

## **CONTINUITY AND TRUST**

### **IN THE CONTEXT OF MATERNITY CARE AND BREASTFEEDING**

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#### **INTRODUCTION**

The present paper aims to - within the context of maternity care - explore the linkages between continuous health care and trust in a care provider; and the pathways of a possible impact of continuous health care and trust on the decision how to feed infants.

#### ***Continuity and trust***

There has been a move to regarding the study of inter-personal relations as crucial in trying to understand the impact of health care systems (Gilson et al. 2003).

As part of this trend, continuous health care (e.g. Cabana and Jee 2004; Donaldson 2001; Hodnett 1998; Saultz and Albedaiwi 2004), and trust (e.g. Gilson 2003; Hall et al. 2001; Mechanic 1998; Thiede 2005) have independently, increasingly received attention.

This has largely been due to evidence that both processes can be associated with improved health outcomes well-being. Both continuous health care and trust have been found to be associated with greater likelihoods of patients: to receive preventative health care (for instance vaccinations (Menec et al. 2005) and timely screening of cancer (Mainous et al. 2004a)); to return for follow-up care (Hall et al. 1994; Steadman et al. 1999; Thom et al. 1999); to disclose problems (Del Piccolo et al. 1998; Mechanic 1998: 286); to adhere to treatment recommendations (Ettner 1999; Hall et al. 1994; Molyneux et al. in press: 6; Thom et al. 1999; Safran et al. 1998); to have an improved therapeutic response (Thom et al. 2002; Walraven et al. 2004)(either through better compliance or a placebo effect (Hall et al. 2001)); and to voice increased satisfaction with their care (Baker et al. 2003: 27; Cabana and Jee 2004; Hall et al. 2001: 617; Safran et al. 1998; Saultz and Albedaiwi 2004; Thom et al. 1999). Continuity has also been shown to be associated with a reduction in resource utilization (Brousseau et al. 2004; Menec et al. 2005)(e.g. a reduction of non-

urgent consultations in emergency rooms (Stein et al. 2002)) and a reduction of costs (Raddish et al. 1999).

Even though the type of indicators of well-being which have been shown to be associated with continuity and trust are to a large extent the same; and even though intuitively one might think that trust may be a key mechanism through which continuity has an influence on well-being, mechanisms through which continuity makes a difference to well-being have been very much under-researched. Haggerty et al. (2003: 1220) warn that 'unless we understand the mechanisms through which care delivered over time improves outcomes, continuity interventions may be misdirected (..)'.<sup>1</sup>

In addition, even though there has been a substantial interest in how trust is built, the possible importance of the structure of health organizations on the forming of trust has hardly received attention. Exceptions have been Thom et al. (2004: 130) who mention 'organizational factors' in general, and 'continuity with the same physician' in particular as 'important in establishing and maintaining trust' - but do not examine these in depth; and Kao et al. (1998) and Mainous et al. (2001) who find relationships between continuity of care by physicians (defined as the length of the patient-provider relationship) and trust (measured with the Trust in Physician Scale)<sup>1</sup> in quantitative studies - but do not explore the mechanisms of this relationship.

There is also a gap in the literature on the exact mechanisms through which trust may make a difference to well-being (e.g. Epstein et al....).

### ***Definitions of continuity and trust***

Continuous health care research is ridden by a lack of a common definition (Adair et al. 2003; Crawford et al. 2004; Freeman et al. 2003). It is hard to draw meaningful conclusions from the consequences of an organizational form from a body of literature which uses wildly different definitions. Definitions range from simple quantitative ones, like the length of the relationship (Hundley et al. 1994; Koda et al. 1998; Mainous et al. 2001), the proportion of care encounters with a particular carer (Mainous et al. 2001), or the total number of carers seen in a particular time period (Tucker et al. 1996);

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<sup>1</sup> Kao et al. (1998) use a version of the original Trust in Physician Scale (Anderson and Dedrick 1990) which they amended in an unpublished manuscript in 1996.

to more sophisticated contextual ones, like Haggerty et al. (2003) who distinguish between informational continuity (disease or person focused), managerial continuity and relational continuity.

Hall et al. (2001: 615) in their review of the concept of trust, found that the majority of definitions highlight 'the *optimistic* acceptance of a *vulnerable* situation in which the truster believes the trustee will *care* for the truster's interests.' A distinction is commonly drawn between inter-personal trust, which characterizes the relationship between particular individuals; and 'general, institutional, social, or system trust, which characterize attitudes toward collective entities or social organizations' (Hall et al. 2002: 1421).

Different definitions stand for different types of processes, which will be more or less likely to have potential to contribute to well-being.

For instance some authors vehemently purport continuous care to be delivered by one sole carer (i.e. 'continuity of carer') (e.g.); others feel there may be advantages in being looked after by a small group of carers - in particular because this entails access to a range of skills and personalities (Currell 1990 - cited in Page 1995; Watts et al. 2003).

Continuity delivered by one carer and trust will become problematic if it means complete reliance on an incompetent carer, or one who does not have one's best interest at heart. At the same time a true getting to know each other and informational continuity will be more difficult to achieve when there is more than one carer involved.

### ***The context: maternity care***

Within British maternity care, starting with the Changing Childbirth Report (Department of Health 1993), there have been repeated statements of political will to introduce continuous care. Most recently continuous care during pregnancy, childbirth and the postnatal period was described in the National Service Framework for Children, Young People and Maternity Services (NSF) as being 'required for optimum health and well-being (...) [by] all women' (Department of Health 2004: 6).

Yet, the facts that first these political statements have hardly been turned into practice (only a very small proportion of women receive continuous care - **accurate figures are not available**); and secondly,

that there continues to be a debate within the maternity literature whether continuity is valuable at all (e.g. doubted by Green et al. 2000); and if yes, what form it should take - suggests that there is an urgent need to explore and publicise examples how effective continuity can be achieved. Similarly, Mechanic (1998: 298) feels about the building of trust that '[m]ost innovators remain invisible, isolated in their efforts (..)' and that '[m]uch greater efforts are still needed to identify innovative approaches (..) and to disseminate ideas on the best forms of practice.'

Hence a further aim of this paper is to help to bring to wider attention the positive processes at work at the small but successful midwifery practice within which the data for this study was collected.<sup>2</sup> The practice was chosen here as a best-practice example because first, the idea of being continuous carers lies at the heart of the midwives' philosophy (with the aim to deliver relational, informational and managerial continuity from the first pregnancy booking to one month post-partum). Second, an evaluation of the midwives' care in 1999-2001 (Sandall et al. 2001: 66) revealed a host of positive indicators both of processes of care and of outcomes. Compared to other practices in the same Trust more women who had attended the practice under study 'reported that their midwives explained what was happening, told them enough about necessary interventions, took enough notice of their views, and were kind and understanding'; induction rates in the practice were lower, vaginal delivery rates higher, intact perineum rates higher; and 93 per cent of women who were cared for by the practice breastfed at birth - in comparison to 75 per cent in surrounding practices.

These high rates are particularly impressive since they are achieved in one of the most socio-economically deprived areas of London. According to the Index of Multiple Deprivation 2004 the sub-areas of the local area have an average rank of 12 out of 354 local authority districts in England; with a rank of 1 indicating that the district is the most deprived (Office of the Deputy Prime Minister 2005).

### ***The outcome: breastfeeding***

The principal reason for focusing on infant feeding in the present study is its location in the final period of midwifery care which lends itself well to being examined in relation to continuous care, as there is likely

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<sup>2</sup> Other publications on the practice under study here include Kemp (2003), Reed (2002a), Reed (2002b), and Sandall et al. (2001).

to have been a relatively long period of repeated encounters between the midwife and woman and her family.

Secondly, policy recommendations have tended to focus particularly on ante-natal to intra-partum continuity, to the neglect of post-partum continuity (Green et al. 2000).

Thirdly, evidence on associations between continuous care and breastfeeding is scant and contradictory. A number of randomized controlled trials (RCTs) did not find statistically significant differences in breastfeeding indicators between women who had experienced continuous care and women who had not (e.g. Hodnett et al. (2002), Page et al. (1999), Rowley et al. (1995) Serwint et al. (1996)). Whereas other studies did find an improvement in breastfeeding indicators under continuous care e.g. Whelan and Lupton (1998: 98) in a qualitative study, Porteous et al. (2000) in a randomized trial, and Klaus and Kennel (1997) in a review of 11 RCTs on the effect of doulas. As is customary for the continuity literature, these studies are difficult to compare since the interventions differ widely in the degree of continuity provided (e.g. whether continuity was provided by a single carer or a team; as to the nature of the women and carer interactions; and over which period of time continuity was provided - whether just pre-natally, just intra-partum, just post-natally, or across two or more maternity phases).

A third reason for studying the influences of continuous care and trust on breastfeeding is the government continuously seeking initiatives which will improve breastfeeding rates.<sup>3</sup> In Britain, even though there has been a significant increase in breastfeeding rates since 1990, the breastfeeding initiation rate of 69 per cent at the time of the last Infant Feeding Survey in 2000 (Hamlyn et al. 2002), was still substantially below that of other European countries (e.g. Norway's 99 per cent in 1998<sup>4</sup> (Cattaneo et al. 2005)).

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<sup>3</sup> As can be seen for instance in the recent series of reviews by the National Institute for Health and Clinical Excellence (NICE) on the effectiveness of public health interventions to promote the initiation (NICE 2003) and duration (NICE 2005) of breastfeeding.

<sup>4</sup> Norway's successful recovery of high breastfeeding rates from the 1970s onwards is believed to be due to a combination of: the establishment of support groups; a gradual improvement of knowledge, skills and routines within the health care system; increased education and occupational activity of women; political pressure by the feminist movement leading to better conditions for breastfeeding mothers; increased duration of maternity leave; and the less aggressive marketing of breast milk substitutes (Istituto per l'Infanzia and Unit for Health Services Research and International Health 2004: 34)).

Continuing low breastfeeding rates are of particular concern, because the steep social class gradient creates and reinforces existing social inequalities: in 2000, 57 per cent of mothers in social class V initiated breastfeeding, in contrast to 91 per cent in social class I (Pain et al. 2001). The current government target, as stated in the recent Priorities and Planning Framework 2003-2006 is to '[d]eliver an increase of 2 percentage points per year in breastfeeding initiation rate, focussing especially on women from disadvantaged groups' (Department of Health 2002: 20).

### ***The present study***

After an introduction of the setting and the data, firstly, links between experiencing a continuous carer and the development of trust will be explored. This will take the shape of an interleaving of the literature on the building of trust with examples of primary data illustrating how continuity can promote the building of trust. Secondly, two key processes triggered by continuity and trust, i.e. calm and improved communication, will be explored. Thirdly, the possible influences of continuity and trust on decision making concerning infant feeding will be illustrated through the experiences of two female interviewees; followed by an overall discussion of the findings.

Breastfeeding will be contextualised within the wider process of continuous maternity care - i.e. throughout the analysis examples will be drawn not just from midwife-woman interactions focused on infant feeding, but also from interactions taking place throughout the prenatal and partum periods. This is to underline the importance of the continuum of care, i.e. how interrelated care interactions and events prior and during birth are with care interactions focused on infant feeding.

## **DATA**

### ***The setting***

The community practice studied cares for women from their first booking appointment until 28 days post-partum. Most care encounters, (apart from some antenatal appointments and ante- and postnatal groups) take place at the woman's home, to facilitate the establishing of a positive rapport. Each midwife (of whom there are 7) is responsible for the maternity care of 36 women per year (plus 36

women whom she cares for as a secondary midwife);<sup>5</sup> she is on call 24 hours, 7 days a week (apart from 3 months of annual leave). Each woman has a primary and a secondary midwife, both of whom she gets to know in the ante-natal period. Women are allocated to the practice by three local General Practices.

The care the midwives provide is underpinned by a strong common philosophy. Some of the main facets of this philosophy are to view birth as a normal yet transformational event, deeply embedded in its wider socio-cultural context. Women are encouraged to give birth at home. Midwives stand back as much as possible, 'to encourage women to take control of, or responsibility over, their bodies' (Kemp 2003: 37-9) and to help them to consolidate their own, lasting social support network – made up both of existing friends and family, and new friends met at the ante- and post-natal groups. Important others are, where possible, included in the care from early on – the latest at 36-weeks, at a so called 'birth talk' where both midwives visit the woman's home principally to enable women and their partners to voice their wishes and expectations, to help them make sense of the details of the birth process, and to define roles for all players (Kemp 2003). The ante- and post-natal groups are drop-in sessions with women- (and partner-) led discussions.

Midwives work as a democratically organized team in a very supportive environment; the whole group of midwives meet up twice a week to socialize, discuss issues arising in their care and in the running of their practice, new research, etc.

## ***Methods***

Following the obtaining of ethical approval, data was collected November-June 2004-05 (with the bulk of the interviews held in second half of February). Formal data collection was preceded by six weeks of shadowing and observing a number of midwives both in one-to-one care and at ante-natal and post-natal groups. A topic guide was piloted with one couple (who are included in the analysis below). The sample consisted of 10 women (aged 21 to 40 years) and their birth partners (in most cases the father of the child) from a variety of socio-economic and ethnic backgrounds (four white British, one black British and five African), who had given birth within one to two months of the

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<sup>5</sup> Currently two midwives have half caseloads.

interview,<sup>6</sup> and who had experienced a different type of care at an earlier birth (with the exception of two women who were purposefully chosen for having given birth for the first time). Women were suggested and initially contacted by the midwives; however, there is no risk of the sample over-representing women who had a positive experience, since there were only a limited number of women who were giving birth during the specified time period, who had experienced a different type of care in a previous birth - and virtually all of these were interviewed.

Four of the seven midwives of the practice were also selected for interview - on the basis of a spread as to for how long they had been working in the practice.

Interviews were initially structured according to the above mentioned topic guide – later they became in-depth conversations about the women's and their partners' experiences of the care they received and their experiences of birth and infant feeding; and about midwives experiences of their care for and relationships with women and their partners. Interviews took place in the women's and midwives' own homes,<sup>7</sup> they were all conducted by the first author, tape-recorded (with written consent) and lasted for about one hour. An information sheet was posted beforehand. Most respondents were interviewed separately from their partners.

Interviews were transcribed by a professional transcriber and analysed independently by the two authors – using N-Vivo. All names in the paper are pseudonyms.

## **FINDINGS**

### **Trust**

All interviewees mentioned trust within the flow of their stories. Once mentioned, it was inquired deeper into what trust meant for each individual.

Of the two types of trust commonly distinguished - i.e. interpersonal and general trust - it was principally the former women and their partners tended to express:

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<sup>6</sup> With the exception of one couple, who was interviewed 4 months after the birth of their child.

<sup>7</sup> With the exception of one partner, who was interviewed in a coffee shop; and one midwife, who was interviewed in a private consultation room at the practice.

*Lilly: 'I suppose, at the back of my mind, because we know Marie [the midwife] so well, I've always completely trusted her. So she would have, if I was in any danger at any point, she would have intervened and done something.'*

This personal trust was felt so strongly, that midwives were often described as being part of the family.

*Patrick: 'but you could actually have a drink with them and you invite them to dinner because you feel they're part of the family because they helped you give birth to your child. And you feel that you know them and they know you. And you feel that they're looking out for you.'*

A number of respondents described their trust as extending to the whole midwifery practice:

*Robert: 'They were tremendous. (..) it didn't matter whether we had Marie, Hannah or Katie. They could have swapped and changed as much as they wanted. The service was exactly the same, they always sang from the same song sheet. It was great.'*

At the same time there were few indications that respondents felt any general trust. More common was an expression of mistrust of the wider health services:

*Cynthia: 'And I'm glad I didn't go to the hospital because my granddad had MRSA in King's College. He had cancer and he went there to have an operation to remove the cancer, and he pick it up in there. So my mum was very happy that I stay at home. Yes.'*

*Laura: 'I hear, not horror stories from hospital, but I can't imagine what it would be like to be in labour and not really know who is going to be with you. You know. And you maybe don't know the midwife. And I think, from what I've heard, some midwives, they do have different approaches to labour and how long they'll allow things to go on for and, you know, some midwives I've heard of, they'll burst the sac, the membranes and all sorts of things.'*

Exceptions were three husbands, who did voice trust towards the NHS and/or midwifery as a profession. Here are quotes of two of them:

Robert: *'And I felt, whatever happened, we could well have to rely on King's and the NHS and what support we could have there. So it was reassuring to feel that there was an NHS based support group (..) [a]nd therefore Marie and Hannah [the midwives] proved just that.'*

John: *'If I go and see a lawyer to get some legal advice, if that's the advice I'm getting, it's the law, if it makes sense, logic says it makes sense, that's why I'm there. I'm not suddenly going to get legal books out and learn the law, the same with accounting. So why is this different with breastfeeding. So, Marie is the health professional, she's a midwife of many years, she's a hands on midwife. She's not a cold midwife, she's very warm hearted, (..) she's been through this process, and she's in it day in and day out. So why am I going to offer an opinion when I've got no experience or knowledge?'*

Whether there is a pattern of men being more likely to feel general trust remains to be tested with a larger sample.

### **Continuity of carer and trust**

Reviewing the literature on the formation of trust, it seems that influences on trust can be divided into three groups: the characteristics of the trustor; the perceptions the trustor holds of the trustee; and the situation and context in which the trust takes place.

Analysis of the transcripts in turn reveals that continuous care can have a bearing on each of these three groups of influences on trust - in a way that it can promote the formation of trust.

In the following three sections first, each of these groups of influences on trust will be introduced through the literature. Then linkages with continuous care will be explored with the help of our interviews.

Figure 1 illustrates the linkages to be explored.

### ***Characteristics of the trustor***

Whether trust is built will partly depend on the trustors' personal characteristics (demographic characteristics such as their age,<sup>8</sup>

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<sup>8</sup> Mechanic and x have shown that ..

education and economic situation<sup>9</sup> (Molyneux et al. 2005); and their (often related) psychological qualities (such as their degree of self-confidence (Giddens 1990; Thorne 1988)).

Experiencing a continuous carer, i.e. getting to know a carer, can enable people to amend initial ideas they may have about their carer or their care (which are often linked to their demographic characteristics or have their roots in earlier experiences). Thiede (2005) finds that through effective communication differences of 'lifeworlds' can be bridged, and a trusting relationship can be achieved.

Women and their partners who took part in the present study displayed a range of different ages and socio-economic as well as ethnic backgrounds – most of which were different from those of the midwives. Nevertheless trust was build between the woman (and in most cases her family) and the midwife in every case.

Asha is an example of someone who was able to overcome her initial hesitation towards her midwife and ended up trusting her, because she had the opportunity to get to know her:

*Asha: 'I did think that she [the midwife] was young when I first met her and I remember thinking, she's young and also she'd only been practicing for a couple of years. And I did kind of think, my whole nervous controlling thing about ... she's not going to be able to do this. Then, after meeting her, it's just – I don't know - I just really felt that she was in tune with me.'*

The importance of the building of a relationship in order to overcome potential distrust can also be seen in examples where important others did not get to know the midwives, and consequently ended up disturbing the birth process or breastfeeding. This takes place even though the midwives try hard to include them into the care from early on. Some relatives or friends may simply refuse to get involved, or live too far to get involved in the prenatal period.

For instance Tricia trusted the midwives enough to plan a home birth behind her partner's back - but not having participated in the planning, he panicked during the birth and persuaded her to go to hospital:

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<sup>9</sup> Riewpaiboon et al. (2005) have for instance shown that it can be difficult for trust to develop across different social strata.

Tricia: '(..) *We were just going to say that it was an accident and that I was too far gone to go to the hospital!*'

[During the labour] *'George kept asking my sister, 'When is she going to hospital? Get her to go to hospital! And it was taking a bit longer than I thought (..) and George was getting nervous, so I asked to go to hospital (..).'*

In addition, to bridging 'lifeworlds', there is evidence that continuous care can make a difference to the trustor's psychological predisposition to trust: for instance to self-confidence, which is regarded as a precondition to trusting by Giddens (1990) and Thorne (1988).

Continuous care can build confidence, partly because the structure of the service means that the carer is always there for the cared for - making the latter feel unique (Earle 2000).

Bella: *'they also make you feel that you're very special, it's just your birth, whereas when you go into [hospital] you just see there's just hundreds of people giving birth every day and you're just this kind of one in and one out person (..) For me it just meant that I felt more confident (..) it was a nice and secure feeling to know that they would be with me, whichever way it went.'*

In addition, midwives were found to employ a myriad of techniques (some 'one-fit-all', others tailor-made to individual women) to help to build women's and their important other's confidence to be able to deliver and to feed their children naturally. Both of these types of techniques were found to be greatly aided by continuous care.

Continuous care provides the time needed to transmit the same 'one-fit-all' message over and over again. There is evidence that the repetition of a same message can be effective in aiding behavioural change (refs.).

It also provides the time needed for midwives to come to understand the woman and her circumstances in sufficient depth to be able to identify where individual confidence is lacking and where there are possibilities to help to build it.

An example of a technique of 'one-fit-all' confidence building is the exposure of women and their partners to birth stories – which means women and their partners who have recently given birth with the practice, returning to antenatal groups to share the stories of their births with expectant mothers or parents.

Laura, a first time mother felt that *'(...) antenatal classes (...) I just thought they were great, you know, every week I'd hear a home birth story with a first birth and it had all gone safely and well. So that increased my confidence that home birth was good. I liked their style, the way they ran their antenatal group, sort of informal, dealing with the issues that the women came with every week, (...).'*

A further 'one-fit-all' technique is for midwives to show women and their families photographs and videos of positive birth and breastfeeding experiences. This usually takes place at the antenatal groups and at the birth talk. Couples are also invited to borrow videos, of e.g. water-births.

Sarah, a midwife explains: *'(...) we show birth photos. And I try and make sure that I show birth photos with the baby feeding on the breast as well. So (...) they can see the whole process of the birth as well as the woman going to bed and the baby breastfeeding (...) It is actually quite a positive thing, I think, visualisation, or seeing, seeing a woman smiling with the baby on the breast, it's really good for women to see.'*<sup>10</sup>

The following are examples of midwives tuning into women's individual needs of restoring their confidence:

Asha recalls how important it was for her that her midwife analysed the labour notes of her previous child together with her (a labour which she had experienced profoundly negatively - and where the care had been discontinuous):

Asha: *'No one had been through the notes with me before. (...) And so [Sarah] kind of read through it and explained it all to me and said, 'You dilated really well, your body can do it' and I just thought, 'God, I can actually do this' and I really felt like, 'Yes let's go for it' kind of thing. (...) that's what she did, she just went through my notes and it just made me feel so confident.'*

Laura, who had had a miscarriage, very much valued Sarah's positive affirmations every time she listened to her baby's heartbeat:

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<sup>10</sup> A study conducted by Khoury (et al. 2002) in Mississippi confirms that videos can be a highly effective method in promoting breastfeeding.

Laura: *'And, at the end of every antenatal check, she'd always sort of say, 'Oh that's a happy baby'. She'd listen to Elsie's heartbeat, you know, and say, 'Happy baby'. And that made a really, really significant difference to how I felt, just that positive affirmation, you know.'*

In Lilly's case, her midwife Marie destroyed niggling doubts in the pre-natal period that she might not be able to breastfeed – which had been introduced by a close friend - at their inception.

Lilly: *'So I went round one night to talk to Marie about it, and to say, 'I want to buy some bottles and an express machine, which ones do you recommend?' [She] took the catalogue and she just said, 'You don't need any of that'. 'Oh right, okay' – and I said, 'What if we've got a problem?' And she said, 'You won't have a problem, I will not leave the house until you are breastfeeding, this is how it works, babies will breastfeed'. So I didn't buy anything.'*

The building of confidence can also be indirectly linked to continuity of care. Most importantly when women - in part because of the positive continuous care they have received - have a positive birth experience, which can trigger a surge in confidence (Langer et al. 1998; Pascali-Bonaro and Kroeger 2004) which, carried into the postnatal period, has potential to increase confidence in breastfeeding.

Statistics confirm that women at the Albany practice are much more likely to have positive birth experiences .. *(have asked the Albany for recent stats)*.

### ***Perceptions the trustor holds of the trustee***

The second group of factors influencing trust comprises the perceptions the trustor holds of the trustee. These perceptions will have their roots either in the reputation of the trustor or direct observation or experience by the trustor of the characteristics or behaviour of the trustee (Molyneux et al. 2005; Thiede 2005).

The length of time over which these shared experiences stretch is likely to have a bearing on trust - in that trust 'may take time to establish' and that 'the longer people trust, the stronger the sense of trust' (Hams (1997: 352); see also Thom et al. 1999).

Specific attributes which have been found to inspire trust include norms and values the trustor can relate to (Jalava 2003; Lewis and Weigert 1985), openness, listening, effective communication, confidentiality, caring, a trusting attitude, reliability and technical competence (Gilson et al. 2003: 2; Lewis and Weigert 1985: 971; Molyneux et al. 2005; Pearson and Raecke 2000: 510; Thiede 2005).

The display of trust-inspiring behaviour by health professionals is in turn likely to be closely linked to the way their work is organized. Tandler (1997), in a study amongst community health care workers in Brazil, finds the building of trusting relationships with patients to be directly related to the health workers' work structures allowing them to pursue tasks that demonstrate care, and to the workers receiving appreciation both from their managers and clients.

Continuous care seems ideally placed to build trust, since the 'getting to know each other over time' - which scholars have found to be so important for trust building - is at the core of the idea of continuous care.

Accordingly, most of our interviewees attributed their feeling of trust to having got to know the midwife over time:

Patrick: *'(..) we trust [her] (..) and that's all from building a relationship with her every time. I don't think you can rush something like that. You gain trust from knowing somebody and feeling comfortable with her.'*

Michael: *'it just became more and more underpinned, more stronger, a stronger relationship (..)'*

Meeting each other over a length of time makes a difference partly because one encounter can profit from the trust built at a previous encounter. In this respect infant feeding, being located in the period straight after birth can capitalize on the trust built during birth.

As Hannah, a midwife, puts it: *'I think if they've heard you talking sense about a lot of other things and they've seen you behaving in such a way at their birth and they've trusted you through that, then I think they are more likely to trust the information that you're giving them with regard to breastfeeding as well.'*

As to attributes that inspired trust (in tune with the literature mentioned above) women and their partners mentioned a large

number, including: listening, communicating well, caring, looking out for you, being committed and reliable, having medical experience and expertise, and having a philosophy around childbearing the woman and her partner can relate to.

A large number of respondents mentioned being caring and being technically proficient in the same breath - suggesting that these two are inseparable ingredients for the development of trust.

David: *'Katie [the midwife] was actually a shoulder to cry on, somebody to pinch, somebody to scream at. It was good. And she was there comforting her and, as a matter of fact, she was actually a nurse, a trained nurse, to be looking after and giving her all the comforts and assuring her it was going to be okay. (...) Katie was excellent, excellent.'*

The combination of technical proficiency and caring is in turn exactly what a continuous way of working enables a midwife to develop: Seeing women throughout pregnancy, birth and the postnatal period is likely first, to accelerate one's learning (because of witnessing the results of one's own actions), and therewith increase confidence and technical proficiency; and second, to be more satisfying and to heighten one's sense of responsibility towards individual women and hence trigger a more caring attitude.

Heather, a newly qualified midwife who had started working at the practice less than a year before the interview, talks about the satisfaction and learning experience that continuity has meant for her:

*'I've seen two or three [women] through the whole process and that's been really – well, incredible really, just really satisfying. (...) I've kind of been honoured in many ways to be involved in that process (...) And in terms of just personal kind of development and confidence, that's been really good (...) a learning thing (...) particularly in terms of kind of things like breastfeeding, I'm much more confident about being able to advise women about breastfeeding now (...).'*<sup>11</sup>

Hannah reflects on how having emotionally invested in the relationship can be crucial for a midwife to support a woman and care for her when circumstances are adverse:

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<sup>11</sup> This quote is amalgamated from different parts of the interview.

*'I think, helping someone breastfeed with it's going wrong, it can be incredibly stressful. (..) And I suppose having a long term project with that woman of actually seeing it through and really wanting it to work and having an investment in that, I think must help. I think if you've come in to a situation like that, and you're never going to see her again, and it's a stressful situation, I think the temptation to think, 'Oh God I've had enough of this, here's the bottle!'*

### ***Situation and context of care***

A third group of factors said to influence trust are the situation and context in which the interaction takes place (Gilson et al. 2005).

Here a key theme is the vulnerability of the trustor. The more vulnerable the situation, the greater the need for trust is likely to be (Mechanic and Meyer 2000; Hall et al. 2001). Influences on the degree of vulnerability include the nature of the condition (Molyneux et al. 2005).

At a first glance, continuous care appears to have potential to reduce the building of trust: because the empowering relationship it means to establish is likely to decrease vulnerability.

On the other hand, birth and breastfeeding will always be potentially vulnerable processes, where trust is needed:

Lilly about her labour:

*'I was just totally unprepared for a short labour and that intensive pain from the word go. So I felt completely out of control (..) I just kept getting waves and waves of pain just straight after each other and I just remember groaning and screaming and sort of saying, 'Oh no' – and Marie was going, 'Lilly, say yes'! And, 'Screaming is not going to help, Lilly, now say yes' (..) we had lots of hugs and cuddles during the process and she was sponging my face with a flannel which was lovely. She is fantastic.'*

Laura about breastfeeding:

*'I was in tears on the phone because Elsie had been crying all day, literally all day. And my husband couldn't be here. And that was just, I was so grateful because she [the midwife] came over and she was just with me for an hour, you know. But in that time we managed to feed Elsie, and I think the baby can sense the mother getting more and more anxious and more and more anxious.'*

Also, it can be argued, that it is much more positive to build trust on an accurate basis (i.e. through getting to know each other in continuous care) than solely through vulnerability (more common under discontinuous care) – because the former type of trust will be less likely to be betrayed.

### **Continuity, Trust and Breastfeeding**

Two key mechanisms through which continuity and trust can have a positive influence on the decision how to feed infants emerged from our data: calm and effective communication (see figure 1).

These will be examined in turn; followed by an illustration of the possible impacts of continuity and trust on breastfeeding through the experiences of two women.

#### ***The Pathways: Calm and Effective Communication***

##### ***Calm***

Calm is a key ingredient both for a positive birth experience (ref.) and a positive breastfeeding experience (ref.).

Trust between the women and their partners and the midwives can enable the establishing of this much needed calm for all involved parties. A beautiful characteristic of calm is that it easily self-perpetuates, spreading between people.

*John: 'So throughout the process Marie [the midwife] was communicative and she was explaining what was going on, but also she was very relaxed and on the basis that she was supposed to be doing the worrying - if she was relaxed, then what do I know? So I relaxed.'*

Calm is borne out of each person knowing who they are dealing with, and how the other person is likely to react. For Giddens (1990: 98-9) 'trust is a continuing protective device (..) against anxieties which even the most casual encounter with others can potentially provoke.'

*Michael: 'you know how you can talk to them, how you can expect them to react, you know, and you get to know how experienced they are and what lines of communication they're likely to use to actually communicate with you (..).'*

From a midwives perspective, Hannah contrasts the calm she feels when delivering continuous care with the anxiety she experienced in women's labour under discontinuous care:

*'I remember births on the labour ward where it's just much more complicated in a sense from a practical point of view and a clinical point of view to actually get your head round an entire, a woman's entire history. And what's going on for her at that point in time and what her expectations are, what her cultural background is, all of that – all in one go, is huge and I suppose, in a sense, how can you possibly hope to meet her hopes of giving birth, when there is so much to take in at once. (..) I suppose at this point, I can just imagine what that feels like. And that feels quite daunting.'*

Under continuity, midwives are also spared the anxiety of not knowing what will happen to women after they have seen them.

Hannah: *'I remember this feeling of trying to pack in all this information, to kind of armour them in a sense, against what was going to come and what they meet and who they might meet and how they might be treated. And that was very stressful - because I knew I wouldn't be with them in labour, I wanted to kind of give them everything I could beforehand.'*

For women (and their partners), trusting that the midwives will act as a shield can also bring with it calm in their encounters with the wider health services.

Bella: *'I'm comparing with my previous birth which I had absolutely, I felt that the whole thing had run away with me. I'd felt completely isolated at [the hospital]. So, [this time], by having the (..) midwife with me [in hospital], it just meant that they sort of took control and it just meant they made everything much calmer for me.'*

Calm for women can also be born out of trusting the advice given by the midwife so entirely, that opinions given by other people can simply be ignored; and that no other sources of information have to be sought.

Interviewer: *'Is there anybody else who is giving you advice on breastfeeding (..) ?*

Lilly: *'It's basically Marie [the midwife]. The health visitor has been a couple of times and he's sort of said there's a clinic down in Deptford. And, you know, the doctor's been twice, my GP, to make sure we are*

*breastfeeding and that we are not having any difficulties. But to be honest, I haven't wanted to listen to anybody else. I mean the mums, my mum and John's mum have tried giving advice from when they did it.'*

### **Communication**

Like calm, improved communication with her care provider can make a vast difference to a woman's birth (ref.) and breastfeeding experiences (ref.).

This can be a result both simply of the organizational features of continuous care; and of continuous care via trust.

For women, the structure of having a continuous carer means being much less likely to be faced with conflicting advice.

Asha about having experienced conflicting advice in the past:

*'(..) one midwife said, 'You can lie down and feed' – and that was quite helpful. (..) That was when [my previous child] was born. Then when I was feeding Ivy lying down this time, because I had to go to hospital because I had a tear (..) [another midwife] said, 'You shouldn't do that because it's dangerous'. And I was just like, 'Oh God' – you know they've just got different ways of working. And you just think – 'I'll just do what makes me feel comfortable.'*

For both midwives and women continuity means more effective communication because *'you're always starting from where you left off, rather than having to start at the beginning again'* (Hannah) - not only because of having communicated previously, but also because of having shared experiences.

Katie, a midwife: *'And again, it all comes back to continuity because with breastfeeding, a lot of breastfeeding problems initiate from very soon after birth. So if you've been there and seen the baby has had a normal birth, hasn't had lots of drugs, so won't be very sleepy, or hasn't had a traumatic birth, so won't have problems that might lead to feeding problems, and you've seen the baby breastfeed well after birth, then you can go away feeling confident that actually here everything was normal and here everything was going well. And equally, the other way (..)'<sup>12</sup>*

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<sup>12</sup> For breastfeeding problems being closely related to birth, also see Shealy et al. (2005).

For women not starting from scratch also means not having to repeat potentially hurtful or embarrassing information.

Continuity also means that midwives can pre-empt a communication breakdown and stop women and their babies from falling through the loops.

Katie:

*'And you know the women who are more likely to call, so you know that you can kind of think of them as being more likely to call, and some women you know might be more hesitant, but then you'd call them and say, 'How's it going?'*

As to continuity making a difference to communication via trust: firstly, women will be more likely to reveal sensitive information if they trust their carer.

Laura: *'I think if it was someone different, I would have felt more self conscious and feel maybe that I couldn't be myself and maybe not be quite so honest with the difficulties I was having or, you know (..).'*

A study by Porter and MacIntyre (1989) shows that even with non-sensitive information women often have difficulties finding the courage to speak to their maternity care providers: 50% of women who were interviewed about a consultation they had with an obstetrician said 'they had had questions they wished to ask but were too inhibited to do so.'

Secondly, trust can make communication more effective, in that advice that is trusted is more likely to be acted upon. As Thiede (in press: 5) crudely puts it: '(t)he value of information becomes zero - or even negative - if it is not trusted.'

Asha: *'you've already got a relationship with them, so you trust what they say and they can give you advice and you are more inclined to take it on.'*

### ***Exemplars***

There is a universe of influences on breastfeeding. Yet, our data shows that having a continuous carer has potential to be an important influence on breastfeeding. In particular, it can help to resolve some of the major stumbling blocks to breastfeeding. Amongst our respondents

two key stumbling blocks to breastfeeding were: first, physical or technical problems (e.g. sore nipples or problems with positioning the baby); second, being deeply embedded in a culture (of family, and or peers) of bottle or mixed feeding.

Lilly and Bisi are examples of two women who experienced one or both of these stumbling blocks, but - largely because their midwives were able to give them the continuous care and support they needed - they both persevered to exclusively breastfeed their babies:

Lilly had firm intentions to breastfeed before her first baby was born:

*'I was going to breastfeed, there was absolutely no doubt' 'So that was always my intention.'*

Yet she had sore nipples and severe problems latching her baby on:

*'Every time she goes on, it really hurts. You've just got to grit your teeth for the first minute until she starts sort of settling down a bit. I still can't bear anything rubbing against the edge of my nipples.'*

*'(..) we just had, I spent two hours trying to feed her and she was getting upset and screaming and frantic and really screaming, screaming, which didn't grate on me, but was upsetting me, because she was frustrated and I suppose I was frustrated. And I just thought she must be in pain to be screaming so loudly and she must be hungry because she was so tiny.'*

Marie, her midwife gave her the repeated support and calm she needed to persevere:

*'And I phoned Marie and sort of said, 'Help'. So she came round about half past three and said, 'For now I'll just latch you on so the baby gets a feed because she needs a feed. And then I'll come back this evening and we'll have another sort of lesson and I'll sit and watch what you're doing and treat it as a tutorial if you like of what you're doing and how we need to get that right'. So we did that, that evening. And then since then we've got much better at it.'*

Lilly feels that she can *'now understand why we've gone from 80% of women saying they're going to breastfeed, down to 40% that are actually persevering. We have had to persevere. And Marie's helped that process enormously. If I hadn't had that level of help, I don't know whether we would have managed it.'*

Bisi is from a West African country - in tune with local culture she mixed fed her first four children. However, because she felt firmly supported, and came to totally trust the advice given to her by her midwife, she decided - against the advice of her family - to exclusively breastfeed her new baby for six months:

*'Oh my God, she [the midwife] helps a lot and keep on coming here whenever I call her. Even at night. PM, AM, she always comes. (..).'*

*'Whenever she tell me something, it's worked. Yes, it's worked, instead of going to GP or something else work, yes. (..) Example when I have my [redacted] my breast was [redacted] and started blood and other things, yes. But she told me to take a cotton wool and put the milk there, breast milk, and wipe it, yes. So after that the pain stopped. It was an experience I didn't know from since I had my elder children, I never knew about it. (..)*

*' (..) some of my family are telling me that it's better (..) to try the bottle too. (..) I just tell them, 'No, I just want to breastfeed her up to six months'.*

## **DISCUSSION**

The above analysis illustrates how trust is likely to be one of the key mechanisms through which having a continuous carer can achieve positive health outcomes. Having a continuous carer is ideally placed to trigger trust: first, by giving people the opportunity to overcome prejudices rooted in their personal histories, i.e. it lends time to 'bridge lifeworlds'. Second, by giving the space to help to develop positive psychological traits, such as self-confidence. Third, by enabling the carer and cared for to get to know each other's attitudes and behaviour and hence to get to know what to expect from each other. Fourth, by providing a work structure which facilitates the carer developing a greater sense of responsibility and greater technical expertise and hence confidence - which are in turn trust-inspiring characteristics. Confidence is key, since the building of confidence by both parties is likely to reinforce itself: the more self-trust someone has, the more likely they are going to trust others; and the more self-trust a person has, the more trustworthy they will appear.

The analysis also shows that two of the key pathways through which continuous care and trust are likely to achieve their often shown positive influences on well-being are calm and effective communication.

Considering that (judging from our data) continuous care seems to primarily foster inter-personal trust; and that there is a much voiced broader trend of declining general trust in the health services (Gilson 2003; Hall et al. 2002; Riewpaiboon et al. 2005); yet, that (as found by Hall et al. 2002) inter-personal trust can help to build general trust - it can be argued that the promotion of continuous health care can also be a useful strategy to slowly rebuild a much needed trust in the wider health services.

At the same time it is important to remember, that continuous health care and trust can go wrong. Both the trust and the continuity literatures have flagged the fact that establishing a trusting relationship does not necessarily mean that this is backed by technical competence (Green et al. 1999; Hall et al. 2001: 616).

It is clear that neither continuity nor trust should be assigned a moral value per se. Page (1995: 96) holds that in addition to having a continuous carer, care needs to be 'informative, accessible, respectful, supportive and competent.' Thiede (1995: 6) asserts that '[o]nly if principles of fairness are in place and processes within a social system are ethical, can trust contribute to well-being.'

In the context of the present study - the positive experiences set in motion by the practice under study cannot be solely attributed to the delivery of continuous care. Important ingredients for the practice's success are first the particular type of continuous care delivered (i.e. the building of a firm relationship, in particular with one caring, skilled and confident midwife, throughout the pre-natal, partum and post-partum periods, backed by a second midwife; 24 hours accessibility of midwives; etc.). And second, many other innovative features of the organization of the practice, which are not tied to continuous care: such as an emphasis on home visits and home births, the encouragement of a strengthening of the woman's own social network, the autonomy of individual midwives, embedded in a supportive, democratically organized team.

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Figure 1:

