume there is no issue because I haven't heard anything. But I guess I assume that appointment will go through some of those test results [...] Other than that I don't really have any other expectations.” [Fiona Interview 1]*

Fiona continues (below) to describe her rationale for placing initial trust, she highlighted a level of trust in the profession, an idea that one can trust a person who has earned the right to belong to the midwifery profession, based on the credibility of

the profession itself, as well as the level of experience gained from year of work leading to an idea of assumed competence:

*“I suppose I think that she is an expert in her job, I would generally trust an expert in their job [...] somebody who has studied to get themselves into that role trained and worked in that role for X amount of years. They know what they are talking about [...] would trust that. Because of the profession that they are in [...] I have only met her once but I know I trust her [...] already I can say that I trust her [...]” [Fiona Interview 1]*

Kate and Paula also discussed midwifery expertise and gave examples of the midwife fulfilling her role through practical tasks – information provision, documentation and blood taking:

*“[...] she went through all the stuff [...] she gave me my green notes and filled in some of the stuff in there. She took my blood pressure and my blood [pause].” [Kate Interview 1]*

*“She gave me lots of information forms to take away and read through, which was really helpful.” [Paula Interview 1]*

In the early stages of the study the women with indirect experience had little knowledge on which to base their expectations or verify the midwife’s assumed competence. Therefore, the midwife’s ability to provide information, document and carry out clinical tasks using specialist equipment were perceived by the women to validate the midwife’s competence and confirm the appropriateness of the initial trust being placed.

Sally highlighted the importance of expectations and how these early encounters ‘*matched*’ her expectations:

*“I think you need to feel confident that your relationship with the midwife [...] She has got all the expertise [...] she has more knowledge [...] I want to be with midwives who are doing it all the time [...] That gives me more confidence [...] they’ve already been here done this with somebody else [...] I think that my idea of how midwives should be is matched by the way that she is. She’s made me feel this great in just one hour you know [...] because even though in the role of the midwife that is a part of the job. You have to have the trust or that person won’t be able to tell you the information, then you can’t fulfil the whole role of the job or what we expect are part of the role of the job.” [Sally Interview 1]*

Sally highlighted [above] that her trust was based on the midwife's knowledge and experience. Sally described how her interactions with the midwife had verified her initial expectations. Sally also suggested that trust was important within the relationship with the midwife in enabling the midwife to fulfil her role.

In a later interview Fiona discussed again the initial trust and suggested that while trust was apparent at this early stage, it required further development during the pregnancy journey:

*“Yes that bit about competence I did assume they were competent. If someone is trained then they have the knowledge. There must be an element of trust there even if I didn't know it. I did also want to just know a bit more about that.” [Fiona Interview 3]*

Fiona acknowledged [above] the presence of trust based on an assumed competence of the profession but also suggested that something more was necessary, a desire to pursue further information. All of the participants talked about an initial '*certain level of trust*' however often they were unable to articulate fully what trust was or how trust came about. They explained it as '*just being there*'. In the most part this initial trust was based around the idea that you can trust the system, information or midwives as professionals.

While the initial contacts with the midwife seemed to focus on trust in relation to tests and medical process, Lucy highlighted the importance of building trust in the relationship over time:

*“[...] I probably assumed that I would be assigned to one midwife. That she would stay with you the whole way through your pregnancy. [...] I thought that you'd be able to build up that trust over time.” [Lucy Interview 1]*

Fiona anticipated the development of a more interpersonal trust as being necessary for the birth suggesting that the birth is the ultimate goal and that this development of trust was an investment process for a specific outcome:

*“But as you move on I think you would need, [...] to stay with that midwife to build a relationship because at the end of the day she is going to be there at the birth [...] You know you can meet somebody once for a couple of hours but you do not automatically trust them 100%. [...] maybe if that was spread over a couple of times you would start to build that relationship with somebody and you would probably build that trust quicker.” [Fiona Interview 1]*

It was common in the accounts for women with indirect experience to express the belief that the midwife who had been allocated to look after them during their pregnancy would be there throughout the pregnancy, birth and postnatal period. While the research site offered continuity of care throughout the antenatal and postnatal period, it could not guarantee continuity to women for intrapartum care. Some women had not considered that the midwife could be unavailable particularly on the day of the birth.

The women anticipated that building a trusting relationship with the midwife could assist them to achieve their goal – the birth. However, for many women at this stage articulating this was difficult as they were unsure exactly what they required from the relationship to achieve this anticipated benefit. They described a lack of direct knowledge and some acceptance that the information gained from friends, family and the media may not be completely reliable. However the initial investment still indicated an initial trust in the midwife's assumed competence.

This was not the same for both groups, as women with direct experience appeared more confident in articulating what they expected from the midwife-mother relationship, which was based on their own past experience and I will discuss this now.

**4.3.2 Expectation- Participants with direct experience:** For the participants who had direct experience of childbirth their expectations of the midwife were informed by their past experience of maternity care and their own knowledge and agency gained previously. For the women in this group there appeared to be an expectation that the care received previously would be repeated again resulting in a similar experience. For Kate, who was the only participant in the direct experience group who did not report a previous negative experience, there was an expectation that this birth would progress in the same way as her previous birth:

*“Yeah, she was my midwife with \*\*\*\*\* [first baby] [...] Well I think that it will just be the same as what it was with \*\*\*\*\* [first baby] [...] I think I had quite an easy birth with \*\*\*\*\* so they said they'd think this will probably be the same again.” [Kate Interview 1]*

Kate described her own anticipation for the birth and implied that this was confirmed by the midwife. Similar to the verification sought by the women with indirect experience, Kate appeared to be gaining confidence from the midwife as verification but for her own knowledge rather than that gained from third parties. She highlighted that this midwife

was known to her from the previous pregnancy and it is possible that this relationship was already established from the previous encounter and may have influenced the trust placed at this time.

The previous journey through pregnancy and birth and the relationships formed in the past appeared to influence the women's agency in this current encounter and the women with direct experience appeared to use their own knowledge alongside that of the midwife. A particular theme for the participants in this group was their expectations and experiences of midwifery-led care in the community and how it compared to care they had previously received in hospital settings. It is noteworthy that for many of the women in this group a previous negative birth had been experienced in hospital followed by a self-reported more positive experience with the midwives in the community setting. Molly and Jo provide good examples of this.

Molly described a positive previous experience, a home birth where contrary to her hospital experience, the midwife had appeared flexible and she felt her agency had been supported:

*"But with her it was just like yeah if you want to do that that's fine. [...] that was a big thing for me to think yeah it was an option not like [pulled horror face again.] [...] to have the freedom to do what you want to do [...] you don't have to do it it's up to you." [Molly Interview 1]*

Molly compared her positive relationship with the community midwife whom she described trusting, to the first hospital birth she had experienced:

*"I think it is purely down to here they (the midwives) can't go anywhere else. They are with you. Whereas at hospital, you know with \*\*\*\*\* I had an episiotomy and she you know literally she cut me, got the baby out and then right that's it I've got to go and deliver another one now. [...] I think that's what it is you know they are busy and you know they don't have time to get to know you [...] Well I am not ok. [...] Here it is just you and they can give that time for you, its twenty-four, seven care. However long you are in labour for they are there." [Molly Interview. 1]*

Molly was able to compare the two past experiences reporting that the hospital birth had left her feeling traumatised by the lack of emotional care and a feeling of having control taken away from her by the midwife. Combined with the more positive

community experience she was able to identify the importance to her of respect for her agency in the trust she placed in community midwives.

Jo, who also had both hospital and community birth experiences, described an expectation of competence and experience in the community midwives as skilled home birth attendants. She described feeling confident that the midwives would share her belief that home birth was a safe option:

*“Yeah, from my experience the \*\*\*\*\* midwives are very confident in home births, [...] they advocate home births, they are doing home births on a regular basis, they seem very confident. [...] I feel very confident that I will get my home birth [...] As long as I can have my home birth because they know what they are doing and they are more than happy to come out [...] They believe what I believe which is that it is safer for me at home so yeah I have every confidence.” [Jo Interview 1]*

Jo’s extract [above] described the pursuit of confidence which could be assumed to verify the level of trust placed in community midwives. Jo’s expectations appear to be for the midwives to respect her agency, describing the birth as ‘my home birth’ in a possessive sense. Jo’s expectations were based on her own past experience of care where this was achieved. Alice was also able to draw on her direct past experience and the knowledge it gave her to verify her expectations:

*“No I think even from just going through all the stuff the first time I know what I want to do already and I have expressed that but she still has to go through it with me. I suppose you would have to go through it all again wouldn’t you.” [Alice Interview 1]*

Alice used her previous experience to formulate the expectations for this pregnancy and, like Jo, she described with confidence her own agency when planning for her birth. However, Alice’s extract [above] also indicated an element of mutual respect in accepting the midwife’s role in discussing the plans with her. Alice appeared to suggest that her initial trust was based on an expectation of reciprocity, a two way process with recognition from the midwife of Alice’s agency as well as Alice’s respect for the role of the midwife.

For the women with direct experience, trust at this stage was influenced by their past experience and their expectation of how their own agency would be respected within the current midwife-mother relationship. This appeared from the data to have more importance for this group than the notion of a clinically safe birth. The outcomes of

previous births in terms of medical safety were not mentioned by the group and they did not appear to dwell on this aspect in their expectations for this birth. Hence respect for their agency appeared to be a central focus in the concept of trust. I will move on to summarise the main similarities and differences between the two groups of participants before exploring the data in relation to the relationship attribute of the concept.

#### **4.3.3 Interpretation of variations in expectations between the two groups:**

Expectations feature in most theoretical descriptions of trust and from the data presented it appears important to understand how women's expectations are formed in order to further understand the basis on which trust is being placed. All of the women described some expectations for how they would be cared for during their pregnancy but for the women with indirect experience this was much more difficult to articulate than for those with direct experience. The women with indirect experience described information they had gained from friends, family and the media but they also appeared to acknowledge that this information was potentially inaccurate. The women in this group often described not knowing what to expect and appeared to find it difficult to articulate what they wanted. This presents a challenge in that the expectations of this group of women may have been unrealistic or unclear. Thus where it is unclear what one is placing trust in another to do, it is more likely that the woman will be disappointed and feel that trust was not upheld. However the trust placed in the midwives by this group was based on an expectation of a professional competence verified by the midwives' clinical skills. This allows some clarity and provides one way that the women can assess if their trust is well placed.

This was different to the data obtained from the women who were able to base their expectations on their own previous experience of midwifery care. The women in this group appeared to know what they wanted or didn't want from the relationship with the midwife. They described an expectation of community midwives to respect and support their agency. When discussing their expectations they focussed on the anticipated day of the birth, similarly to the women with indirect experience, but rather than relying on an assumed competence for midwives to promote a feeling of trust, they appeared to place importance on an expectation that the midwife would share the woman's values and support the woman's agency as the contributing factor to their development of trust.

Earlier in the antecedents section I have suggested that two blocks are evident within the empirical data: need and expectation. The focus within this section has been a



need to feel safe which was experienced differently by these two groups of participants. It is important to recognise the differences in the experience of need and the desire to feel safe between these two groups of participants because it is intertwined with their expectations of the midwife and the trusting relationship. For the women with indirect experience, need to feel safe was influenced by a lack of knowledge and the need for information. This would be achieved by engaging with midwives who they felt were technically competent and able to deliver accurate information and share knowledge. There was an expectation that as the pregnancy progressed, participants would assimilate information gathered to develop initial trust, through the process of getting to know the midwife. For the women with direct experience this development had already commenced with their previous experience of midwifery care and they demonstrated an expectation that the community midwives could meet their needs. For women with direct experience the need to feel safe was associated more with emotional wellbeing, enhanced by the midwife's support for the women's agency.

The relationship between midwife and mother was identified as the core attribute of the concept of trust. Both groups of participants expected to establish a positive relationship with the midwife. I will discuss the importance of understanding the midwife-mother relationship and the evolution of trust through the building blocks identified as reciprocity and empathy.

**4.4 Attribute:** When considering the attribute of the concept- the relationship, the accounts of those with direct experience and those with indirect experience were similar. All the women's accounts indicated that development of a trusting relationship was as stated by Sally, 'a two way thing' resulting in an understanding of each other's motivations and roles within the relationship [See figure 7].

**Figure 7: Attribute of the concept sub themes.**

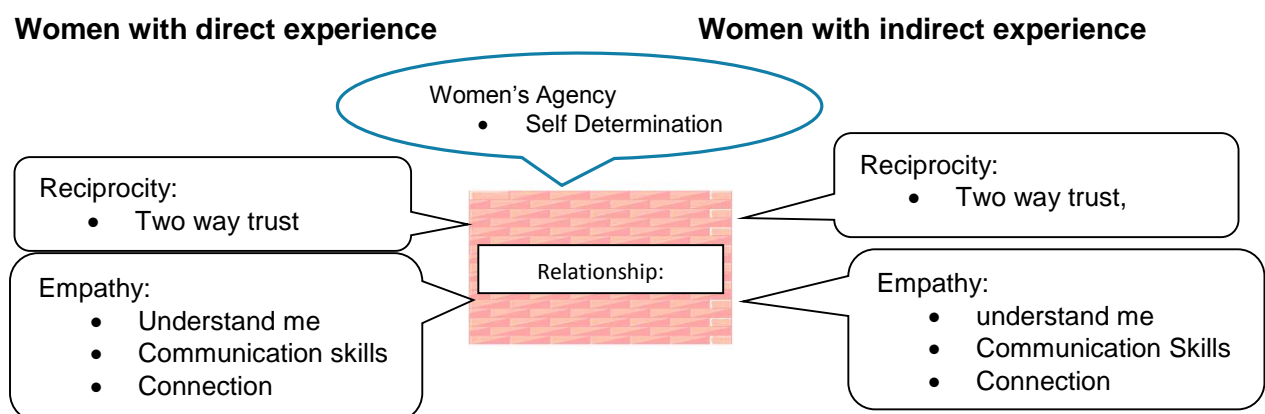


Figure seven demonstrates my interpretation of the building blocks within the attribute of the concept- the relationship. The women appeared to make assessments of whether the midwife was able to develop a reciprocal, empathetic relationship through their repeated interactions with the midwife. Women identified the importance of a social connection; the shared experience of childbirth was highlighted by some participants as essential to improve the midwives understanding of what the woman was experiencing. The midwife's ability to communicate her understanding of the woman was indicative of the possibility for forming a positive relationship and the involvement of trust. Alongside the building blocks there was also the important aspect of women's agency and the notion of self-determination. I will take each of the building blocks of the attribute: reciprocity and empathy in turn to present the data from each group of participants, commencing with reciprocity. I will then discuss the women's desire for self-determination within the relationship before going on to discuss empathy and communication skills.

**4.4.1 Reciprocity:** The participants described valuing a 'two way' relationship, where getting to know each other was important for the evolution of the concept of trust.

**4.4.1.2 Participants with indirect experience:** Sally anticipated a need to get to know the midwife and for the midwife to get to know her in a reciprocal relationship. Sally's account indicated that trust as a concept, was not simply a mother placing trust in a midwife but that the midwife would need to also place trust in the mother. Sally highlighted the importance to her of the midwife's personality and the ability to 'get along':

*"I think you need to feel confident [...] that you trust her but I guess in reality that she should also trust you. That you are telling her the truth and that you're not going out I don't know doing things that you shouldn't do [...]. So it's not just a one-way thing is it? It's a two-way thing I guess." Sally Interview 1]*

Sally anticipated the benefits of getting to know each other for the day of the birth, and implied that if the midwife got to know her then she would be able to understand how Sally would approach her labour and birth. She described the midwife being 'happy' with her doing what she wanted and appeared to associate this with reciprocal trust:

*"They will kind of get to know whether you are like an internal person who just sits and you know or whether you are somebody who goes into themselves or shouts or whatever. [...] you have the one midwife who was happy with you doing something,*

*listening to music or whatever. [...] So I guess it is a little bit of both her trusting you and you trusting them.” [Sally Interview 2]*

Similarly, Paula clearly described the perceived benefits of the midwife knowing her and knowing about her pregnancy:

*“She knows now what I want. I've been able to talk to her about what I want. I think she has taken it all on board. [...] every midwife is different [...] I have been to \*\*\*\*\* [DGH] and they don't see the same patient throughout [...] but they do in \*\*\*\*\* [Local birth centre] so they do get to know you. [...] that is what I like about it actually [...] I just feel like if you see the same midwife they get to know you. They get to know about your pregnancy [...] if you are in \*\*\*\*\* [DGH] and you see a different person every time they don't know you from Adam do they?” [Paula Interview 2]*

Paula's account demonstrated the importance of some give and take which involved the midwife recognising and supporting the woman's agency. This could potentially be seen as the development of a more interpersonal trust which Paula seemed to associate with aspects of continuity of carer enabling her to feel confident to talk in an open reciprocal exchange.

The participants with direct experience described reciprocity as a dynamic process within the midwife- mother relationship which influenced the development of trust. I will consider their accounts in the following section to explore reciprocity further.

**4.4.1.3 Participants with direct experience:** Molly and Jo described the benefits of 'getting to know the midwife' in a reciprocal relationship. Molly described how this contributed to her emotional wellbeing:

*“They know you, how you feel [...] how to be with you [...] they know you and they know you as a person and maybe know me as being a bit more sensitive [...] So that's nice because you get to know them and they get to know you [...] it made me feel a bit easier and a bit happier.” [Molly Interview 1]*

Molly [above] and Jo [below] described the benefits of reciprocity in terms of making the journey 'easier' and the experience 'more positive':

*“...that it has only got more positive. [...] I've got to know her a bit better [...] I value their opinions very highly. [...] my relationship with them has got better.” [Jo interview2]*

Jo and Molly suggested that '*knowing*' increased confidence and influenced the trust being placed. Jo's reference to '*their*' and '*them*' indicated that this trust may be increased not only for the individual named midwife but also for the wider midwifery team.

It is important to remember that this part of the journey was not simply during this pregnancy. These women had met and been cared for by midwives before and the development of interpersonal trust was ongoing from all their previous pregnancies suggesting that the concept of trust was perhaps a continuum, an evolving concept.

*"...it was very relaxed and more like a friend talking to you than the midwife who you don't know[...] I have been able to say more to her and laughed with her more than the first time and she probably has with me because we're here again and so very relaxed and easy. " [Molly Interview.1]*

The more developed the relationship became, so trust evolved in a way that Molly [above] described as '*easy*' when you feel '*relaxed*'. I suggest that this could be attributed to the need to feel emotionally safe. As Molly got to know the midwife and the relationship developed, the risks of not having a '*nice midwife*' or not being looked after were reduced and Molly may have felt safer.

An important element of the reciprocity described by the women appeared to be an investment in developing a trusting relationship that would assist the woman in maintaining agency for the day of the birth. The women's accounts indicated an awareness from their past experience that respect for their agency was not guaranteed within the midwife-mother relationship and would require some investment to establish a two way trust for sharing decision-making, information, skills and power. Women's agency and the midwife's ability to support the woman's decision-making was apparent in many of the participants' responses in relation to their experience of developing trust.

**4.4.2 Women's agency- decision-making:** Lucy recognised the midwife's potential to influence and coerce, describing midwives as in '*a position of authority*'. While she recognised this as a risk she clearly articulated that she remained aware of the choices and options open to her:

*"Because when it is a choice. Because they are in a position of authority and it is very easy for them to persuade people and convince them that that is the absolute*

*thing that they have to do when in fact actually it is a choice and there are a lot of different options.” [Lucy Interview 1]*

Lucy exemplified the self-determination of the participants and the strategies, such as ‘*my own birth plan*’ that they had employed to ensure they remained in control of decisions:

*“Getting into your head what is really going to happen [...] I hadn't have read those two books I think might still feel quite nervous [...] If I hadn't have prepared for it [...] It has really helped [...] I have a pile of books by the bed this big [...] I mean they range from the Haynes manual to babies to like an old what's it called you know unassisted birth [...] I flicked through them and thought.” [Lucy Interview 2]*

*“I probably didn't listen to them [...] I wasn't going to let her do what she wants to do [...] I said no actually I have got my own [...] I had my own birth plan here and then we did go through it. But if I hadn't have done that I could have been left here having never spoken about those thoughts that I had.” [Lucy Interview 3]*

Lucy [above] seemed to place importance on having a ‘*range*’ of information allowing her to digest as much as she could and evaluate which information best suited her needs. Lucy’s account does not suggest that midwifery advice and information was not important or trusted but more that a wider knowledge base was required for her personal decision-making.

The existence of the initial professional trust was the foundation which appeared to support women to gain experience and knowledge during the pregnancy journey. The women described the initial trust as something ‘*we will build on it later*’; the data from women with indirect experience suggests that women’s confidence in self-determination developed during the pregnancy journey.

The time available during the development of the relationship with the midwife allowed women to evaluate the quality of the information provided by the midwife and to test how the information available fitted with their own values. It provided an avenue to verify the midwife’s knowledge base, allowing the women time to establish who can be trusted and in what situations. Lucy’s experience described below is a good example of this:

*“.....at that point they were saying ‘you know you can't have a homebirth’. [...] but then me and \*\*\*\*\* [partner] started looking and seeing why? we couldn't really*

*understand why they were panicking and saying kind of things to make me, 'you know you can have a massive haemorrhage' that made me feel quite uncomfortable about [...] I think \*\*\*\*\* [midwife] was just a bit short about what it was. [...] She just said 'I have to tell you at this point that if we don't get your iron level up you won't be delivering at home' and 'you have an increased risk of bad bleeding', things like that. [Nervous giggle] It just seemed to come from nowhere and then when I looked into it, you know. I realised it's not actually making me more likely to haemorrhage it's if you haemorrhage it can be worse [...] but then there's things like 'you're less likely to haemorrhage if you're at home' because of the environment that you're in. I had all these things going round and round in my head. [...] I started to prepare myself to think 'right am I going to have to fight for my homebirth'? You know it's my decision whether I'm prepared to take that risk." [Lucy Interview 2]*

When a complication arose, the information supplied by the midwife was 'tested' when it was contrary to what Lucy desired. This appeared to be an important stage in the evolvment of trust assisting Lucy to verify whether her initial expectation of technical competence had been well placed. Lucy's calculation was not based purely on the information provided but was also influenced by the way the midwife communicated which aided Lucy's assessment of the midwife's confidence. From Lucy's description there appeared to be some disparity in the information supplied by the midwife and that discovered by Lucy. This may have changed the dynamics of the relationship and had an influence on the development of trust as a concept as Lucy described preparing to 'fight'.

While Lucy's extract [above] did not discuss power as many of the participants were reluctant to do, it is clear that she anticipated a power struggle with the midwife and a need to boost her own power through gaining knowledge in the preparation for the 'fight'. Lucy's desire for self-determination was perhaps in conflict with her initial trust for the midwife. The description reflected women's need to place trust in midwives to support their agency, as described earlier in the data from those women with direct experience. In participants with indirect experience a change was noted over the course of the interviews as their focus appeared to alter from one of trusting a midwife as a professional to more of a desire for reciprocal trust where the midwife also trusted them in determining what was best for them. It could be that this shift towards self-determination was a result of the journey through pregnancy which had given them

their own experiences on which to base their expectations and an increase in self-confidence.

There was evidence in the accounts of Jo, Alice and Lucy that they considered elements of power, control and vulnerability in their own risk assessments, making choices to exercise agency and achieve their ultimate goal. Some of the participants made attempts to equalise the power balance through the pursuit of information and preparation for what they anticipated as the *'fight'* for power, control and recognition of their own authoritative knowledge. Alice described *'doing her homework'*, implying the need to prepare for the midwife's possible response regarding place of birth:

*"She booked me in as quickly as possible because I may have left it a little late [...] I have got a tarpaulin and a big living room that's all I'd need [...] I know that she will do what I need to do, because I am awkward and I'm not very accommodating [...] I must have a home birth and I don't care about anything else I'm just not going to hospital again."* [Alice Interview 1]

*"I do my homework [...] I had an answer for everything this time."* [Alice Interview 2]

Alice's account suggested that she felt the need to be strong and prepare in order to counteract the possible lack of support from the midwife. It has already been established that women initially have trust in the midwife's skills and training. With the benefit of longitudinal data however it becomes clear from participants' accounts that as the pregnancy progressed they did not completely trust the midwife to support them as equal partners in the relationship and to be supportive of their decisions if not congruent with medical recommendations. In the extract below Jo explained the information that she sought with regard to being diagnosed with a low lying placenta which may have hindered her plans for a home birth:

*"I think when I saw \*\*\*\*\* [midwife] about the birth plan I had read an awful lot about that placenta and how far away it can be. [...] I went to town reading this and that and the other. [...] so you know '6 cm anything below will be in hospital' but if it's above that I'll be here. So yes it is a two-way thing [...] it is not entirely their responsibility [...] you've got to try and persuade them to do it."* [Jo Interview 2]

Jo described preparing herself to discuss on an equal basis the information available about the condition and remain in control of the decision where to give birth. Jo clearly

articulates her perception of the shared responsibility between the midwife and the mother:

*“...but it was when I was talking to other women that I realised that for me if I could find a way to find out more about what was happening and to trust in myself actually I could do it a lot better than those medical people[...] self-belief but also skills and competence.” [Jo Interview 2]*

Jo further articulated her experiences of support for her agency in the final interview:

*“...they are not accepting of you as being the person in control [...] you [the woman] knows what is best. They [the midwives] are assuming that they know what is best [...] I have to make a decision and tell you.” [Jo Interview 3]*

Jo clearly explained here her experience of midwives' attitudes to the validity of the woman's own knowledge and ability to make the right decisions. Jo [above] highlighted the difference between the health professional's perception of what is best and the woman's ability to know what is best for her. Jo is clear that she had wanted to make her own decisions indicating that trust is not necessarily placed in the midwife to perform this action on her behalf but to support Jo's ability to do it herself. This confirmed the principle that the concept of trust needed to be two way. The participants were clear that it was important for the midwife to trust the woman as an equal partner and this was most likely to be achieved through developing the interpersonal relationship. Jo's [above] accounts indicated the how women's agency is strengthened through the development of knowledge and experience.

The data extracts from the women with indirect experience were similar to those from the women with direct experience in the desire for the midwife and mother to get to know each other and develop a two way trust. Both groups highlighted the importance for the midwife to trust the woman in a reciprocal way. This was related to the women's agency and a desire for self-determination. Women described feeling an increased confidence making the development of interpersonal trust easier and their experiences more positive than when getting to know each other was not possible. For women with direct experience it is possible that the evolvment of trust was a continuum of a previous experience of a reciprocal relationship and their need to feel emotionally safe.

The initial trust provided a foundation which the women used to build knowledge and experience verifying the midwives' assumed competence and using the information to



be able to make decisions for themselves. The women's experiences of the midwife's ability to support and trust them to make their own decisions influenced the development of trust for both groups. The participant accounts from both those with indirect and those with direct experience suggested that for midwives to be able to develop a reciprocal relationship that supported women's agency, they needed to understand the woman. In order to do so, empathy appeared important.

**4.4.3 Empathy:** The participant accounts emphasised the importance to the women of empathy and its influence on the development of trust. Women appeared to place importance on the midwife and woman understanding each other.

**4.4.3.1 Participants with indirect experience:** Developing a trusting relationship was an investment for the anticipated need to feel understood and safe on the day of the birth. Jane, one of the participants with indirect experience described the importance to her of the midwife developing an understanding of her as an individual:

*"I am almost thinking of myself being different [...] It is my needs [...] definitely it helps you know when she knows my background and kind of where I'm from [...] it's that practical knowledge of what my life is like [...] she understands that. That does mean a lot really." [Jane Interview 1]*

Lucy also described the need for the midwife to understand her as an individual but added a rationale for why this was important:

*"When somebody is not sympathetic to the way that you want to have your birth maybe you wouldn't feel comfortable on the day. And I think that it is important that you feel comfortable on the day so that you don't start tensing yourself because I know you've got to be completely relaxed." [Lucy Interview 2]*

Lucy anticipated that the empathy developed now would benefit her in achieving the birth that she wanted. She implied that the midwife needed to understand her individual needs in order for her to feel emotionally safe enough to relax and not impede the physiological process by focussing on the experience of childbirth completely. Sally [below] described an older, seemingly 'wise' midwife who made her feel confident to discuss intimate issues:

*"It was nice [...] some women are, you know, older [laughing]. [...] sort of like a wise woman. [...] if you knew her, she would be one of those people that if you had a problem [...] If you were in a just like 'oh god I don't know what to do' situation. [...]*

*could sort of hint at it and they would come in and help you. [...] she would always have been that kind of person if she wasn't like that I don't think I'd have that same feeling.” [Sally Interview 1]*

Sally [above] indicated that the midwife was a certain type of person with an innate understanding, something which cannot be learnt. It appeared from the accounts that women’s experience of developing trust was easier with a midwife to whom they could relate. Jane’s account below indicated an idea shared by other participants in the indirect group- that it was more likely that the midwife would understand their needs and have empathy if they had similar social backgrounds and personal experience which has implications for the evolution of trust as a two way exchange:

*“It is easier to trust someone you relate to. [...] It helps you know when she knows my background of where I'm from and the things I do as well [...] it's that practical knowledge of what my life is like [...] she understands [...] we got on because we are from the same type of background [...] the same kind of person as me and you can relate to the same kind of person.” [Jane Interview 1]*

Fiona also emphasised the important contribution that a shared experience has on empathy. Trust appeared to develop as a result of two people who were able to make a connection.

*“She had recently had a baby herself within the last year [...] she was really supportive of the breastfeeding [...] She was fantastic in helping me through that [...] because I knew she had had one quite recently [...] So it was quite current to her [...] knowing that she had recently breastfed [...] it helped me to know that somebody had done it quite recently [...] So she was up to date with the latest techniques [...] it is just that it was not too distant in the past for her [...] So she remembers what it's like [...] She could understand and empathise with how I was feeling [...] if you feel a closer bond with somebody because you have experienced it [...] from a peer situation it is more supportive maybe just because they can remember [...] they can remember how it feels [...] So I thought she could fully empathise [...] she was very nice [...] Whereas the other one was.” [Fiona Interview 3]*

Fiona [above] reflected on her contact with a midwife who had experienced childbirth and more specifically breastfeeding her own child. She viewed the midwife as more empathetic in that they shared a common life experience as they had both had babies in recent months and had both breastfed. The ability of midwives to empathise with the

women appeared [from the accounts] to be important for the women to maintain or develop trust further. The participants indicated that this process of developing reciprocity and empathy was an investment enabling women and midwives to work together. This was also true for the women with direct experience.

**4.4.3.2 Participants with direct experience:** The women with direct experience had an understanding of the importance of empathy which for many appeared more important than technical competence. From their past experience they had identified that empathy was not always achieved. Similar to those with indirect experience, those with direct experience anticipated developing empathy through a social understanding. For Molly it was important to see the midwife as an *'actual'* person with a similar background to her own family:

*"She talks about her own children. [...] My husband is one of six and she was telling me she was one of five, talking about experiences like when she was growing up with hers, so it's quite nice. Because you know you get to know a bit about them [...] it shows that they are an actual person at the end of the day. [...] I think they want you to know a bit about them. "[Molly Interview 1]*

It appeared important to Molly [above] to see the midwife as someone with a life outside of her job when placing trust in the midwife and she described the emotional benefits of this trust. Similar to Fiona's suggestion in the previous section, childbirth as a shared social connection was mentioned as an important consideration by many of the participants. Some suggested that to be a good midwife you needed to have had children yourself. For Molly, understanding appeared to be based on a belief that a midwife should be able to empathise with her through a shared experience – childbirth:

*"I think that to be a good midwife you should have to have had children [...] Because until you have had children you have no idea really [...] I know there are midwives who have not had children but you need to experience it to understand women's thoughts and ideas, feelings and labour because until you have been through labour you really don't know." [Molly Interview 2]*

*"Women just know, \*\*\*\*\* [other midwife] she did, she just knew? [...] it's not experience because it is in you. You are just that kind of person. It is not something you can learn or be taught. [Molly Interview 3]*

Molly [above] described an emotional understanding that she believed was different to experience, more something that is *'just in you'*, and that empathy was linked to a shared experience.

For those women with direct experience, their previous pregnancy had provided some insight into how maternity care was delivered and what to expect from the relationship with the midwife. This could have influenced the value women placed on certain aspects of care. Jo described how the midwife showed empathy in her understanding of Jo's feelings which appeared to influence the building of trust within the relationship:

*"That would mean a lot because it would show that they understand where I am coming from and that they understand how I am feeling which goes that bit towards building trust relationship for later on in the pregnancy."* [Jo Interview 1]

Jo seemed to value the emotional care provided by the midwife. The midwife's communication skills provided women with the opportunity to assess the midwife's ability to understand their personal needs. I will return to the participants with indirect experience first to explore the relevance of communication skills to the development of trust.

#### **4.4.3.3 Communication skills as a window to assessing empathy:** Paula

highlighted the importance of easy communication between the midwife and mother:

*"...very easy to chat to [...] she was easy to chat."* [Paula Interview 1]

Jane similarly described the midwife's ability to make her feel at ease by being friendly and how this led to a feeling of warmth:

*"She was lovely [...] she just made me feel at ease [...] it was nice [...] I am so lucky that she is the person that she is [...] very friendly [...] friendly and helpful really [...] type of person that I could warm to."* [Jane Interview 1]

The interactions with the midwife and her communication skills were a window for participants to assess their ability to develop a positive trusting relationship.

Participants from the direct experience group such as Jo highlighted the key ingredients that made a midwife *'everything you would want'*.

*"Conversation about it, [...] you just want opinions as to why things happen the way they do. [...] So having them on my wave length is quite important even if they are*

*not actually the person on duty for the birth. It's that they would communicate it to you know the sort of person that I am, what I liked to the other midwives so that they understood."* [Jo Interview 1]

Jo [above], emphasised the importance of the midwife's communication skills and the art of conversation as an indication of the midwife's ability to be 'on my wave length'. Communication skills were therefore viewed as essential in demonstrating empathy. This included the exchange of information needed to develop an understanding of each other, indication from the midwife that she respected the woman as an individual and supported the woman's agency.

Jo also described [below] the midwife's role as a conduit in sharing this understanding with other midwives, placing trust in the midwife to transfer understanding of Jo as an individual to other midwives on Jo's behalf. The intention of investment in developing trust in one midwife could be viewed as transferrable through that person to any other midwife:

*"Million dollar midwife [...] she is everything that you would want [...] she's not that tick box midwife, she is talking to you the whole time [...] she is that kind of midwife [...] Very good at spotting what might be wrong [...] talking you through things [...] She was fantastic [...] she makes you feel more relaxed [...] she has got you talking about something else [...] She's asking open questions she's wanting to hear about you [...] she gives you time it is good when you feel that you are not rushed."* [Jo Interview 3]

Jo [above] makes an important distinction between the 'tick box midwife', one who fulfils her role in a routine manner without acknowledgment of the individual's needs, and a midwife who makes the woman feel that she has time for her and demonstrates good communication skills. Jo implies that the midwife's ability to help women feel relaxed and taking time to listen to them improves the relationship and ensures that the midwife has a better understanding of the woman. This display of empathy seems to have a positive impact on the development of interpersonal trust.

The participant accounts from both those with direct and those with indirect experience highlighted the importance of the midwife's communication skills in enabling the women to assess whether an empathetic relationship could be achieved. Where this was felt potentially possible, the women invested in the relationship in an attempt to develop an understanding and sharing of self. This required a level of trust where the women felt

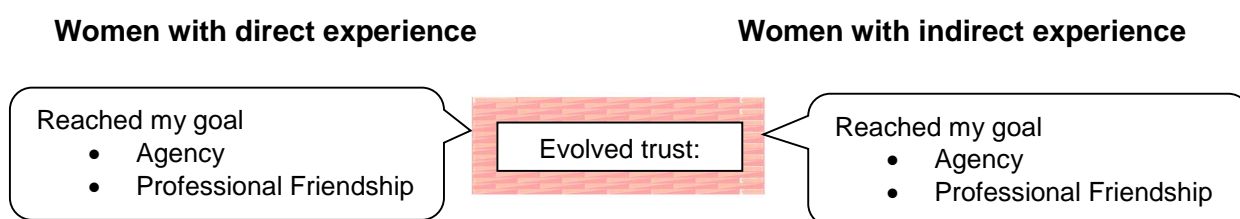
confident to disclose personal information and supported to maintain agency at a time when the woman may be less able to exercise it.

**4.4.4 Summary of attributes:** The repeated interactions with the midwife during pregnancy gave women an opportunity to develop a relationship with the midwife and this relationship was the core attribute of the concept of trust. The empirical data presented concentrated on the two identified building blocks of reciprocity and empathy.

The participants described a two way relationship that not only involved the woman trusting the midwife but the midwife trusting the woman. The participants appeared to invest in developing two way trust to ensure that their agency and desire for self-determination would be supported. Essential to this was an ability for the midwife to understand the woman as an individual. Women appeared to assess the potential for such empathy through the midwife's communication skills. Developing a deep level of understanding appeared to be an investment to achieve the woman's goal - an ability to concentrate on the physiological requirements of the birth. This brings me to the end of the journey and the consequences of the concept which I will discuss here.

**4.5 Consequences:** The consequence of the concept of trust within the midwife-mother relationship was an evolved trust based on an interpersonal relationship that had elements of friendship combined with a professional service – a professional friend [see figure 8].

**Figure 8: Consequences and sub themes**



Women in the study appeared to demonstrate agency in how they risk assessed, communicated and made decisions leading to the development of a '*different sort of*' evolved trust based on the interpersonal relationship they developed with the midwife.

I will present the data for the women with indirect experience before discussing the data for those with direct experience. By the end of the pregnancy journey the

differences between these two groups were less apparent than in the antecedent section. The women who began the journey with only indirect experience, by the end of the journey had gained their own direct experience. I will present the consequences for each group under the heading of 'evolved trust' and the sub heading 'reached my goal'.

**4.5.1. Evolved trust:** Through the repeated contact with the midwife during pregnancy women had the opportunity to build on the initial trust that was '*just there*'. The development of trust was linked to the existence of a reciprocal, empathetic relationship and where this was achieved participants described the consequence as a '*more than trust*':

*"I think it is more [...] I think it is the same level of trust [...] But it is more [...] I'm not sure trust is the right word [...] in a personal way it would be a different sort of trust."*  
[Sally Interview 2]

The '*more*' was described by the women as being achieved through an important process of getting to know each other and building an understanding of the relationship, the pregnancy and the role of the midwife. Women talked about needing to '*get to know*' the midwife in order to be able to build a '*different sort of trust*' that I have termed interpersonal trust and that appeared to be associated with what could be described as a professional friendship.

During her interviews Paula consistently returned to her understanding that the midwife was a professional and was '*doing a job*':

*"It's not like you're going to be best friends is it? They are there for you if you need to chat and I know I can give them a ring if I have any worries which is nice if it's somebody who was easy to talk to in that respect but other than that it is just their job isn't it?"* [Paula Interview 1]

Paula [above] was clear that the midwife was providing a professional service and that they would not be developing a friendship. However, the friendly qualities of the relationship were important to her: she described an emotional benefit of the midwife being '*there for you*'. Many of the women explored the idea of friendship during the interviews, and discussed whether their relationship with the midwife had an element of friendship. Other participants such as Sally [below] similarly mentioned this combination of friendliness with professionalism:

*“..Because she was quite sort of friendly as opposed to if you get somebody who was like ‘come on in \*\*\*\*’ [snooty sounding voice.] [...] maintaining a kind of friendliness but being professional at the same time [...], no I think it is friendly and not like a friendship. That wouldn't really be like that, that would be a bit weird. [,,] I think that a friendship [...] sort of develops normally, you meet somebody and you get on and you just become friends, whereas here you are forced together as well and she is helping you. Not that it is a power thing but she has kind of got all the knowledge and all the things so you are going to need her and then together you will work it out so it is not a friendship at all. I would say it is more like a team.” [Sally Interview 1]*

*“she's not like your family but she somebody who is kind of like on your side [...] it is more of a professional thing [...] it is still professional but not quite in the same way as other things.” [Sally Interview 2]*

Sally [above] described “being friendly” as a personal characteristic rather than becoming a friend. Molly described the relationship she had with the midwife as not so much a friendship but definitely more than just midwife and mother. This ‘professional friendship’ appeared integral to developing a ‘different sort of trust’.

*“They are not your friends [...] but you do feel that you can talk to them.” [Molly Interview 2]*

*“I don't really see them as friends as such. [...] I think we have gone a bit further than midwife patient. [...] I think it is lovely. Especially with having four, you do get to build up a bond with them. Really you do get to know them a lot. I think it is good really.” [Molly Interview 3]*

Molly [above] described a sense of feeling comfortable and at ease in the midwife’s presence. Her accounts described reciprocity in terms of knowing and being known, the result being an enhanced empathy. I suggested that the women’s accounts imply an evolved trust which they experienced as a result of developing the relationship into a ‘professional friendship’. Molly [above] described this as *‘building a bond’* and Sally [above] as a *‘different sort of trust’*. The women appeared to describe a trust in midwives that consisted of more than the initial professional trust. From the participant accounts the trust described as *‘more than’* appeared to be emotionally enhancing as indicated by Molly’s [above] description *‘it was lovely’*.



Throughout the data collection the women appeared to suggest that engaging and developing a trusting relationship with the midwife was not accidental but was an investment to assist them in reaching their goal.

**4.5.2 Reached my goal:** Most women in the study described a desire to invest in developing trust through their interpersonal relationship with the midwife. They appreciated the midwife as an individual and anticipated that the relationship they had with her could make a significant difference to their satisfaction with the birth, which was seen as their goal. There were many similarities between the accounts of women who had indirect and direct experience. The differences between the groups by the end of the journey was less noticeable however for consistency I will continue to separate the data into the two groups.

**4.5.2.1 Participants with indirect experience:** From the initial interviews it was evident that even in early pregnancy the women had a defined goal. Paula, although experiencing her first pregnancy, had an idea of what she wanted from the trusting relationship:

*“...it's those goals that you want to hit [...] once you hit that you are that bit nearer.” [Paula Interview 1]*

*“I've been able to talk to her about what I want [...] I think she has taken it all on board.” [Paula Interview 2]*

Paula [above] described how she had set herself goals to ‘hit’ along the journey. Paula saw the midwife as assisting her in getting close to those goals by supporting with the required information. Paula focussed on investing time in developing a trusting relationship to ensure that the midwife understood what she ‘wanted’ and that the midwife had at least given Paula the impression that she had ‘taken it on board’. This implied an investment on Paula’s behalf to ensure that the midwife would be supportive. Sally identified birth as the goal in her discussion of the midwife’s role.

*“Not that it is a power thing [...] I think the midwife will grow in power a little bit but I think that is a good thing really although I have been saying I don't like the word power it probably is good in the long run. If something really goes wrong or it gets a bit more complicated she would be working in the interest of me and my baby she would need to exert that power and I would be unable to exert any power at that point [...] So yeah I accept that it will change and that it will need to change.” [Sally Interview 1]*

Sally [above] described the sharing of power, so that the midwife '*grew in power*' which she did not perceive to be a negative occurrence but was perhaps an integral part of the developing trust within the relationship. Sally foresaw a situation- the birth, where she may need the midwife to act in her best interests and assumed that this transfer of power may be necessary as she herself may be unable to maintain agency if the birth became complicated. Interpersonal trust would in this context appear to be a rational decision on Sally's part linked to her need to feel safe. Trust appeared to be associated with the midwife's ability to support the women in getting '*what I want*'. Jane described looking '*after number one*' and the need for the midwife to be able to assist her:

*" she was very accommodating [...] she has got to be able to assist me [...] You just think about yourself [...] what you will be going through [...] it's only natural that we would look after number one [...] It was done and it was lovely."* [Jane Interview 1]

Jane [above] indicated a level of satisfaction with her midwife's ability to assist her. Some of the participants described the support as '*being on my side*'. Sally expressed this with a perceived sense of satisfaction:

*"It's a lot better I think [...] they are more on your side kind of thing [...] you are kind of talking about something and it reiterates that they are on your side."* [Sally Interview 3]

Jane, like many of the participants, developed complications during her pregnancy and described adjusting to the '*different situation*', highlighting a change to her perceived goal.

*"The situation was different the things that you thought were important you know [...] By then I was having contractions so I was happy to be going to theatre [...] yes I knew I felt all right and it's okay but there was just [...] It didn't really matter who was here or whatever really."* [Jane Interview 3]

For Jane [above] the change in circumstances appeared to alter the need for investment in interpersonal trust. '*It didn't matter who was there*' is an indication of her acceptance that she was not going to reach her original goal. All of the participants had elements of care contrary to what they had expected or wanted. But they appeared to accept this in hindsight once their ultimate goal – the birth of a healthy baby was achieved. Jane, Paula and Fiona gave good examples of this which encapsulates similar comments from other participants:

*“...probably wasn't ideal [...] it wasn't a big deal it didn't bother me that much [...] I think you are just used to it being that kind of process, that kind of way [...] it was fine.”*  
[Jane Interview 1]

*“We would move on, life carries on sort of thing [...] that was just the way it happened you cannot do much about it [...] It was just my impression.”* [Fiona Interview 3]

*“You don't care do you? [...] I just accepted it [...] I'm quite laid back so I just thought 'oh well she's fine' [...] I think it was just such a week and I was just knackered.”*  
[Paula Interview 3]

What is interesting amongst this group is an apparent reluctance to express dissatisfaction. They instead discussed how they ‘*accepted*’, and reminded themselves that it could have been worse. Acceptance and downplaying could be viewed as coping mechanisms, a protection of the woman’s emotional being or preservation of initial trust in maternity care in preparation for the next journey. I suggest that this was a strategy employed by the women to achieve some cognitive distance as part of their agency, protecting themselves for future interactions, preserving the elements of initial trust. To allow oneself to focus on the disappointments would influence the woman’s ability to place trust in the future and it could even reduce the propensity to trust other areas of health care. This element of reconciling past experience in order to achieve a current goal was evident in the early interviews with those with direct experience and in the antecedents they discussed, as I will return to now.

**4.5.2.2 Participants with direct experience:** The majority of participants with direct experience were able to articulate their own personal goal within the journey of developing trust. This linked back to the initial discussions about why they engaged with the maternity services in the first instance. The women’s accounts indicated that the need to place trust was associated with the anticipated birth and fear relating to how this would be managed. Their goal therefore appeared to be the achievement of the birth in the way that they wanted it to be. Jo identified the investment in the trusting relationship with the midwife and its perceived benefit to the goal, as the midwife would be ‘the person delivering your baby’. Conversely Jo indicated a reluctance to continue investing in her relationship with the medical team as she identified no benefit to this.

*“That midwife is the person delivering your baby. So that trust relationship is really important. As I said to Dr \*\*\*\*\* on Thursday he will be the last Doctor that I will see.” [Jo Interview 1]*

There was clear evidence of the effect of previous birth experiences. For example, Molly’s goal was to have a midwife stay with her throughout labour without rushing off to care for another woman. This was her experience previously and she knew it was not what she wanted.

*“When you are the mum you need her. They can’t go off, they can’t leave you. They are there for you [...] I have got what I want.” [Molly Interview 3]*

Molly sounds almost euphoric when she adds ‘I got what I want’ indicating a satisfaction with the outcome. It would seem clear that trust for these women had a purpose. From their past experience, participants in this group had an awareness that the process of birth could result in them feeling less in control at times. From the earlier discussions it is apparent that feeling in control was important to the women and a strong influence on the evolvment of trust. During the antenatal period the women described preparing to fight to secure support from the midwife to achieve what they wanted. Investing in developing an effective trusting relationship with the midwife seemed to be an indication of women’s agency; investing in preparing and planning so that they felt safe enough to let themselves concentrate on the intimate birth process.

For some women, a strong sense of agency was demonstrated in their choice of place of birth. For example, Alice had a clear idea of what she wanted for her birth and sounded determined to achieve it:

*“I must have a home birth and I don’t care about anything else I’m just not going to hospital again.” [Alice Interview 1]*

Alice had experience of feeling out of control in her previous birth:

*“I just wanted to know what was going on with me [...] I don’t mind so long as I can be prepared [...] I’m aware that things have to change at the last minute but and I just want to know. If someone is running late, I don’t mind if they tell me. I don’t mind if they miss an appointment and don’t mind the fact that they wanted me to wait I just want to know. Or even if I have to all of a sudden change my birth plan its fine. Just let me know rather than just doing it. And that’s not unreasonable is it? It is about communication, it’s not even about who makes the decision’s. It’s about knowing what*

*is expected of me. And not always feeling like, well not necessarily that I don't always know what is happening but not feeling able to ask.” [Alice Interview 1]*

Alice [above] reflected on what felt important to her, which she articulated as a desire to know what was happening and for an opportunity to prepare herself for decisions that may need to be made. Alice discussed the importance of good communication to assist in feeling comfortable and the relevance of communication in maintaining feelings of control and being ‘able to ask’ for further information when required. The development of trust for Alice was not so embedded in who was making the decisions but more in the ability to understand and prepare oneself and hence maintain a degree of agency.

Similar to the women with indirect experience, achieving their goals was an important focus for the participants with direct experience but these women were also able to accommodate change to their goals when necessary. An interesting example of goal changing was the journey of Jo. Jo’s experience varies from the changing of goals discussed by the women with indirect experience in that their goals changed due to medical changes in their pregnancy, whereas Jo used her agency to actively change her goal for her own social reasons. In the early interviews Jo discussed how important it was for her to have a home birth and that she was placing trust in the community midwives as they were best placed to assist her in achieving this and had congruent beliefs. Jo was very clear in her first interview that her goal was to achieve a home birth:

*“I feel very confident that I will get my home birth [...] As long as I can have my home birth because they know what they are doing [...] They believe what I believe which is that it is safer for me at home so yeah I have every confidence.” [Jo Interview 1]*

In her second interview Jo again emphasised her desire for a home birth and the importance of the midwife ‘agreeing’ with her:

*“I want a natural birth in a homely environment [...] I’d already done quite a detailed birth plan [...] I got that out and just said look this hasn’t changed to be honest [...] \*\*\*\*\* [midwife] was totally in agreement with everything I said [...] that means agree with me.” [Jo Interview 2]*

Jo's extracts highlight the women's ownership of their experience clearly describing the birth as 'my birth'. Jo had specifically sought a midwife whom she felt would share her values for a '*natural birth in a homely environment*'. She appeared to work hard for her birth plan investing in the relationship with the midwife to secure her '*agreement*'.

Jo's case is an interesting example of a woman exercising agency in order to achieve a different goal. Following my second interview, Jo's goal was completely changed because of some family difficulties. Due to her social circumstances Jo decided that what she 'wanted' was to be induced at thirty-eight weeks in the hospital setting. Jo exercised her agency in seeking another midwife from her local team as she didn't feel that her named midwife would support her decision and she also sought another hospital who she had heard would perform inductions of labour for social reasons.

*"I wanted to have her out in time [...] I was really pleased with that [...] so it was okay." [Jo Interview 3]*

Jo [above] was describing a desire to birth her baby within a specific time scale. What therefore appeared important was the midwife's ability to have empathy with the woman and be flexible and supportive even when the woman made alternative decisions. Jo used her agency to secure the birth she wanted but she was not confident that her midwife would support her decisions so used her agency in seeking alternative care. The participants did not always feel that had been able to develop a reciprocal, empathetic relationship that supported their agency all of the time.

The participant accounts indicated elements of care received from the midwife that the women were disappointed with, yet none of the participants described overt dissatisfaction. There remained an overall satisfaction in the achievement of their goal – the birth of the baby and perhaps an element of gratitude to the midwife for her assistance. However some of the participant descriptions were less positive than others, particularly where the relationship with the midwife was more difficult to form or where the goal had changed significantly. This provided an insight into some of the barriers that may interrupt the development or evolvment of trust, with which I will finish my discussion.

**4.5.3 Barriers to developing trust:** One of the main influences to developing trust as described in the earlier sections was the midwife's communication skills which, depending on the midwife's style of communication, could act as either a facilitator or a barrier to the evolvment of trust. In her last interview Sally described the difference

between midwives who appeared nice and friendly to those who appeared 'grumpy' and 'sharp':

*"Midwife who was a bit grumpy [...] less likely to trust her opinion as well as limiting what I would tell her I suppose [...] how they are if somebody was particularly grumpy or sharp you would think why are you like that? None of the others have been like that and they seem to know what they were going on about so perhaps you don't know what you're going on about?" [Sally Interview 3]*

The midwife's communication style led Sally to question the midwife's knowledge and hence limited what Sally would communicate to her in return. Fiona also reported not feeling completely at ease and using her first impressions to consider her compatibility with the midwife:

*"...but if the first time you meet somebody you get off on the wrong foot. When she first came in I didn't feel completely at ease with her [...] one person was quite, quite stand-off-ish [...] I had got in my mind then what sort of person that was [...] you immediately have a different viewpoint don't you?" [Fiona Interview 3]*

The accounts [above] illustrate the emotional aspect of the relationship and the development of trust. Fiona [above] suggested it would change her 'viewpoint' highlighting the influence the midwife's characteristics could have on the development of trust or as a barrier to that development. Lucy's journey provided a good example of the barriers to the development of interpersonal trust described by some of the participants and is therefore worth considering in some detail. The reason for concentrating on Lucy is that her examples, while reflecting similar points to the other participants, span the journey through her pregnancy and therefore add more context to aid understanding of the longitudinal influences of such experiences on the development of trust. Lucy's very first account highlighted issues that may disrupt the development of trust:

*"There was one incident actually made me sort of think, [...] I can kind of see how people's opinions might differ between. You know people have various assumptions about how you should be in your pregnancy. How you should be in your birth [...] it was just this one thing about the swine flu vaccine [...] I did decide not to go ahead and have it. A couple of weeks after that I spoke to the midwife and she mentioned it [...] 'you'll need to go and book yourself in for it'. So I said that 'I had decided not to have the swine flu jab'. So she said, I think she just kind of said*

*something off the top of her head but what she said to me was 'just to let you know somebody in \*\*\*\*\* has just died from swine flu.' I thought then you know I could tell she had just blurted it out. But I thought you know that's your opinion and I don't think that's a very sensitive way to kind of express it. I didn't feel any sort of bad feeling towards her because of that. I could kind of sense that it was a bit of a slip. But I did think I could tell she had got a few different values to me. I imagine that that could come up in the future."* [Lucy Interview 1]

Lucy [above] described the midwife's communication skills as lacking. As a result, the midwife was perceived by Lucy to make mistakes and to be '*insensitive*'. Although Lucy says that she '*didn't feel any bad feeling towards the midwife*' her account indicated recognition from this interaction that the midwife did not necessarily share or understand her values and anticipated this difference in values may influence the relationship in the future.

Lucy was cared for by a small team of midwives, unlike the majority of the participants who were cared for by one named midwife in a similar way to that described earlier in the chapter by Jo, who suggested that trust placed in one midwife could act as a conduit and be positively transferred to other midwives. It could be that this initial interaction not only influenced Lucy's relationship with this particular midwife but that the experience would be negatively transferrable to other relationships with midwives. In later interviews Lucy discussed her experiences in the appointments with the other midwives from the team whom she was also struggling to build a trusting relationship with.

*"I've had this little glitch with her [...] it did make me feel a bit like 'oh I hope it's not \*\*\*\*\*' [midwife] who is at the birth."* [Lucy Interview 2]

Lucy's [above] '*little glitch*' with the second team midwife was another indication things were not progressing as she had expected and that midwives were not behaving in the way she had anticipated that they should. This appeared to lead to reluctance on Lucy's part to develop a relationship with the midwife for the anticipated birth.

In Lucy's [below] third interview she described in some detail the midwife who had cared for her on the day of the birth. Lucy started labour at home where she intended to birth. The midwife was different again to the ones whom she had met during her pregnancy. Complications were identified during the progress of labour and Lucy was transferred to hospital where she experienced a normal birth:



*“I guess I just didn’t trust her doing what she was doing. I got the impression that she was thinking it is getting to the end of my shift. I was going to transfer her to go kind of thing [...] I thought I don’t really trust you much [...] She does have a very nervous way about her.” [Lucy Interview 3]*

When I asked Lucy whether she felt that she didn’t trust her? She replied:

*“No, I don’t think I do anymore.”*

Lucy’s experiences were similar to those she described earlier in that the midwife communicated a difference in values, or at least Lucy’s perception of the interaction was that the midwife was not fully congruent with assisting her to achieve the birth that she had planned. Lucy perceived that the midwife was concerned for her own wellbeing and getting home on time and that this desire influenced the decisions being made about her care. This was further complicated by the midwife’s body language which led Lucy to describe her as ‘*nervous*’ and this influenced Lucy’s ability to fully trust in her level of competence. What is interesting is that in her final interview Lucy replied that she did not trust this midwife ‘anymore’. Despite the earlier experiences in pregnancy, Lucy still retained an amount of initial trust for the midwife who cared for her at the birth. To not trust anymore suggested that some trust was present but had now been lost. There would also appear to be reluctance in Lucy’s words to fully acknowledge that trust was not there at all at the end. She used words such as: ‘I don’t *really* trust you *much*’ and ‘I don’t *think* I do’. The potential for achieving reciprocity and empathy was assessed by the midwife’s personal characteristics such as her communication skills. Lucy’s [above] accounts assist in the understanding of what could help or hinder the process of developing trust further from the initial trust. The interaction between midwives and women provided an opportunity for women to ‘suss out’ whether their initial trust was well placed and worthy of development. It would appear to be linked to a notion of reciprocity and empathy. The relationship formed with the midwife appeared to have a direct impact on the development of trust as a concept and would influence the consequences.

**4.5.4 Summary of consequences:** In this section I have presented the data from participants which suggested that developing trust within the midwife-mother relationship was an investment in achieving the woman’s identified goal of safe birth. Trust in the context of the relationship with the midwife assisted the woman to achieve what she wanted in supporting her agency. Both groups of participants were similar in

this section, differences between the two groups were not noticeable. Women who started the journey with indirect experience had now become women of direct experience.

The third interviews were interesting when looking at the development of trust as they did differ from the early interviews. In the initial interviews women discussed trust in the context of the midwife as a professional, the organisational system and midwives training. In the second interviews their descriptions focussed much more on trust in relation to feeling at ease, comfortable and liking the midwife as in a friendship. The women described the relationship with fondness but also with a purpose. The discussions in the third interviews were reflective of the journey and the process of developing trust.

Unsurprisingly the women's views differed from the first interview to the third interview. In the third interview the women spent time discussing the birth, telling their story and reflecting on their experiences. They appeared to use the interview as a process of debriefing themselves. The outcome of the trusting relationship was associated with a sense of satisfaction or acceptance experienced at the end of the participant's pregnancy journey. This appeared to be associated with the achievement of the participant's goal and the participants highlighted the importance to them of the midwife sharing or at least understanding their values. The women accepted that their wishes may change and highlighted the need for the midwife to respect their agency and accommodate their individual needs.

**4.6 Conclusion:** In this chapter I have suggested that the concept of trust is made up of building blocks and interwoven with women's agency. Women risk assessed, communicated and made decisions leading to the development of trust, from initial trust to the evolved interpersonal trust based on the relationship they developed with the midwife. I have presented data related to the antecedents, attributes and consequences of trust and the aspects of women's agency that appeared to surround and weave through every block within the concept of trust.

The antecedents of the concept included two main building blocks identified through the empirical data: need and expectation. I have suggested that the main focus for the women was a need to feel safe, which for those with indirect experience was based on medical safety. For those with direct experience, the focus was emotional safety where the woman's agency would be supported. The initial trust appeared to be associated

with an expectation of assumed competence in the midwife to meet the woman's needs.

The core attribute of the concept was identified as the relationship between midwife and mother. This included the identified building blocks of reciprocity and empathy. Women in both groups expressed a desire to develop a two way trust that included the midwife trusting the woman to take make decisions. Essential to this was the women's experience of the midwife's demonstration of empathy. The participants appeared to assess the potential for developing a reciprocal, empathetic relationship through the midwife's communication skills. Achievement of such a relationship influenced how the concept of trust evolved. Developing trust was an investment to assist the woman to achieve her goal – the birth and the consequence of the trust concept was an evolved trust that I have referred to as interpersonal trust. The differences noted earlier on between those women with indirect experience and those with direct experience were not noticeable in the consequences section as all of the participants by this stage had some direct experience of midwifery care.

In the next chapter I will use stage three of the hybrid model to develop a deeper understanding of the concept of trust through exploring the lived experience of the participants alongside the original theoretical concept. Schwartz-Barcott and Kim [1993] suggested three key questions to structure this final stage of the analysis: Does the study support the presence and frequency of the concept? How much is the concept applicable and important? Was the selection of the concept justified? These questions will be the framework of the following chapter.

## Chapter 5: Final Analysis: Hybrid Model stage 3.

**5.1 Introduction:** Within the hybrid model Schwartz-Barcott and Kim [1993] suggested three key questions to structure this third and final stage of the analysis: Does the study support the presence and frequency of the concept? How much is the concept applicable and important? Was the selection of the concept justified? As a clinical midwife it is important for me to frame the discussion within a clinical context and I will do this using these three questions. The key themes identified from stage two, the empirical data phase will be used to further understand the concept of trust and its relevance to midwifery practice. I will begin with some brief background information before taking each of the questions in turn to structure my discussion within this chapter.

**5.1.1 Background:** The study's aim was to explore the concept of trust within the midwife-mother relationship and to improve understanding of how this was experienced by women throughout their pregnancy journey. The hybrid model approach [Schwartz – Barcott and Kim 1993] was used to structure the study, commencing with a concept analysis to establish an understanding of the theoretical meaning of trust. The concept analysis explored two main types of trust; initial trust based on social norms and interpersonal trust based on the individual midwife-mother relationship. Literature suggested that trust as a concept was multi-dimensional and would vary depending on the context in which it was being considered. Using Rodgers' [1989] concept analysis framework I structured the theoretical analysis into the antecedents [that which come before the concept], the attributes [that which are at the core of the concept] and the consequences [that which comes as a result of the concept]. Based on this analysis, I suggested that trust was a multi-faceted phenomenon, incorporating values, emotions, beliefs, confidence, satisfaction and reliance, which would all be influenced by a woman's expectations. I was able to define and clarify what was meant by the term trust, exploring common uses of the word and surrogate terms to achieve greater understanding of the meaning of trust within the midwife-mother relationship. Whilst developing the theoretical concept of trust a key influence was Johns' [1996] process-outcome model of trust. She suggested capturing the concept at given points in time to aid understanding of trust as a developmental process as well as an outcome. Hence my decision to study trust longitudinally over the course of the pregnancy journey.

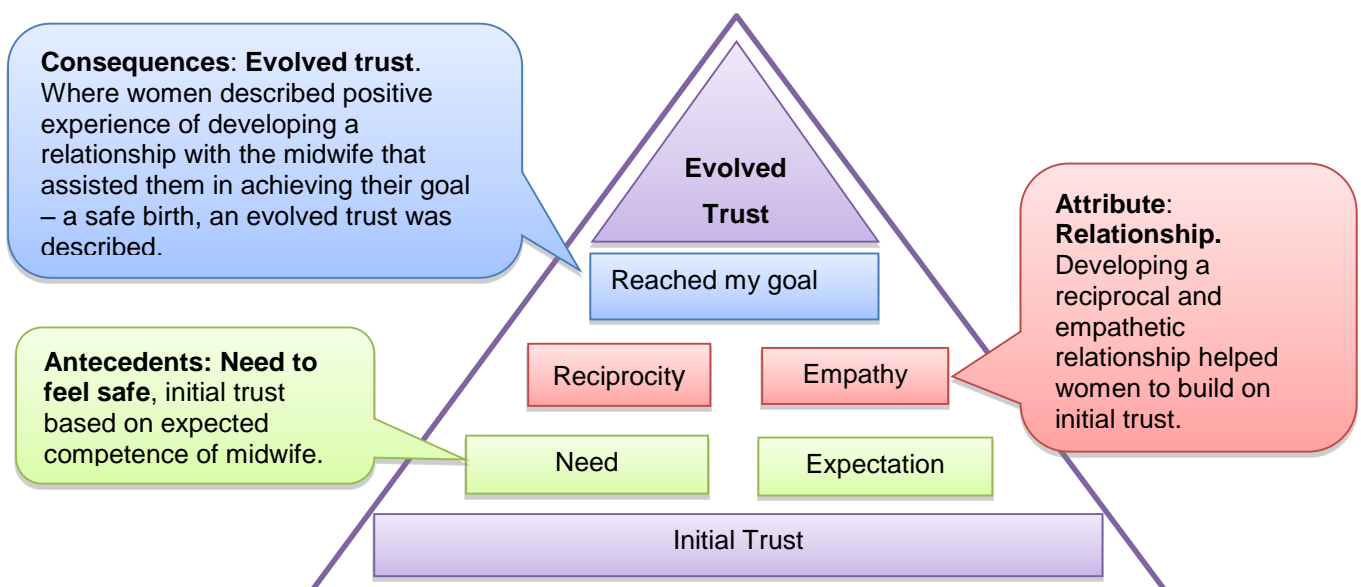
While the concept analysis of trust completed in stage one gave a strong theoretical basis for the study, further understanding was gained from the analysis of empirical

data in stage two which added contextual depth to understanding the concept of trust. In this stage I explored women’s lived experience of the concept of trust during pregnancy, using a longitudinal approach to aid understanding of the developmental, evolutionary aspects of the concept. The metaphor of building blocks used by one participant was used to describe the evolution of trust from its initial foundation to an evolved interpersonal trust.

**5.1.2 Building blocks:** The idea of trust being built up was a consistent theme in the data:

*“The trust is there and it is something that you will build on.” [Jane Interview 1]*

The participant journey progressed through a series of building blocks from initial trust that participants described as *‘just there’* to an evolved trust based more on the interpersonal relationship with the midwife [Figure 9].



**Figure 9: Building blocks of trust**

The concept of trust appeared to be made up of building blocks. Women risk assessed, communicated and made decisions leading to the development of an evolved trust based on their experiences of the blocks, particularly the experience of reciprocity and empathy within the relationship with the midwife. All the participants described an initial trust that was the foundation for the journey. Initial trust was based on an expectation of professional competence and could be built on in subsequent encounters. Within initial trust the participant accounts indicated two main building blocks: need and expectation, with an emphasis on women’s need to feel safe. Initial trust was placed on

the expectation that the midwife would be competent to meet a woman's needs. Need and expectation also featured strongly in the theoretical concept analysis and are considered to be the antecedents of the concept of trust. The literature suggested that the concept of trust began with an identified need by one person to place trust in another and an expectation that the person in whom trust was placed would be trustworthy. This was identified in the empirical data where participants expressed a need to feel safe and an expectation that the midwife could assist them in achieving a safe birth. However, my analysis adds to the theoretical concept as it shows that how the participants experienced these two building blocks influenced the next stage in building on the initial trust – the interpersonal relationship with the midwife. Participants identified the importance of their first impressions of the midwife and the midwife's ability to demonstrate empathy and understanding of the woman's needs. If the early encounters with the midwife led to a positive experience for the woman, she was more likely to invest in developing trust.

I have suggested that the relationship between midwife and mother was the core attribute of the concept. From the participant interviews I identified two key building blocks which appeared to influence the development of an evolved trust within the relationship: reciprocity and empathy. Women's agency ran throughout all the building blocks. The participants indicated that their motivation for investing in the midwife-mother relationship and building on initial trust was primarily to assist them in achieving their goal - safe birth. The participants indicated that for them a safe birth included respect for a woman's agency and that the woman would feel that the midwife trusted her in a two-way exchange.

How the participants experienced achieving their goal was the final building block in developing evolved trust. I have considered 'evolved trust', which was based on the interpersonal relationship with the midwife, as the consequence of the concept of trust within the midwife-mother relationship. While all the participants described an initial trust, the development of an evolved trust was not achieved in every case. For example, through getting to know the midwife, women were able to decide whether their initial trust was well placed and worthy of development. If a particular building block resulted in a negatively perceived experience, the participant was less likely to describe an evolved trust.

In this chapter I will use both the theoretical concept analysis and the empirical data to develop understanding of the concept of trust within the midwife-mother relationship. I will use the three questions posed within the hybrid model to structure this further exploration of the concept and highlight the main areas of relevance to midwifery. I will commence with the first question described by Schwartz-Barcott and Kim [1993]; does the study support the presence and frequency of trust as a concept?

**5.2 Does the study support the presence and frequency of trust as a concept?** Overall the empirical data appeared to support the presence of the concept of trust within the midwife-mother relationship in the sample being studied. The data confirmed the presence of an initial trust based on an assumed professional competence similar to that identified in the literature. The findings add further depth to the theoretical concept in the improved understanding of the importance of the interpersonal relationship and the interaction of woman's agency in the development of an evolved trust. Woman's agency is not well documented in the trust literature or the concept analysis, particularly in relation to the concept of trust within midwifery. I will begin by discussing the data that supports the *presence* of the concept before considering the data which adds to our *understanding* of the concept.

**5.2.1 Presence of the concept within the midwife-mother relationship.** All of the participants indicated the presence of an initial '*certain type*' of trust that was '*just there*'. The trust placed at this stage appeared to be based on a commonly held idea that the women could trust a midwife as she was a member of a profession. That is, she had undergone the necessary training and therefore had an assumed competence to fulfil her professional role. For example, Fiona described trusting the midwife as an '*expert*' in her role and Kate described the midwife as a '*professional*' fulfilling a professional role. Svensson [2006] related professionalism to a confidence in the systems as well as the individuals, data from his empirical study emphasised the importance of the professionals knowledge, competence and skill but that it was the cognitive attitude that formed the basis for deciding to place trust in a professional. While Kuhlmann's [2006] new patterns of building trust in health care noted in her empirical study of modernisation in Germany highlighted a transformation over time of trust based on professionalism. Kuhlmann noted a change from a traditional embodied trust to a more disembodied professionalism where trust was built on the signifiers and proof of quality visible to the public through control and regulation. It would appear from the debate in the sociological literature that professional trust has transformed over the

years and is set to continue to do so. However the data from my study did not indicate any such shift. The participants expressed an initial trust based on a traditional view of the midwife as a trained professional which was linked to an identified need to engage and an expectation that the midwife was a skilled and knowledgeable professional.

In the previous chapter I have suggested that the two building blocks identified as the antecedents to trust are: need, and expectation. The participants placed initial trust in the midwife's assumed competence to meet their needs. Need constituted the primary reason for engagement with maternity services but varied across the sample. For example, the need to feel safe was experienced differently by those participants with indirect and direct experience of childbirth. The women with direct experience described childbirth as '*scary*' and identified risks associated with not being cared for in a way that supported their agency. The women with indirect experience described feeling '*blind*' and '*not knowing*' and their subsequent need for information in order to feel more safe.

I will commence my discussion here with the need for information as an indication of the presence of the concept of trust within the study. The participants' discussion of their need for information in order to feel safe provides an exemplar of how the empirical findings support the concept of trust.

**5.2.2 The need to feel safe- information:** Participants experiencing childbirth for the first time articulated some anxiety of the unknown. They described that they '*lacked information*' and knowledge about pregnancy and birth. The women highlighted the need for involvement with the midwife as they perceived her to be knowledgeable and a source of support, hence initial trust was placed. Lucy described herself as '*blind*' – a situation where a lack of knowledge and experience left her unable to envisage what to expect, how to prepare herself and how to manage pregnancy and childbirth. This suggested a sense of feeling insecure or unsafe, perhaps resulting from a feeling of reduced agency. Lucy's '*blindness*' was associated with a lack of direct experience and knowledge and her trust appeared to indicate a reliance on the midwife to support her in gaining information. Similarly some of the others, including Sally, Jane, Fiona and Paula, described gathering information and knowledge to help build their own agency. These findings are reflected in the wider literature: Hupcey et al [2001] proposed that trust is important when a person has a specific need for something such as health care that cannot be met without embarking on a relationship with another person. Therefore,



by placing trust in that person the individuals place themselves in a vulnerable or dependent position. The relationship between vulnerability and trust has been discussed in the literature. Shenoliker et al [2004] explained that where feelings of vulnerability exist a person is more likely to place trust in another. Theide [2005] also suggested that trust as a psychological concept is 'rooted in experience' [p1456] and when placed in a given context 'assumes the reliability of another' [p1456].

The experiences of the participants in my study and their description of being 'new' to the process indicated they felt like somewhat of a novice in not knowing what to expect. The novice birthing was the core category identified in Dahlen et al's [2010] study and included data from first time mothers who reported feeling disadvantaged by not knowing what to expect. They mediated this by preparing with information, communication and support to enhance choice and control. They considered birth stories and previous life experiences as influential in the formulation of women's expectations which Dahlen et al [2010] termed 'life's baggage' [p55]. 'Setting up birth expectations' as described by Dahlen et al [2010] appeared similar to the antecedents of trust – identified in the theoretical concept and in the expectations described by the women in my study.

The participants in my study reported basing their expectations about their childbirth journey on stories from friends, family and the media. It was also the case that, given the local model of care, the midwife had built up a local reputation. All of these factors created a pattern of beliefs about how the childbirth journey was likely to be experienced. This store of knowledge seemed similar to that described in the theoretical concept analysis as a trusting culture and the trusting impulse [Harrison et al 2003]. There is a suggestion in the literature that this is either present or not, however it should be noted that the women in my study, whilst acknowledging the influence of the culture also demonstrated some awareness that this culture of beliefs or reputation may not necessarily be accurate and they still described feeling '*blind*' and '*not knowing what to expect*'. It may be accurate to describe this group of women as 'novice'. Recognition of the need for information was important to the development of the concept of trust and highlighted the need for midwives to be aware of woman's reaction to the unknown and support women in preparing for birth.

The need for information was evident in the theoretical concept of trust where Johns [1996] described one of the antecedents of trust as the assimilation of information,

which included within this not only the information regarding the situation i.e. childbirth but also the information and risk assessment of the person in whom trust is being placed. For the participants in my study the gathering of information appeared to be an important aspect of the antecedents of trust. Assimilation of information allowed them to verify their expectations and to risk assess and make decisions that were right for them. It would appear important to gather information and knowledge to build agency to feel safer, taking the women from a feeling of novice to experienced woman and enabling them to progress in building trust.

In Johns' [1996] process-outcome model the antecedents of trust are associated with the first two steps of her model, the assimilation of information and the decision-making phase. Within this she focused on risk assessment and the expectation of a positive outcome which encompassed perceptions of competence, trustworthiness of the trustee and reliability. Mechanic and Meyer [2000] highlighted in their study of seriously ill patients in the USA that professional competence and a notion of users testing this competence was central to their concept of trust. They suggested that the willingness to place trust initially in the health professional was influenced by the recommendations of friends and family and that this was then further tested during the interactions with the doctors. This would appear to be supported by my findings specifically from the group of women with indirect experience who had limited expectations from their assimilation of information and then used their interaction and relationship with the midwife to assess their competence and build on trust.

Expectation was an important feature of the concept analysis and is considered by many authors such as Thom et al [2004] as a core attribute of the concept of trust. However, the empirical data in this study indicated that expectation was primarily an antecedent of trust and it should also be acknowledged from the participants with direct experience that the journey of trust in one pregnancy had an influence on their subsequent expectations for their next pregnancy. A snowball effect was noted, in that previous experience was influential in the expectations present as an antecedent to the current initial trust placed. Experience was transferred from one relationship to another relationship within a similar context. For example, Molly, Jo and Alice based their initial trust for community midwives on their own past experience of building trust with community midwives in a previous pregnancy. I have suggested that the expectation of professional competence existed at the beginning of the woman's journey and

influenced a woman's willingness to engage and place initial trust but that this was only the beginning. Expectations were then verified through the interpersonal relationship and interactions with the midwife. Hence expectation was present at the beginning – an antecedent but it was the *relationship* that was a core attribute of the concept of trust. For those women who had direct experience, the assimilation of information was influenced by their previous experience of building a trusting relationship with a midwife. They indicated a comparison with their previous encounters with a midwife, using this to risk assess and compare the trustworthiness of the midwife allocated to care for them on this occasion.

The women in my study with direct experience did not appear as 'novice' as the focus was on the knowledge they had gained from their past experience particularly where a traumatic birth had been described. The participants who had direct experience of childbirth concentrated much of their initial interview on telling their story of previous encounters and the emotional effect that this had on them, what Dahlen et al [2010] termed 'life's baggage'. This seemed a fitting description that was reflected by Molly, Jo and Alice as women with experience of childbirth who appeared to demonstrate more confidence in their own knowledge as a result. The building block of need which they described was more a need for support than information and I will consider this next.

**5.2.3 The need to feel safe - support:** Molly was an interesting example of the need for emotional support within this group of women with direct experience. On the one hand, Molly was confident in her knowledge and demonstrated her agency in discussing what she wanted from the midwife but on the other hand, Molly described childbirth as a '*scary experience*', one that had left her feeling '*really frightened*'. In the theoretical concept analysis I discussed how past experience may lead to withdrawal of trust and how placing trust in someone could also leave one feeling vulnerable. Yet despite her previous birth experience Molly continued to need to engage with services. It would seem that as a result of her fear being related to the risks of birth she placed trust in midwives to '*help her through that*'. Initial trust was placed as midwives were seen as a source of support to assist women in managing fear.

Molly, Jo and Alice described having had a previous traumatic birth and how this had influenced the trust present in this pregnancy. The women's accounts indicated that they perceived these negative feelings to be associated with hospital maternity care, which left them feeling unheard and uncared for by busy staff. Hospital care was

experienced as not flexible enough to allow them to be part of decision- making, leading to a subsequent reduction in trust for this type of environment. Birth context is known to impact on women's experiences. Symon et al [2007] studied over four hundred women during a six month period to explore their experience of birth based on birth environment. They found that women who birthed in obstetric units experienced longer labours, increased intervention, increased need for pain relief and were more likely to be cared for by a greater number of midwives during their labour. Overgaard et al [2012] examined the influence of birth place on women's birth experiences in Denmark. Satisfaction with care was significantly lower in low-risk women who gave birth in an obstetric unit. This was attributed to feeling less supported and not being listened to. Thus 'high quality' care from the women's perspective as in my study appeared to be associated with much more than physical safety but also encompassed feeling included and supported to make decisions. Molly, Alice and Jo had previously experienced out of hospital births which they appeared to perceive more positively than their previous hospital birth experience. The positive birth experience influenced their present trust and their subsequent expectations of community midwives. Molly associated community midwifery with a reassurance that she would receive emotionally 'safe' care and that she would not be left alone. For Molly and Jo their fear and subsequent need to engage was strongly influenced by their past experience and their expectations of assumed competence in community midwives to provide services that best meet their needs. They appeared to imply that community midwives would potentially be more trustworthy than hospital midwives.

The three personal experiences of birth trauma described by Molly, Alice and Jo all took place in hospital settings. Interestingly, there was no indication during their story-telling that the perceived trauma was due to a particular obstetric intervention or extreme adverse event during the birth and may not have been considered a traumatic birth by a clinician such as a midwife. Yet for the participants, their negative recollection of previous births and subsequent fear had an impact on the initial trust placed in midwives and had particular influence on the value they placed on support for women's agency in the development of an evolved trust in community midwives. In their recent study Storksen et al [2013] explored fear of childbirth following past traumatic birth in 1357 women in Norway. The subjective negative birth experience had led to greater incidence of fear in future childbirth than the association between actual obstetric complications and fear. This seemed important when considering the concept of trust.

A professional midwife works in a primarily medically focussed system where a birth may be viewed as positive so long as it had been medically safe. A woman's subjective negative birth experience even though the birth was medically uncomplicated may be difficult for a professional to understand and this lack of understanding could influence the development of trust as empathy was identified as an important building block for the concept of trust. A midwife would need to consider all the contributing factors to a woman's fear and remain non-judgemental in her perception of the birth experience in order to support the woman emotionally and uphold the trust placed.

Various studies have identified several contributing factors to fear in childbearing women, for example Nilson and Lundgren [2007] conducted a qualitative study investigating fear of childbirth in a group of Swedish women and Otley [2011] reviewed the literature related to fear of childbirth, drawn from a range of international midwifery and obstetric studies. One of the most common reasons identified by women for fear was lack of trust in health care staff. Fear was often a result of feeling powerless or that women would lose control both physically and emotionally. The women reported fear that the midwife would be unfriendly, which had led to reduced trust and confidence in their own perceived ability to give birth.

Based on her review findings, Otley [2011] suggested that midwives need to ensure that women feel in control, are well informed and reduce women's stress in order to reverse the detrimental effect that fear of childbirth can have on a woman's [perceived] ability to give birth. She argued that by building a trusting midwife-mother relationship women would be able to discuss their feelings and midwives would respond to them individually helping to alleviate fear. Fahy [2008] suggested that women will have more satisfying birth experiences if they feel strong and confident and that midwives should ensure that the birth territory<sup>3</sup> enables women to feel safe and the physiology of birth is undisturbed. This appeared to resonate with the experiences described by Molly, Jo and Alice in their discussions of trust for community midwives and out of hospital births. They perceived these to be safer as they maintained women's agency and provided the emotional support necessary to boost women's confidence. The initial trust placed was influenced by the expectation that the community midwife would be able to meet their needs for support.

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<sup>3</sup> Physical, geographical and dynamic features of the space where a woman births.

I have demonstrated through the data the presence of initial trust and discussed this in relation to the antecedent building blocks. It is important to continue here in exploring the presence and frequency of the concept as the pregnancy journey continued. To do this I will concentrate now on the data related to the core attribute of the concept- the relationship.

**5.2.4 The importance of relationship for interpersonal trust:** Participants described the evolvment of trust as adding 'something more'. The process of developing interpersonal trust appeared to be dependent on the ability to develop a reciprocal relationship with the midwife who the women perceived as empathetic. The women in the study anticipated the need to build trust with a particular person in order to ensure that their later perceived needs would be met. Edwards and Leap [2006] suggested that establishing trusting relationships based on reciprocity and mutuality enable situations where women can be fully involved in decision-making. Reciprocity was most apparent in Molly's experience where she had already got to know the midwife from previous pregnancies. Molly's experiences indicated how the development of interpersonal trust was based on her experience of partnership with the midwife. In their literature review on trust within the nurse-patient relationship, Dinc and Gastmans [2013] suggest that trust is not simply given or possessed; trust is earned, requires investment and is most likely to be achieved through developing a partnership that is a two-way reciprocal relationship. Brass [2012] in her opinion piece wrote of the importance of midwives and women working together, sharing the childbirth experience, collaborating and negotiating plans of care that recognise the woman's beliefs and values. This seems congruent with how Molly described the partnership she had with the midwife. Similar to Molly's accounts, Brass [2012] suggests that listening and understanding enable the midwife to show empathy.

All of the participants' accounts indicated the importance of empathy within the midwife-mother relationship and a desire for the midwife to be empathetic toward the woman. The participants also demonstrated an ability to empathise with the midwife. The women described an understanding of the midwife's role, and the responsibilities and challenges they may face in supporting a woman's individual needs whilst working in a standardised system. Women such as Jo described how they themselves may intimidate the midwife and leave her feeling less confident in the face of a woman who knows what she wants and has the agency with which to achieve her aims. A report by

AIMS<sup>4</sup> [2012] detailed survey feedback from women about their experiences of midwifery care. The women described difficulty in forming trusting relationships with midwives as their role had become one of surveillance and protection rather than supportive partner to the woman. The report suggested that women highlighted a need for midwives who they could trust to be on their side, as highlighted by Sally in my study - "*you are kind of talking about something and it reiterates that they are on your side*".

Empathy within the relationship appeared from the data to be an instrumental building block for evolved trust. Jo's account highlighted advantages in the midwife understanding her needs and values and the importance of the midwife's ability to communicate and transfer that understanding to other midwives. For Jane and Fiona the importance of having a midwife with whom they could connect socially and emotionally was important in building confidence that the midwife understood their individual needs. The participants described the importance of finding a midwife who 'fitted' and for some this was based on their ability to empathise through a shared experience- for example, childbirth or womanhood. This connection was perceived by Molly as 'just in you' and was linked to the ability to connect on a more intimate emotional level. The participants indicated that a key way for the women to assess the potential for developing an empathetic relationship was through the midwives' communication skills.

The empirical data identified key ingredients for trust to be present and be sustained: support for women's agency, reciprocity and empathy, which were assessed primarily through the midwife's personal characteristics. Trustworthy characteristics were not specifically explored within my study but the participants accounts did indicate similar characteristics to that described by Dinc and Gastmans [2012] in their literature review which included: generosity, compassion, honesty and reliability. Demonstration of characteristics such as giving time, being 'nice', non-judgemental and understanding were described by the participants in my study as necessary for trust to be present in the relationship. John [2009] suggested that it was important for the women in her study to feel that the midwives empathised with them and were not judgmental of their decisions and this was also apparent in my study for trust to develop.

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<sup>4</sup> Association for improvements in maternity services

The reciprocal relationship appeared to require some sort of investment of self. The women described their motivation for doing this was an expectation of having the midwife there at the birth as Sally articulated, 'if *she is not there at the end it almost seems pointless building a relationship.*' The participant accounts suggested that the investment in developing trust was deliberate in order to assist the women in achieving their goal and that the consequence would be the presence of an evolved trust. The data gained from my study indicated an end point to the relationship. The evolved trust experienced at this end stage could be considered the consequences as described in the theoretical concept. I will now consider the presence of the concept in the later part of the journey and the building block of 'reached my goal'.

**5.2.5 Consequences - Reached my goal:** The birth appeared to be the ultimate goal and the women invested in the relationship with their community midwife so that they understood their values and could help them in achieving the birth they wanted. Alice articulated her goal with confidence '*I must have a home birth.*' Many of the participants discussed getting to know the midwife through repeated pregnancy interactions to develop reciprocal trust '*both her trusting you and you trusting them.*' Molly and Paula described their motivation for developing trust within the relationship as getting '*what I want.*' Jo indicated that developing trust was an investment as the midwife is '*the person delivering your baby*', implying a need to rely on the midwives skills and competence.

Reaching their goal or receiving care that matched their expectations was influential in the women's accounts of the trust they experienced. From the data, satisfaction [one of the consequences described in the theoretical concept] appeared to be linked to the midwife's ability to aid the women in '*getting what I want*' or '*being on my side.*' This is similar to that noted in AIMS [2012] reported 'top ten tips' explaining what women want from midwives. Tip two highlighted the desire from women for midwives to be 'on their side' as their advocate and tip three to encourage understanding of true informed decision-making where informed refusal is also accepted. This was connected in my study findings to the idea that the midwife understood or shared the women's values. The women acknowledged a requirement for an adaptable, flexible relationship which was important for accepting changes to the woman's goals or values and for maintaining trust.

The philosophical viewpoint presented in the concept analysis suggested that trust was based on the belief that a person will 'do what is right'. The empirical data



demonstrated a challenge to this suggestion that 'right' can be clearly defined. Participants suggested that what is 'right' is in fact subtle and individual. Rather than a fixed, dictated guideline, the women exercised their agency in deciding what is right for them. This poses a challenge to professionals especially where there is tension surrounding 'what is right'. The participants' accounts highlight that trust within the midwife-mother relationship is largely influenced by the values of the individual. The women clearly articulated that what was right for one person was not necessarily right for another. They placed trust in the midwife to adapt, be flexible and to not judge. This was particularly apparent in their discussions around safety and the desire for their own agency to be supported. The empirical data confirms the presence of value as a central component as described in the theoretical concept.

The empirical data appeared to support the sociological perspective that trust was a rational concept built over time. Initial trust was based on an expectation of professional competence- the idea that a professional will do what is 'right', as dictated by their professional code [NMC 2015]. However, the accountability and interaction of the individuals experiencing life events in different social contexts was important to the participant's willingness to build on this further and develop an evolved trust over time.

One of the main differences between the first stage theoretical concept analysis and the empirical findings from stage two was the presence of women's agency. Within the literature on trust the subject of agency is referred to but usually only in relation to the vulnerability of the person placing trust and the professional being in a position of power [Petersen et al 2009, Crawford 2011]. However, contrary to this the participant accounts in stage two suggested that the women experienced, at times, a strong sense of agency and highlighted the importance of this to the presence of an evolved trust. This was a key finding that adds to the understanding of the concept of trust present in the midwife-mother relationship. I will explore the influence of women's agency further in the following section.

### **5.3 Further understanding of the concept of trust through the empirical**

**data:** In addition to the antecedents, attributes and consequences of the concept of trust the empirical data emphasises the importance of two further concepts that influenced the women's experience of trust. Connectedness and women's agency were evident in all the participants' accounts throughout all stages of the development of trust. To aid understanding of trust as the women experienced it, I will consider these two concepts briefly here.

**5.3.1 Women's Agency:** In relation to the study, women's agency meant the woman's ability to 'exert power' and remain in control and make her own decisions to assist in the achievement of her goal- safe birth. Women's agency was evident from the beginning of their journey in their willingness to engage with the midwife, their processing of their past experience, information gathering and allowing midwives to complete tasks. Women's agency was most apparent in the data discussing the women's goal - the birth and their investment in developing a reciprocal, empathetic relationship as a way of ensuring they would achieve their own birth plan. The participant accounts suggested that trust evolved over several months of negotiations between the midwife and the mother. The women acknowledged in the early interviews some vulnerability and their need to place initial trust in midwives. The participants also identified the potential for midwives to exert power or abuse their trust- '*it is very easy for them to persuade people*'. The participant data indicated that the women in my study did not lack agency and they did not succumb to the potential power imbalance but instead gathered information and invested their energies in finding a midwife who could support them. The women's accounts indicated the participant's own ability to risk assess and make decisions.

The participant accounts indicated a need for information to assist the women in making the right decision for themselves to feel safe. Women in Janssen et al's [2009] study similarly acknowledged the importance of evidenced based care, professional competence and the midwife's receptiveness to the woman and her partner's wishes and choices. Janssen et al [2009] suggested that these things were not taken for granted by the women but that women knew how to judge their presence from their perceptions of the midwife's characteristics and the women appeared to watch for competence to be demonstrated. In my study the women were seeking to be active agents within the midwife-mother relationship and demonstrated empathy and consideration of the midwife as a professional working in a system that itself has processes which may constrain them. The participants recognised the challenge for midwives in attempting to understand the woman's own individual decisions particularly where these decisions conflicted with the more generic hospital guidelines. The women appeared mindful that this may influence the midwife's ability to uphold the trust the women were placing in her to support their agency and right to self-determination. Goering [2009] suggested that respecting a woman's autonomy was not solely focussed on providing informed consent but encompassed understanding of the individual's knowledge, skills and social background as women were seen to make

decisions based on more holistic embodied values and their interpretations of the midwife's goodwill and integrity. Similar findings can be seen in the participant data from my study; testing or interpreting the midwife's will and integrity was noted as women invested time in getting to know their midwife to help build on their initial trust.

For example, Lucy emphasised the desire to make her own decisions and valued midwives who supported and respected her own authoritative knowledge and autonomy. Yet Lucy's interviews highlighted how these 'fights' to make her own decisions could become a barrier to developing trust as midwives were perceived as not understanding the woman's values. For Molly and Alice, home births were described as a way to ensure self-determination as the community midwives were perceived as more flexible and accommodating than the hospital staff. Edwards and Leap [2006] described increased long term confidence in becoming a mother by women where midwives supported women to make decisions, this included a feeling of empowerment from placing control and responsibility in the woman's hands. Cheyney [2008] reported on their grounded theory study in the USA with fifty woman that faced medical and social pressure as a result of their decision to birth their babies at home. The women had chosen home births as they valued the opportunity this offered for decision-making and the sense of personal power gained from avoiding the medical establishment. They valued the opportunity to develop relationships with midwives built on trust and connectedness, allowing for disclosure of information and a more equal partnership.

Within the theoretical concept analysis I suggested that trust is most needed where a person is vulnerable and in need. Hence it could be argued that where a woman demonstrates a strong sense of agency the need to place trust in the midwife could be reduced. However, the data from my study adds depth to this discussion as the participants' interviews indicated that respect for women's agency appeared to have a positive impact on the presence of trust. Where the women in my study felt supported in maintaining their agency, the concept of trust was described positively by the women. Conversely, Lucy's account of having to 'fight' with the midwife because she did not perceive them to support her agency acted as a barrier to the development of trust. Lucy described getting ready to battle with the midwife to secure support for the place of birth that she felt was right for her. The midwife's inability to understand Lucy's rationale for her decision indicated to Lucy that they did not have a connection and she described a reduction in the presence of trust.

**5.3.2 Connectedness:** 'Connectedness' is an interesting concept that appears to contribute to feelings of trust. In their concept analysis Philips-Salimi et al [2012] used the hybrid model to understand the antecedents, attributes and consequences of connectedness within nursing relationships. Philips-Salimi et al's [2012] concept analysis had some similarities to my own concept analysis of trust in their focus on aspects of the interpersonal relationship that included empathy and reciprocity. They described the attributes of connectedness as: intimacy, belonging, caring, empathy, respect, trust and reciprocity. They associated better connectedness within health care relationships as influential to patients' ability to participate in decision-making.

Molly, Jo and Alice described the evolvment of trust which they associated with continuity of care from the community midwives with whom they built a relationship. They described getting to know each other which resulted in them feeling at ease and confident to make decisions. This was primarily based on an expectation that they would be able to 'connect' with the community midwife and that this would result in a positive birth experience for the woman. Cooper and Lavender [2013] conducted a qualitative study to gain understanding of women's perceptions of the midwife's role which used focus groups with women who received care from various care providers at different times during their pregnancy. They found that women experiencing midwife-led care had different perceptions of the midwife's role to those women who experienced consultant-led care. The women who received midwife-led care viewed the midwife's role as one of empowerment and described a connectedness which the women reported helped them to achieve a physiological birth. The progress of labour was attributed to feelings of trust described by the women as giving them a notion of safety, allowing them to relax, increasing the levels of oxytocin and so aiding the physiological process of the birth. Thomson and Downe's [2013] secondary analysis of data from their study of women who experienced a self-reported traumatic birth followed by a more positive birth experience described how the positive birth had enabled the women to feel whole again. Positive birth was associated with a feeling of control which resulted from 'connected' care that was founded on mutual trust and respect between professionals and women as partners. Dahlberg and Aune's [2013] study in the Netherlands also suggested that positive birth was linked to connectedness and that the midwife-mother connection was based on trust, mutuality and respect. Dahlberg and Aune [2013] attributed closeness in the relationship to greater feelings of confidence gained by psychological trust which they suggested resulted from relational continuity of care. Continuity of carer enabled the women and

midwives in my study to get to know each other and this assisted them in verifying whether a connection existed. However continuity of carer alone did not necessarily result in connected care or a subsequent evolved trust. The participants in my study described the connection as womanhood or motherhood, highlighting the importance of a shared social experience – childbirth and breastfeeding in particular. Hence where a midwife indicated that she had experienced childbirth herself, the connection would exist between them even if they had met only once.

Molly and Fiona described feeling able to relate to a midwife who had experienced what they were experiencing. This is in agreement with Wilkins' [2000] study where it is suggested that women valued that the midwife was a woman and for some a mother. It was felt important for midwives and women to have this shared identity and shared experience. The women in my study described the development of trust being enhanced by a shared childbirth experience, however it is interesting to note that the midwives they described had in fact not all had children. The development of trust, therefore, could not have been attributed to the midwives' actual reproductive experience as the important connection. Rather the perceived experience and the midwives ability to show empathy to the women through understanding of the woman's social context and support for the women's agency would appear to be indicated as the authentic connection that influenced the concept of trust.

In this section I have demonstrated how the empirical data supports and adds to the theoretical concept of trust demonstrating its presence within the midwife-mother relationship and enhancing understanding of its characteristics. It is essential to now consider *why* this is important and how understanding can be applied to midwifery practice.

**5.4 How much is the concept applicable and important to midwifery?** I will consider this question from two perspectives; firstly what do midwives need to *know* about the concept of trust and secondly what should midwives *do* in light of this knowledge.

**5.4.1 What do midwives need to know?** In this section I will concentrate my discussion on the key themes identified as important for the presence of and evolution of trust that I believe are most important for midwives to consider, based on my professional experience and reading of the professional literature. This will include exploration of safety, reciprocity and empathy. To begin this section I will return to the

antecedents of the concept and the building blocks of need and expectation. Within these two blocks a key theme of importance to women which I suggest midwives need to know is women's experiences of safety and what the participants meant by the need to feel safe.

**5.4.1.1 Feeling Safe:** From the data it would appear that feeling safe was integral to the women's willingness to place trust [figure 10].



**Figure 10: trust to feel safe- feel safe to develop trust.**

The women required a level of trust in the midwife to assist them in feeling safe. Achieving a feeling of safety enhanced the development of trust further. The important factor here was that the women felt safe and that feeling safe was not necessarily the same as being safe from a clinical perspective.

The participants' accounts indicated that for women with indirect experience safety was entwined in the need for more information and improved knowledge of pregnancy. For the women who had experienced childbirth before, their need to feel safe appeared to focus on their past experience and any fear of childbirth associated with this. The women's accounts indicated that their initial trust, particularly for those with indirect experience, was based on a belief that the midwife was a professional and had the necessary skills to ensure their physical safety through the use of equipment, knowledge and tests. However, equally important to the women was the need to feel safe emotionally, encompassing the need to be cared for in such a way that would maintain their agency. Women's perceptions of safety have been investigated in other studies such as Lavender and Chapple [2005] who surveyed women across twelve maternity units in England. Sixty-two percent of the women surveyed wanted to give birth in a place where doctors were available and they felt 'safer'. Seventy-three percent said they wanted to give birth in a place with special care baby facilities. These findings support an idea that women have an underlying expectation that they will need

medical help with either the birth itself or for their babies and that they frame safety as clinical safety. Similarly Rogers et al [2011] carried out a survey involving one hundred and twenty-one women who were asked to identify reasons why they would chose to give birth in an out of hospital birth unit. Women chose to birth in the birth centres because of the homely environment, availability of water birth and because they perceived the birth centre to be more woman focussed. However, the main reason given for not choosing this option were the women's concerns around safety and transfer. These studies focus on perceived safety in relation to obstetric medical care and indicate that women's trust is embedded in medical and technical support.

The women in my study with indirect experience initially described similar aspects of clinical and medical safety in their focus on the midwife being able to competently perform medical tests and having access to specialist equipment. However, for participants with direct childbirth experience, the perception of safety was influenced by other more emotional factors and the need to respect women's agency. This was also apparent in the women with indirect experience as the pregnancy journey progressed and their sense of agency increased. For example, Molly discussed safety in relation to her emotional wellbeing and she indicated that her trust was placed in midwives to '*not leave her*' and to provide her with '*TLC*'<sup>5</sup>. The women in my study indicated that being left alone and not being cared for kindly on the day of the birth would make them feel unsafe and increase their feeling of fear. As suggested by De Vries [2012] and by Rouhe et al [2013] such findings have implications for maternity health care professionals, who need to acknowledge the likelihood of fear and use this to inform how they establish trusting relationships with women from the first contact, ensuring women's emotional and psychological wellbeing is enhanced.

The findings indicate that from the participants' perspective the concept of trust was more complex than simply being based on a perception of, or reliance on medical safety and competence. There are similar findings in the 2007 study conducted by the King's Fund who explored views on safety in maternity care, collecting data from maternity health professionals and women within the UK. Several safety themes were identified by health professionals. These were focussed around operational issues; the increased medical and social complexities in pregnant women, low staffing levels, inappropriate skill mix, low staff morale, increasing technology and poor management.

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<sup>5</sup> Tender loving care

The solutions identified by staff to increase safety included: more staff, training, guidelines and lesson learning from incidents [Smith and Dixon 2007]. In contrast, the women in the King's Fund study reported NHS care as safe at a basic level and that they trusted professionals to be supportive, caring and experienced [Magee and Askham 2007]. The women differentiated between safe care – the basic level - and high quality care which included respect, one to one relationships and choice. This included the women feeling well informed and able to share decision-making, knowing what to expect and not being left alone.

There are many similarities between these findings and those of my study. The interpersonal relationship with the midwife was mentioned by many of the participants in my study in relation to evolved trust. Evolved trust may share characteristics with the 'high quality care' identified in the King's Fund study. Support for women's agency appeared more important for feeling safe than organisational safety measures such as guidelines, audit and risk management. The women in Magee and Askham's [2007] study rarely mentioned hospital policies or procedures in relation to feeling safe and in fact some of the women in their study described how rigid policies contributed to them feeling unsafe in that they were restricted in the amount of control and shared decision-making which these hospital policies afforded them. Magee and Askham's [2007] study sample had a higher percentage of vulnerable women and women from ethnic minorities than would be expected in the average population and it is not possible to ascertain whether this skew in population affected the findings. However my own study findings gained from a sample of white British women and not categorised as vulnerable or from a minority group, raised similar issues in terms of safety being linked to quality of care. The interpersonal aspects of the relationship with the midwife were mentioned much more frequently than organisational policies and risk management processes, adding further support to this area. The findings from my study indicated that to make one's own decisions was identified as part of feeling safe and influenced the evolvment of trust.

Reference to this link between self-determination and safety is found in the midwifery literature when discussing women who choose alternative care models or make decisions outside of the medical recommendations. For example, Edwards and Kirkham [2013] suggested that trust and emotional wellbeing play a key role in the decisions of women choosing to free birth [birth without a midwife present]. They proposed that women mostly begin their journey with maternity services with a certain



level of trust, as also indicated in my study. But for women who chose to free birth this trust was often eroded over the course of their pregnancy. They stressed that mothers who free birth carry out their own risk assessment, deciding which risks they are willing to accept. They may not perceive birth as risk free, but rather they balance those physiological risks against potential risks of entering the hospital system and its potential impact on their social, emotional and psychological welfare and the long term health of the baby [Edwards 2008].

Insight into how women manage safety, risk and take ownership of related decisions is also apparent in the accounts of mothers who do access maternity services. For example Lyberg and Sereinsson [2010] explored mothers' fear of childbirth and their experience of care from a small team of midwives providing continuity of care. The main finding was a woman's right to ownership of her pregnancy and birth as a means to maintaining her dignity. The women identified several aspects of fear: encountering midwives who were unable to create a close relationship, being dependent on midwives, loss of control and being excluded from decision-making. While the study identified benefits achieved through continuity models of care, the most beneficial aspects for the women were the qualities and attitude of the midwife in being authentic, honest and having courage to take responsibility.

Based on the empirical data, I have suggested that the need to feel safe is an antecedent to trust and that the women anticipated building trust with the midwife to assist them in reaching their goal, namely that of achieving a safe birth. Thus placing trust in their relationship with the midwife is an investment process in which a consideration of safety is a central component. While the women needed to develop trust in order to feel safe, feeling safe could also be influential in the ongoing development of trust as an investment for something in the future [figure 10 above].

One of the challenges for midwives in responding to and supporting women in their need to feel safe and upholding their trust can be highlighted in the debate around safety and what safety means to women. The NHS has developed a strong culture of risk management informed by the medical model based on the premise that a safe birth is a birth without adverse outcome or physical injury [Vincent 2007]. As a result improvement initiatives such as the Patient Safety First Campaign encouraged midwives to develop skills in protective practice, responding quickly to deterioration. All of the Patient First aims primarily focus on safety in relation to physical health [Lovatt 2009]. Yet Molly emphasised in her quotes that safety meant something more than this.

Stage one and two of my study indicated that emotional wellbeing was part of safe care and highlight the lack of attention to this within the hospital setting. NHS practice and policy doesn't pay sufficient attention to how trust develops, how trust and safety are linked and how important emotional safety is to users of the maternity services.

It is also important to understand that although women may start their journey with an assumption of trust in midwives' competence, this is then tested through the interactions with the midwives and their ability to assist the women in feeling safe. Initial trust was based on an expectation of assumed competence that community midwives would assist the women in feeling safe. Mechanic and Meyer [2000] described trust as an anticipation for what would happen in the future and they suggested that to achieve maintenance of trust professionals must balance risk and protective arrangements. Mechanic and Meyer [2000] highlighted competence and a notion of testing competence as central to their concept of trust. The data from my study indicated that to develop an evolved trust, the women used their agency within the interactions with the midwife to verify the midwife's assumed competence. This process appeared similar to that described by Johns [1996] as the assimilation of information antecedent of trust.

So, in essence, what a midwife needs to know in relation to the concept of trust is what women need from the midwife in order to feel safe both clinically and emotionally as emotional safety was critical to the participant's experience of feeling safe. Participants described the importance of the relationship with the midwife and key ingredients within that relationship which influenced the development of trust. The women described the importance of reciprocity and empathy which I will now explore further.

**5.4.1.2 Reciprocity:** Reciprocity was described by many of the participants as one of the building blocks, within the core attribute- the relationship. Repeated interaction and communication enabled the women and midwives to get to know and trust each other in a reciprocal way. Molly described it as 'it's a two way thing'. It is important to consider the benefits of reciprocity to the concept of trust. Hunter [2006] described reciprocity as:

*"...exchange things with others for mutual benefit." [Hunter 2006 P309.]*

Hunter [2006] proposed a model of reciprocity in the midwife-mother relationship, based on midwives' experiences that included four main types of exchange: Balanced<sup>6</sup>, rejected<sup>7</sup>, reversal<sup>8</sup> and unsustainable exchange<sup>9</sup>. Her study did not explore women's experience of reciprocity though the women in my study appeared to seek a balanced exchange within the reciprocal relationship, it is difficult to ascertain from the data obtained whether they actually achieved this. For some participants like Molly, reciprocity was important for her emotional wellbeing. For others, such as Lucy and Jo, it was important for improving their knowledge and self-confidence through a more practical sharing of skills. The participants indicated a desire to develop mutual trust and the importance of an emotional connection in the relationship with the midwife for this to be achieved.

Reciprocity was also a theme within Wilkins' [2000] study which researched the mother–community midwife relationship from a sociological perspective; data were collected from both women and their community midwives. Her findings suggest the midwife-mother relationship was special for the participants because of the emotional connection, a sharing of experience and expertise resulting in the relationship being embedded in the women's values and concerns. Gilson [2003] argued that trust is based on emotional bonds developed through repeated interaction and a greater understanding of each other's desires which could be described as a form of reciprocity. The participants in my study valued feeling that the midwife trusted them. Where women felt trusted the evolution of interpersonal trust was described. In Thorstensen's [2000] opinion based paper exploring the concept of trust within midwifery, she described the trusting relationship as most effective when midwives acknowledge the importance of women as the expert on themselves and the importance of trusting women to know what is best for them. She suggested that women who feel trusted would be more likely to reciprocate that trust to their carers as confirmed by my study findings. Since the completion of stage one and two of my study Dinc and Gastmans [2012] published their literature review of trust and trustworthiness in nursing and add to the understanding of willingness to place trust with their argument that trust arises from a person's capacity to trust themselves and to then extend that trust to others. This is an interesting consideration for understanding the influence of

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<sup>6</sup> give and take on both sides

<sup>7</sup> midwife gives but woman rejects

<sup>8</sup> both woman and midwife give with woman supporting the midwife

<sup>9</sup> midwife gives and the woman takes wanting more and more

women's agency noted in my own study. It could be that women who displayed a strong sense of agency in their accounts held a high level of self-trust and a capacity to extend that trust to the midwife as described by Dinc and Gastmans [2012]. Leap [2010] describes how the relationship with the midwife can enhance the self-confidence of the woman ensuring that the woman is able to embrace her own power and the impact this can have on the positive physiological birth process. She emphasises the midwife's role to trust the woman's own birth process without fuss or interference, promoting confidence in the woman's natural ability to become a mother. Walsh's [2010] paper exploring the literature in relation to childbirth embodiment describes the tensions present in the theory of embodiment and within maternity care. He highlights the individual nature of embodiment experienced by women, some of whom will embrace natural physiology while others invite intervention but that all women can benefit from a respectful, empathetic, trusting relationship with the midwife that results in an embodiment and support of the woman's agency. Leap [2010] suggested that where a midwife is reluctant to show trust in the mother, the mother is less likely to trust in the midwife. Hence as confirmed by my study findings, where women's agency was supported by the midwife, the woman's self-confidence may have been enhanced and trust in the midwife further developed as a consequence.

The participants described the importance of the midwife getting to know them and understanding what they wanted for trust to evolve. Their discussions suggested that within this understanding a key ingredient was empathy.

**5.4.1.3 Empathy:** Women described the importance of the midwife and woman understanding each other. It appeared from their accounts that women's experience of developing trust was easier with a midwife to whom they could relate and connect. The ability of midwives to empathise with the women appeared from the accounts to be important for the women to maintain or develop trust further. The participant accounts from both those with direct and those with indirect experience highlighted the importance of the midwife's communication skills in enabling the women to assess whether an empathetic relationship could be achieved. Where this was felt potentially possible the women invested in the relationship in an attempt to develop an understanding and sharing of oneself or forming a connection.

Both the empirical data and the theoretical literature appeared to support the idea that interpersonal trust was most likely to develop where the midwife and mother have an

opportunity to 'get to know' each other in a reciprocal exchange. From the participant accounts it seemed that the primary focus for the women was for the midwife to understand her values in order for her to feel safe in handing over some element of control to the midwife on the day of the birth. The importance of supportive relationships was highlighted in Howarth et al's [2011] New Zealand study involving first time mothers which suggested that the midwife-mother relationship as well as the partner-mother relationship were important for enhanced birth satisfaction. Bryanton et al [2008] suggested that midwives are in an optimal position to influence the women's birth experience and their subsequent levels of satisfaction. As indicated by the participants in my study, it is important for midwives to understand the needs of the woman to ensure she achieves a satisfying birth experience and empathy plays a key role in developing authentic understanding. According to the patient perspectives reported by Lelorian et al [2012] in their study involving oncology patients, a clinician's understanding of the patient's perspective was the core to showing empathy which had the beneficial effect of increased patient satisfaction and lower reports of feelings of distress. Nuemann et al [2009] discussed the theory based understanding of the potential benefits of empathy and described the nature of empathy. They suggested that clinical empathy enabled the clinician to fulfil their tasks effectively and improved outcomes for patients. Similar findings were noted by Moore [2010] who suggests the presence of empathy within the nurse-patient relationship improves patient satisfaction, pain management and a reduction in medical errors as the nurse remains focussed on the priority of the patient's individual care. However, Moore also goes on to describe the challenges for professionals in demonstrating empathy while controlling their own personal emotions and maintaining evidenced based practice which may be in conflict with the patient's beliefs and wishes. It would appear from the literature that empathy has many benefits to the patient but can also be challenging to the professionals, though the available evidence is predominantly written from the patient perspective with a lack of studies exploring the challenges from the professionals' perspective. However, the indication from my study and the literature available suggests that empathy is essential within the relationship between the midwife and mother this works best as a process of getting to know each other. The participants in my study were able to show empathy to the midwife and the challenges that the mother perceived the midwife to face.

The core attribute of trust identified in my study was the relationship with the midwife, particularly the presence of empathy and reciprocity. This could be described as a sense of connectedness as described in the previous section and that connectedness was influential in the evolvment of a more interpersonal trust.

It is therefore apparent that an important part of the midwife's role is to form a connection with the woman to assist in the development of trust. Midwives would need to understand the importance of the emotional connection required. Gilson [2003] argued that trust was based on an emotional bond signifying an understanding between two people. Halldorsdottir and Karisdottir [2011] suggested that the midwife has an ability through her role to connect and co-operate with the woman to aid achievement of a shared goal. I suggested in the theoretical concept analysis that an underlying element of trust was a notion of goodwill and that primarily trust is placed in the goodwill of the midwife. This leads me to discuss what midwives could do in response to the themes I have identified as important within the concept of trust.

**5.4.2 What should midwives do?** In this section I will explore further the themes identified in the empirical data that indicate key actions for midwives to ensure that trust has an opportunity to evolve: get to know each other, demonstrate friendly and kind personal characteristics, and develop professional friendships. From the data it is clear that the women placed importance on repeated interactions with the same midwife as a means of the midwife and mother getting to know each other. Participants indicated that they wanted the midwife to connect with them on a more interpersonal level. In order to do this the midwife needs to develop a professional friendship with the woman and through this relationship demonstrate her ability to empathise and develop a two-way trust. The participants in my study used their repeated interactions with the midwife to assess the midwife's personal characteristics and the possibility of developing evolved trust. Dinc and Gastmans [2013] suggested that initial, pre-existing trust may be related to previous experience and familiarity but they also associated development of trust to professional competence and the demonstration of trustworthiness and caring. All of the participants in my study discussed the type of relationship they either had or desired from the midwife. They were expressive of the characteristics of the relationships and the importance for the development of trust of 'friendly' relationships. The continuity of carer model that was available within the research site was important in facilitating the development of a professional friendship

and one example of what midwives can do to establish trust through optimising relationships with women. I will briefly consider this here.

#### **5.4.2.1 Establishing trust through optimising connectedness within the**

**relationship:** The participants in my study highlighted the importance to involvement of trust that midwives were able to place them at the centre of care, acknowledging their individuality, demonstrating understanding and supporting them to maintain their agency. Through the trusting relationship midwives could develop a better understanding of what the individual woman needed to feel safe. Participants used the opportunity to get to know the midwife and learn from her communication skills whether kindness, empathy and non-judgemental support could potentially be experienced.

There are various models of midwifery care - case load midwifery, team midwifery, one to one care, midwife-led birth centres - within the western world that all provide different opportunities for establishing trust by optimising relationships through continuity of carer [Sandall et al 2013]. Sandall et al described the benefits of continuity of care which included a focus on the natural philosophy for birth, fewer interventions and the ability to develop a relationship which enhances the provision of woman-centred care and increases client satisfaction. Dahlberg and Aune [2013] found that continuity of carer enabled the midwife to give holistic care including emotional support by developing a trusting relationship with the woman and her family that resulted in a personal closeness and positive descriptions of trust. Similarly, Puthussery et al [2010] stressed the need for professionals to be sensitive and that continuity would allow professionals to get to know women and know what they need. The benefits of continuity were also highlighted in an Australian study by Williams et al [2010] who suggested that continuous care supported the development of the midwife-mother relationship, linking continuity to higher levels of respect, friendship, trust and satisfaction. In the initial interviews the participants in my study described anticipating that continuity of care would result in the midwives 'knowing' what they wanted which could lead to the development of interpersonal trust. As we saw, this expectation was sometimes, but not always, realised. Dagustun [2013] wrote of the challenges for providing continuity through case loading due to midwives working practices and their willingness to provide a 24/7 cover. She emphasised that even from the woman's perspective continuity of carer works well when a midwife and mother have a good relationship but being stuck with one midwife could also be a disadvantage where the

midwife and mother did not develop a good relationship or where the midwife was not able to demonstrate empathy and caring.

I have demonstrated the potential benefits of maternity services introducing models of care that promote continuity and enable the midwife and mother to get to know each other as this provides an ideal opportunity for the development of interpersonal trust. However, the data from my study also highlighted that this could still be dependent on the specific characteristics of the midwife, not simply continuity. Therefore maternity services will need to promote positive personal characteristics and encourage midwives to engage in positive relationships with women in order for this model of care to truly enhance the trust experienced by women.

**5.4.2.2 Personal Characteristics:** The participants highlighted the contribution a midwife's personal characteristics and her interactions with woman have on building a relationship; they identified good communication skills as an essential tool for building trust. The women's first impressions or 'gut instinct' were important indicators of the 'type of person the midwife was' – or, as Fiona described it, the midwife's 'aura'. The data indicated several aspects of the midwife's personal characteristics identified as important by the women in building trust and that it was important for them to find a midwife who 'fitted'. They identified the importance of 'kindness', 'nice' and 'friendly', which they considered to be part of the person's make up - 'just the way you are' and which could not be learnt as a skill. Nicholls et al [2011] used an expert panel of women, midwives and teachers in their Delphi study to prioritise the characteristics of the 'good midwife'. The three characteristics with the highest score were lifelong learning, tailoring care to the individual and good communication skills.

Communication, attitude of the midwife and the personal interaction were what made the distinction between a competent midwife and a 'good' midwife. It was suggested that this contributed to the ability to build trusting relationships. Participants in my study who described an evolved trust often associated this with what Fiona described as the 'million dollar' midwife; Molly articulated this midwife as friendly, calm and kind. Conversely other participants described a loss of trust in midwives who they felt unable to establish an optimum relationship. From the data there is an indication that initial trust was fragile as all the women described it as not one hundred percent and dependent on the characteristics of the midwife –



*“If you didn’t get along or she was very harsh or whatever for some reason you just didn’t get along. It would definitely make the process quite difficult, hope you made the right decision”.* [Lucy Interview 1]

The participants in my study described the characteristics of the ‘wrong’ midwife whom they described as ‘grumpy’, ‘sharp’ and ‘brusque’. Hence continuity with the ‘wrong’ midwife would be unlikely to aid the development of trust as highlighted above. Dagustun [2013] suggested some initial benefits of continuity when a ‘good’ midwife was caring for the woman but she also warns of the disadvantages of continuity when a woman is ‘stuck’ with the ‘wrong’ midwife. Davey et al [2005] suggested that continuity of care alone was not linked to higher levels of satisfaction. Instead satisfaction was significantly higher when midwives spent time personalising their encounters, getting to know the woman. The quality of the interaction being notably more important than the quantity. This is important for midwives to know in order for them to connect with the woman and optimise the opportunities they have for forming trusting relationships especially when continuity models are not in existence.

The women in my study highlighted the need for midwives to ensure that communication was easy, reciprocal and could allow women the opportunity to assess the empathy of the midwife within their relationship. Kate, Paula and Sally identified the importance of communication in aiding them to feel comfortable and while they did not describe it as essential for building trust they did acknowledge the importance of communication in allowing them to continue to hold initial trust in the midwife as a professional. It is suggested by Byrom and Downe [2010] that women often take competence for granted, assuming that all midwives will have good basic practical skills, but what is important for establishment of trust is that midwives demonstrate emotional intelligence including empathy, adaptability, approachability, motivation, rapport and excellent communication. In my own study they identified good communication as an essential tool for building trust. What the participants described was a need for emotionally intelligent communication. Gibbon [2010] highlights that midwives need to think carefully about communication and to go beyond simply imparting information and use counselling skills to assist women in understanding and matching this to their needs. She highlighted the importance for midwifery of Carl Rogers [1980] core conditions for counselling and specifically three core elements:

congruence<sup>10</sup>, unconditional positive regard<sup>11</sup> and empathy<sup>12</sup> [p37]. This appears to resonate with the participants' descriptions within my study of the connection with the midwife that they required in order for trust to develop: to know the midwife as a real person, for the midwife to respect and support their agency, and to understand the woman's individual values. The data and the theory available would suggest that the principles noted as important for trust to develop are relevant to all women regardless of individual pregnancy circumstance and should be considered in other maternity care settings.

**5.4.2.3 Professional Friendship:** The importance for developing trust of seeing midwives as 'real' people was described by the participants; for example, Molly valued getting to know the midwives' personal circumstances to aid the development of trust. This is important information for midwives to consider when engaging with women. It would appear that trust was most likely to evolve when the midwife was open with the woman and allowed the woman to get to know the 'real' person rather than the professional persona.

The value that women place on getting to know midwives personally was identified in other studies, such as Walsh [1999] who, in his ethnographic study of women receiving midwifery care through a case loading model, suggested that women viewed the midwife as a friend. The term 'professional friendship' has been used to describe the particular nature of the relationship between the women and the midwife. The participants in my study described the relationship as more than client-professional but not a true friend. Professional friendship would seem an appropriate description and encompasses the elements of the relationship described by the women to help establish interpersonal trust. The outcome of evolved trust was achieved through the successful relationship formed and the women described this as '*more than professional*' but not a '*friendship*'. Pairman [2000] conducted a qualitative research study exploring the nature of the midwife-mother relationship with six independent midwives and their clients. The midwives described their relationship with women as a partnership influenced by their professional dictates. While the women described their experience of the relationship as a friendship, on further analysis it was noted that both midwives and women were describing the same relationship characteristics and both

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<sup>10</sup> genuine and honest

<sup>11</sup> non- judgemental, acceptance, respect

<sup>12</sup> the ability to feel what the women feels

recognised the professional limited nature of the relationship. The women described the characteristics of this 'friendship' as different to other professional relationships in that it involved getting to know each other, women being with women, equality and trust allowing them to talk openly and not feel judged. Women in McCourt and Stevens' [2009] study described this reciprocal relationship as being important to them, and that it was 'like' a friendship but not a real friendship. McCourt and Stevens [2009] described experiences of one to one midwife-led care from the perspective of those providing it as well as those receiving it. They identified six key themes where conceptual links were noted between the experiences of the midwives and the women. The first two are relevant to this study: 'Knowing and being known', that is getting to know each other in a reciprocal way. Women described the midwife as 'my midwife', while midwives described women as 'my woman.' McCourt and Stevens [2009] suggested that this language represented development of a relationship that is not a friendship but like a friendship, where both parties have a sense of obligation and responsibility to each other. The second key theme involved person centred care, where women described a desire for care to be 'focussed on them' as an individual, while the midwives discussed feeling valued within the relationship as 'a person not simply a role'. Midwives in McCourt and Stevens' study described gaining as much from the relationship as they were giving. They also suggested that the continuity experienced through case loading assisted them in understanding women and that this engendered a sense of mutual trust and obligation. Pairman [2000] suggested that a better description for the midwife-mother relationship may be 'professional friend' as the relationship did not contain the distinctive features of pure friendship in that it was not a voluntary relationship. Participants in my study invested in developing trust within the midwife-mother relationship to ensure that their own needs for emotional care and support would be met. The bond in the relationship as described in Pairman [2000] was the shared experience of childbirth and once this was complete most of the women did not want the relationship to continue and it naturally changed and ceased.

**5.4.3 So what does the empirical data indicate that midwives need to know and do to support the concept of trust?** From both the theoretical concept and the empirical data it would appear important for midwives to know and understand the importance of developing reciprocal, empathetic relationships that assist the woman to feel safe in order for women to develop trust. Women assessed the potential for developing such a relationship through the interactions and insights gained from the midwife's personal characteristics, particularly the midwife's communication skills.

Midwives need to display friendly, calm and kind characteristics to promote the development of a professional friendship which will optimize their relationship with women and the evolution of trust. I suggested that fostering this type of relationship is the real art of midwifery but is not easily achieved within the current NHS services that often prioritize organisation requirements over woman-centered care, where models of care provision do not allow the woman to 'get to know' the midwife.

Understanding and acknowledging the key themes identified in this concept analysis of trust could be used to inform midwifery education with attention needed within the curriculum to developing student midwife's interpersonal skills and emotionally intelligent communication through the use of role play or teaching through drama. Hunter [2004] suggested that working in partnership with women requires greater emotional intelligence if midwives are going to meet the psychosocial needs of the woman. MacLellan [2011] generated a theoretical framework for midwifery practice from her analysis and synthesis of the literature surrounding midwifery skills, the art of midwifery and women's experience of quality midwifery care. She identified four discreet concepts for her fundamental skills pyramid model for the art of midwifery: presence, guardianship, intuition and confidence/ courage. These concepts were intertwined with the trust and reciprocity within the midwife-mother relationship. The recommendations from MacLellan's study are to disseminate and debate the appropriateness of applying the theoretical model to midwifery practice and to explore its potential from a qualitative perspective. MacLellan mentioned midwives' confidence and courage which was evident in the data collected in my study. Women described a need for midwives to have confidence to trust the woman.

In this section I have described the key themes that apply to midwifery practice. Firstly addressing what midwives need to know, followed by what midwives could do to support the presence of trust within the midwife-mother relationship. As we have seen, there is much in this study that has relevance to practice in highlighting the importance of developing effective empathetic, reciprocal professional friendships with women and the resulting opportunities to optimise the evolvment of trust. It is this section that forms the main justification for selecting trust as a concept to study. It was important to me as a clinician to be able to understand the concept in order to improve clinical practice and I will move on now to the third question in justifying the selection of the concept.

**5.5. Was the selection of the concept justified?** I will answer this question in three main sections: 1] the concept appeared to mean something important to women and had significance in their pregnancy journey, 2] the concept has ongoing relevance to midwifery practice and policy, 3] the study findings provided new insights, an original contribution into the concept and indicated areas of the concept that need further study.

**5.5.1 Importance to women:** In the previous sections I have demonstrated the importance to the women of trust within the midwife-mother relationships. While the participants often found it difficult to articulate the concept, it is apparent from their interviews that trust was important to them. Initial trust in professional competence was important for the women to engage with maternity services. The need to engage was evident in their interviews when they described the antecedents to trust- the need to feel safe and an expectation that the midwife could meet this need by providing information and emotional support.

The empirical data supported the theoretical concept that suggested that trust was most likely to be placed when a person has a need for something [Selman 2007] – in this case, maternity services. All of the participants reported an initial trust in the midwife and hence had engaged with maternity services based on their need to feel safe. Anderson [2000] suggested that women have to trust midwives in case not doing so puts their baby at risk. The participants also acknowledged that initial trust was fragile and required an effective midwife-mother relationship in order to evolve into an interpersonal trust. The women stressed the importance for the concept of trust that their interactions with the midwife were friendly and demonstrated reciprocity and empathy. It appeared important to the women that the midwife could trust the woman in a two-way exchange. This is important to understand within the concept of trust as feeling trusted appeared to directly influence the woman's willingness to place trust in the midwife. This was associated with the midwife's ability to support the woman's agency. The women described the importance of the midwife trusting the woman to make her own decisions. Where a reciprocal trust was not achieved the participants, for example Lucy, described how this was interpreted as a barrier to evolution of trust and the negative effect this could have on the trust she would place in the future. Lucy admitted that at the end of her journey she did not trust the midwife anymore and would be likely to seek the support of a doula in her next pregnancy. This has relevance to midwifery practice and policy in the importance of ensuring service provision optimises the midwife-mother relationship and secures the evolution of trust.

**5.5.2 Relevance to midwifery practice and policy:** It is important for midwives to understand the concept of trust in order to maintain and optimise the trust placed by women and appreciate the reliance from women on midwives to be trustworthy. From the longitudinal empirical data it is apparent that what was critical to the women for the evolution of trust were the interactions with the midwife. The interactions throughout pregnancy gave the women the opportunity to check and verify their initial expectations and assess whether trust was well placed. I initially chose to study the concept of trust to fulfil a personal and professional curiosity that originated in my experience of working in an area providing midwife-led care and observing women's decisions around accessing care and place of birth. The justification for the study lies in the relevance it has to midwifery practice and I will focus my discussion on the key practice areas identified: how previous experience affects trust and how the experience of trust varied between women.

**5.5.2.1 How previous experience of maternity care affects trust:** Lucy's experience of the barriers to evolution of trust and its subsequent effect on the trust she had for the midwife at the end of her journey highlighted the importance of the midwife getting it right first time. Women in the indirect group emphasised their need for information to increase their knowledge of the unknown and midwives have a key role to play in providing information to women and supporting them to build confidence. The women used the interactions with the midwife to assess whether their initial trust was well placed. This indicated the importance of the midwife's first impressions and her ability to demonstrate emotionally intelligent communication. In order for midwives to 'get it right' first time and trust to develop, emphasis needs to be placed on the midwife's personal characteristics and maternity services need to be designed in a way that enables women and midwives to get to know each other. It is clear from the participant accounts that where women finished this pregnancy journey in relation to trust would influence the trust they placed in the next. Hence initial trust would be changed in response to a woman's past experience.

Past experience was highlighted within the antecedents of trust for the women in the study with direct experience. Jo, Molly and Alice all described previous traumatic births that had resulted in increased feelings of fear and the need for emotional support. The midwife's ability to provide emotional support was essential to the development of trust for this group. Otley [2011] highlighted fear of childbirth as a priority for maternity services. In response to women's fear of childbirth and the subsequent impact that this

can have on trust, Sweden have introduced 'Aurora' services, aimed at counselling, maximising continuity and addressing women's fear. Women in Sweden reported high levels of satisfaction in the Aurora, trust-building service [Otley 2011, Waldenstrom et al 2006].

Jo, Molly and Alice described reduced trust for hospital midwives and a reluctance to engage with hospital services as a result of their past experience. Their accounts indicated a reduction of trust in the hospital maternity services based on their past experience of hospital maternity care that had led to them being reluctant to engage with hospital midwives in this pregnancy. Their experience of hospital midwives were that the midwives were too busy to care for them, that the midwives prioritised hospital policy over the woman's individual needs and as a result they feared losing control over the childbirth experience. They all highlighted the difference in the trust they placed in the local community midwives with whom they had experienced a positive relationship. Their initial trust appeared to indicate an expectation that community midwives would develop a relationship that would support their agency and assist them in achieving a safe birth.

The data from my study suggests that midwives need to recognise the impact of fear and their possible contribution to its presence and develop a relationship with the women that encourages feelings to be discussed openly and addressed in such a way that the woman feels able to take control of factors that may increase her anxiety. All three women described managing fear, which originated in the lack of control and emotional care provided by hospital midwives, by engaging in a relationship with community midwives for whom they described a willingness to place trust as they perceived community midwives to have time to listen and understand their concerns. This would indicate the potential benefits of midwife-led continuity models to encourage relationship building and the development of trust. This may be challenging for maternity services where care is provided predominantly in the hospital setting but alternative ideas for promoting trust may be found in the provision of listening clinics such as the ideas used in Sweden, where dedicated time is given to women to discuss fear and individualised care planning, allowing the woman to feel in control. For women who are required to place trust in hospital services it is important to keep them informed and involved in decision-making, where possible ensuring that continuity of care is optimised and providing one to one midwifery care in labour, ensuring that

midwives act quickly to connect with the woman and demonstrate empathy in her communication.

Understanding the concept of trust and the differences in trust experienced by women and hospital midwives and women and community midwives is justified in the need for all services to be responsive to a woman's individual needs and encourage appropriate engagement. What is important here is for services to recognise that the experience of trust as a concept is complex in nature and varied between individuals.

**5.5.2.2 The experience of trust was not the same for every woman:** This study has undertaken an exploration of the concept of trust and the findings confirm the multi-faceted nature of trust. The study is justified in the insight it has provided into the key influences that affect the evolution of trust experienced by the participants and the difference in the experience of trust between women with indirect experience and women with direct experience. It appeared important to recognise the development of trust for the women as they moved from novice to expert during the pregnancy journey and the importance of woman's agency in the development of evolved trust. Walsh [2006] explored the culture, customs and practices evident in free-standing birth centres in England where women's 'nesting –like behaviours' were noted. Walsh described the midwives' role in creating the ideal ambience for birth supporting the woman's transition to become a mother, what Walsh describes as 'Matrescence'. Midwives have a key role to play in sharing their knowledge with women and promoting trust and confidence in the woman's ability to make decisions as part of their transition into motherhood. However this challenges maternity services to shift their culture from a focus on perceived clinical safety and risk management to respect for the individuals embodied knowledge

The women in my study demonstrated empathy and consideration of the midwife as a professional working in a system where organisational policy and processes are required. However the women appeared mindful that this may influence the midwife's ability to uphold the trust the women were placing in her to support their agency, particularly where individual choice was contrary to those policies. The women described the importance of a two-way trust. Hunter [2004] explored the conflicting ideologies between community and hospital midwives who were seen to have two different occupational identities. Hospital midwives were viewed as 'with institution' while community midwives were identified as 'with woman'. For community midwives working 'with woman' was emotionally rewarding, yet hospital midwives described their



work as emotionally challenging as they were unable to achieve individualised care. In a later paper Hunter [2005] described in more detail the challenges faced by junior hospital midwives who, felt the ability to do provide woman-centred care was influenced by the relationships formed with more senior colleagues who provide support and affirmation but also confirm the organisational hierarchy and prioritise the organisational needs. Senior midwives were often seen to be advocates for the institution, using their power to ensure that more junior midwives were compliant with the needs of the organisation. Junior midwives described a frustration in their lack of power to challenge and managed this by negotiating these collegial relationships and, on the face of it at least, appearing compliant. This appearance of compliance and organisational priority, could be visible by women and may account for the participants in my study reporting of lack of trust in the hospital midwives.

In order to assist midwives in optimising trust within the midwife-mother relationship maternity services need to develop systems that demonstrate trust in the midwife to work autonomously, recognising her level of skill and ability to support women. In order to achieve this the culture in hospitals and the inter-collegial relationships will need to develop a shared philosophy for supporting woman-centred care and trust in individual midwives to work in partnership with each woman. The midwife-mother relationship positively influenced the evolvment of trust where the midwife was able to adapt and respond to the woman's individual needs. Responding to their needs required time from the midwife to get to know the woman, connect on a social level and understand what was important for the woman to feel safe. Hayes [2010] suggested that women need support from midwives to ensure their expectations were met and that midwives should recognise that birth was one of the most important days in a woman's life. Testing or interpreting the midwife's commitment and integrity was noted in my study as women invested time in getting to know their midwife to help build on their initial trust and reassure themselves that the midwife was trustworthy. Within the theoretical concept analysis, I suggested that trust was an important concept to explore within the midwife-mother relationship, as a better understanding of the concept of trust is essential when developing maternity services to meet the needs of mothers. In a recent article Ozawa and Sripad [2013] summarised the importance of trust as it is associated with better utilisation of health care, improved satisfaction and that patients who display high levels of trust are more likely to recommend healthcare to their friends and have self-reported better health. It is important that models of care support midwives in forming positive relationships with women, understanding how women experience trust

is essential for midwives to develop services that are responsive to the woman's needs assisting midwives to demonstrate trustworthiness. The study also identified new insights and areas for further study which will be discussed in the following concluding chapter.

**5.3 Conclusion:** The aim of this chapter was to use the lived experience of the participants to aid understanding and development of the initial theoretical concept analysis. It was not my intention to use stage two to prove or disprove the original concept, nor was it my intention to develop a new model of trust but rather to add an original contribution to the contextual understanding as experienced by the participants. I have attempted in this chapter to demonstrate this through responding to the three questions of the final analysis: the presence of trust as a concept, how much the concept was applicable to midwifery and finally the justification of the concept.

I have highlighted key themes from the empirical data that are important to midwifery practice, including the need to feel safe and the participant's expectations of the midwife to assist her in achieving a safe birth. I have suggested that it is important for midwifery to understand women's perception of safety as it will impact on their ability to uphold the trust being placed by the woman. I have suggested that the core attribute of the concept of trust is the relationship. The interactions with the midwife gave women the opportunity to verify the initial trust placed and assess whether development of a professional friendship could be achieved. Getting to know the midwife and developing an understanding of each other was identified as important for trust to evolve and assisted the women in achieving their goal of a safe birth. For those participants where the relationship was not seen positively the data were useful in identifying the barriers to developing trust. Responding to increasing women's trust in the midwife will be challenging for midwives if they do not understand what is meant by the women when they seek support.

In the following chapter I will discuss the study and the reflexivity of the researcher, continuing to demonstrate my original contribution to knowledge and suggestions for further study.

## Chapter 6: Conclusion

**6.1 Introduction:** The aim of the study was to explore the concept of trust within the midwife-mother relationship, increasing understanding of the individuals' experience of trust and its meaning to women. Through the writing of this thesis I have demonstrated achievement of this aim and increased understanding of the contextual nature of trust and its development. I have presented a clear picture of the research process, particularly how I used the hybrid model within a phenomenological type approach. The thesis has detailed each stage of the hybrid model; the theoretical concept analysis, the empirical data collection and the final analysis of the findings. The study design had particular strengths that enabled a contextual understanding of trust; use of the hybrid model within midwifery research is limited and this study will add to the knowledge base for its use. In this chapter I will discuss the the study design and the challenges faced during the study, my personal reflections, new insights and ideas for further study before summarising what has been presented within the thesis.

I will begin by discussing the reflexivity within the study.

**6.2 Reflexivity:** Using a Heideggarian phenomenological approach to collect the empirical data ensured that the woman's voice was central to the concept analysis. The longitudinal study design enabled observation of trust over a specified period of time, which contributed to the body of knowledge around trust as a changing and developing concept, rather than a static state of mind. Using the hybrid model was beneficial to me as a novice researcher and aided the robust format in which the study was carried out but it also presented some challenges in its unusual application within a study inspired by phenomenology. Few studies were available to inform how to use this within the context of phenomenology and as such this study demonstrates a new use of the method for exploring the concept of trust within the midwife-mother relationship. The hybrid model alters the typical phenomenological method in introducing the theoretical basis of the concept into the world of the participants and potentially affects the purest nature of 'lived experience'. It alters the interpretation of the data from being unique to having aspects of shared identity in the form of the theoretical concept. This was felt necessary in this study in order to establish meaning of the language used to describe trust within this context.

Combining the theoretical concept with the empirical data in stage three of the hybrid model adds original contribution to understanding the concept of trust and its meaning to the women as presented in chapter five.

One of the main considerations for this study is the unique setting in which the study took place and the specific characteristics of the service offered to the participants. The research site is fairly unique within the UK in the way care is provided. It is the only NHS maternity model that facilitates complete midwife-led care [there are non-NHS services that offer this] in the absence of any other health care workers and without a District General Hospital provision. The setting utilised a case loading model which particularly lends itself to the foregrounding of trust. My clinical experience of working in the research site and observing interactions between midwives and women prompted the idea for the study. I had knowledge of the model of care and structures in place for research which made it easier to design the study and to gain the relevant approvals and I was fortunate to have the full support of my employer and colleagues for conducting the study. The prominent reason for choosing the research site was that the model of care provided an opportunity for women to get to know the midwife through a model of continuity. I felt that this was important for exploring the concept of trust within the midwife-mother relationship. This may not have been possible in a model of care where women receive care from several care givers or a caregiver who is not a midwife. While this uniqueness was of value in terms of exploring a close relationship formed between women and their midwives, I must acknowledge that this may affect the transferability of the findings to other settings where this type of midwifery care is not routine.

It is also important for me to acknowledge the method of purposive sampling and recruitment via the midwives as a possible limitation to the transferability of findings. Following advice from the Ethics committee it was decided that rather than making direct contact with women booked for care, the women should, in the first instance, be informed of the study by their community midwife and permission sought from the women for me to make further contact and gain consent for the study. This required motivation from the midwives to inform women of the study and the woman's decision to allow further contact was likely to be influenced by the enthusiasm with which the midwife delivered the study information. Hence participants were recruited by a small number of local midwives and did not represent the service as a whole. It is also possible that the midwives who were most enthusiastic about recruitment were the

midwives who were themselves keen to understand trust as a concept and not feel threatened by the study. The relationships that they developed with the women could have been influenced by the knowledge that the study was taking place. Although the actual recruitment was confidential and the midwife was not informed that a woman had consented, it is possible that the women themselves informed the midwife that she had met with me. Recruitment was a key challenge and all the participants were recruited via maternity services and had by default already engaged with the midwives. This could have influenced the data obtained relating to the initial trust. I reflected on this possibility in my reflective diary:

*I guess if midwives choose to influence a woman's decision I cannot completely stop them, if there was a woman whom they would rather not encourage to take part then they simply may not give her the information in the first place. There is no way for me to know this but I will need to ensure that I have informed them of the purpose of the study and reassured the midwives that it will be anonymised and is not a test of them as a midwife. Reflective diary 20/09/2010*

It could be assumed that as all the participants had all engaged with maternity services they would demonstrate an initial trust. This was evident in the challenge of identifying a contrary case from the sample. This could have been possible if participants had been recruited who had not voluntarily engaged with midwifery services.

All the participants in the study were of white British origin and it was apparent from their interviews and the way they answered the questions that they were well educated. The women would tell me of literature that they had read in between the interviews and would discuss relevant theory around the concept of trust. They were a homogenous group of women, who were not representative of the population as a whole. It would be interesting to study trust in a group of women with different characteristics to see if they experienced trust differently. Having a group of participants who were articulate and able to understand some of the theory relating to the concept was an advantage when using the hybrid model and a phenomenological type approach. The idea of working backwards and forwards from each stage developing co-constructions of the concept, researcher and participants together was probably more easily achievable.

The study has potential for further exploration with other populations and services and would be particularly interesting to me as a researcher to explore this phenomenon with the small group of women in the UK who choose not to access midwifery services.

This group of women would potentially more accurately be categorised as true contrary cases as described within the hybrid model and would enable valuable exploration of the concept of trust.

The study was conducted part time over a six year period as part of a formal PhD programme. It was beneficial to complete the study in this way as the PhD programme provided excellent learning opportunities to me as a novice researcher. I was able to access support from expert supervisors who advised and supported my learning ensuring that rigour and trustworthiness were upheld within the study. The part-time nature of the study was beneficial in allowing time for the longitudinal aspect of data collection which may have been more challenging if attempted in the shorter full-time PhD timeframe I reflected on the positive aspect of returning to the participants at the end of their pregnancy journey:

*It was lovely going back to follow up the participants. They were short interviews as most of the information in relation to trust had already been said. It was an ideal opportunity to revisit some aspects and to validate information already recorded. I am not really sure that the third interviews were necessary as far as the concept of trust in concerned as in these first two participants little had changed from the previous interviews. It was useful to be able to show them the mind maps so that they had an opportunity to say what they thought about my early impressions. Both participants were very positive and said that my ideas were right.*

*I guess it is difficult to know whether they really do think that or whether they just say that at the time to me as they feel unable to criticise what I have done. I think they were genuinely agreeing as their facial expressions were good and they appeared to smile in remembrance of things they had said.*

*I had planned to return to participants when their babies were 28 days but both of these babies were approx. 8 weeks. This was because of time and personal commitments. It was too quick for me in terms of conducting the other birth plan interviews to return any sooner. I did not have time to start the third interviews until now. I think it worked well though as they had been discharged from midwifery for a couple of weeks and had had time to reflect on the whole experience. I also think it was probably easier for them as they were both now settling into life with their new baby and able to organise the time to speak to me. Reflective Diary 09/09/2011*

The very nature of qualitative research combined with the longitudinal aspects of this study generated a wealth of interesting data and many areas worthy of further exploration and discussion.

The PhD programme is a learning process and there is an acceptance that the researcher is inexperienced at the outset. I found the last six years a huge learning curve and at times an immense emotional roller-coaster. Feeling like a novice when carrying out the research process was uncomfortable and at times frustrating. In this section I will discuss my own reflexivity as a novice researcher. This will include my influence as part of the research study and the challenges of working in the research site.

As a qualified midwife working in the research site, although I do not practise clinically, I must acknowledge that I too was developing my own midwife-mother relationship with the participants for the purpose of the research study. I needed to acknowledge my background as a midwife to manage any preconceived ideas that I may bring to the research. I used my reflective diary to record some of these:

*I bring to this research both my professional and my personal experiences of trust within the midwife mother relationship. As a midwife I was trained to believe that normality was the key to midwife led care, within this was an inherent trust of the physiological processes of normal childbirth. I progressed in my training with mentors and midwives who supported me in developing my trust in the physiological processes of normal childbirth and on qualifying as a midwife I had an in-depth belief in normality. It was only as a qualified midwife that I discovered not everybody shared my philosophy and that I would battle with those around me to ensure that normality was a primary concern. Reflective Diary 20/09/2010*

It is possible that the women found it difficult to differentiate between me as a midwife and me as a researcher. I needed to develop a rapport with the participants and being a midwife could have been the connection that they had with me. The rapport they developed with me could also have influenced the ongoing relationship with their own midwife. Within the study it was evident that trust built with one midwife often influenced the trust they were placing in other midwives. Hence it is possible that the trust that was being built between the participants and myself was influencing the trust concept experience as a whole.

A good example of this was in Kate's journey. Kate appeared to find it difficult to make an emotional connection with her midwife and her responses in the interviews were limited and appeared a little indifferent at times. I also found it difficult to build a rapport with Kate and I reflected in my diary how difficult it was to interview her. I sometimes ran out of questions or struggled with the one word answers that she often gave. I believed at the time that this was due to my inexperience, however I have also considered that it could have been due to me being a midwife. If she had less trust in midwives she may also have had less trust in me and hence was reluctant to engage. Kate appeared to have initial trust, in that she had engaged with the midwives and had chosen to engage with the research study, but that trust did not appear to develop any further from this point. The interviews with Kate were limited indicating similarly that my relationship with her had also not developed. It is apparent from the transcripts that this did impact on the quantity and quality of the data. This is reflected in the thesis where examples from Kate are minimal due to the lack of data available.

Another indication of my influence as a midwife, particularly working in the research site was the women's responses to my job role. I felt it was ethical to inform participants of my role within the organisation to ensure that I was honest and transparent. From what I now understand of the concept of trust I believe that this was the right thing to do. However, during the interviews the women would often use the opportunity to give user feedback and ask me to make small changes to the service provision based on my role as the Practice Development Midwife. This was an indication that the participants did not find it easy to separate my role as a midwife from my role as a researcher and they could have viewed the study as a method of user feedback which was not my intention.

*I also had to acknowledge that as a senior midwife working in this area, some of her comments about her first meeting with the midwife were interesting, it made me feel partly responsible for her experience and I guess I have found it difficult not to report back some of the issues for us to learn from as a service. She would actually make a very good user representative on our local forums. I am not really sure whether it is ethical to use what I have found out in the interview to influence this. It is a little frustrating having the information but not really knowing what I can do with it.*

**Key Points:**

- **Discuss with supervisors how best to use this data – if at all?**
- **Discuss with supervisors issues around local practice and feeling of obligation. Reflective Dairy 29/12/2010**



I managed this as a researcher by separating the data for the study from the user feedback and storing this separately within Nvivo. I accessed supervision and advice to ensure that I maintained this separation in my thinking. This has influenced my reflexions on the original contribution to knowledge and possible areas for future study.

**6.2.1 Transferability:** As I have discussed earlier in the thesis the concept of trust was contextual in nature and as such the findings are specific to the context in which the study took place. The findings could not be generalised to other maternity service models of care. However the findings could assist understanding of the important factors for trust to be established and maintained and as such influence the decisions made by other maternity services and be transferred to wider health care in how care is provided. The importance of establishing a reciprocal relationship in order to build trust could be transferred to all areas of healthcare. Important themes within this concept analysis included making a connection and demonstrating empathy to foster the development of trust and most importantly that trust is a two-way process. This is important for all therapeutic relationships where patients are working in partnership with the health care professional to achieve their own personal goal. Readers may be able to identify with the experiences described and the data can highlight aspects of the phenomenon previously unknown and this could be transferable to other contexts. This requires a degree of transparency in what decisions the researcher has made in analysing the findings and a clear mapping for the reader to follow how the researcher arrived at his or her conclusions. The analysis can indicate key findings which may be transferable and support findings of other studies carried out within other contexts.

The core attribute of trust was an interpersonal relationship between the midwife and mother and participants highlighted the importance of two-way trust that develops when midwives support a woman's agency and demonstrate empathy within the relationship. The biggest limitation and challenge relating to the research was that the sample only represented women who use the service. It did not include the midwives' view of the concept of trust. It would appear from the data obtained and the importance of the relationship within the concept that exploration of both sides of the relationship would aid understanding of how trust changed and developed. I suggest that other maternity services should consider the possibility of developing trusting relationships as central to service design. As one of the key findings was the idea that trust should be two-way and it was important to the women for the midwife to trust them as individuals, it would

seem appropriate to seek the views of the midwives as partners in this key relationship in a further area for research.

The trustworthiness, as described in chapter two has been maintained through researcher reflexion, sharing themes and co-constructing ideas with the participants and transparency, combined with effective use of research supervision ensuring the credibility of the research findings.

**6.4 Original contribution to knowledge:** Chapter five, which details stage three of the hybrid model, represents my original contribution to knowledge but I will recap the main points here.

The theoretical concept analysis was important in developing a working concept that would assist in understanding the meaning of the word trust within the context being studied. However the theoretical concept did not explore the meaning of trust as experienced by women within the midwife-mother relationship. Some aspects remained unclear, for example; whether the concept of trust would be the same regardless of why the women were placing it. That is, would trust placed during the antenatal period be the same as the trust placed for birth? It is clear from the empirical data that trust was built over time with a specific purpose- the day of the birth and trust was associated with the desire for a safe birth. This study adds valuable insight by identifying how trust is built up in stages or building blocks. Midwives need to consider the importance of these building blocks as they aid understanding of how trust develops or subsequently what the barriers to the development of trust might be. Women used the repeated interaction with the midwife to assess her personal characteristics and communication to verify whether a connection would be possible and trust for the day of birth be well-placed.

Hence it is apparent from the empirical data that the initial ante-natal trust placed was not the same as the evolved trust that the women invested in developing for the day of the birth. This is important for UK maternity services to consider as the majority of women attend hospital for birth with a midwife whom they do not know. Optimum trust would be achieved if models of care were changed to enable attendance at the birth of a known and trusted midwife. However the study did also indicate that trust built with one midwife may be transferred to another midwife, so building antenatal trust with a known midwife could still be beneficial to the woman's experience of trust for the birth even where continuity was not possible. What seems important then is the personal

characteristics of the individual midwife and her ability to demonstrate, through her communication skills, empathy and willingness to support the woman's agency.

This leads to the second aspect of trust that remained unclear after the theoretical concept analysis and to which the empirical data provided important insights; what particular aspects of trust would be important to the midwife-mother relationship at various stages? Crucial to this was the development of a midwife-mother relationship that was empathetic and reciprocal. This was particularly important for those participants who described previous traumatic experiences and the influence this had on their trust or subsequent distrust of services. The key theme that was present in the empirical data, but not well represented in the theoretical concept, was women's agency. Recognition of and support for women's agency was an important influence on the participants' experience of the evolution of trust. The empirical stage of the study has enabled a closer look at the concept as experienced by the mother which has added new insight into the theoretical concept of trust. I have suggested that maternity services need to implement listening and care planning services that support the women to feel in control of decision-making.

One question raised by the theoretical concept analysis that was not further clarified by the empirical data was the placing of trust on behalf of the fetus. The participants didn't make reference to the fetus when discussing their experiences of trust. This could be due to a lack of direct questions and therefore no opportunity to consider this aspect. It could be argued that the participants considered the fetus to be an integral part of their own body and the woman used her agency as a protection of her fetus in making the right decisions for her. The importance placed on the goal of a safe birth could be recognition of the trust placed on behalf of the fetus. In order to answer this question further research is required.

**6.5 Suggestions for further study:** The participant data emphasised the importance of the concept to the women and the need for trust to exist. It also highlighted the importance of understanding trust as an evolving concept. There were noted differences in the early experiences of the concept described by those with direct and those with indirect experience. These differences are not well documented within the literature and indicate a need for further research. It would be interesting to interview the participants who were experiencing their first pregnancy again in their future pregnancies to see whether the interpersonal trust within the relationship required more than one episode of care to develop.

It is important for the midwife's role to understand how to establish effective relationships with women that will support the development of a two-way trust though support for a woman's agency. Further study is indicated to explore this, especially for vulnerable women as the study participants were not representative of women from vulnerable groups. The model of care offered at the research site was fairly unique and it would be beneficial to compare the research site with an alternative care model to add a further dimension to the data. There is a need to further study the evolvement of trust experienced in different models of midwifery care. For example, whether the concept of trust would be experienced differently by women receiving care from independent midwives or perhaps women who had chosen not to access midwifery care to explore the concept from the perspective of women who may not have had the initial trust experienced by my participants. However it would also seem important for further understanding of the concept of trust to study it from the midwife's perspective. Gathering data from midwives as well as the participant interviews would appear important to more fully explore the nature of the two-way trust described by the women.

**6.6 Conclusion:** In this thesis I have used a hybrid model approach to achieve understanding of the concept of trust. The methodology chapter described the hybrid model framework used for the exploration of the concept of trust. The findings were presented as a series of 'building blocks' which captured the evolving nature of trust within the midwife-mother relationship. I suggested that the main focus for the women was a need to feel safe but there were differences in what safe birth meant to the women. It is important for midwives to understand women's perception of safety as it will impact on their ability to up hold the trust being placed by the woman. This is important for the development of maternity services that can be trusted to meet the woman's need to feel safe. Safe birth for the participants was not associated with strict organisational policies or rigid risk management procedures. On the contrary safe birth for the participants was an emotional safety, where women remained in control of decisions and the midwife was able to support her agency. This type of birth was more often associated with out of hospital births. What appeared important for the placing of trust was the woman's perceptions of the midwives support for their agency. The core attribute of the concept of trust was identified as the relationship between midwife and mother. This included the identified building blocks of reciprocity and empathy. Getting to know the midwife and developing an understanding of each other was identified as important for trust to evolve. This development of trust required investment from the women which they appeared keen to do in the pursuit of a two-way trust.

Women in both groups expressed a desire to develop a two-way trust that included the midwife trusting the woman to make decisions. In order to achieve this two-way trust a culture change will be required in the majority of maternity services, where often particularly in hospital settings, the focus is on organisational needs rather than the needs of individual women.

Exploring the concept of trust within the midwife-mother relationship has been valuable to me in several ways. As a researcher, I have had the opportunity of learning the research process and developing research skills. As a midwife I have developed understanding of the woman's lived experience of trust and as a lead within the maternity services in Powys, understanding gained from listening to the participants' journey has had a positive impact on service development. While the findings of this study are not generalisable to the population as a whole, the key findings are transferable to other services within health care. It is anticipated that disseminating the findings of the research study will assist other services to understand the concept of trust from the woman's perspective.

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## 7. Appendices:

## 7.1 Ethics and R&D approval

[REDACTED] H BOARD  
R&D PROPOSALS: R&D OFFICE CHECKLIST

Title of project: *Trust in the Midwife Mother relationship*

[REDACTED] PTHB/10/10

	SPARC	Direct
Date application received	/	2/9/10
Date application acknowledged		3/9/10
Initial entry on RaDOS		
ReDA checks commenced		
ReDA checks completed		
All documents on R&D checklist present - application validated		7/9/10

	Yes	No	N/A	Comments
<b>EXTERNAL PROJECTS</b>				
Caldicott Guardian approval required	✓			
Caldicott Guardian outcome	✓			Approved 5/10/10
Quality review	✓			Sponsor responsibility
Honorary contract/research passport required?		✓		
Confidentiality letter required?		✓		
Sponsor identity?	✓			
Evidence of indemnity insurance?	✓			
Evidence of funding?				n/a
Is the study a clinical trial? Medical devices used?		✓		
Relevant permissions obtained? EudraCT/CTA			✓	
Ethics approval documents	✓			
Date sent for risk & resources review	8/9/10			
Date set for reply	22/9/10			
Completion date/outcome	Approved @ Committee 23/09/10			
Sent/E-mailed to manager	SSI signed by Julie Richards			
Management approval received	2/9/10			
Sent/E-mailed to manager (2)				
Management approval received (2)				
<b>INTERNAL PROJECTS</b>				
Permanent member of staff on the team?	N/A			} University sponsored
Date sent for appraisal				
Name of appraiser				
Completion date/outcome				

OUTCOME OF REVIEW		Date letter sent
Initial decision	Approve	23/09/10
	Approve with amendments	
	Refuse	
Final Approval letter sent		5/10/10
RaDOS entry completed		7/10/10
GP practice(s) informed if appropriate		n/a



Research and Development Office  
Adran Ymchwil a Datblygu

Direct Line: 01874 7126  
Internal Extension: 2638

E-mail: marian.boug

05 October 2010

Mrs M Lewis  
Keepers Gate  
Trewern  
Nr WELSH  
SY21 8EA

### R&D Management Approval

Dear Mrs Lewis,

Re: **Exploration of the concept of trust within the midwife mother relationship**  
Ethics Reference: 10/WMW01/20

This project has received R&D management approval to take place in Powys  
Teaching Hospital

The approval is offered subject to the conditions set out below:

1. The protocol approved by the Research Ethics Committee is followed.
2. The R&D Office is advised of any changes/amendments to the protocol. This includes changes to research staff, funding arrangements and the end date of the project.
3. Any adverse events are reported following Powys Teaching Hospital procedures and the R&D Office is notified.
4. Progress and final reports are provided to the R&D Office.
5. All questionnaires sent by the R&D Office regarding the project are completed.
6. The research complies with the Research Governance Framework.
7. The research complies with the Data Protection Act 1998.
8. The Caldicott principles for handling patient-identifiable information are followed. **(The Health Board Caldicott Guardian has been advised of your project and a response will be forwarded to you when available).**
9. The R&D Office is notified when the research is concluded.

Pencadlys y Bwll  
Y Plasty, Bronllys  
Ffon: 01874 71

Rydym yn croeso  
Bwrdd Iechyd Adloniaeth  
Bwrdd Iechyd Llywodraethol



**GIG**  
CYMRU  
**NHS**  
WALES

Canolfan Gwasanaethau  
Busnes  
Business Services  
Centre

**Dyfed Powys Research Ethics Committee**

PO Box 108  
Building 1  
St David's Park  
Carmarthen  
SA31 3WY

Telephone: 01267 225045  
Facsimile: 01267 225226

Mrs Marie Lewis

Senior Midwife  
Trust Board

29 September 2010

Dear Mrs Lewis

**Study Title:** Exploration of the concept of trust within the midwife  
mother relationship  
**REC reference number:** 10/WMW01/20

Thank you for your email of 28 September 2010, responding to the Committee's request for further information on the above research and submitting revised documentation.

The further information has been considered on behalf of the Committee by the Chair.

**Confirmation of ethical opinion**

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised, subject to the conditions specified below.

**Ethical review of research sites**

The favourable opinion applies to all NHS sites taking part in the study, subject to management permission being obtained from the NHS/HSC R&D office prior to the start of the study (see "Conditions of the favourable opinion" below).

**Conditions of the favourable opinion**

The favourable opinion is subject to the following conditions being met prior to the start of the study.

Management permission or approval must be obtained from each host organisation prior to the start of the study at the site concerned.

Canolfan Gwasanaethau Busnes GIG Cymru,  
Canolfan Henffordd, 36 Stryd y Berllan,  
Abertawe. SA1 5AQ  
Ffôn: 01792 458066  
WHTN: 1780  
Ffacs: 01792 607533  
Ffacs yr hafan ddiogel: 01792 607234  
TNT QW5/QW3 32



NHS Wales Business Services Centre,  
The Oldway Centre, 36 Orchard Street,  
Swansea. SA1 5AQ  
Telephone: 01792 458066  
WHTN: 1780  
Fax: 01792 607533  
Safe Haven Fax: 01792 607234  
TNT QW5/QW3 32

For NHS research sites only, management permission for research (“R&D approval”) should be obtained from the relevant care organisation(s) in accordance with NHS research governance arrangements. Guidance on applying for NHS permission for research is available in the Integrated Research Application System or at <http://www.rdforum.nhs.uk>.

*Where the only involvement of the NHS organisation is as a Participant Identification Centre (PIC), management permission for research is not required but the R&D office should be notified of the study and agree to the organisation’s involvement. Guidance on procedures for PICs is available in IRAS. Further advice should be sought from the R&D office where necessary.*

*Sponsors are not required to notify the Committee of approvals from host organisations.*

**It is the responsibility of the sponsor to ensure that all the conditions are complied with before the start of the study or its initiation at a particular site (as applicable).**

### Approved documents

The final list of documents reviewed and approved by the Committee is as follows:

<i>Document</i>	<i>Version</i>	<i>Date</i>
Investigator CV		01 September 2010
Protocol	4	28 August 2010
Supervisor's CV		
REC application	3.0	06 September 2010
Covering Letter		31 August 2010
Letter from Sponsor	signed by Ceri Jones	02 September 2010
Interview Schedules/Topic Guides		
Letter of invitation to participant	2	24 August 2010
Participant Information Sheet	2	24 August 2010
Participant Consent Form	2	24 August 2010
Evidence of insurance or indemnity	UMAL 1/8/10 to 31/7/11	06 July 2010
<b>Response to Request for Further Information:</b>		
Participant Information Sheet	3	27 September 2010
Covering Letter	email	28 September 2010
Letter of invitation to participant	3	27 September 2010
Participant Consent Form	3	27 September 2010

### Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees (July 2001) and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

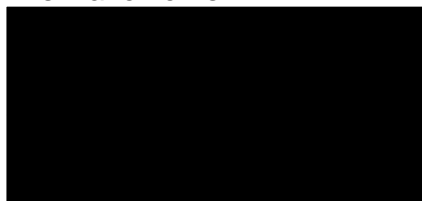
### After ethical review

Now that you have completed the application process please visit the National Research Ethics Service website > After Review

PO Box 108  
Building 1  
St David's Park  
Carmarthen  
SA31 3WY

Telephone: 01267 225045  
Facsimile: 01267 225226

Mrs Marie Lewis



24 September 2010

Dear Mrs Lewis

**Study Title:** Exploration of the concept of trust within the midwife mother relationship

**REC reference number:** 10/WMW01/20

The Research Ethics Committee reviewed the above application at the meeting held on 20 September 2010. Thank you for attending to discuss the study.

#### Documents reviewed

The documents reviewed at the meeting were:

<i>Document</i>	<i>Version</i>	<i>Date</i>	
Investigator CV		01 September 2010	
Protocol	4	28 August 2010	
Supervisor's CV			
REC application	3.0	06 September 2010	
Covering Letter		31 August 2010	
Letter from Sponsor	signed by Ceri Jones	02 September 2010	
Interview Schedules/Topic Guides			
Letter of invitation to participant	2	24 August 2010	
Participant Information Sheet	2	24 August 2010	
Participant Consent Form	2	24 August 2010	
Evidence of insurance or indemnity	UMAL 1/8/10 to 31/7/11	06 July 2010	



**Provisional opinion** The Committee would be content to give a favourable ethical opinion of the research, subject to receiving a complete response to the request for further information set out below. The Committee delegated authority to confirm its final opinion on the application to the Chair.

**Further information or clarification required**

The Committee would like the Participant Information Sheet to be amended as follows:-

- Be more explicit to emphasise to participants that their responses would not be disclosed to the midwives.
- On page 3 the word 'small' in the first paragraph should be amended as a significant amount of time was required to participate in the study and therefore this was misleading. Omit the word 'valuable' in the second paragraph.
- Be more explicit to make participants aware that even though quotations were being anonymised it could still be possible to identify their comments due to the small geographical area in which the research was being undertaken.

The Consent Form should be amended to omit the brackets around 'anonymised'.

The Invitation Letter should be re-written in lay language.

With regard to an adverse birth outcome, the Committee suggested discussing this issue with participants at the debrief following the first interview and reiterating it throughout the study. The Committee felt that these women should have the opportunity to continue to participate in the study and provided the Chief Investigator was aware of the outcome of the birth it was acceptable for her to arrange the final interview, in writing.

When submitting your response to the Committee, please send revised documentation where appropriate underlining or otherwise highlighting the changes you have made and giving revised version numbers and dates.

If the committee has asked for clarification or changes to any answers given in the application form, please do not submit a revised copy of the application form; these can be addressed in a covering letter to the REC.

The Committee will confirm the final ethical opinion within a maximum of 60 days from the date of initial receipt of the application, excluding the time taken by you to respond fully to the above points. A response should be submitted by no later than 22 January 2011.

**Membership of the Committee**

The members of the Committee who were present at the meeting are listed on the attached sheet.

**Statement of compliance**

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees (July 2001) and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

**10/WMW01/20  
correspondence**

**Please quote this number on all**

Yours sincerely

**Dr Mark Turtle, Chair**

Email: sue.byng@wales.nhs.uk

Enclosures:

List of names and professions of members who were present at the meeting and those who submitted written comments.

Copy to:

Professor Billie Hunter  
R&D Department for NHS care organisation at lead site

## Dyfed Powys Research Ethics Committee

### Attendance at Committee meeting on 20 September 2010

#### Committee Members:

<i>Name</i>	<i>Profession</i>	<i>Present</i>	<i>Notes</i>
Dr Amit Banerjee	Speciality Registrar in General Practice	Yes	
Mr Hugo Cosh	Acting Senior Public Health Information Analyst	Yes	
Dr Anthony Evans	General Practitioner	Yes	
Dr Roger Hayter	Consultant Geriatrician	Yes	
Mr Owen Hughes	Consultant Psychologist	Yes	
Mrs Sarah Jones	Clinical Trials Nurse	Yes	
Mr Keith Jones	Lay Member	Yes	
Mr Gareth Lewis	Pharmacist	No	
Dr Graham O'Connor	Consultant Psychiatrist	No	
Mr Chris Olchawski	Lay Member	Yes	
Mr Jon Pearson	Physiotherapist	No	
Mr David Peek	Lay Member	No	
Dr Gopinath Selvaraj	Associate Specialist in Anaesthetics	Yes	
Dr Mark Turtle	Consultant Anaesthetist	Yes	
Ms Kate Williams	Lay Member	Yes	

#### Also in attendance:

<i>Name</i>	<i>Position (or reason for attending)</i>
Mrs Sue Byng	REC Administrator
Dr Corinne Scott	Research Ethics Operational Manager



## 7.2a Participant information and consent

### Participant Information Sheet Part 1

#### **Project Title: Exploring trust in the midwife mother relationship**

*I would like to invite you to take part in a research study which is part of my PhD studies.*

*Before you decide I would like to explain why the research is being done and what it would involve for you. If you are interested in knowing more about this study I will contact you by phone to discuss the information in this sheet and allow you time to ask questions before you decide whether or not to continue. The phone call should only take approximately fifteen minutes. Please take time to read the following information.*

#### **What is the research project about?**

The purpose of this study is to explore the idea of trust and what it means to women.

#### **Who is carrying out the research?**

My name is Marie Lewis *I am a practising midwife who is undertaking a PhD in Health Science at Swansea University I am completing this with the support of my employers [REDACTED] Health Board.* This study has been reviewed by the Dyfed Powys Research Ethics Committee.

#### **Why am I being invited to take part?**

I hope to hear about a range of experiences and so pregnant women in [REDACTED] who have chosen a variety of forms of care have been invited to take part. I would like to find out about your views and experience of Trust. I hope to interview a total of 5 women.

#### **Do I have to take part?**

No, it is up to you whether or not you wish to join the study; Whether or not you decide to participate in the study will not affect the care you receive from your midwife in any way, she will not be informed of your decision. You can also withdraw from the study at any point with no consequences, and you do not have to give a reason.

#### **Do I have to decide now?**

You do not have to decide now, if you are interested I will contact you to discuss the information in this leaflet and answer any questions you may have. If you want to take part you can

complete the consent form which can be found at the end of this information sheet. In approximately two weeks' time, I will telephone you to find out if you still want to take part and arrange the first interview. This should give you plenty of time to think it over. If you do not wish to take part, just let me know; you do not need to give a reason and I will not contact you again.

### **What will happen to me if I take part?**

If you agree to take part in the research study, I will invite you to take part in three interviews on three different occasions. Two will take place during your pregnancy (around the time of booking and at 37 weeks) and one a month after the birth of your baby.

I will arrange to meet with you at a mutually convenient date, time and venue. I am happy to travel to your home or a venue of your choice. I would be grateful if you would be able to provide approximately 60-90 minutes of your valuable time for an audio recorded interview. This will be in the style of a discussion where you will be asked to describe and discuss your experiences of midwifery care. I expect that each interview will last approximately 60-90 minutes but I will be guided by you and the information you wish to discuss. Interviews can be stopped at your request for any reason.

***All information about you will be confidential. Your midwife will not be informed of your decision whether to participate in the study and will not have access to any of the information you give during the study.***

### **If I want to take part, what will happen next?**

Please read part two of the participant information sheet, then complete the attached form and return to me. Please keep both information sheets for future reference. I will contact you by telephone if you are happy to participate we will arrange a date and time that suits you to carry out the interview.

### **How can I find out more information?**

Attached to this sheet is Part 2 of the participant information sheet which will give further information about the study, if there is anything you don't understand you can speak to me before you decide whether or not you wish to take part. My contact details are available on the following pages.

*Thank you for taking the time to read this, if this study is of interest to you, further information can be found on Participant Information Sheet Part 2 - which is attached to this.*

**Participant Information Sheet Part 2**  
**Exploring trust in the midwife mother relationship**

*Thank you for your interest in this research study. Please take the time to read through the information contained in this sheet. If you have any questions please contact the researcher, contact details are at the bottom of this page.*

**What are the possible disadvantages in taking part?**

This research project does not involve any risk to you or your baby. It does, however, require a significant amount of your time. If you find any of the discussions intrusive or upsetting, the interview will be suspended in order for your needs to be addressed. If further assistance is required you will be offered the opportunity to discuss your experience with a local supervisor of midwives who can follow it up appropriately.

**What are the advantages in taking part?**

Your participation in this study will be contributing to research which will help with the understanding of women's views and experiences of trust in the midwife mother relationship and may, in turn, assist midwives in providing future care in this area.

**What will be done to make sure that the information is confidential?**

All the information gathered from you through the study will be kept strictly confidential. Your midwife will not have access to any of the information you supply. Any contact details obtained, including your name, will be kept separate from the interview information. The transcripts (typed version) of the interview will have all identifiable information removed, including any details that could potentially identify you. The recordings of the interview will be destroyed at the end of the research. The academic supervisors will have access to the transcripts but only I will have access to your contact details. Any quotes from the interview that may be used in the writing up of a report will be anonymous; you will not be able to directly identify who the quotes are from. However the quotes will be exactly as said by you and as such it may be possible to identify the comments. Should any problems with health or welfare be identified during your participation in the study, you will be referred to an appropriate health professional such as your named midwife or Supervisor of Midwives.

**Will I be informed of the research results once it is finished?**

If you would like, a summary of the final report can be sent to you.

**If you wish to contact someone about this study please contact:**

<b>Researcher:</b>	<b>Academic Supervisor</b>
Marie Lewis on 0781 490 7925 or email marie.lewis@wales.nhs.uk	Professor Billie Hunter 01792 518584 B.J.Hunter@swansea.ac.uk

**For general advice about taking part in research you can contact** [REDACTED]  
[REDACTED] **committee on: 01874**  
712368

This form shows that you are considering taking part in this research. You do not have to decide now. Please complete and return in the envelope provided.

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Name: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Postcode: \_\_\_\_\_

Telephone: \_\_\_\_\_

Mobile No: \_\_\_\_\_

Date form completed: \_\_\_/\_\_\_/\_\_\_\_\_

Thank you for completing this form. I will contact you to find out if you would like to take part, this should give you time to think it over.

If you do not wish to take part, just let me know; your contact details will be destroyed. You do not need to give a reason and I will not contact you again.

Please remember to keep the information sheets for future reference.

**Appendix 7.2b: Consent to take part.**

Title of Project: Trust in the Midwife Mother relationship

Name of Researcher: Marie Lewis



**Please initial box**

1. I confirm that I have read and understand the information sheet version 3 dated  27/09/2010, for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.
2. I understand that my participation is voluntary and that I am free to withdraw at  any time without giving any reason and this will be respected.
3. I understand that this study is not part of my routine care and my decision  whether or not to take part will have no influence on the care I receive from my midwife.
4. I have been given a contact name and details should I have any questions
5. I have had time to think about whether I want to take part
6. I give permission for anonymous direct quotations from the interviews to be  included in the report or publications
7. I understand that my name or other identifying details will not be used in any  report or publication
8. I am willing to take part in an interview for the above named study
9. I understand that the interview will be audio recorded
- 10 I understand that relevant sections of my medical notes and data collected  during the study, may be looked at by individuals from regulatory authorities or from the NHS Health Board, where it is relevant to my taking part in this research. I give permission for these individuals to have access to my records.

**Please sign this form to show you understand and agree with the statements above:**

-----

Print name: .....

Signed: .....

Date: .....

Address.....

.....

## 7.3 Interview guide

### Exploring Trust in the midwife mother relationship

#### Interview Schedule:

The study interviews will be organised in a format described by Legard et al [2003] that sets out the interview process as a set of stages.

Interview Stage one: Arrival- the first few moments of meeting are crucial in establishing a rapport with the participant and will include general personal introduction and the background of the researcher.

Interview Stage two: Introduce the research- a brief explanation about the intention of the research will be explained similar to that which has already been supplied through the participant information pack.

Interview Stage three: Beginning the interview- the interviewer will begin with a broad open question.

Interview one: "Can you tell me about your first contact with the midwife?"

Interview two: "Can you tell me about your relationship with your midwife?"

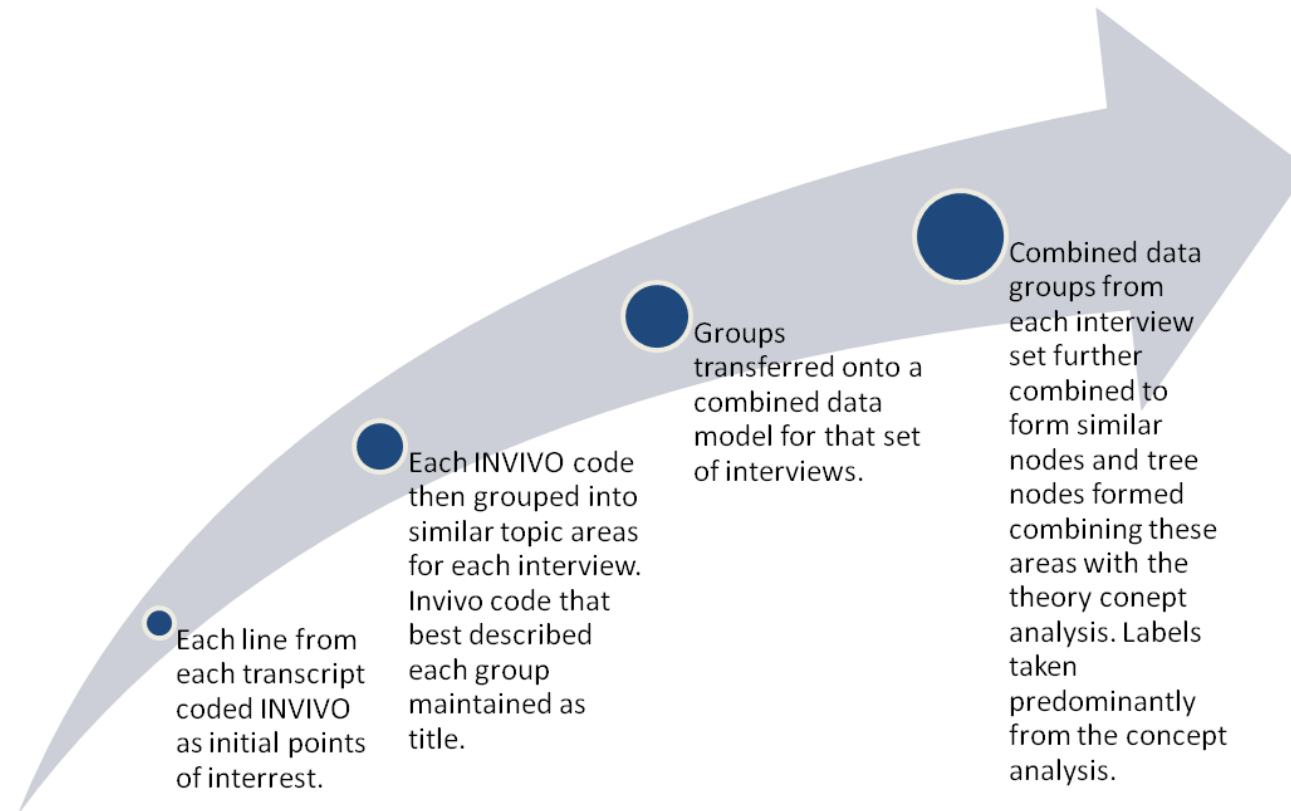
Interview three: "Can you tell me about your relationship with the midwife since your baby was born?"

Interview Stage four: Guiding the participant through the key themes identified in the literature. It is not possible in a study such as this to detail exactly what these questions will be as they will be developed concurrently with the literature, participant experience and researchers reflections as described within the Hybrid model. The four categories of probing will be used as described by Legard et al [2003]. Exploratory: views and feeling behind described behaviour. Explanatory: exploring the reasons, asking why. Clarificatory: Clarify terms and explore the language used and sequences. Challenge: explore any inconsistencies. Where a theme is perhaps more difficult to explore in the initial interviews notes will be made in the reflective diary and will be followed up with both theory and empirical data at later interviews.

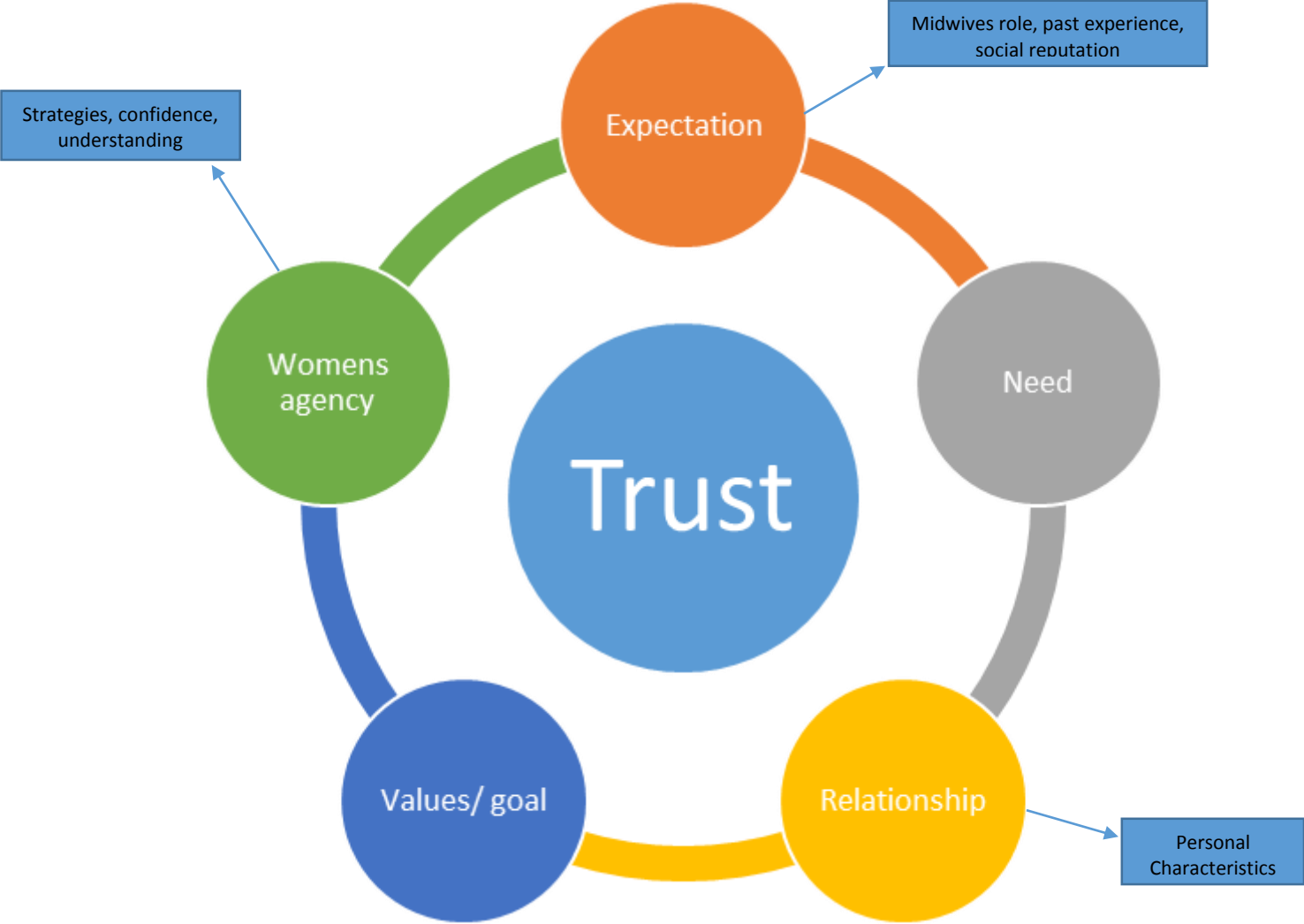


## 7.4 Nvivo Models

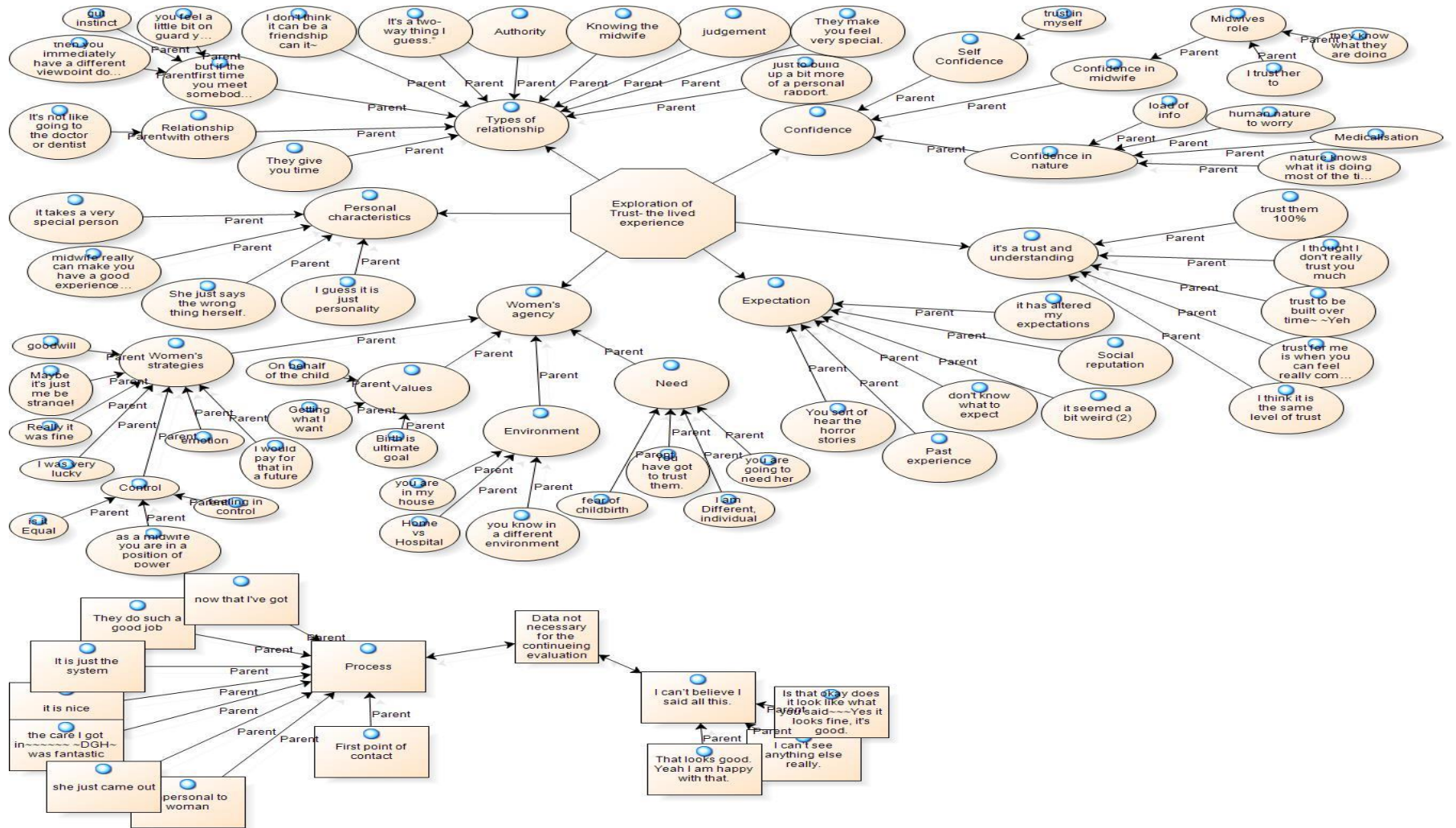
Example of data analysis models:



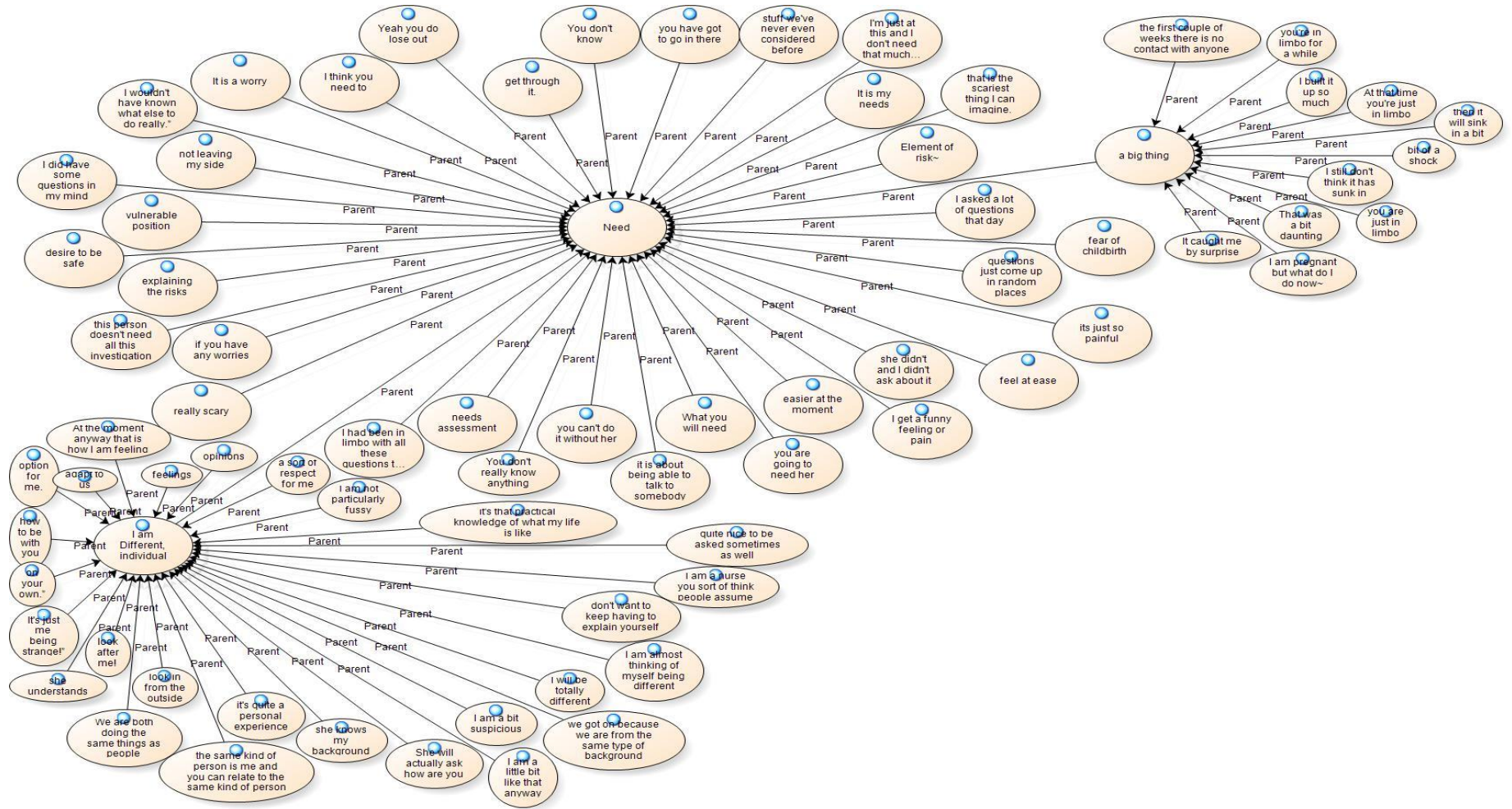
Appendix 7.4a: Model of themes



Appendix 7.4b: Example of overall refined tree nodes:

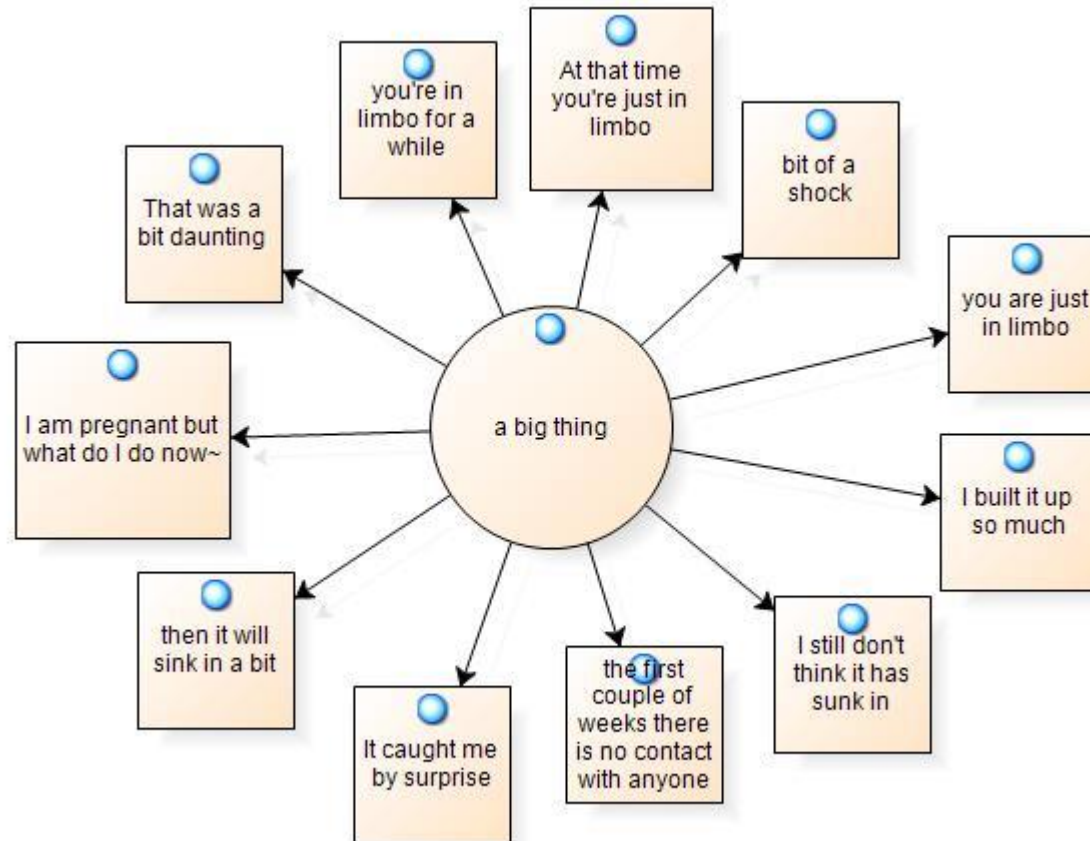


Appendix 7.4c: Example model for need nodes:



Exploration of the concept of trust within the midwife-mother relationship

Appendix 7.4d: Example model, it's a big thing:



## 7.5 Participant Mapping –model, borderline and contrary cases

Building trust through the pregnancy journey : Cases mapping against concept analysis

Participant											Initial Trust		
	Expectation	Emotion	Value	Risk	Trust belief	confidence	satisfaction	reliance	Past exp	social norm	Reputation	Health care	professional
1	Positive	√	√	√	√	√√√ self	√√		√ positive	√	√	√	√√
2	complex	√√√	√√	√√√	√	√√ MW	√	√√√	√ mixed	√√	√	√	√
3	Low	√	√√√	√	√self	√√ self	√		√ mixed	√√ neg	√	√ neg	√√ mixed
*4	Mixed	√√	√	√√				√				√	√
5	Mixed	√	√	√√	√√	√√ self	√low		√	√neg	√neg	√	√low
6	Low					√	indifferent	√	√	√	√	√	√
7	Adaptable	√	√√	√√	√√	√√MW		√		√	√	√	√√
*8	Limited	√	√	√						√	√	√	√
9	General	√		√√	√	√		√√		√√	√	√	

	Interpersonal trust				Building blocks				Category	
Two way process	competence	responsibility	personal characteristics	first impressions	Testing competence	communication	Weaker trust to stronger	stronger to weaker	Outcomes	
√	√√	√	√	√	√√	√√	√ marginal change as was fairly strong throughout		Model case [Positive]	1
√√	√	√	√√		√	√√	√		Model case [Positive]	2
	√√	√	√	√√	√		Stayed the same		Border line	3
√	√		√√	√	√√	√ neg			Border line	4
√√	√		√√	√neg	√√neg	√neg		√adapted	Model case [Negative]	5
	√		√√				Stayed the same		Contrary	6
		√√	√√	√	√neg	√	'same but different'		Border line	7
			√	√	√				Border line	8
√	√		√	√	√neg	√√neg		√	Border line	9

Explanation: \*= Missed the second interview as in hospital therefore unable to complete data for pregnancy journey = Borderline

√= Reference to this area in at least one interview

√√ = some discussion related to this on more than one occasion

√√√= featured on several occasions throughout the journey

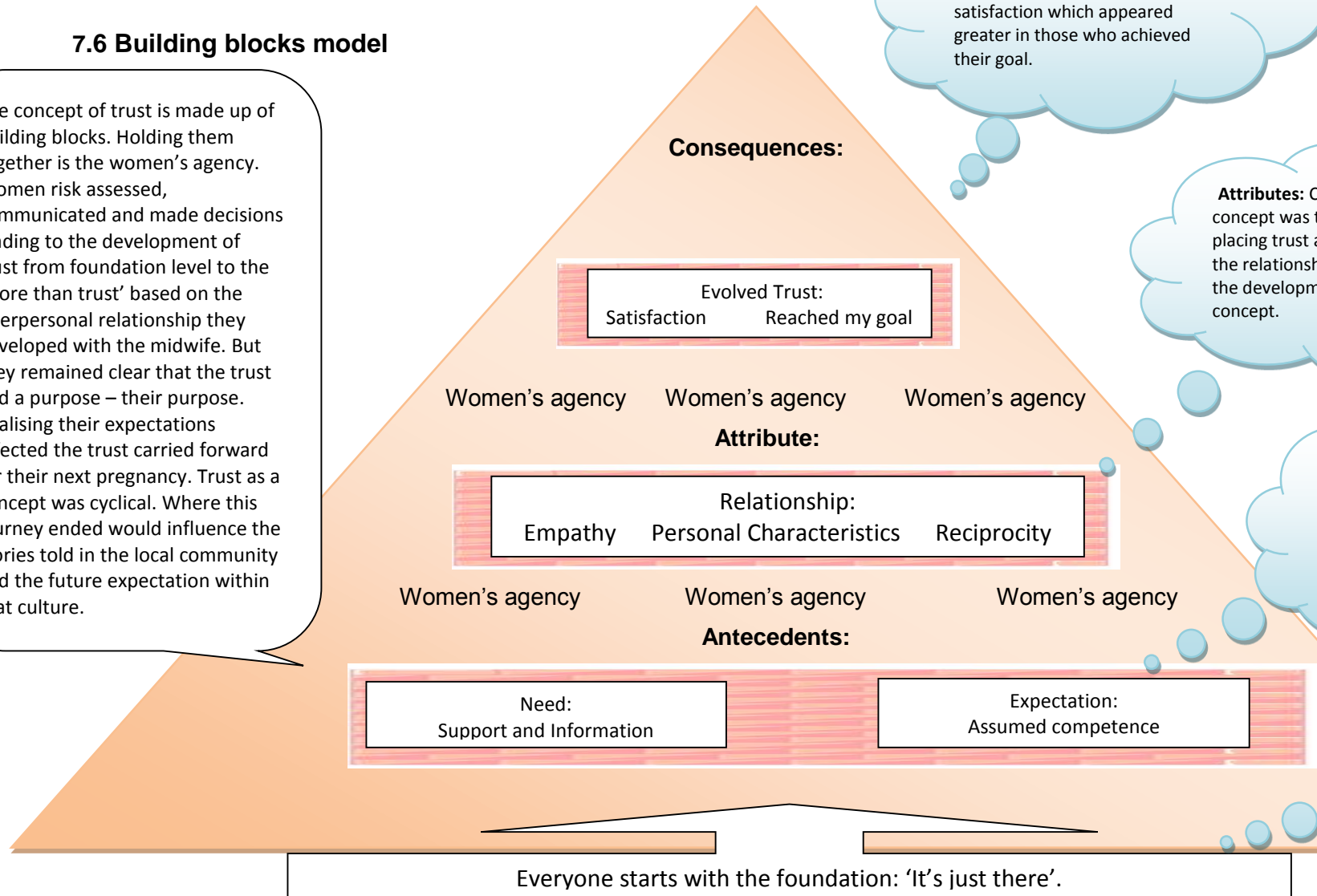
Cases chosen for further discussion and exploration

<b>Model cases [most closely matched with concept analysis]</b>	<b>Border line cases [unable to classify as some elements but not all matched]</b>	<b>Contrary Cases [Least closely matched to the concept analysis]</b>
Participant 1 matched most elements to some degree resulting in positive experience	Participant 3 matched some of the common elements but trust remained the same throughout	Participant 6 made reference to a limited number of the elements and the overall journey was unremarkable with no change in the baseline level of trust
Participant 2 matched all elements on several occasions resulting in positive experience	Participant 4 missed second interview so unable to map complete journey	
Participant 5 matched most elements to some degree resulting in negative experience	Participant 7 Matched many of the elements to some degree but had many midwives and referenced items in a more general sense	
	Participant 8 missed second interview so unable to map complete journey	
	Participant 9 made reference to some of the elements mainly on a negative note	



## 7.6 Building blocks model

The concept of trust is made up of building blocks. Holding them together is the women's agency. Women risk assessed, communicated and made decisions leading to the development of trust from foundation level to the 'more than trust' based on the interpersonal relationship they developed with the midwife. But they remained clear that the trust had a purpose – their purpose. Realising their expectations affected the trust carried forward for their next pregnancy. Trust as a concept was cyclical. Where this journey ended would influence the stories told in the local community and the future expectation within that culture.



**Consequences:** The consequence of the trusting relationship was 'more than trust'. There was a satisfaction which appeared greater in those who achieved their goal.

**Attributes:** Central core of the concept was the relationship. Those placing trust and the trustee. How the relationship formed influenced the development of trust as a concept.

**Antecedents:** What existed before the concept was a need to engage and an expectation of those with whom the woman engaged.

**Foundations:** influenced maybe by their trusting culture or trusting impulse?