AIMS JOURNAL

A Matter of Trust

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Editorial - Trust and responsibility: Going with the flow

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By Alex Smith

Welcome to the September 2024 issue of the AIMS journal. The theme for this quarter explores different aspects of trust encountered in the course of a person's maternity care.

Bringing a baby into the world is fraught with uncertainty, and always has been. Do I really want this? Will I find the support I need? Will the pregnancy go to term? Will the baby be all right? Will I survive this? WIll my partner-relationship (if there is one) survive this? Will I still have a job? Will I be a good parent? Will I be able to provide for another person? And, an uncertainty down the generations, will the world be a safe place for my baby? The honest answer to all of those questions is, 'probably, hopefully, I trust it will, but who knows?'.

Uncertainty is part of life. It is natural and inevitable, and we weigh probabilities every time we climb the stairs, cross the road or use a toaster. While our mothers may secretly worry about us, we generally get used to living with these everyday uncertainties; we generally learn to trust ourselves. In pregnancy however, self-trust is systematically undermined. From the moment of conception we are taught to defer decision-making to the midwife and doctor, and to the birth technology - it is*as if* the mother is merely an incubator and cannot be trusted with responsibility for the baby, but that is not the case in law. With very rare exception, even when we might actively want to abdicate responsibility and appoint 'experts' to make the best decisions, the appointment of those other people, and whether or not we comply with their advice, require 'master' decisions that are ours and ours alone to make. However much we may want to trust the doctor or midwife, if we experience any sense of doubt or reluctance or uneasiness in response to their advice or behaviour, we have a moral and ethical duty to ourselves and our baby to

respect and trust this intuition. As Rachel Wolfe and Sarah Fisher describe in their accounts in this issue of the journal, parents too often look back at their birth experience wishing they had trusted themselves more. Medical authority is not always right, and even when it may be right for some, it may not be right for others. Therefore, unquestioning obedience, in the presence of personal doubt, could be regarded as irresponsible - we have only to think of the Milgram experiments in the 1960s to be reminded of this.

Unquestioning obedience ("I will do anything they tell me to") is also unfair to the practitioner who is then burdened with a *sense* of total responsibility. It is a powerful sense, but only a sense because, legally, nothing can happen without the mother's consent. In truth, the practitioner is only responsible for the *quality* of care that they offer; they are not responsible for whether or not that care is accepted. Unfortunately, this sense of total responsibility is so real and so burdensome (as is the accompanying fear of litigation) that the practitioner, as Mary Nolan touches on in her article, may feel that they cannot trust themselves, or indeed, trust the mother. Instead, just as many parents unquestioningly trust the midwife and doctor, many midwives and doctors unquestioningly trust the current protocols and feel unsafe when parents do not comply. This is when the shroud-waving begins - further undermining the ability of parents to trust their own instincts.

Parents who do experience doubt, reluctance or uneasiness about medical advice are obliged to make an active decision. In the face of uncertainty, a common decision-making strategy is to 'do what most other people do', or 'to go with the flow'. But there are two flows, *the flow of the physiological process*, a flow that does not require decisions, only responses, and the *mainstream maternity care flow*, which, in modern times, is the deeper channel carved by what most people currently do. Naturally, without one's hand on the rudder, this is the flow that we tend to be swept into, and to resist this flow risks incurring social disapprobation. Reflecting on freebirth recently, Malika Bonapace, who writes in this issue, said to me:

> *Isn't it ironic that those who place 100% of the responsibility for their birth into the hands of strangers are considered the most responsible, while those who assume 100% of the responsibility for their birth are considered the most irresponsible.*

Even if we know the maternity care flow has risks or repercussions we would rather avoid, the fear of the disapproval makes it hard to really trust ourselves and our instincts. What to do?

When parents tell me that they wouldn't trust themselves to know what to do at any given point, I invite them to 'trust their traffic lights'.

Imagine that you have an internal set of traffic lights, red, amber and green:

- **The red light** would flash if someone wants you to agree to something that immediately makes you feel distressed, on high alert, afraid or coerced. Red is for when your instinct is to shout NO or STOP.
-

The green light would flash if the suggestion immediately triggers a wave of relief and a sense of being heard, cared for and respected, if it resonates comfortably with every fibre of your body and you want to shout YES, LET'S GO.

- **The amber light** would flash if you are just not sure. You may need time alone to tune in to your body, you may need more information, you may need to discuss things in private…or you may just be feeling 'possibly yes, but not just now'. Amber is always WAIT.

The body is intelligent and the green light will always respond to an offer of help if the situation is urgent. Reaching out for help is one of our deepest instincts. It is safe (as safe as life gets - stairs, road and toaster safe) to trust our internal traffic lights. Whichever flow you decide to go with, only *flow on green.*

Flow on green

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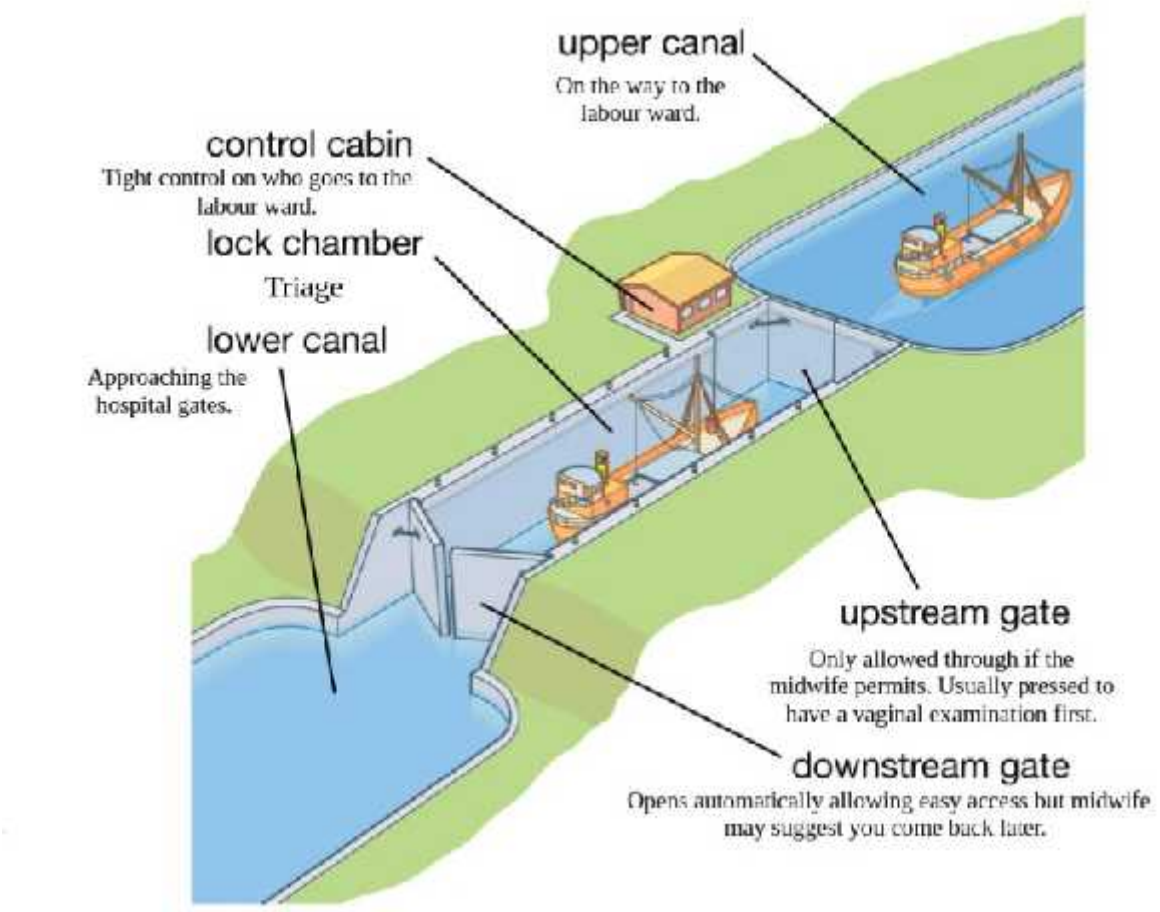
Flowing on green means that you trust and do what *feels* best at any given point. The physiological process of labour is like a river. With rare exception, it is likely to flow unimpeded, to its destination. No decisions are required but instincts might draw you to move or vocalise in certain ways, seek a deep warm bath, hide away in the loo, or call out for help. The body knows what it is doing. As Kath Revell writes in this issue, "Trust is at the heart of physiological birth", and this was certainly the case with Salli Ward when she had her three babies at home. When the idea of letting nature take her course stirs a green light feeling, trusting this is entirely reasonable and responsible, and safer today than ever before with easy access to medical support should the lights change.

The maternity care flow in labour is more like a canal with a series of 'locks' representing the sequence of predetermined maternity care customs and procedures that both disrupt and then govern the course of labour.[1] **Lock one**: labour must start by a certain time or be medically induced. The mother must trust whether this is really necessary or not. **Lock two**: when labour starts spontaneously the mother must trust herself to know when to 'go in', or call the hospital and trust that someone who she has never met will be better placed to make that judgement. **Lock three**: when she does go in the mother is 'triaged' to determine whether she can go to the labour ward, her own feelings about this are not to be trusted; and so the flow proceeds.



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If a mother has decided to go with the maternity care flow, each 'lock' (or offer of a test, examination or procedure) is a chance to check in with the traffic lights, and to only flow on green. For example:

- When a mother is told she is not in labour and should go home, but she is not so sure (amber light) she can simply stay put and WAIT for a while.
- If she really doesn't want a vaginal examination but is told she has to have one in order to progress to the labour ward (red light), she can cheerfully and firmly say NO.
- If she is having really strong contractions and the midwife offers to get the pool ready and the thought of that feels glorious (green light) she will say YES, LET'S GO!

Even when there is a good reason for the advice being given, there are always alternative ways of going about things. Nothing can be done without the mother's willing consent, and legally, gaining consent must involve all the options being on the table.[3] However, the maternity care flow runs along a deeply entrenched 'canal'. The midwife or doctor's assumption that you will 'go with the flow' (accepting every procedure offered) is a powerful force for compliance. It almost feels dangerous, badly behaved and

ungrateful to say no, stop or wait.

If the mother's red or amber light is flashing it may be useful for everyone to know what the possibility of actual danger really is. The parents should be able to trust the person offering the procedure to provide an accurate answer and then to support the mother's decision. For example, a midwife offering induction because pregnancy is continuing beyond 40 weeks could refer to research showing that for mothers continuing pregnancy to 42 weeks or beyond the possibility of a perinatal death is about 2 in 1000 compared with 1.3 in 1000 for babies born at 40 weeks, and that when babies struggling to grow in the womb are taken out of the equation, there may be no difference in risk at all. She should then have the information to hand that will enable the mother to balance this risk with the risks of induction. If the parents cannot trust the midwife or doctor to offer impartial and balanced information - and if the midwife or doctor cannot trust that they will still have their job if they do support women in this way - then the system is untrustworthy. As Claire Dunn and Ryan Jones found from their separate experiences, when trust in maternity care has been breached it feels quite shocking.

The maternity care flow works best when, as midwives Marie Lewis and Bernadett Kasza note in their personal reflections, there is continuity of carer and a developed relationship of trust between the mother and her midwife. The AIMS Campaigns team actively campaigns for this, because as described in this issue, continuity matters. When there is no continuity, the next best thing is that every 'stranger' practitioner trusts and respects the consent process by offering every option at every 'lock'. For example:

> *At this point in the pregnancy we are able to offer you induction of labour, but there are other options you may prefer to consider. What are your immediate feelings? Here is some information so that you can consider the pros and cons. Have a think and let me know. Whatever you decide, you have our total support.*

Truly consensual care allows the person, the person whose body is doing the work, to trust their instincts and to flow through those 'lock gates' on green. At the same time it safeguards the practitioner who is acting in accordance with their code of practice[4] by offering truly consensual care at every step of the way - a prerequisite of every NICE guideline and an absolute legal requirement. The midwife or doctor practising in this way need have no fear that 'trusting the mother' may result in disciplinary procedures, as they will be recording this *"properly informed consent"* process in the notes - "*before carrying out any action*". No one can argue with that, it is stipulated in The Code.[5] Trusting the law (the 'rules') in this way is a brilliant form of 'working to rule' or of non-violent direct action, or ironically, of civil disobedience (ironic because the act of resistance is taking the form of obedience to the law) - and perhaps even, a brilliant way of changing the system and restoring our trust in birth.

Continuing the exploration of trust in this issue, AIMS volunteer Danielle Gilmour has sourced two thought-provoking poems on the theme. Jo Dagustun reflects on whether the word 'trust' in relation to 'NHS trusts' is simply a way to seduce us into believing exactly what they want us to believe about their organisation, and Gemma McKenzie challenges yet another attempt by health care practitioners to silence women and their use of the term 'obstetric violence'. Birth activist Mars Lord gives an impassioned account of the disparities for Black bodied women in trusting maternity care, while the AIMS Campaigns Team calls on all birth activists to help their local community - and improve national practice - by investigating the accessibility (and trustworthiness) of the Care Quality Commission (CQC)'s rating for their local maternity services. In her second piece, Jo Dagustun calls on us all to 'actively' attend more conferences, and Nadia Higson on behalf of the AIMS Management Team asks you to consider supporting us to continue our work by becoming an AIMS member, if you are not already one. We also have an update from our PIMS (Physiology-Informed Maternity Services) team, and last but never least, the AIMS Campaigns Team updates us about their recent activities.

We are very grateful to all the volunteers who help in the production of our Journal: our authors, peer reviewers, proofreaders, website uploaders and, of course, our readers and supporters. This edition especially benefited from the help of Anne Glover, Katherine Revell, Jo Dagustun, Jo Williams, Esther Shackleton, Carolyn Warrington, Danielle Gilmour, Salli Ward and Josey Smith.

The theme for the December issue of the AIMS journal will be focused on the experience of maternity care for Deaf parents and on the experience of parents who find that their baby is deaf. If you have an experience or insight about this topic and would like to write about it for the journal - I would love to hear from you. Please email: alex.smith@aims.org.uk

1 I once heard an obstetrician proudly describe the channelling of labouring women through the hospital care system as being like the channelling of flight passengers through the airport security system.

2 Adapted from an image in the Encyclopedia Britannica

3 AIMS Making decisions about your care. www.aims.org.uk/information/item/making-decisions

4 NMC The Code: Professional standards of practice and behaviour for nurses, midwives and nursing

associates.

www.nmc.org.uk/standards/code/read-the-code-online

5 NMC The Code: "**4.2** make sure that you get properly informed consent and document it before carrying out any action."

An interview with Dr Malika M. Bonapace, D.Psy

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"The way the world sees pregnancy is broken…and it's our mission to change that! We're teaching the world to trust in birth."

Dr Malika M. Bonapace, D.Psy

Interview by Alex Smith

Thank you for agreeing to be interviewed by AIMS, Malika. How would you introduce yourself?

My name is Malika Morisset Bonapace. I am a doctor of clinical psychology and I specialise in perinatal psychiatry. It was in the course of this work that I discovered how Mother Nature has provided the innate vulnerability of the perinatal phase and how protective this is supposed to be. Yet I saw with my own two eyes what the system's lack of respect for this does to women's health. I saw that when women give birth in a context that is not safe, it creates a lot of damage. I was a clinician for some years but have now closed my clinic and am training health care professionals about physiologic birth and about an approach to non-pharmacological pain management called the Bonapace method.

The Bonapace method was put together by my mother Julie Bonapace. My mother has been training parents and health professionals for 35 years, enabling those accompanying the birthing woman to help her, her partner and the baby in a humane way.

What drew you towards your interest in birth and early parenting?

I feel as if I was born into it, literally. My mother developed the method while she was pregnant with me and it has been part of my life since I was very young. I remember her addressing conferences and

bringing and showing pictures of my tooth that had been drilled by the dentist. She would explain to the delegates how non-pharmacological methods of pain management work and that even children can use them, that even I could get a filling without a local anaesthetic. So I discovered through the teachings of my mom that the body is resourceful and by tapping into those resources we can accomplish amazing things and feel really empowered. This discovery fostered my deep trust of human potential, my deep belief that we are part of a beautiful world of love and energy and that through love we can truly make humans shine and that's always been something that I wanted to do.

Taking the work that my mom has done and making sure that it keeps on going through the generations made so much sense because I believe that birth is not only a fundamental moment in the experience of women but also in the development of a society. I believe that birth is pivotal and if you can get birth right you can change the world. That is my true belief.

You say that *"the way the world sees pregnancy is broken…"*, can you say a bit more about that?

Yes, I do believe that. Humans exist today because humans are able to reproduce. Based on evolution principles, it is highly likely that some species became extinct because their method of reproduction was unsustainable, and those species are no longer here. But we are still here, and I believe that we are still here specifically because our bodies are perfectly adapted and made to reproduce; it is our innate ability. I believe that seeing women as *unable* to bring their babies to the world causes tremendous harm. I believe that, because we are so fearful, we routinely do things in caring for pregnant women that cause problems,[1] and then we are really good at fixing those problems. This vicious circle (FEAR - MEDICAL RESPONSE - IATROGENIC HARM - FEAR) perpetuates our belief that pregnancy and birth is dangerous. In actuality, the way we take care of pregnant and birthing women is the problem. If we understood that behind this uterus and this fetus there is a human that is intrinsically made to create connections with other humans, we would never send her into the arms of strangers; never, that's dangerous. So when we say what's 'safe' is for you to give up all of your responsibility and give it to someone else who is a stranger who doesn't know who you are and where you come from and who has no emotional links and connections to you, that's when we cause harm and create these problems that we're really good at fixing. And then healthcare professionals say, "It's a good thing we were there to fix the problem" while, so often, they caused the problem in the first place.

As long as we're good at fixing these harms, why does it matter?

Birth is a pivotal moment for the mother and the baby, the father, the couple, and the family. Birth is a transformative experience for mothers, an opportunity for them to discover their power, to discover their innate abilities, to discover their connection with the universe, and to heal from deep trauma. Birth is meant to be protective for women. Birth also has a deep impact on babies because during birth, in order for birth to happen, oxytocin needs to be released and oxytocin is the hormone of love. Humans are deeply emotional creatures and so we are meant to experience this huge tsunami of love from oxytocin when we come to the world. We now know through the study of epigenetics that the way humans are born will impact the way their brains develop.[2] So birth is protective for babies. We are meant to come to

the world with this huge wave of oxytocin. When we give birth in unfamiliar clinical settings where the oxytocin levels are so much lower, coupled with synthetic oxytocin quasi-systematically used in labour, we probably impact those babies' ability to create oxytocin for the rest of their lives.[4] Lower daily levels of oxytocin increase depressive symptoms,[5] and, in years to come, girl babies grow into women who may be unable to produce sufficient oxytocin to give birth easily themselves. When Michel Odent talks about the risk of no longer being able to reproduce,[6] he says that, sure, we were able to make that baby come out of the mom alive, but what about the safety of our species?

When mothers experience this huge wave of oxytocin and when they are connecting with their baby, they fall deeply deeply in love, mother and baby. This is what is necessary to make sure that these mothers will take fierce care of these babies, that they will protect them and choose for them exactly what they need. When you take that away from mothers and you tell them, "We will tell you what your child needs", then we lose the most precious resource that we have as humans, which is human connection.

So yes, I do believe that this matters and I believe that it's very important for couples too. Mothers and babies fall deeply deeply in love because of all this oxytocin and this happens *in proximity* to the *father*. The father also gets submerged by the wave of oxytocin and in turn falls deeply in love with his wife and with his baby. We want this because a father who is present, who is dedicated, who is in love with his wife and baby, is a father who will protect them. We need that. We need men to step up[7] and protect this dyad, the mother-baby dyad. When men are there to protect and to support women and to say to their wife: "You know our baby best - you know your body - you know who you are, you are the holder of the sacred knowledge of what this dyad needs and I will fiercely support and protect you", then this shapes the way families operate as a whole and function in society. The way this family will then take care of the child, being bonded and in sync with its needs will shape the next generation and in turn, society and the rest of humanity. Truly, birth is a pivotal moment.

This moment can't just be discarded as, "Oh it's just the baby coming out of the mother". No, it is a moment where everybody gets empowered and imbued with this knowledge that humans are to be loved, and are to love, and are to be surrounded in this deep love.

Have we reached a tipping point? Is it too late to rescue physiological birth?

Wow, that's a tough question! There is a part of me that believes that that's the case. When I've had a really bad day and I've been exposed to the obstetrical violence that we perpetrate on women and babies, I start to wonder if that's the case. Then at other times I have real hope, especially when I see more and more mothers awakening and questioning, "Wait a minute, why is it that we all have these broken bodies that can't work?". When I see these beautiful books written about free births (births unattended by a midwife or doctor), and these women reclaiming their birthright of being able to give birth under their own resources, then I become more hopeful. Ultimately I believe that God has a plan for humanity and that I can only do what God's plan is for me and that is to talk about physiologic birth to as many health care professionals as I can find who are willing to question current birth practices. I don't

know the bigger picture but I trust that yes, all I have to do is my part.

You are teaching all of these health professionals about trusting birth. How do you go about that? What exactly is the Bonapace method?

Its hidden objective is to protect families; that was my mother's goal from the very beginning. What do we know about protecting families? We know that a lot of couples get separated and divorced and we know that a lot of those divorces are initiated by women. When my mother worked for the Ministry of Justice here in Canada, she worked with couples who were in the process of separating. She always asked the same question, "When did it start going wrong - when did this relationship start dismantling?" and they systematically answered, "When we started having kids". The men would say, "I know we weren't doing so great, she was no longer very interested in intimacy, but I had no idea it was that bad". But the women would say, "Look it's simple, I've got to take care of the kids, the house, the groceries, the food, the car, my job and him. If I get divorced, not only will I no longer have to take care of him but on top of it I'll have every second weekend off from the kids". And so basically, many separations stemmed from the unfair distribution of work between the couple reaching a point that was unsustainable. It didn't feel fair and didn't add up mathematically. Research on paternal involvement shows that couples are more likely to stick together when the women say, "I don't know how I would do it without him; we're such a good partnership; we do this together".

My mother considered what was necessary for men to become more involved postpartum and what the predictive factors for this involvement were. She discovered through research that really clear prenatal involvement of fathers predicted their postnatal involvement, but she knew that if she offered dads a class on how to protect the family unit, nobody would come. What parents were really motivated to learn about in pregnancy was connected with their fear of pain in childbirth. So my mom studied in a lab that was dedicated to pain management and she was able to create a connection between the non-pharmacological methods that the human body has access to and show how these apply specifically in childbirth. She enabled the dads to become highly involved prenatally by preparing the couple together during pregnancy ensuring that the dads could be highly involved in the management of pain during childbirth.

As such, the Bonapace method, at its origin, was really focused on pain management. The more my mom studied the more she discovered that actually, if you respect what the body is supposed to do, you have less pain, and that's when we started learning and teaching about physiologic birth. In our experience, the primary ways of ensuring the family is safe is by understanding the nature of birth; by showing women that they have deeply embedded natural resources and strategies to manage whatever Mother Nature presents them with in childbirth; and by giving men specific tools and techniques for supporting their wives in that moment. And so we create this deep sense of trust within women that they are able to harness these innate resources, that they can work in partnership with their husbands, and that together, they can safely bring this baby to the world.

What opposition or challenges have you faced and how do you counter these?

When health care professionals are only trained to see what goes wrong, and to only use outside resources to fix problems, huge doubt is cast on the natural or physiologic ability of the body to do what it is meant to do. We could apply this to any form of physiologic process. There's a wonderful (spoof)video that was made by an Italian group that compares birth to conception. A couple goes to the hospital and the really well-intending health care professionals try to assist them in having sex to conceive their baby. However, the health professionals don't understand that privacy and non-disturbance is necessary for the couple to be able to just have physiologic sex. They keep intervening and it just doesn't happen, so artificial insemination is required. The point is that, if this is only what health professionals have ever seen, then they will naturally be convinced that the only way women can become pregnant is through insemination.

So the opposition I am faced with most often is from health care professionals who have never seen physiologic birth. They don't even know that it exists and what it looks like. The vast majority of healthy women come to them for care - care that disrupts the physiologic process and creates pathology and danger, from which they then rescue the mother and baby. They do not understand the vicious circle effect and have no knowledge of the virtuous circle of TRUST - PHYSIOLOGIC CARE APPROACHES - SAFER BIRTHS - TRUST.

So the absence of knowledge creates this opposition. As soon as information starts seeping through to them though, if it's done with sensitivity and love and gentleness, then they can start seeing the problems that they cause, but it's a long and arduous process. I was once told by an obstetrician that the definition of birth is a catastrophe to be prevented. The belief that you can only know in retrospect if you've done a good job as a doctor or midwife by having avoided all those catastrophes, shows how deeply ingrained is the accompanying belief that women's bodies cannot be trusted to give birth safely to their babies.

If you had a magic wand and could change the birth world in any way, what would you do?

If I had a magic wand the thing that we would need to do first and foremost is to take all of our health care professionals and take care of them really really well. We would need to allow them lots of healing time because they have been very mistreated, both through their education process, and by the way the system treats them. It would require a lot of self-love, self-compassion and willingness to heal on their part, but that would be step one.

Next, I would abolish women giving birth with strangers. I would make sure that women are only accompanied in birth by health care professionals who love them. The creation of a deep bond between the mother and her attendants, one where they can trust each other on a deep fundamental basis, is vital.

I believe that if we were to allow the care-givers to heal, and if we were able to create the space for there to be a bond of deep human connection between the care-giver and the pregnant women, that this would drastically, rapidly and spontaneously change what is going on in the way we give birth presently. As it is right now, the absence of connection allows the continuation of harmful practices. With healing and

connection, our broken view of birth would fix itself because health care professionals who are there with really good intentions would realise where they are going wrong and they would figure it out, and women's innate abilities would be honoured and supported.

The last use of my wand would be to sprinkle training about physiologic processes to everybody so that they would understand what's going on and have a model to grasp what undisturbed birth actually looks like. Then, I feel like things would just fall into place from there on. I think those are the necessary ingredients for a different world of birth.

Author Bio: Malika M. Bonapace is a doctor of clinical psychology specialised in perinatal psychiatry, a trainer of the Bonapace Method for over 15 years, and an internationally recognised speaker.

1 Editor's note: Harm caused as a result of medical care is referred to as*iatrogenic* harm.

Read: Liese, Kylea & Davis-Floyd, Robbie & Stewart, Karie & Cheyney, Melissa. (2021). Obstetric iatrogenesis in the United States: the spectrum of unintentional harm, disrespect, violence, and abuse. Anthropology & medicine. 28. 1-17. 10.1080/13648470.2021.1938510.

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6 Michel Odent (2015) Do we need midwives? Pinter & Martin

7 Editor's note: The Bonapace Method has an inclusive approach and during the official training they systematically refer to 'the partner' rather than 'the father'. The use of the words 'father' and 'wife' in the context of this informal interview is in no way meant to exclude female partners and co-parents.

An invitation to contemplate the meaning of trust

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By Bernadett Kasza

When I began my midwifery training, I was beaming with hope, eager to be 'with woman' and fulfil my lifelong call. Coming from a world where I believed in the ethos of the Hippocratic Oath: "I will do no harm or injustice to them." I still get goosebumps when I read the translation of this ancient Greek text.

Although taking this oath today is rarely required, I feel it should be basic moral guidance for all medical professionals - the foundation on which trust can flourish between families and maternity staff, and among colleagues working together to support women, birthing people, and families, during one of the most pivotal life events: birth.

Trust feels like a hollow word only mentioned briefly during university lectures and, in reality, has faded into the realm of some long-forgotten ancient kingdom.

It's almost as if the tapestry of maternity care provision had been ripped, and the threads were disintegrating between midwives and policymakers, healthcare practitioners and families but most importantly between policymakers and women's bodies.

This rupture was so great that it pushed me to leave midwifery to carve a path to support women and

families in the way that is best for them. I aim to stay true to the deepest meaning of the word: trust. According to the Oxford Dictionary of English, 'trust' is, " A firm belief in the reliability, truth, or ability of someone or something".[1]

When it comes to pregnancy, birth, and early parenthood, it seems that trust is an extremely complex and fragile phenomenon. In this modern, busy, overwhelming, and loud world, it has become difficult for women to trust themselves, trust in their own body and trust in their deep instincts. The widespread feeling of mistrust in one's ability to conceive, to grow a baby, and to meet the baby's needs in the womb is experienced at a visceral level, and when the ability to trust in one's capabilities is damaged, birth suffers. This loss of trust has become an avalanche that affects everything we hold as precious, rolling onto early parenthood and its questions, concerns, and worries. Of course, I cannot speak for everyone, as I am limited to my own professional experience, and there are always notable examples of women whose body confidence is greatly intact, however, I cannot dislodge the sadness from my heart when I think of how women's trust in their body's natural abilities is bleeding from a thousand wounds.

Could the loss of trust be a symptom of our modern ways of living? Can patriarchy be blamed for spreading its power and robbing women of their unwavering and proud trust in themselves across millennia? This issue, like many others, is not simple but multifaceted; however, it could be of great benefit if women were fully aware of their worth, and could say no without concerns, feelings of guilt, and second thoughts.

Which trust was lost first? Women's confidence in their capabilities of growing and birthing a child - or the 'medical men's' loss of trust in women's bodies and their need to date, sedate, medicalise, proceduralise, and un-naturalise the process because there is a perceived danger in the female body that cannot be trusted? I trust you know the answer.

Medical trial and error, the obstetric dilemma, one-size-fits-all care, and the constantly reaffirming messages implying that women's bodies are failing. Expressions like failure to progress, prolonged pregnancy, trial of labour, incompetent cervix, poor maternal effort, and so on, send the message that women's bodies, and thus women per se, cannot be trusted.

If women are not supposed to trust their bodies, who can they trust then? Doctors, midwives, doulas, antenatal teachers, sisters, their mother or mother-in-law, social media groups, friends, or their neighbours? Research? Guidelines? Old wives' tales? Superstition? Google? Logic? Physiology? All of them? None of them? Some of them?

Why do I feel like there is a lack of an expecting family's 'firm belief in the reliability, truth, or ability' of maternity care providers? Is it a Herculean task to anchor our trust in medical professionals? I have seen it in my practice. I have worked mostly with second-time mums as a doula, and their choice of working with a doula was fuelled by the general wish of not wanting to have the same birth experience they had before. They were looking for someone they could trust, a person from outside the system who would represent their wishes and keep them safe. That's when I could see that those women and families lost their trust in midwives and doctors.

Let me share another very personal experience. Back in the days when I had my uniform on, I felt an omnipresent barrier between me and the women, whether it was on a ward or at the antenatal clinic. Generally speaking, women were a lot more withdrawn. This could have been for a plethora of reasons of course, but it made me wonder whether not feeling so at ease in the presence of a uniformed healthcare practitioner could have a negative impact on women's birth experiences, or if that distance was a sign of an already inherent mistrust that I picked up on. When I meet an expecting couple for the first time as a doula, they are relaxed. Understandably, we aren't meeting in a hospital or a birth centre, so that might be partly adding to the general mood of the meeting.

I am aware, there is a long list of reasons for both of the above, however, I can't help but think that some of those reasons are rooted in the loss of trust in healthcare practitioners. How can trust be restored; in whom can a pregnant person trust?

Maybe women are looking for answers from outside as opposed to searching from within. Restoring an individual's self-trust, both in their intuition or instinct, and in their ability to interpret appropriate, quality information, may lead to them making better choices about who they would choose to support them during birth and what they want and don't want to happen during pregnancy and birth and postpartum.

Wouldn't it be amazing if women could tell poor-quality information apart from good-quality information? But that isn't necessarily their job. Of course, like every hero or heroine in global folklore, women and families could go through the arduous task of sorting out the seeds of information and meticulously separating them. It is a laborious task, one that is rooted in mistrust and feeling the need to arm themselves with information and research in anticipation of their consultant appointment.

How can professionals enhance their trustworthiness? Good intentions are not enough. Do you know the saying about good intentions and how the road to hell is paved with them? I think that professional dedication and loyalty to the birthing families can be a good starting point, but this does not mean just working a shift. It is my belief that to be with women during childbirth is a calling, not a 'workload'.

A driven and eager midwife may always find the best way to acquire new knowledge to integrate into their practice to enhance women's and birthing people's experiences. Listening is gold but most professionals do that. The real concern is that listening does not equate with respecting, believing and trusting what is heard. During my years of working in the field of birth support, the problem I heard the

most started with, "They didn't believe me when I said…". This issue could be easily solved by simply trusting what women say is happening in their bodies. The simple notion of giving credit to women may enhance their trust in their healthcare providers.

I will leave you with a few questions:

> What can be done about outdated protocols, low-quality research, and decades of 'cultural conditioning'?
>
> What can be done about the low morale and backstabbing culture among staff of some maternity units?
>
> What can be done about long-embedded notions of medicalised, 'high-risk label', trigger-happy maternity care?
>
> What can be done about the litigation culture so that midwives and doctors are not fully preoccupied with continuously watching their backs?
>
> How can education increase the level of mutual trust between women and healthcare practitioners?
>
> What can be done to build trustworthy maternity services?

Perhaps we already have the answers and we simply need to trust them.

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She can be found at: Womanly Art of Birth

1 Stevenson, Angus. Oxford Dictionary of English. 3rd ed., Oxford, Oxford University Press, 2010.

A review of the Joint position statement: 'Substandard and disrespectful care in labour – because words matter'.

[1]

AIMS Journal, 2024, Vol 36, No 3

This is the joint statement of the European Association of Perinatal Medicine (EAPM), the European Board and College of Obstetricians and Gynaecologists (EBCOG), and the European Midwives Association (EMA).

By Gemma McKenzie

I read the article in the title with a cup of tea and a raised eyebrow. It comprises yet another attempt by health care practitioners to silence women and their use of the term 'obstetric violence' when describing their own knowledge and experience. As someone who researches obstetric violence and who has been subjected to it, I find the article both startling and confusing. There are a lot of linguistic gymnastics used as a way of (unsuccessfully) arguing that 'violence' should not be used in the terminology. I do note with some relief however that no British obstetrician or midwife has signed their name to the piece; my hope is that anyone who was approached, recognised the authors' argument for what it is: out of touch, one

dimensional and misinformed.

Before we dive into the article under review, let's ask a basic question: who has the right to decide what should be labelled 'violence'? When we discuss other forms of violence, we do not ask the perpetrators or their institutions what language they prefer. If they offered a suggestion, we would certainly not be under any obligation to use it. And that is doubly true if we are the victim/survivor. While there may be many more articles written by health care practitioners on their distaste of the term and the labels they would prefer to use, no one is required to follow their attempts at instruction.

Importantly, there is power in language. Suppose we refrained from using the term 'domestic violence' and instead replaced it with 'marital disharmony.' Or if we dropped the term 'rape' in favour of 'non-consensual sexual relations'. Perhaps a more appropriate example reflecting the insidious nature of obstetric violence would be to swap the word 'racism' to 'unfavourable treatment'. If these changes were pursued, the seriousness of the acts would be undermined, resulting in a minimisation of the victim/survivor experience. Ultimately, we need to ask whose needs are served when violence is minimised. Whilst the authors may consider this a good way to forge collaborative working "between individuals and institutions" in aid of improving women's experiences, I consider it a way for the medical establishment to dictate the narrative and silence women.

Obstetric violence versus 'substandard and disrespectful care'

Obstetric violence is a nebulous term. Academics who study the phenomenon are still grappling with the creation of a specific definition and the ways in which it can manifest. One thing that muddies the waters is when authors substitute the term for other phrases, such as 'disrespect and abuse', 'D&A', 'mistreatment' and even sometimes 'birth trauma'. 'The authors in the article under review have introduced an additional term: substandard and disrespectful care in labour.

There are several problems with the authors' use of this term and their description of what it constitutes. Let's begin with substandard care. This is described as:

- The use of healthcare interventions that are not considered best practice.
- Inadequate use of interventions.
- Situations where best-practice interventions are not offered or are withheld from patients.

What the authors are describing here is medical negligence. In the UK, laws already exist regarding this. An additional example the authors provide for substandard care is:

- The performance of healthcare interventions without adequate informed consent.

In England and Wales, this is not simply 'substandard care' – this is a criminal assault. A non-consensual vaginal examination, episiotomy, stretch and sweep, forceps birth, and all other non-consensual interventions are forms of battery. Laws already exist against this, and assault and battery are legally recognised forms of violence.

The authors' use of the term 'disrespectful care' creates an even more incoherent picture. Although in their title, the authors contend that "words matter", the term 'disrespectful care' is an oxymoron. Care is the very opposite of disrespect and it is difficult to think of an example when both can co-exist.

According to the authors, 'disrespectful care' includes "disrespect for ethnic, cultural, religious, gender or other beliefs". It is interesting that this language is used. Are the authors actually referring to behaviour that would be better described as racist, homophobic, sexist, misogynistic, transphobic or incorporating forms of religious discrimination such as antisemitism or islamophobia? The dangers attached to these types of discrimination go far beyond the concept of 'disrespect'.

The authors also state that 'disrespectful care' includes verbal, emotional, physical and financial abuse. Again, such behaviour can amount to a criminal act. Notably, verbal, emotional, physical and financial abuse are forms of domestic violence. Within that sphere, we do not describe those acts as simply 'disrespectful'; we correctly describe them as forms of violence. Yet the authors perceive the label of 'disrespect' as appropriate when such violence is carried out on pregnant women by health care practitioners.

The authors do provide a definition of 'violence'. There are (feminist) scholars who have spent their whole careers exploring this term, its meaning and the way it manifests. Sadly, the authors did not engage with this literature, preferring instead to simply refer to the dictionary. Bizarrely, the authors' definition of violence includes "the use of physical force so as to injure, abuse…" yet this is exactly what they describe as simply 'disrespectful care' and argue should **not** be termed violence.

So why is obstetric violence a more appropriate term?

It is unfortunate that the authors believe obstetric violence is simply healthcare practitioners' substandard or disrespectful 'care'. This limits their understanding of the concept to the idea that it occurs simply during one-to-one interactions. This is not the case with obstetric violence. Of course, there are 'bad apples' in medicine – as there are in all professions – but obstetric violence is not just about individuals not following guidelines. To make an analogy, that would be as simplistic as saying sexism only occurs when men hit women.

Obstetric violence does not require a 'bad' midwife or doctor who deliberately harms people in their care. It can exist even when health care staff have the best of intentions. For example, obstetric violence can be institutional. A hospital may insist a woman be 6 cm dilated before she can move to the delivery ward. This requires the labouring woman to submit to a vaginal examination and undermines any notion of real informed consent. It is likely that the midwife who undertakes the vaginal examination has no

intention of violating the woman concerned, but her act is a violation of both the woman's rights and her body.

Obstetric violence can also be structural and emanate from wider social inequality and discrimination. For example, the maternity system operates within a capitalist and patriarchal society that reveres scientific and medical knowledge and the people who claim to possess it. In capitalist countries without free maternity care, women may be subjected to over-medicalised births because they are financially more lucrative to the health care practitioner and the institute in which they work. In patriarchal societies like our own, there is a power imbalance weighted against women and this does not suddenly disappear once they enter the maternity system.

With regards to scientific knowledge, this assumption is evident in the article under review. The authors write that some doctors may have "judgemental or paternalistic" approaches and allow this to reflect in their behaviour "particularly in situations where they hold the power of knowledge and decision". It is important to consider here, when do doctors hold the "power of knowledge and decision"? In other words, when do pregnant women and people have no knowledge and no right to decide? Beyond situations in which women do not have mental capacity, for example, if they are unconscious, it is difficult to conceive of such a situation. Even in an emergency situation, if a woman has mental capacity, she can decline a medical intervention.

In addition, women always possess some form of knowledge, for example, of their own bodies, preferences, needs, previous life history and family lives. These are all important forms of knowledge that impact decision making. When health care practitioners do not recognise this, they have fallen foul of social assumptions that there is a knowledge hierarchy, and their medical knowledge is at the top. It is this very attitude that permeates maternity care and fuels obstetric violence. It also flies in the face of what the authors are claiming they want to achieve: individuals and organisations coming together to improve maternity care.

A final note

I wanted to make one final point with regards to this review. The authors simply do not understand the impact obstetric violence can have on a woman's life. They claim that it can leave her with "negative feelings" and she may "feel mistreated, humiliated ... abused". Negative feelings minimise the reality of women experiencing post-traumatic stress disorder (PTSD) and post-natal depression (PND), not to mention stress and anxiety linked to obstetric violence. These are recognised mental health conditions and are not simply "negative feelings".

Further, when people use this turn of phrase about *feeling* mistreated or abused, it avoids any contrition from the abusers, their institutions and systems. It is similar to the type of apology that begins "we are sorry you feel that we…" In other words, the fact that you *feel* abused does not mean that you actually were. This type of approach smacks of the dehumanisation that is central to obstetric violence. If the maternity system and its practitioners cannot empathise with the people they are supporting, then

obstetric violence will continue unabated.

And finally

Everyone is entitled to call their own knowledge and experiences what they want – especially victims/survivors. Some victims/survivors may hate the term obstetric violence, and that's fine. Others may feel it appropriately reflects their experience. As to health care practitioners' attempts to stop people using the phrase, the horse has already bolted, and the genie is well and truly out of the bottle. We do not need health care practitioners' blessing to use the language we feel most appropriate.

Whilst it would be great to have as many medical professionals aligned with the views of organisations such as AIMS, it is not entirely necessary. Vast improvements to the culture of maternity care, and in particular that which enables obstetric violence to thrive, will only come from pressure outside of the system. The problems fuelling obstetric violence are too ingrained socially, institutionally, structurally and culturally. It is up to us as women, pregnant and birthing people, activists, researchers and all others who want to challenge obstetric violence, to use our voice, to use the language that feels right for us, and to share our knowledge and experiences in the ways *we* feel best.

For more information on obstetric violence see:

Obstetric Violence – What is it?

AIMS Information Page – Obstetric Violence

AIMS Position Paper on Obstetric Violence

Obstetric and Gynaecological Violence in the EU

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[1]

EJOG (2024) European Association of Perinatal Medicine (EAPM), European Board and College of Obstetricians and Gynaecologists (EBCOG), European Midwives Association (EMA). Joint position statement: Substandard and disrespectful care in labour – because words matter

www.ejog.org/article/S0301-2115(24)00107-6/fulltext

Exploring trust within the midwife-mother relationship

AIMS Journal, 2024, Vol 36, No 3

By Dr Marie Lewis (RM BSC MA Phd)

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

My perspective on relationship-based trust:

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

Background:

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

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

Research summary:

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

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

Trust within the context of today's maternity services:

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

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

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

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

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

Developing understanding as a cornerstone to building trust:

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

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

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

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

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

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

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

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

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

Closing remarks:

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

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

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

Author Bio: Dr Marie Lewis, a senior midwife with wide-ranging experience and a passion for woman-centred care, is now working as an independent healthcare improvement consultant.

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

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

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

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

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

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

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

[8] Betron, M.L., McClair, T.L., Currie, S. et al. (2018) Expanding the agenda for addressing mistreatment in maternity care: a mapping review and gender analysis. Reprod Health 15, 143.

https://doi.org/10.1186/s12978-018-0584-6

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

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

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I trust we can change

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By Claire Dunn

I found myself sitting in the waiting room of a prestigious hospital in West London pondering what lay ahead, for I was on my first placement studying as an Adult Nurse. The details given to me by the University had been somewhat scant; however, I trusted that my mentor would soon arrive, explain what was expected and provide me with an outline of the day.

Time was ticking by and I was starting to feel anxious. I left the room and started to enquire if anyone had seen or knew the whereabouts of my mentor, Maia. No success; she seemed elusive, so I settled myself in the staff room and waited patiently. My excitement started to dwindle and I had a feeling that new students on the ward were something of a bind.

This unfortunate beginning was the start of a spiralling downward progression that confirmed my suspicions about the medical world, but it also fueled my passion to help bring about change. Ultimately, we can and must strive for a better future. I was already a Naturopathic Nutritionist[1] and had healed my own issues where doctors had failed. I saw the integration of holistic and modern as the way forward.

The door was suddenly flung open and a flurry of midwives entered the room ready for the 'hand-over'. I had been waiting for nearly two hours and was relieved to finally meet Maia.

"But I have no information about you. I was not told I was to mentor you", she said. It was clear that Maia was not interested in sharing her time with a student. She was very serious and I sensed she was on her

own journey, climbing her own ladder, so to speak, and that I was definitely not on her agenda! I followed diligently behind Maia and was told to "observe". I took that to mean, "Don't get in the way!".

So, finally, we entered a private room on the ward where a lady had been in labour for some time. It was quite bizarre. No words were spoken. Maia took to checking monitors, reading notes and writing down stats. That was it. I felt such compassion for this lady and her husband as, to me, they did not seem to be in a good place. Intuition told me that she was exhausted and in a great deal of pain. I wanted to get a cool flannel for her sweat-beaded brow. I wanted to talk to her anxious husband. I wanted to help her move into a position that felt more comfortable for her. As it was, she was lying on her back on the hospital bed with half a dozen wires and beeping machines hooked up to her, and her ability to move was completely restricted. Is this really what a maternity ward is all about? Surely not, for haven't we progressed as a society to the very best in health care? I pushed this doubt aside and held on to the adage, 'Trust in the plan' - this presumably is the best for modern women in childbirth.

I waited and waited, standing in the corner of the room as Maia scurried in and out. Hardly any words were spoken let alone directed to me. It was such a bizarre situation. I had to keep trusting that the very best things were happening in this situation and that this was what was expected of a student nurse. My entire first day consisted of simply standing and watching this poor couple go through their first experience of childbirth with such anxiety, confusion, and exhaustion. The underlying dogma was 'this is how we always do it and no one is going to stray from the guidelines' - and God forbid anyone to actually help this woman with a change of position or with other humane and natural efforts. I am afraid to say that her labour continued with the administration of an epidural, after which I could see that not only the mother but the baby as well was getting tired. Finally, the mother was taken for a caesarean later that evening.

I had moved to West London from my home in Wales with the hope that I could bring my knowledge and passion for health and total body healing to the larger audience of our capital. I wanted the opportunity to show how, by merging innate knowledge and wisdom and natural integrative approaches with modern medicine, we could bridge the gap between success or failure in how we approach medicine today. Unfortunately, that was not to be. The events that unfolded over the following week became even more concerning and ultimately led to me walking out of the ward and never returning to nursing. My high hopes were dashed.

To summarise what I observed over the following days - I observed mothers-to-be and their families placing their whole-hearted trust in a system that was creaking and groaning under the weight of a dogmatic management that favoured procedure and checklists over nurturing care - with never a hint of the uplifting and exciting energy that one would expect to accompany the bringing of new life into the world.

"Can anyone help please!" A gentleman stood in front of the reception desk on the ward, wide-eyed and clearly distraught. I waited for a midwife to answer him. Silence!

Again - "Please, anyone. Can you help my wife, she is covered in a rash and it's driving her mad. What can I

do?" Silence again! I had learned that being behind the reception desk was where midwives could hide away and no one ever wanted to be the first to help out. My mouth opened and I felt desperate to reach out to this man. "What about trying calamine lotion or calendula? That may help with the irritation", I offered. Then an older midwife finally joined in saying, "We have done what we can. Your wife can take some paracetamol. We can't administer any lotion; you will have to go and buy some". My heart sank. So many ideas rushed through my mind on how I could help soothe this poor woman's skin condition - surely these things were common knowledge?

Later, I followed 'Sue' into a private room where a very young new mother of around 17 years was waiting to see us. Sue had told me that she was going to help the young mother in getting her baby to latch on to the breast. We must have been in there for a whole eight minutes; it definitely was under ten! Sue had a brief conversation with the mother, saying, "Ahh, is the baby not feeding properly?" The young woman looked very upset and in discomfort. Apparently her nipples were sore, but the baby was strong and healthy and eager to feed. Sue immediately said, "Well, sometimes it's just not to be. Better on the whole if we start with the bottle. Don't worry, it happens all the time"! Sue then reported to the sister on the ward saying, "Yes, I've spent some time with the mother showing her how to latch the baby on correctly; there doesn't seem to be any more we can do". Case closed - the mother was to bottle feed.

I couldn't believe what had just happened. It was utter nonsense. We had spent no time at all with the young mother let alone made any efforts to help her and her baby try different positions - no offer of extra pillows - nothing. I felt saddened. I knew only too well the importance of breastfeeding for the baby and for the mother, and she received no skilled support at all. This was definitely not my idea of care. The mother was alone and had complete trust in the midwives; a trust that was very much betrayed. It was nearly the end of the shift and I had the feeling that I just couldn't accept the methods and practices that were being used. I would either get into trouble or get thrown off the ward if I spoke about everything I had observed.

Two midwives came to the desk. "Well, I'm not having another late one so we've managed to stretch her", said one. Apparently, I learned, this practice was all part of a system where the mother needed to be at a certain dilation (of the cervix) before she could be moved to the active labour ward. I couldn't believe my ears when I was told that in the process of trying to speed things up they had accidentally ruptured the mother's membranes as well,[2] and then "overdosed" her.[3] "Well, we will keep that quiet", said one of the midwives, and this incident wasn't recorded. I was in utter disbelief. Three midwives were huddled in a corner with a clipboard; the incident was kept quiet, and I suspect that the mother was unaware of what had happened. This was the final straw. I had seen enough and couldn't cope with this experience any longer. It was a far cry from what you would expect on a maternity ward. I gathered my belongings and left.

I left not with a heavy heart or broken morale - the experience fuelled my belief that, even if it was to be in a small way, I could still forge ahead in sharing knowledge, information and better practice in helping others embark on a more nurturing and empowering journey of self-healing. When it comes to caring for ourselves and others, how have we become so far removed from our deep, innate, intuitive and inherited

wisdom - wisdom that has stood the test of time. It was not so long ago that midwives made daily visits, patiently offering all of their knowledge and support on a one-to-one basis in the calm, familiar and caring space of the mother's own home. Why did we let that go so easily?

This account is not intended to be a criticism of the NHS and all of its employees. In many cases we are indebted to their help, support and intervention. But, I believe we must stand in our sovereignty and authenticity when speaking the truth. Just because a system has evolved in a way where standard practices have become entrenched, it doesn't mean that those practices are good practice; it doesn't mean that things cannot be changed. The willingness to change is a practice we should all embrace. We should not be afraid to return to older ways now that, with hindsight, we can appreciate their value - or to merge these older ways with modern skills in a new integrative approach.

I know there is a movement, a shift within society where people are becoming more conscious of a desire to explore and delve deeper into their intuitive knowledge of self-help, and a desire to return to a more natural way of living and all that that encompasses.[4] I truly believe that, one by one, little by little, if we all speak out for what we know is the truth, the collective consciousness would support this shift. There are better practices, there is greater knowledge and this older wisdom could work seamlessly alongside the true advances in modern medicine. But there has to be a desire from all of us as individuals to push the powers that be to hear the voice of those who speak out and speak in truth. I trust that we can do this. I have faith.

Author Bio: Claire Dunn lives in a magical area of West Wales. She has been a naturopathic nutritionist, laser therapist, energy worker and lover of the natural sciences for over 20 years. Her passion and vision is that of sharing her knowledge for all those who seek the transition of their everyday lives into a healthy harmony with themselves and with Mother Earth.

1 College of Naturopathic Medicine - What is Naturopathic Nutrition? www.naturopathy-uk.com/home/home-what-is-naturopathic-nutrition

2 Editor's note: This is at best, 'meddlesome midwifery', and without the fully informed consent of the mother, it qualifies as obstetric violence.

3 Editor's note: I imagine that the mother was given a large dose of pethidine to sedate her.

4 Editor's note: Perhaps an undercurrent shift away from the pathogenic and toward the salutogenic? See - 'Salutogenesis: Putting the health back into healthcare.' www.aims.org.uk/journal/index/33/1

Trusting myself in birth

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Salli and her mum on a bench commemorating the midwife who attended when she was born.

By Salli Ward

I was born at home in 1962 in rural Cheshire. My mum recalls watching from her bedroom window as the midwife arrived on her bike across the field. The midwife/district nurse who delivered me into the world was well known and highly respected. My mum recalls the doctors (there were only two) saying, 'yes Maud' when she instructed them. She was *the* expert.

When I was first pregnant in 1986, I assumed I would also have my baby at home. In my innocence, I

didn't think this was so controversial - though obviously I was aware it was slightly unusual - because I didn't associate giving birth with anything medical – certainly not with illness. I didn't entirely mistrust the medical profession; I wouldn't hesitate to involve them if I was poorly, and they have saved much loved lives and limbs over the period of my life.

In birth, however, I believed in my body, in the bodies of women, and in nature. This isn't to say I don't think we should interfere with nature – surgery, antibiotics, defibrillators – they all interfere with nature that would have us die – but what has this to do with birth? Yes, people can have problems giving birth (I now believe, the more interventions, the more problems) but we can have problems climbing mountains, crossing the road, slicing bread, yet we don't have doctors on stand-by when we do those things.

Back then I didn't think all this through until my GP refused to – well, what do you call it? - be my GP! I found another GP, read a book called Birth Matters, and found out about my rights and about research into homebirth. All long before the recent very worrying signs of impending doom in maternity services. [1]

Back then I somehow knew my body would be able to give birth. I wasn't super-assertive, so I found it hard to insist, but I trusted myself. I didn't even ask my then husband; to me, it was no-one's business but my own. I expected (and got) his full support.

I now have two grown up daughters; one has experienced giving birth and it was awful. She did plan to have her baby in an excellent birthing centre but it was closed on the day. My second daughter is pregnant now and planning something similar, but in a different area. My step daughter-in-law is also pregnant but I can't claim to have the right or the reality of much influence over grown people.

I cannot understand why women, particularly feminist women like my own stroppy, strong and mighty daughters, put so much trust in medics, in hospitals, in intervention, when they are planning delivery of their babies. I don't understand why they fight misogyny, stand up for equality, dismiss damaging stereotypes and push themselves forward – yet willingly hand their beautiful, powerful pregnant bodies over to male dominated services (I know there are plenty of women in medicine now, but I believe it is forged in the fires of masculine domination). Furthermore, why do they fall for the notion that their bodies aren't good enough, that they can't stand the pain of childbirth, that they need interference to do what their bodies are built to do?

I am aware this sounds critical of other people's choices. I want to stress that I believe in choice and if women want to choose hospital birth or caesarean or pain relief or whatever, that's fine by me. What I question is how much it is a free choice. What puzzles me is why people make that choice when they are otherwise quick to stand up for women's rights.

When I announced I was having my baby at home, the most common response was 'how brave'. I took this to mean they thought I was doing something dangerous – this is worse than criticism to me. It means they thought I was deliberately putting myself and my baby in danger. For years I wanted to say, 'how brave' when friends announced their impending hospital birth, but I'm older now and have two birthing

daughters – what can I say?

I *did* have my baby at home – and two others. My pregnancies were marred by concerns that I would be two weeks overdue and feel forced into being induced (my daughter was automatically booked for a cervical sweep when she was only a week 'overdue'). With each of my births, I had to find my own doctor – all three were good – and work with the community midwives, who were amazing. I trusted them. I trusted myself and I trusted the power of nature. In labour with my first baby, I paced the floor until ready to push. I know that natural birth[2] can happen in a hospital but I would be scared ('how brave!') of interventions and attitudes getting in my way (possibly literally).

I am aware that these days some conditions of birth – such as breech – can be dangerous because there are so few midwives left with the skills to assist a natural birth under those circumstances. Women's bodies are essentially the same (actually better and stronger) and birth is unchanged, but so few people really know how to assist. My dad, born in 1927, famously (in the confines of our village!) came out feet first and had to be 'pushed back in' (full disclosure – he was a twin). My daughter's baby is breech now – 5 weeks before she is due – I can't advise her to resist intervention if the baby doesn't move because I don't know if we can trust anyone to deliver that baby safely. The skills may not be there.

This is a tragedy. As we move towards more caesareans and other interventions, will the human race eventually lose complete trust in women's bodies? If my granddaughter is pregnant in 30 years' time, will there be no-one who knows how to attend a natural birth?

This isn't progress for women. I learnt recently that in America natural birthing (and breast-feeding) women are considered anti-feminist. It seems to be connected to the idea that women should be able to do exactly what men do – go back to work ten minutes after birth? What women do – especially if men can't do it – has become so devalued that even ardent feminists are convinced it has little worth.

Why aren't we demanding respect for what we do – what *only* we can do?

I try to trust the next generation will see sense. My three-year-old granddaughter knows that boys can wear dresses, that some children have two mummies (or daddies), that no-one can touch her without her consent, that bodies vary – and that's all so very good. I hope that one day she trusts herself, her body and nature enough – I hope we can still leave her that legacy.

Bench in the village where I was born, remembering Nurse Hatton who delivered me.

Author Bio: Salli is mother/stepmother to 8 grown-up children with 2 – almost 3 – grandchildren. Born and bred in the north west of England, she now lives with her husband on a narrowboat around London – to where most of the children have moved – but she dreams of the countryside and looks forward to inter-generational communal living planned by two of the kids. Salli has been a dramatherapist, a charity CEO, a celebrant, and a fundraiser but is now a writer of policies, funding applications, articles, letters to the Guardian and unpublished (but extraordinarily good) books.

[1] Editor's note: The author may be referring to the increasing reports from parents of poor support and of traumatic experiences, alongside documented concerns about staffing numbers, increased rates of induction and caesarean, and lack of support for women's choices about where they have their baby.

[2] Editor's note: Please refer to the AIMS position paper on Physiology-Informed Maternity Services: www.aims.org.uk/assets/media/730/aims-position-paper-physiology-informed-maternity-care.pdf

Trust in maternity care – Going, going, gone?

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By Mary Nolan

While in this article, 'woman', 'women', 'she' and 'her' are used to refer to the person giving birth, this is in no way meant to exclude birthing people who do not identify as women.

What is trust?

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

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

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

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

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

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

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

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

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

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

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

When even independent trustees can't be trusted

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

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

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

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

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

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

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

Where do we go from here?

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

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

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

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

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

Health:

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

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

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

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

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

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

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

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

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

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

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

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